Council of Deans of Health

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

Health Education England – Strategic Framework Call for Evidence 2021

Council of Deans of Health written submission – August 2021

The Council of Deans of Health is grateful for the opportunity to contribute to this consultation. The Council represents the 100 UK university faculties engaged in education and research for nursing, midwifery and the allied health professions.

Drivers of Change

Driver of change 1: Demographics and Disease

Workforce Demographics

There is a need to improve recruitment strategies, but also retention rates in the registered population so that we have the clinical education workforce to educate and supervise the students of the future. Retention of registered professionals is as important as recruitment. We need to develop new career pathways in different practice settings and expand opportunities for the development of clinical academic careers. There is a need to develop more interdisciplinary practice education and ensure we have the right skills mix in different settings to open up high quality practice placements to as many students as possible. This will better ensure the sustainability of the workforce.

Expansion of healthcare programmes and student numbers on the intended scale over the course of the next 15 years requires expansion of healthcare staff in teaching roles. The Council of Deans of Health's 2019 academic staffing census[1] identified challenges for universities in recruiting teaching staff and an aging academic workforce in healthcare subjects.[2] We would like to see new funding and support for clinical staff interested in joint appointments or secondments to HEIs. A more flexible approach to academic staffing and funding, including a different approach to NHS pensions, would support education delivery and academic workload challenges.

Driver of change 3: Socio-Economic and Environmental Factors

Public Funding

Healthcare education is resource intensive and costly, and it must be adequately funded to meet the high costs involved. There is a need for multi-year funding settlements from Government to ensure the healthcare system and partners in education can plan effectively for the future. We must sustain

[1] Council of Deans of Health, 2020, The academic workforce in health faculties – Analysis of the Council's academic staffing census 2019

[2] Ibid.

investment in placement capacity and innovation and fund initiatives to increase placement opportunities outside the NHS.

In order to grow the future workforce, healthcare higher education needs capital investment for additional buildings, facilities, and equipment to manage the current and expected student growth. We need innovation and investment in infrastructure to enhance digital innovation and remote delivery. Simulation will be needed to modernise the learning experience and produce staff equipped for the future NHS.

Healthcare education growth is constrained by premises, facilities, equipment, and staffing. It is difficult for universities to borrow money to invest. This is likely to become harder across the next 15 years. Universities also have to manage competing priorities for investment. Capital investment through dedicated Government grants should include funding to support:

- Digital infrastructure to include development of digital content with a view to increasing teaching capacity in universities and clinical placements, supporting blended learning to deliver education to students in remote and rural locations, and using innovation to prepare graduates able to work with cutting edge technology. We should be making sustained investment in digital innovation and infrastructure, simulation, artificial intelligence, virtual reality, and robotics.

- Additional buildings, facilities, and equipment to include new buildings and the repurposing of existing estate to create new clinical skills laboratories to increase space for simulation and accommodating additional students. All universities providing healthcare education in England require capital investment of at least £4m/university between 21/22 and 23/24 to support the growth of these programmes. Some may require significantly more to build new facilities or establish provision in new geographies. We recommend directing infrastructure funding equitably rather than competitively.

In 2017, the Higher Education Funding Council for England (HEFCE), the forerunner to the Office for Students (OfS), commissioned KPMG to undertake a costing study of pre-registration nursing, midwifery and allied health education. This found that the mean unit cost of healthcare education to be £9,669 per annum per student. The mean unit cost of nursing education across all four fields of nursing (adult, child, mental health and learning disability nursing) was £9,259 per annum per student. For allied health programmes, the mean unit cost can be significantly higher. For example, the mean unit cost for therapeutic radiography is £11,341 and for diagnostic radiography it is £11,309.[3]
Considering the Augar Review[4] there is uncertainty in the higher education sector around the future of tuition fees. Any decision to lower tuition fees without a commensurate increase in public subsidies for high-cost courses would be disastrous. A reduction in tuition fee income for HEIs could make certain healthcare programmes operate at a loss of thousands of pounds per student making many programmes

[3] HEFCE, 2017, Costing study of pre-registration nursing, midwifery and allied health disciplines, p5
[4] https://www.gov.uk/government/publications/post-18-review-of-education-and-funding-independent-panel-report

unviable to run. This could potentially lead to significant supply gaps as programmes close, particularly for certain high-cost allied health professions.

