



Council of
Deans of Health

The voice of UK university
faculties for nursing, midwifery
and the allied health professions

A false economy

**Cuts to Continuing Professional Development funding for nursing,
midwifery and the Allied Health Professions in England**

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1. Executive summary

“We can design innovative new care models, but they simply won’t become a reality unless we have a workforce with the right numbers, skills, values and behaviours to deliver it.”

(Five Year Forward View, NHS 2014: 29-30)

1.1. The purpose of this report

This report focuses on the impact of funding cuts across England to ongoing education and training for nurses, midwives and allied health professionals (AHPs) and the risks this poses to the NHS. With the constant evolution of treatments and technology, as well as rapidly changing roles for many healthcare staff, ongoing education and training is an essential foundation for safe, effective care. Health Education England (HEE), an arm’s length body of the Department of Health (DH), funds a measure of this education through Continued Professional Development (CPD) for the nurses, midwives and AHPs that make up more than 75% of the health professional workforce.

The funding supports the delivery of short courses, modules and programmes that meet the needs of the NHS workforce at national, regional and local levels. For 2016/17 this funding in England has been the subject of deep cuts of up to 45%, often without much warning and with little evidence of strategic planning at national level. Funding for postgraduate medical education has continued to be protected.

1.2. Methodology

The report is based on semi-structured telephone interviews with university deans who lead faculties engaged in CPD for nurses, midwives and allied health professionals. The interviews were conducted in May and June 2016. The research encompassed all of the thirteen Local Education and Training Boards (LETBs) that have been operating in England up until summer 2016.

1.3. Main findings

Although these cuts will adversely affect universities, the most significant impact will be on the NHS workforce and the NHS’s ability to meet its own strategic objectives. Given the profound changes that are expected to nursing, midwifery and AHP roles as demand for services grows and patient needs and service configurations change, this transformation is at risk without investment in education and training. CPD is also equally important for sustaining core NHS services, such as accident and emergency and intensive care, where specialist and advanced practice knowledge and skills are required for staff to be able to deliver safe, up to date care.

There is already evidence that the significant cuts to mentorship budgets are damaging mentorship training for NHS staff, which is central to the current strategy to expand pre-registration programmes in the coming years. The Government's strategic priorities and these funding decisions simply do not add up.

1.4. What to do next

This report proposes five actions at national and local level:

- For Government to recognise the gap between national strategic priorities and funding decisions;
- For DH to convene a national strategic discussion to address the disconnect;
- For DH and its arms' length bodies to strengthen medium and longer-term decision-making at system level;
- For those leading local Sustainability and Transformation Plans (STPs) to make more consistent use of the higher education sector's expertise at local level in supporting development of the existing workforce;
- For LETBs and HEE at national level to communicate change more effectively.

2. Introduction

“HEE will work with employers, employees and commissioners to identify the education and training needs of our current workforce, equipping them with the skills and flexibilities to deliver the new models of care, including the development of transitional roles. This will require a greater investment in training for existing staff, and the active engagement of clinicians and managers who are best placed to know what support they need to deliver new models of care.”

(Five Year Forward View, NHS 2014: 29-30)

2.1. The purpose of this report

This report explores the impact of CPD cuts on the NHS and the higher education sector in England and suggests actions that need to be taken to ensure that the NHS is able to achieve its own strategic objectives and the Government’s policies on nursing, midwifery and AHPs.

More specifically, the report:

- Considers the extent of the CPD cuts in England for 2016/17, broken down by LETB and considers how these are mediated via the different commissioning arrangements used by the LETBs;
- Establishes the likely short term and medium term impact of the cuts in 2016/17, both in terms of on the NHS and its workforce and the impact on the higher education sector (such as redundancies);
- Explores the connection between CPD and pre-registration education programmes and looks at whether the cuts may affect undergraduate education;
- Considers whether these cuts are likely to undermine the NHS in achieving its own strategic objectives and the Government’s policies on nursing, midwifery and AHPs in England.

2.2. Context

Although all health professionals complete a prescribed programme of study (pre-registration education) before they can practise, opportunities for education after they join the workforce vary depending on their profession or the organisation for which they work. Health Education England (HEE), an arm’s length body of the Department of Health, funds a measure of this education, or Continued Professional Development (CPD, also sometimes called Continuing Personal and Professional Development (CPPD)) for nurses, midwives and AHPs via its allocation to its LETBs.

LETBs either provide NHS trusts with an overall CPD budget that the trusts then use to commission universities to deliver education and training, or they spend the funding directly with universities under Learning Beyond Registration (LBR) contracts. The funding supports the delivery of short courses, modules and programmes to meet the rapidly changing needs of the NHS workforce at national, regional and local levels.

These are taught at undergraduate and postgraduate level and cover subjects relating to a wide range of different clinical specialisms and areas of practice such as primary care, chronic disease management and mental health, as well as generic subjects such as leadership and management.

