Council of Deans of Health

Twenty years of leadership in education and research

Teaching Excellence and Student Outcomes Framework: Subject-level consultation

Council of Deans of Health written submission – May 2018

The Council of Deans of Health is grateful for the opportunity to contribute to this consultation. The Council represents the 83 UK university faculties engaged in education and research for nursing, midwifery and the allied health professions.

Executive summary

1. The Council supports a Model B 'bottom up' approach for the implementation of subject-level TEF. This will be most useful to students in providing them with information regarding the quality of teaching and student outcomes. Efforts must be made to reduce any burden to both providers and assessors.

2. Healthcare programmes are approved and regulated by professional regulators. Education standards are outcome rather than process based and whilst standards of proficiency on graduation are defined, the exact curriculum in each institution may vary. Therefore, it remains to be seen what effect professional regulation and standardisation has on subject-level TEF for healthcare courses.

3. The Council disagrees with the introduction of a measure of teaching intensity, particularly a gross teaching quotient (GTQ) weighted by qualification or seniority. The proposed metrics will not adequately capture the complexity and range of teaching and learning and will fail to act as sufficient proxies for teaching intensity.

4. The inclusion of LEO data within TEF is strongly opposed by the Council. Using graduate earnings to grade universities will be an imperfect measurement if direct comparisons are made between healthcare courses and programmes whose graduates have more pay flexibility. Whilst this is not the current intention, the inclusion of this data within TEF sets a worrying precedent.

Consultation responses

Q1. To define 'subjects' in subject-level TEF, do you:

a) agree with using level 2 of the Common Aggregation Hierarchy as the classification system (CAH2, with 35 subjects), and if not, what other systems could be used and why?

b) think that specific changes or tweaks need to be made to the definition of the 35 subjects in CAH2, or to the 7 subject groups used in Model B, and if so, please explain why?

The Council is supportive of the use of subject groupings based on CAH2 within subject-level TEF.

However, the 'Nursing' subject should be renamed 'Nursing and midwifery' to better reflect the scope of degree options that this category encompasses and thereby provide better information for students.

The subject 'Health and social care' should be included within the subject grouping 'Medical and health sciences'. It currently sits within the subject grouping 'Social sciences', which includes architecture and politics. This change would better reflect that this subject is more closely aligned with subjects in the health and medical sectors, as well as the trend towards better integration of health and social care in practice.

If Model B were to be adopted and the seven subject groupings used, they would provide adequate differentiation between broadly aligned subjects and still offer students useful information. We welcome the flexibility that providers will have in being able to move one subject out of a subject grouping.

Q2. Do you agree that we should have a longer duration and re-application period in subject-level TEF?

The Council prefers the option of an award duration of 6 years with a minimum reapplication period of 4 years. However, greater flexibility with regards to re-application periods would be welcome as this would increase the utility of the information available to students.

An annual reassessment at provider and subject-level may not be realistic and the viability of this approach should be considered in any changes to the duration and reapplication periods. Regulation should be risk and outcome based and low risk providers should not be subject to repeated regular assessment.

Q3. Should subject-level TEF retain the existing key elements of the provider-level framework (including the 10 TEF criteria, the same suite of metrics, benchmarking, submissions, an independent panel assessment process and the rating system)?

Yes.

Q4. For the design of the subject-level TEF, should the Government adopt:

- A 'by exception' approach (i.e. a form of Model A), or
- A 'bottom up' approach (i.e. a form of Model B), or
- An alternative approach (please specify)?

The Council supports the adoption of Model B for subject-level TEF. This would be of most use to students in providing them with information regarding the quality of teaching and student outcomes. Efforts must be made to reduce the burden to both providers and assessors via this approach.

If Model A were to be introduced, it is essential that providers should be able to submit subject-level written submissions for those subjects viewed as exceptional compared to the initial hypothesis.

Q5. Under Model A, do you agree with the proposed approach for identifying subjects that will be assessed, which would constitute:

a) the initial hypothesis rule for generating exceptions from the metrics?

Yes. It is important that subjects with both very high and very low absolute values be included in the calculation of an initial hypothesis.

b) allowing providers to select a small number of additional subjects?

Yes. Providers should be able to select a small number of additional subjects of their choosing. This will allow greater scrutiny of particular subjects where contextual factors may require a more in-depth review by assessors. This would also add to the holistic approach of subject-level TEF.

Q6. In Model A, should the subject ratings influence the provider rating?

No. Model A is based on a 'by exception' model, which is predicated on provider-level metrics, which are used to create an initial hypothesis. The addition of a feedback loop where subject-level ratings affect the provider-level rating questions the validity of the model. Model B would be a more appropriate approach for subjects to inform provider-level ratings.

Q7. In Model B, do you agree with the method for how the subject ratings inform the provider-level rating?

The Council supports the use of a subject-based initial hypothesis. This will be a transparent process. The effect of individual subject ratings on this hypothesis should be proportionately weighted by student headcount.

However, it is not proportionate to create a bronze initial hypothesis if just 33% of students receive bronze provision. The subject based initial hypothesis should be linked to the initial rating for most students.

Q8. Do you agree that grade inflation should only apply in the provider-level metrics?

If a grade inflation metric were to be introduced, this should not be applied at subject-level as institutional factors may play a role in determining grades at subject-level.

Q9. What are your views on how we are approaching potential differences in the distribution of subject ratings?

As indicated in this consultation's technical document, there will be subjects which cluster around particular data points, either at high or low absolute values. This is a product of the metrics used and the circumstances related to some subjects.

A natural variation in the distribution of values should be employed rather than a forced attempt at a uniform distribution. The same thresholds should be used at both provider and subject-level.