The OfS high-cost subject subsidy must be protected and regularly reviewed to ensure it meets the costs of education. Increased recurrent funding will be required for student maintenance grants and bursaries, the placement tariff and teaching grant.

Health Inequalities

The experiences of the pandemic highlighted in stark terms the impact of inequalities on the health of individuals and communities. The connection between inequalities and poor health was evidenced in the Marmot Review in 2010[5] and reiterated in 2020.[6] Regarding Covid-19, it was clear even at the start of the pandemic that those with existing inequalities, including with poor health and living in deprivation, were most at risk.[7] We must ensure that we develop a workforce that is able to meet the needs of different communities across England. In recent years there has been a focus on inclusion health and other strategies to better meet the needs of those experiencing structural inequalities. These efforts must be redoubled post-pandemic.

Driver of change 4: Staff and Student Expectations

Working life expectations

Different individuals and generations have different expectations about work-life balance. HEIs work with placement providers to tailor placement opportunities to individual requirements as best as possible. The health service will need to continue work to consider flexible careers and development of new career pathways, including in new technologies and digital innovation, informatics, AI, robotics, and genomics. Crucially any new career framework must speak to extensive opportunities in healthcare education and clinical academic careers.

Workforce pandemic recovery

The experience of Covid has shown that as a system we can rapidly evolve services for the benefit of patients. This is a key lesson for the future. Going forward we will also need to focus efforts on ensuring that we have a sustainable ICU nursing workforce and ensure that as we develop rehabilitation services in response to long Covid. Students across a range of disciplines must be trained in these settings to ensure the workforce pipeline.

The pandemic also re-emphasised the critical importance of the public health workforce for wider healthcare. Going forward, this workforce should be better integrated with other parts of the system. We

[5] https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf
[6] https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on
[7] https://www.health.org.uk/publications/long-reads/will-covid-19-be-a-watershed-moment-for-health-inequalities

must look to develop more placement opportunities in these settings to provide healthcare students diverse learning experiences, so they consider future careers in the public health and community workforce. Similarly, the critical importance of interdisciplinary teams and professionals working at the top of their license was emphasised. Enabling greater interdisciplinary working is also key to pandemic recovery.

Training Expectations

Students are the workforce of the future. Their needs and expectations must be central to workforce strategy. Students need to be able to continue to access high quality placements close to home in a range of practice settings to meet professional standards, graduate and join the relevant professional register. These placement opportunities must include opportunities to experience placement settings across primary, community, secondary, acute, and social care to enable students to consider where they want to work in the future.

We must sustain investment in placement capacity and innovation and fund initiatives to increase placement opportunities outside the NHS including private healthcare, the third sector, social care, research and teaching and international exchange. New and innovative virtual approaches to achieving practice outcomes must also be considered due to the opportunities provided by simulation and blended learning.

EDI

The NHS must be a service whose staff reflect the communities that it serves. CoDH is committed to working with partners to ensure widening access and participation to healthcare education for communities who are underrepresented in healthcare employment across the protected characteristics. We must also learn the lessons of the impact of the pandemic on different communities, including people from BAME backgrounds.[8]

Widening Participation

Universities have a proud record of widening access and participation into healthcare careers. They are rooted in their local and regional areas and focused on improving health outcomes and driving up economic and social wellbeing, through providing programmes to meet the skills gap in local areas. Higher education is aspirational and central to social mobility and the levelling up agenda.