Examples of courses/modules funded through HEE's CPD budget

Diploma Level (Level 5)

Chronic heart failure
Diabetes Care and Management
Management and leadership in the health and social care setting
Leg Ulcer Management

Degree Level (Level 6)

Advanced Renal Nursing Practice
Cervical Screening for Health Care Professionals
Nurse/Midwifery Independent/Supplementary Prescribing
Specialist Neonatal Practice: Work Based Learning
Relationship-centred Dementia Care
Stabilisation and Management of the Special Care Baby
Palliative and End of Life Care for People with Life Threatening Illness

Postgraduate Level (Level 7)

MSc Psychological Therapies
Cancer Pathophysiology and Therapeutics
Care of the Critically Ill Neonate
Palliative and Supportive Care of People with Dementia
Cancer Pathophysiology and Therapeutics
Sonography (PG Cert or Masters level)

Stand Alone Modules

Principles of Assessing People with Learning Disabilities and Mental Health Problems
Management of the Acute Critically Ill Patient
Autonomous Nursing Practice (A&E Minor Injuries)

Bespoke CPD Provision

Customised clinical and non-clinical training

Figure 1: Examples of courses/modules funded through HEE's CPD budget

2.3. The scale of the cuts

For 2016/17 this funding in England has been the subject of deep cuts, often without much warning and with little evidence of strategic planning at national level. These cuts will have a material impact both on universities and on the NHS and its workforce. There is little in the public domain that sets out the extent of the cuts and almost no policy discussion of the potential consequences, either for the NHS or the higher education sector. However, these cuts could undermine the NHS in achieving its own strategic objectives, as set out in the Five Year Forward View (NHS, October 2014) and the General Practice Forward View (NHS, April 2016) because CPD is vital to equip staff with the knowledge, skills and values required by the huge transformation programmes currently taking place in the NHS.

The cuts are also already damaging mentorship preparation for NHS staff in some areas, courses which are crucial to delivering the pre-registration programmes for nursing, midwifery and AHPs that the Government wants to expand in England. Every student spends a substantial part of their course in practice placements, so mentors and practice educators are essential to support students during their practice placements.¹

These reductions in mentorship training for qualified staff put at risk the Government's ambition to increase nursing, midwifery and allied health pre-registration places during the current Parliament due to the possibility that there will be too few mentors available to support practice placements in pre-registration education.

2.4. Methodology

This report is based on findings of qualitative research conducted in May and June 2016 to provide detailed insight into the scale and impact of the cuts to funding for CPD. The research involved semi-structured telephone interviews with university deans who lead faculties engaged in CPD for nurses, midwives and allied health professionals. Their faculties' income from CPD ranged from around £500k to £5.5m in 2015-2016, most of which came from the LETBs either through LBR contracts or via commissions from NHS Trusts.

The faculties varied in terms of the extent to which they employed dedicated CPD teaching staff, used undergraduate teaching staff to deliver their CPD offer and/or employed associate lecturers and consultants. Some receive funding from two or more LETBs. The research encompassed all of the thirteen LETBs that are currently operating in England (these are currently being reduced to four in summer 2016).

The interviews with the university deans lasted approximately 40-45 minutes and involved the use of a topic guide that covered the key research questions. In some cases, issues were clarified through subsequent email exchanges. A small amount of desk research was undertaken to establish the context, however there is little information on HEE's approach to CPD funding in England within the public domain.

¹ Nursing students spend 2300 hours in practice placements over their course; AHP students typically spend around 1000 hours in practice placements.

3. CPD budgets for 2016-2017

3.1. LETB CPD budgets for 2016-2017

The universities indicated that, with the exception of HEE Wessex, where it was reported that CPD funding remains roughly the same as in 2015-2016, the LETBs have announced cuts to their CPD budgets in the 2016-2017 financial year. The cuts have been made because of a decision taken at national level by HEE's board to reduce workforce development funding by 49.1%.² There is no minute of any discussion or of any concerns being raised by HEE board members in relation to the impact of these cuts, in contrast to some of the LETBs.^{3 4}

Although all LETBs face similar reductions to their workforce development allocation, the extent to which this has affected CPD funding for 2016-2017 varies significantly. As Figure 2 shows, the cuts reported by universities range from 12% in the East Midlands to 45% in the North East. Where publicly available, the detailed figures for the LETBs' reduced workforce development allocation (which includes CPD funding) are also given.

LETB	Reported CPD cuts in 2016-2017	Reductions in LETB Workforce Dev funding, 2016-2017
East of England	25-30%	50.3%
East Midlands	12%	41.0%
Kent, Surrey and Sussex	33%	Not available
North Central and East London	25%-30%/40%	Not available
North East	45%	49%
North West	40%	47.8%
North West London	30%	Not available
South London	25%-40%	52.6%
South West	c. the same as last year but up to 50% cuts to mentorship	44.1%
Thames Valley	30%	Not available
Wessex	c. the same as last year.	46.6%
West Midlands	13%	43%
Yorkshire and the Humber	40%	Not available

Figure 2: Cuts to CPD funding by LETBs in England as reported by universities. Figures for the reduced workforce development allocation are from LETBs' board papers, where available (www.hee.nhs.uk).