The alternative would be potentially unequitable, especially if there were small sample sizes. It would question the utility of absolute values at provider-level and likely misinform students by creating very low thresholds, which are very high in other subjects and at provider level. Such an unnatural effect would be particularly pronounced for subjects such as nursing.

Healthcare programmes are approved and regulated by professional regulators. Education standards are outcome rather than process based and whilst standards of proficiency on graduation are defined, the exact curriculum in each institution may vary. Therefore, it remains to be seen what effect professional regulation and standardisation has on subject-level TEF for healthcare courses.

Q10. To address the issue of non-reportable metrics:

a) Do you agree with the proposed approach?

b) When assessment occurs, do you prefer that assessors:

- Rely on group metrics alongside any reportable subject-level metrics?
- Rely on provider metrics alongside any reportable subject-level metrics?
- Follow an alternative approach (please specify)?

The Council is concerned by the number of providers who have non-reportable metrics at subject-level. 24 providers do not have core reportable metrics for the subject of nursing. 69 providers do not have this information for subjects allied to medicine. It is crucial for both universities and students that TEF can provide accurate information about teaching quality and outcomes. This is questionable with such high numbers of providers with unreportable core metrics.

We broadly support the proposed approach, particularly the choice given to providers in taking forward subject-level assessment if only 2 metrics are available. It will be more beneficial for students to rely on group rather than provider-level metrics alongside any reportable metrics in this scenario, as there is likely to be greater commonality within a group rather than within a provider.

If a subject has 1 or less data sources available then there will not be enough information to allow a subject-level rating to be created. Therefore, students should be referred to the group-level rating.

The threshold for assessment should be based on the number of metrics available and not the student cohort size.

Q11. Do you:

a) Agree that QAA Subject Benchmark Statements and PSRB accreditation or recognition should remain as a voluntary declaration, and if not, why?

b) Think that there are any subjects where mandatory declaration should apply?

Healthcare education is regulated and approved by professional regulators such as the Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC). Providers are not permitted to offer these courses without that approval. It is therefore not necessary for recognition by regulatory bodies to be mandatory for healthcare subjects within TEF.

QAA subject benchmark statements are not up to date compared to standards provided by professional regulators. For example, the NMC updated its education standards for nursing programmes this year. The QAA subject benchmark statement for nursing has not been updated since 2009 in Scotland and 2001 in the rest of the UK. There is also uncertainty as to whether QAA will continue to provide subject benchmark statements for healthcare subjects. This means that declarations regarding subject benchmark statements should remain voluntary.

Q12. Do you agree with our approach to capturing interdisciplinary provision (in particular, joint and multi-subject combined courses)?

Neither agree nor disagree.

Q13. On balance, are you in favour of introducing a measure of teaching intensity in the TEF, and what might be the positive impacts or unintended consequences of implementing a measure of teaching intensity?

No. We do not believe that the proposed metrics will adequately capture the complexity and range of teaching and learning and will fail to act as sufficient proxies for teaching intensity.

Q14. What forms of contact and learning (e.g. lectures, seminars, work based learning) should and should not be included in a measure of teaching intensity?

If a measurement of teaching intensity were to be introduced, it must consider learning in both university and healthcare practice settings, given that healthcare regulation means this can include up to 50% of learning. Whilst not all practical education takes places outside universities, the full range of healthcare scenarios must be included in any assessment. There should also be flexibility to include hours spent on field visits and online activities.

Q15. What method(s)/option(s) do you think are best to measure teaching intensity? Please state if there are any options that you strongly oppose and suggest any alternative options.

The Council strongly opposes the introduction of a gross teaching quotient (GTQ) weighted by qualification or seniority. This is not a useful proxy for teaching quality and devalues the contributions of early career academics to innovation in teaching and learning.

If a GTQ measurement were to be introduced, there is also a need to ensure that university and healthcare practice settings are treated equally. According to new NMC education standards, to be implemented across the UK by 2020, any registered healthcare professional may be a practice supervisor. In practice settings, registration rather than hierarchy demarcates ability to support education. This will be problematic for any metric based on the seniority of educators.

Any measurement based on contracted teaching hours must also account for practice supervisors. However, this would be intrusive and it may be difficult for providers to acquire this information from practice partners.

For some healthcare courses, such as nursing, there is a regulatory requirement that courses include 4,600 hours. Therefore, it is highly likely that there will be standardisation across these courses as to the number of hours included in a degree programme.

Q16: Do you have any other comments on the design of subject-level TEF that are not captured in your response to the preceding questions in this consultation?

The Council would welcome a robust reflection on the pilots with the learning from these sites and the views of these providers being central to the development of subject-level TEF. We also welcome that an independent review of TEF will take place before the full implementation of subject-level TEF.

The unintended consequences of TEF on institutional architecture are of concern. A focus on seven subject groupings may lead to institutional redesign on this basis, which may be costly to providers.

LEO data

The potential effect of the inclusion of LEO data within TEF is profoundly concerning. There are important caveats to its utility. It is raw and is not indexed to inflation. It does not take account of the composition of each institution's intake, which is likely to influence graduate outcomes. Nor does it consider differing economic realities across the country, such as London weighting. Significantly for professions such as nursing, with a higher number of female graduates, the activity of those who leave the labour market due to care-related responsibilities is excluded from LEO data.

Using graduate earnings to grade universities will be an imperfect measurement if direct comparisons are made between healthcare courses and programmes whose graduates have more pay flexibility. Healthcare pay structures are often set centrally by Government and courses should not be disadvantaged on this basis, especially as healthcare graduates undertake critical roles in our economy and society. It is positive that this is not the current intention. However, the inclusion of this data within TEF is a worrying precedent.

For more information contact:

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