New qualifications at Level 3 in England must ensure the ability to progress into healthcare higher education, including both university-based programmes and higher-level apprenticeships. Programme outcomes should enable student choice and be aligned closely with entrance requirements. The Government must ensure that there is sufficient provision at level 3 to meet the needs of all learners and

[8] https://committees.parliament.uk/publications/3965/documents/39887/default/

that no decision about future provision restricts access to higher level education or has a negative impact on widening access and participation.

We are committed to ensuring smooth articulation between secondary and further education and higher education and are part of discussions about building the contribution of colleges to healthcare education. Universities are working with colleges to ensure that healthcare T levels and new higher technical qualifications (HTQs) are rolled out successfully. Placement capacity for pre-registration programmes must take priority over placements for T levels and HTQs, whilst capacity is constrained.

Driver of change 5: Science, Digital, Data and Technology

The last 15 years have witnessed extensive developments in digital innovation and the use of new technologies. The next 15 years are likely to be as, if not more, transformative. The implications for healthcare are profiled in the Topol Review.[9] The digital and technological consequences of the pandemic are likely to have accelerated such changes. For example, at the height of the pandemic healthcare professionals were 'treating half of patients in outpatients and primary care online.'[10]

Importantly, HEE must develop a plan to implement the innovation heralded in the Topol Review. This will require significant investment in digital infrastructure and training for existing staff. However, this will become increasingly necessary as new roles develop and existing staff will need to be reskilled considering new ways of working and new equipment and infrastructure.

Blended Learning

Advancements in online and distance teaching technologies have made possible the greater use of blended learning in deliberately designed curricula. While certain aspects of training will not be possible outside of in person education, workforce planning should consider the expansion of blended learning programmes. These programmes speak to different student needs, including those who want to learn at times that better suit existing commitments. Digitally enhanced and virtual placements will be needed to meet the requirements of these learners as well as flexible access to traditional placement opportunities.

In recent years HEE has developed a Blended Learning Programme, which has led to the development of blended learning nursing programmes at 7 English HEIs.[11] Plans to roll this out across other disciplines, including midwifery are in progress. CoDH has also been involved in an advisory group to guide the future implementation of this programme. We await publication of final HEE guidance. Furthermore, we welcome that the Nursing and Midwifery Council (NMC) has approved these programmes. Regulatory flexibility will be needed as digital innovation and changing pedagogy meet to provide new and high-quality options for learners to meet professional standards.

Simulation

[9] Health Education England, 2019, The Topol Review
[10] https://www.gov.uk/government/speeches/the-future-of-healthcare
[11] https://www.hee.nhs.uk/our-work/blended-learning

Simulation is key to education and training to become a healthcare professional. Digital innovation has provided new opportunities for the advancement of simulation, which is likely to continue to develop over the next 15 years. This has been accelerated by the pandemic, which forced educators to develop more simulated placements. HEIs have been quick to innovate and adopt new technologies and pedagogies. Many institutions have begun using virtual reality, augmented reality, and other new digital simulation technologies. This will continue to expand across the sector.

The NMC has already introduced recovery standards to allow an additional 300 hours of simulated practice in the 4.600 hours of education required to qualify as a registered nurse. This should be made permanent and extended to midwifery.

Demand and Supply Gaps Over the Next 15 years

Please provide details of where you feel the greatest workforce demand and supply gaps will be over the next 15 years. Where possible please be precise with regards to workforce groups/professions, services/pathways and place (geographic area), as well as timescales.

The healthcare higher education sector stands ready to continue working with partners across health and social care both nationally and locally to meet the workforce challenge. Demand on healthcare services is increasing due to the impact of the pandemic and the subsequent backlog in waiting lists. This will take some time to manage. However, demand will almost certainly be higher in 2036 than in 2021. Making sure we have the right numbers in the workforce with the right skills will therefore continue to be essential. Universities are central to meeting this challenge.

Profession Based Supply Gaps

Across the healthcare professions significant demand and supply gaps are likely to remain over the next 15 years as the result of a combination of changing demands on the healthcare system and historical and ongoing supply constraints in the training of new professionals. In particular, there are continuing issues around access to practice placements, with certain regions experiencing severe capacity constraints. Not all professions face equivalent gaps with certain disciplines requiring particular attention to reduce workforce gaps.