² Health Education England Board, 15 March 2016, 2016/17: [Budget Setting and Business Plan: Paper 1](#), pp. 4-5.

³ [Minutes of the HEE Board, 15 March 2016](#), p.3.

⁴ West Midlands LETB, for example, challenged proposed reductions to CPD (LBR) funding and cuts were redistributed (see [Draft Minutes of the HEE West Midlands Board Meeting](#), p.9).

3.2. The impact of different commissioning arrangements

The ways in which the cuts will flow through the CPD system varies according to whether the funding is allocated directly to universities via LBR contracts, allocated to universities via competitive tendering or allocated to trusts who then commission from universities.

3.2.1. Funding allocated directly to universities via LBR contracts

Six LETBs allocate funding directly to universities under LBR contracts. In some cases, the cuts experienced by universities with these contracts are in addition to regional HEE offices having 'clawed back' substantial sums of money due to underutilisation of their LBR contracts in the previous financial year. The universities reported that this underutilisation of funding was largely due to NHS trusts not being able to release their staff for CPD and/or a lack of interest amongst NHS staff. It appears that the money that was clawed back by the LETBs has been put into their CPD budgets for 2016-2017. One dean commented:

"We have got an equally [large] problem in getting the trusts to use their money. So although the university has got this money for this year, our biggest challenge is getting the trusts to use it. This has to do with problems regarding releasing staff, motivation, staff's interest in doing things, the motivation of the trusts to say that this is something they want and what their needs are at any given time.

An example would be mentorship. Filling the mentorship places is the devil's own job. When we have got the funding it is then a question of the trusts' willingness to release staff to do it and the staff's motivation to do it as well. As a result, we lose money."

There is also a trend towards LETBs specifying that a proportion of the funds allocated to universities under LBR contracts should be spent on specific types of CPD. For example, it was reported that HEE North West is instructing universities to spend half of the money that is allocated to them in 2016-2017 on modules focussed on non-medical prescribing, mentorship, clinical leadership, clinical examination and primary care. Similarly, HEE Yorkshire and Humber is stipulating that only CPD that meets their strategic priorities will be funded. It is, however, sometimes unclear whether HEE local office priorities are effectively aligned to either national strategies or to the priorities of local providers.

In previous financial years, some universities have had in-year additions to LBR contract value, which has been perpetuated by service requirements. Additional activity has included areas such as sonography, an increase in mentorship training or increases in advanced clinical practice courses. As a result, there has been a fairly predictable uplift in their contract value year on year. However, some LETBs have made it clear that this uplift is likely to be reduced or unavailable in 2016-2017.

3.2.2. Funding allocated to universities via competitive tendering

One LETB, HEE North East, has replaced block LBR contracts with competitive tendering. Last year the LETB invited bids from providers to become a preferred provider on its framework which was advertised nationally. There are seven universities on the framework, which HEE North East will use now as a group of preferred providers. Universities on the framework are:

Northumbria, Teesside, Sunderland, the Open University, Cumbria, Sheffield Hallam, and a consortium of Newcastle University, Northumberland, Tyne and Wear NHS Foundation Trust (one of the largest mental health and disabilities trust in England) and Newcastle Upon Tyne Hospitals NHS Foundation Trust. All funding will now come through the preferred bidder framework. Some other regions have had some competition in the system for some time but it appears that HEE North East is the first to use the preferred provider framework as a form of tendering.

Tendering for work is common in higher education but the HEE arrangements have exposed some problems. A tender was circulated to those on the framework in May 2016. In parallel the amount of CPD that HEE North East is commissioning has been cut by 45%. The tender identifies various themes and activities, some of which are academically accredited, some of which are not, with some operating only in one year, whilst others continue over two or three years. There are only financial details against the tenders for 2016-2017. CPD providers will have one chance to bid for provision beyond 2016-2017 but some of the lists of proposed provision do not have any details in relation to the finances. In effect, CPD providers are being asked to bid for work two years ahead with no proposed budget. As one dean remarked:

“The problem is [that] even if we bid for large volumes, we may gain small volumes and then we will have committed ourselves to low volume delivery with high costs to the university and no surplus (although obviously we could pull out at the point of contract).”

3.2.3. Funding allocated to trusts who then commission from universities

Four LETBs manage their CPD budgets by allocating an amount to each NHS unit, which then commissions according to workforce needs from whichever university they wish. In these cases, trusts elect to spend their allocation of CPD money wherever they choose, although it may be expected that the trusts' identified 'core' education and training will be spent on modules/units of study with universities within the footprint of the local LETBs (sometimes referred to as 'preferred providers'). The remainder of the allocated budget is spent on modules of learning that are not considered 'core' and can be used with any education provider whether inside the footprint of local LETBs or not (sometimes known as 'non-preferred' providers).

This system means there is no guarantee that any trust will purchase anything from a particular institution and universities must wait until the commissioning process is completed before they are able to calculate how much income they will receive from LETB funding. In practice, trusts have tended to prioritise and protect their preferred commissions. However, there is evidence that this is less likely to be the case in the face of significant cuts. A dean from London noted that:

“In London (...) trusts have their preferred university partners with whom they do big business and they will go to others with smaller bits of work or specialist pieces of work. In the past when cuts have been made the trusts have tended to protect their preferred university commissions, but they are telling me that that is going to be quite difficult because the cuts are so swingeing.”

Concerns were also expressed, particularly in one LETB area, of misalignment between the annual training needs analysis carried out at Trust level and the purchasing behaviours at ward

or unit level, which saw managers buying 'more of the same thing' because they were unsure what to commission.

3.3. Timing of the announcements of the cuts

The impact of the 2016–2017 cuts is compounded by their late notification. Although in part this may be explained by the timing of the Comprehensive Spending Review (which was published in November 2015), there appears to have been little strategic planning at national level and poor communication of decisions, with a failure to consider the lead-in times for education provision.

Many universities found out about their funding in late May/early June, forcing them to bear the costs of late notification. While universities had assumed or been told that less money would be available for CPD, they usually did not know how much. This adds to existing complications due to the NHS and university financial year being out of step.

Taken together, this has meant that some universities have had to 'guesstimate' in their budget plan and also undermines university operating systems, such as effective timetabling. This is a challenge in terms of ensuring that resources are available to support programmes scheduled for September 2016. A number of deans commented on the impact of this:

"We are living in a short-term planning cycle, which means that by the time I find out what my CPD commissions are we are well on with accepting applications. So at the moment believe it or not we have got hundreds if not thousands of CPD students who are applying to come and do courses with us in September that may not get funded."

"The challenge that we are having at the moment is that each year the decision on funding and confirmation of the commissions for that contract have got later and later in the year. (...) This year [as of 20th May 2016] we know that there is less money available for CPD but we don't know how much and therefore we are having to guesstimate."

Universities reported widespread poor communication from LETBs in relation to CPD and a lack of awareness in some areas of the legal requirements of the Competition and Markets Authority (CMA) in relation to making offers to students and the information about price and course materials that must be included.

It was clear, however, that some LETB areas had engaged better than others with universities and NHS service providers in order to manage the reductions in a rational way. By contrast, several LETBs no longer have regular CPD meetings with universities and it was reported that in one area all CPD provision for AHPs has been effectively wiped out by the cuts. As one dean observed:

"The short timescale/notice was really disappointing, as was the fact that (the LETB) didn't take advantage of other opportunities where they could have had a more open and transparent discussion with the universities, knowing that they were waiting to hear what the cut was going to be and that it was going to be bigger than envisaged."

4. Impact on the NHS workforce

4.1. Impact on NHS staff and service delivery

Although these cuts impact on universities, the most significant impact is on the NHS workforce and the NHS's ability to meet its own objectives.

Nurses, midwives and AHPs make up around 75% of the NHS clinical workforce. Although policy attention is often focused on the future workforce, most of the health professionals that will be in the workforce in 20 years are already there. Given this, and the profound changes that are expected to nursing, midwifery and AHP roles as demand for services grows and patient needs and service configurations change, CPD is vital. CPD is equally important for sustaining services that are core to the NHS, such as accident and emergency and intensive care, where specialist training is required for staff to be able to deliver the care that patients require.

Some students do already fund their own CPD and interviewees recognised the need to explore expectations on self-funding further. However, if it is simply assumed that all individuals must fund themselves, universities anticipate that the numbers enrolling on these programmes would fall substantially. Universities are concerned that this would have obvious negative implications for workforce development, as well as universities having to withdraw their CPD offer in some areas.

"If it was a 20% cut across an area, different providers might have to pull out of some areas and that could be detrimental to workforce development. I just can't understand why (HEE) are going down this way when there is already such a horrendous situation in the workforce anyway.

If there isn't going to be any development that is a really dangerous place for the workforce to be in. And once you close down an area of expertise in an organisation it is really difficult to build that back up again."

The lack of a genuinely multi-professional approach in allocating funding and the inequity between the resources for different professions was a key theme. Interviewees drew particular attention to the contrast between CPD and career pathways for medical staff and other professions. It was noted that some doctors will not become consultants: some will remain at staff grade, others will become clinical academics or pursue other careers; but these choices are underpinned by a supported education and training pathway. Despite the intention when HEE was created that it would take a multi-professional approach to funding allocations and redirect resources where necessary, this aspiration has not been delivered.

The interviewees also raised specific concerns in relation to London, where CPD is one of the few remaining 'carrots' to attract people into jobs. Since housing in London is so expensive (NHS staff no longer have access to subsidised housing) and there is sometimes little in the way of career progression, in London hospitals CPD is often very attractive for newly qualified nurses and AHPs. Interviewees underlined that cuts to CPD budgets send out a powerful message to

newly qualified staff in particular and create a significant disincentive to take on jobs with organisations that are not going to invest in people's personal and career development. In one university, many final year students now applying for their first post are considering offers from private sector organisations that have emphasised opportunities for career development, fast track promotions and management training.