Learning Disability Nursing

As the smallest of the four branches of nursing, learning disability (LD) nursing has a smaller number of HEIs that provide this course and practice educators to lead clinical education. With around 25 undergraduate providers, many regions in England have few or just one provider. This makes it difficult to respond to national and regional workforce demands. This situation has worsened in recent years as certain providers have not run LD cohorts in some circumstances.

There are ongoing recruitment issues within LD nursing as providers often seek to fill spaces through clearing, in contrast to other nursing branches which often close before clearing. This has the potential to threaten the viability of existing LD nursing provision with the potential to increase the existing healthcare inequalities that exist for individuals with learning disabilities over the next 15 years.

HEE must accelerate work with partners to look at incentives to ensure that LD nursing remains attractive to students. This includes reviewing if the specialist subject payment (SSP) part of the training grant for this discipline has enough of a pull factor for applicants. Work is needed to ensure that we have enough practice educators in service to facilitate the education of the next generation. This should include consideration of a relaxation of the NMC's standards of student supervision and assessment (SSSA) for a period so practice assessors could come from outside the LD nursing field. This should be with the goal of growing the LD nursing workforce and should be possible considering the Future Nurse standards of proficiency are the same across all nursing fields.

Vulnerable AHP Professions

Some allied health professions continue to be vulnerable considering small workforce numbers. As a result of the vulnerability of the therapeutic radiography, podiatry, orthoptics, and prosthetics and orthotics professions, the OfS funded the Strategic Interventions in Health Education Disciplines (SIHED) programme. The SIHED programme has now reached its legacy phase, which continues to promote the professions and share information produced as part of the programme. This work is led by CoDH. While these professions have seen increases in student numbers in recent years this has happened in the wider context of increasing application rates across most healthcare programmes. Accordingly, these professions are likely to continue to experience workforce gaps.

Further demand interventions may be required by profession, geography or demographic group. For example, to meet the specific needs of the NHS Long Term Plan and to ensure the sustainability of vulnerable allied health programmes such as orthoptics, podiatry, prosthetics and orthotics, and radiography.

Placements

Healthcare programmes are holistic and are constituted of both theory and practice components. Placement capacity has been recognised as a constraint to sector growth for some time. We have welcomed new funding by NHS England and HEE over recent years. We must sustain investment in placement capacity and innovation and fund initiatives to increase placement opportunities outside the NHS including private healthcare, the third sector, social care, research and teaching and international exchange. New and innovative virtual approaches to achieving practice outcomes will require regulatory support to manage the growth in the workforce. The non-medical placement tariff must be increased to meet the costs of delivery and to encourage clinical settings to develop more placements across the healthcare professions.

Existing nursing and midwifery standards stipulate that 50% of minimum education hours must be spent in practice education. As a result, the availability of placements represents a significant limiting factor on the potential number of students undertaking training at any given time. Several mechanisms exist to fund placements including the non-medical placement tariff and clinical placement expansion programme (CPEP). While these seek to standardise funding rates across England and expand the overall number of placements in the system, placements remain a consistent issue. This may be attributable to significant existing inequalities between medical and non-medical tariff rates and lack of a long-term plan for CPEP

funding. CPEP provision for this year was decided late in the academic year and came unexpectedly. This shortened the long lead in time that systems need to increase placement provision. Suggestions that CPEP funding will end this year further increases uncertainty about the sustainability of increases to placement numbers.

Funding

Healthcare education is resource intensive and costly. Healthcare education must be adequately funded to meet the high costs involved. The sector needs capital investment for additional buildings, facilities, and equipment to manage the current and expected student growth. We need innovation and investment in infrastructure to enhance digital innovation and remote delivery.