4.2. Implications for NHS strategies

There was a clear consensus that the cuts to the LETBs' CPD budgets are at odds with the Government's vision, both to transform the workforce and to create more placement capacity to meet the aspiration of expanding student places. The NHS is facing a period of immense change and universities are trying to support the Five Year Forward View and the General Practice Forward View by supporting employers to transform their workforce; at the same time the funding to do this is being cut. There was consensus across all interviews that CPD is central to the transformation programmes currently taking place in NHS in terms of ensuring staff have the skills needed for the new services. Comments included:

"I am on the governing council of three big hospitals and they have all got huge cost improvement programmes and big service transformation programmes to deliver. They are all of them in one way or another dependent on nurses, midwives and allied health professionals and medics doing things differently, working in different ways and in different places...

...I can't see how they can turn that enormous piece of work around without properly funded CPD. I think it will just end up with people retreating to where they are safest and back to "and that's the way we have always done it around here". My fear is that we won't get the change that we all know is necessary... Lots has gone into thinking about what that change needs to look like and the money is being ploughed into the system to support new ways of working but actually if we don't back that up with solid education, it won't succeed."

"You've got the Five Year Forward View, you've got the Shape of Caring Review, and you've got the Strategic and Transformation Plans (STPs) coming through, all of which have big implications for the existing workforce. Yet the finances for that are being cut away. We agree with what is in all those documents but how is it going to be funded? If providers are going to do it themselves, where are the levers to ensure that (NHS) providers, many of whom are in deficit, spend this money? It all just doesn't fit together. The policy agenda is helpful but the cuts are going against that agenda. Where are the incentives in the system going to be to ensure people fund CPD?"

"In order to deliver on tomorrow's agenda, the workforce needs to think differently, they need to work differently and they need the skills they require to work differently. Some skills will be transferable but they are also going to need to have different types of skills and knowledge and understanding in order to work with the vision of the Five Year Forward View and integrated care.

Look at supervision, which is going to be very strong for our qualified workforce as we move forward. They are going to have a very strong supervisory role. So we have got to

have developments for qualified staff because, while pre-registration programmes equip people for lifelong learning, they still need that lifelong learning. We have got to keep that momentum going in order to improve the quality of care. We need to make sure that more people are learning and that the environments in practice are going to be strong learning environments.”

There was agreement that unless there is reasonable investment in transformation of the workforce – into things like community roles, 24/7 services and leadership in the community - the NHS is not going to be able to deliver keeping patients at home or out of hours and community care.

“We are doing a lot of work with our trust partners helping them to modernise their services, to bring them more into the community for example, to bring services out of the hospitals into the community, or into people’s homes.

They are incredibly exciting projects but the educational requirements are huge and they are having to think about training people very differently but if they are pulling that money out it is going to be very difficult to do that and ensure it works well and so the trusts will say they have no choice but to do it themselves. Which doesn’t make sense. Why have trusts designing core courses and delivering them in-house when there are academic institutions that are experts in making that work and evaluating it.”

Universities reported that trusts’ education leads are also concerned about the scale of the cuts and the lack of strategic planning. Some of the Trusts are said to be puzzled by how they can deliver on their change programmes without the resources they need to commission CPD to equip their staff.

“Speaking to our trusts’ education colleagues, they are very concerned about the scale of the cuts because they have got services to transform and new skills to deliver but they are not being given the money to bring that forward.”

Those interviewed recognised the financial pressures on education and training budgets and the need for difficult decisions about how education for the registered workforce will be funded. However, they contrasted the lack of discussion or strategic direction with the difficult decisions announced in the 2015 Comprehensive Spending Review in relation to pre-registration education funding. There was a unanimous call for an urgent strategic discussion involving DH, NHS Improvement and HEE about what their workforce plan is and how it is going to be funded, in order to address the profound disconnect between policy intentions and funding decisions that these cuts reveal.

5. Impact on the HE sector

5.1. General impact on the HE sector

In the regions where LETBs have cut their CPD budgets for 2016-2017, the likely short term and medium term impact of the cuts on the higher education sector vary. In some cases the immediate impact on universities will be relatively minor because they either have comparatively small CPD contracts or have gained new commissions from trusts which balance out the impact of the cuts to their LBR budgets.

However, a number of the institutions with large CPD offers report that the cuts are going to have a substantial impact on their staffing and the scale and scope of their CPD provision. Downsizing also remains a possibility in institutions operating in regions where trusts have yet to complete their commissioning of CPD. All of the institutions that participated in this study indicated that they had been told there were further plans for additional significant cuts to follow in 2017-2018 and beyond that would have a significant impact on their ability to deliver CPD.

The situation is made worse in some cases by the reluctance of some trusts to release staff for CPD. Some institutions are considering the possibility of pulling out of CPD altogether (apart from mentorship courses) and concentrating on pre-registration education and, in one case, focusing more on private and business and enterprise led CPD.

“Yesterday I had a meeting with staff to look at current CPD provision and consider whether we should start pulling it. The chief executives of trusts are telling me that they are not going to release staff even if they (the staff) pay for themselves. So whatever we deliver has got to be something that can be done in their own time but their actual motivation for doing it is going to be limited, I would imagine, because everybody is worried about money and their job security. What is the motivation for staff to actually do CPD?”

5.2. The impact on university staff

Universities left with a significant reduction in their 2016-2017 CPD budgets are looking at a range of measures in relation to their staff. In some cases, shortfalls will be managed by redeploying dedicated CPD staff to work in other areas of the curriculum on other programmes (such as Foundation degrees) and/or leaving vacant posts unfilled or not increasing staffing as they had intended. In other institutions, however, it will include losing CPD staff.

“We have been left with a massive hole in next year’s budget and have had to take action accordingly as a business. The approach that the university want us to use is one of immediate downsizing. This includes losing staff and expertise out of the system because it is not sustainable. We will have to have a voluntary targeted severance deal in this area to downsize the staff. The hole in the budget is too big, we can’t weather it.”

“We will be looking to revisit our staff resource. We don’t have too many people who only work on CPD but we will certainly be looking long and hard at our staffing base. We do have some people of associate lecturer contracts that only contribute to CPD and if there is no uptake in their areas then we will end their contracts.”

Other institutions are currently debating long-term strategies to address the changing CPD funding landscape, which they cannot achieve between now and the start of the next financial year. This includes considering how they might re-profile and shrink their core CPD teams significantly and, in some cases, use expert associate lecturers and consultants on non-substantive and non-tenured arrangements, who can be brought in at certain times of the year.

“We have some dedicated CPD staff but also draw on our prequalifying staff as well. In the future we may have to look at this in a very different way. We might operate with some CPD staff on short-term contracts, and buy in some associate lecturers to deliver on some of the programmes. And we might appoint someone as a fractional [appointment] as they are delivering on a particular module.

(..) We may (also) have to say, we can no longer have a dedicated person delivering on a specific area, it needs to be a team of people who are also delivering in other areas as well. We might have to look at losing people who are purely focussed on CPD.”

5.3. Wider system issues

Universities are used to managing their provision and to taking decisions to increase or downsize as appropriate. However, this is likely to create wider issues for the NHS in the longer term. From a system perspective, once universities start losing CPD staff, some of whom are very experienced and experts in their field, they will not be able to recruit or rebuild expertise quickly should there be a change in direction and the money for CPD were to increase.

Specifically, interviewees reported that whereas there are numerous people that can teach pre-registration, CPD often involves clinical specialisms and so recruitment of teaching staff is much more difficult. It was felt that there is a lack of awareness in the NHS that that is an issue and an unwillingness to consider the medium to longer term consequences.

“We have an ageing workforce in our universities. I can see some people thinking right now that some of their staff will go through voluntary redundancy and it might be difficult to recruit new people who have got both the subject expertise and the required educational competence. It takes a while to bring in people that are new to education and then support them to be module leaders and course leaders and personal tutors. Once you start to let that go it does take a while to bring that back again. That expertise could be eroded and lost quite quickly if we are not careful. The issue is how do we let Government and other people know what the risk is here?”

All nurses and midwives are required by the NMC Code and recently introduced NMC revalidation process to engage in CPD. Several of the deans emphasised that whilst this is the responsibility of the individual, it is important that employers, HEE and universities work together to ensure systems are in place to facilitate this.

5.4. The impact on CPD provision

Having anticipated reductions in funding from the LETBs, some institutions have diversified over the last two years, building up other areas of provision by developing programmes that are not in the health arena directly or are in areas that are not related to their commissioned programmes.

Some universities are reviewing recruitment figures for all of their CPD modules and either reducing or considering the possibility of reducing their CPD portfolios. In one case, a university RAG-rated all of their modules over three years; they rated them as follows: anything below 6 participants was red, anything between 7 and 10 participants was amber, anything with 11 or above participants was green. They have kept some of the modules which run with 6 or less (for example where these are core modules) but have removed 19 modules from their portfolio for 2016-2017.

The process of prioritising according to student volumes may also have longer-term implications for the NHS, particularly for specialist regional units that cannot release staff all at the same time. Previously, universities have run modules sometimes with five or six participants at an increased cost because they know that without this staff would not get access to those modules. It is unclear whether this will be possible in the future.

“We tend to work on a module being viable when we have ten students on it. We do occasionally run modules and particularly specialist modules for high intensity neo-natal units and things. Those are the sorts of modules that would come under scrutiny and any module around that figure of ten would probably be axed.”

Other universities are looking at the viability of their CPD activities that are heavily tailored to specific NHS organisations. For example, one university currently has a list of programmes on offer but works hard with NHS partners to ensure that the development their staff gets is relevant to their environment. If their LETB funding is substantially reduced, the university will not be able to offer this kind of tailored, flexible activity in the future. Another university provides a range of modules that students can pick and mix from according to their specific roles and requirements; however, they can only do that because they have a breadth of a portfolio and this will now be reviewed.

The situation is exacerbated by the fact that some LETBs and trusts are reducing the range of modules and programmes they are willing to fund. This can also create challenges in terms of managing performance indicators within the university.

“There are fewer modules now that trusts state that they will support (in terms of funding staff to participate). In general they may support a module but they will not support an individual to go on an entire programme. So we end up with people who have collected modules, which are seen to be of benefit to the trust but they may not be able to financially progress with the rest of the modules on a programme to enable them to end up with a programme award.

From the university’s perspective, that is quite a challenge because it looks as though we are attracting a whole bunch of people to the programme and we are suffering incredible attrition, which we are not, we are actually feeding the workforce need but it

does need to be contextualised when you are having those conversations in the university. Because if you just look at the figures, it doesn't look good."

Universities are developing a range of strategies to address the fact that some areas of provision could become untenable due to small numbers of students. These include the use of flexible endorsement and, in one case, the introduction of a negotiated learning module, which allows the university to put people interested in different areas in a group so that delivery becomes tenable.

In the future it may be necessary for universities to speak to each other and to try to work together and share data given that they will not have viable cohorts for some courses that trusts need and it will be necessary to ensure that those courses are available.

"There will be some really big decisions by universities over the next three or four months around which courses they just stop running (because the numbers are not big enough) (...) and it may be important for universities to speak to each other – it could be that I haven't got a viable health visiting course but (another university) has, so I could direct my applications to them or vice versa. (...) So, for example, a Trust may need nurse practitioners, so they could make sure that somebody somewhere is running the course.

The alternative is that you could end up with 13 universities (in London), none of which have a viable cohort and you could end up with them pulling the plug on a whole lot of courses that are essential for the service (NHS) to progress. It is essential that universities make sure that whatever the NHS requires is provided somewhere. More collaboration will be needed as the cuts progress and in particular if there are additional cuts next year."

However, universities recognise that this will not be a straightforward matter, as universities tend to operate independently and are competing with each other.

"Generally HEIs are competing with each other. It is difficult to know at the moment how HEIs are all going to behave individually and possibly collectively. I just don't know at the moment. We are sometimes saying one thing publically and doing another thing privately and I think that goes for all institutions."

5.5. The impact on pre-registration provision

The impact of the cuts will be largely confined to universities' CPD activities because those institutions with large CPD portfolios have, to varying degrees, different people involved in delivering their CPD provision than their pre-registration provision.

However, there is one particular area in which cuts to CPD funding could be detrimental to pre-registration provision. Specific, serious concerns were expressed about cuts to the funding that LETBs provide to train qualified people to become clinical mentors. Unless universities start to run mentorship courses at their own cost (which some may do) or individuals were willing to fund themselves (which is unlikely), these cuts will have a ripple effect on pre-registration courses; they will limit the numbers of mentors in the system and the ability of universities to offer clinical placements to undergraduates. This would clearly have implications for the

Government's strategy (HM Treasury 2015) of expanding student places across the current parliament.

"If this cut meant that trusts wouldn't fund (mentorship training) and individuals wouldn't fund it themselves and therefore we are not updating mentors or replenishing those that are ceasing, then we could see a reduction in the number of clinical placements being offered to the undergraduates, which means that we couldn't respond to any supposed demand from undergraduates."

"My biggest concern is mentorship because we usually get a huge contract for that. We have got a contract for that this year (...) but it isn't as much. It is a couple of hundred thousand pound less than we would normally get. (...) That's the one that really worries me. Where is the money going to come from (to support the) infrastructure for our pre-registration programme?"

"They've cut the funding that's put into the system for mentorship in particular. (...) Hasn't anyone sat down and thought through what the implications are for the Government's strategy of getting 10,000 more health professionals through the system in the life of the parliament?"

It was also noted that developing the workforce is a strong component of a partnership working with trusts, and so it would be inconsistent to work with a trust to develop their future workforce and then not have any engagement in CPD. Universities reported that any relationship they have, particularly with their bigger trusts, is usually in the context of the whole workforce and cannot simply be split into pre-registration and post-registration categories. It is likewise important that mentors are competent to deliver contemporary practice and that they are current and credible when they role model and share their knowledge and skills with students.

5.6. The option of new income streams

In order to combat the cuts, universities will have to find new business with NHS Trusts and other providers in the health landscape on a private financial arrangement. Many do this anyway, working with the third sector and with trusts who have additional money and want something different or extra; however, that will not compensate for the cuts.

Universities are now working through the options for different ways of operating, looking beyond their region to national and international markets, increasing the numbers of self-funding students and collaborating with other HEIs. They are also looking at different models, such as masterclasses or workshops which could be unaccredited or could offer a few credits, perhaps working more closely with the training arms of the trusts.

Some universities are looking at converting courses into e-learning and, in some cases, offering flexible payment options so that students can self-fund. However, in most cases this is a longer-term strategy because it will take universities time to get courses converted and into an electronic format. It is also recognised that initially the market is going to be quite small because nurses and midwives generally expect their CPD part paid for or fully paid for (this is less so with AHPs) and it will take time for the culture to change.

Some universities are actively exploring the possibility of securing future funding for CPD through the use of apprenticeships (which are now available through to post-graduate levels) following the introduction of the apprenticeship levy. Trusts need to be enabled to get their apprenticeship levy back (in partnership with universities) because potentially they will have a greater amount of money withdrawn from them by the apprenticeship levy than they would have spent on CPD funding. However, universities are not yet clear how trusts could draw down funding to support CPD as part of apprenticeship programmes, pending further policy announcements in 2016.

6. What to do next

6.1. Recognise the current gap between national strategic priorities and funding decisions

The first step is for Government to acknowledge that national strategic priorities and funding decisions on CPD are at odds with each other. A clear message from universities is that if Government does not recognise and deal with the stark disparity between what is expected of the workforce in the Five Year Forward View (NHS, October 2014) and the General Practice Forward View (NHS April 2016) and decisions about CPD funding, it is highly unlikely that these strategies will be delivered. There is also likely to be a negative impact on the Government's plans to expand pre-registration education for the future workforce.

6.2. Convene a national strategic discussion to address the disconnect

Universities recognise the pressures on NHS funding and the need to find new and creative ways to meet education and training needs. Short-term budget cuts with little or no strategic direction are probably the worst way of addressing difficult questions about funding for education and training. It is essential that changes are planned strategically and from a genuinely multi-professional perspective. If new models involve more students self-funding, this will take time to embed and the NHS could be left with significant skills shortages. As one interviewee dean observed, it is likely that any plans to reduce funding for nurses, midwives and AHPs will be a particular bone of contention given the widening gap between the education and training opportunities for doctors and other health professionals.

To navigate these issues, there is an urgent need for discussion at national level to align strategies and funding. This must involve NHS England and NHS Improvement, as the bodies leading STPs, HEE and should be led by DH, as the system steward. There is no evidence that current national fora, such as the Workforce Advisory Board are effective in convening these discussions and DH should consider reconfiguring advisory structures to ensure that strategy and funding align.

6.3. Strengthen medium and longer-term decision-making at system level

There is a long history of education and training for the existing workforce being a soft financial target; as one dean put it: "a back office investment that doesn't look like it impacts on patient care." Having experienced the disastrous consequences of short-term funding cuts in relation to pre-registration education, there is a responsibility for DH and its arm's length bodies to consider what structures they can put in place that will act as a counterweight to inevitable short term financial pressures.

6.4. Make more consistent use of the HE sector's expertise at local level

At local level, many universities have decades of experience of delivering education and training to the NHS and have seen funding wax and wane. They are already reshaping their offer to ensure that they remain viable and are maximising their flexibility within their business planning to make sure that they maintain roles for their teaching staff. In this context, universities with CPD provision can offer significant expertise at local level, particularly to STPs. Some universities are already engaged but in other areas STPs are yet to involve higher education in discussions on education and training for the NHS workforce.

6.5. Communicate change more effectively

Both universities and the NHS need better communication from HEE, both locally and nationally, about the future of education and training for the existing workforce. In many areas, communication for the 2016-2017 year has been notably poor. Without better communication, it is more likely that universities will reduce their CPD provision to manage the business risk of uncertainty, potentially losing knowledgeable staff who will not be easily replaced should the cuts be reversed.

7. References

HM Treasury (2015). Spending Review and Autumn Statements 2015: Policy Paper.

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NHS (October 2014). Five Year Forward View.

<https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

NHS (April 2016). General Practice Forward View.

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Appendix: Local Education and Training Boards

Health Education England (HEE) defines its purpose as follows: to support the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce has the right numbers, skills, values and behaviours, at the right time and in the right place.

Prior to August 2016, HEE had 13 Local Education and Training Boards (LETBs), responsible for the training and education of NHS staff, both clinical and non-clinical, within their area.

- | | |
|----------------------------------|------------------------------|
| 1. East of England | 8. South London |
| 2. East Midlands | 9. South West |
| 3. Kent, Surrey and Sussex | 10. Thames Valley |
| 4. North Central and East London | 11. Wessex |
| 5. North East | 12. West Midlands |
| 6. North West | 13. Yorkshire and the Humber |
| 7. North West London | |

LETBs have three main functions:

- To identify and agree the local needs for education and training - to deliver the right people and skills to meet future service needs
- To plan and commission high quality education and training in its region in order to secure future workforce supply and improve patient outcomes
- To support national workforce priorities set by HEE

HEE's Board has recently decided to move from thirteen LETBs to four new LETBs based on the four regions: South, London & South East, Midlands and East and North. The new LETBs will carry out the same functions as the previous thirteen boards on a larger footprint. However, the 13 local HEE teams and the funding to these remains unchanged. This is designed to support the aims of the Five Year Forward View and the current development of Sustainability and Transformation Plans (STPs) and the Local Workforce Action Boards (LWABs).

For further information

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