The period since the Covid-19 pandemic began has seen an increase in innovation already underway within healthcare education. Part of this is the increased use of simulation, which was made necessary due to reduced in-person education opportunities. This use of simulation was supported by the £15m in funding provided by HEE to make investments in simulation equipment, staffing, and facilities. This investment has been vital in allowing HEIs to quickly modify their programmes and make use of the NMC's recovery standards (RN5 and RN5.1) to increase simulation in nursing education.

Without continued investment in this area however the potential for workforce gaps could emerge. As simulation technologies become more prevalent student expectations around their use in healthcare education will increase, creating disincentives to join programmes that are not seen to enable access to contemporary infrastructure. Given the rapid development of these technologies, investments in current technology will seem outdated in 15 years, necessitating continual investment.

The non-medical placement tariff must be increased to meet the costs of delivery and to encourage clinical settings to develop more placements across the healthcare professions.

Regarding student finance, we need to ensure that students are adequately funded whilst undertaking education. This includes via general student finance support and specific support for healthcare students. The introduction of the £5,000 training grant via the NHS Learning Support Fund has coincided with a significant increase in the number of students applying for and starting in healthcare courses. The funding has signalled a commitment by the Government to invest in the long-term healthcare workforce and to support its sustainable expansion. The continuation of this grant is essential in ensuring that demand for healthcare education remains high. Expansion of the training grant's eligibility to include nursing associates and international students would be beneficial to workforce expansion.

Staffing

Ageing Workforce

Ensuring that we have sufficient numbers in the healthcare academic workforce will also be key to ensuring workforce sustainability. The Council's own report on the academic workforce in healthcare faculties showed a number of concerning issues. In England 36% of the academic staff are over the age of 50 and 9% are over the age of 60. This suggests that the academic workforce skews significantly older

than the healthcare workforce as a whole. It also suggests that within the next 15 years almost half of the academic staff will be at or nearing retirement age with many to have likely already retired. Without significant renewal in the academic healthcare workforce not enough staff will be left to keep up with the number of students.

Recruitment

The sustainability of the academic healthcare workforce is threatened by recruitment challenges. This results from a combination of factors including increasing disparities between pay in the NHS and pay in healthcare education, competition between HEIs for a limited applicant pool, and mismatches between job requirements and applicant skills.

Retention

Given existing constraints on staffing it is increasingly important to ensure that the existing academic faculty are retained. While retirement is the top reason for leaving positions, competition from the public and private sector plays a role, with lecturer level positions experiencing the most retention difficulty. The Covid-19 pandemic has impacted on the workforce as well. Staff have had to adapt learning environments, work increasing hours, respond to public criticism, and sometimes move to working in clinical settings full time. These factors combined have potential long-term consequences for the morale of staff.

Pedagogical Evolution and Innovation

Apprenticeships

Universities work in close collaboration with local employers to develop and deliver healthcare apprenticeships and widen access to healthcare careers. Apprenticeships provide another route into healthcare careers for learners. We welcome the Institute for Apprenticeships and Technical Education's (IfATE) flexible approach during the pandemic, including the integration of end point assessments (EPAs) in programmes.

However, apprenticeship programmes do take longer to complete than university-based programmes, so they cannot expand the workforce at pace and scale in comparison to traditional courses. Furthermore, they are very costly for employers, considering the cost of backfill and contracting.

Current funding arrangements do not cover the full costs of apprenticeship delivery for providers. Apprenticeship funding bands must be expanded to meet the full costs of education. A number of costs currently ineligible should be reclassified as eligible costs to ensure the financial viability of healthcare professional apprenticeships for both providers and employers. The list of eligible costs should be expanded to include capital equipment and facilities, including clinical skills and simulation labs, digital learning platforms, and libraries. The development and refresh of teaching and learning materials; information, advice, and guidance delivery to apprentices; and recognition of prior learning mapping should also be classified as eligible costs.

These costs make provision more expensive for healthcare programmes and are essential for apprentices undertaking healthcare apprenticeships leading to professional registration. Any removal of currently eligible costs from the apprenticeship funding band or wider reduction in funding bands will have a detrimental impact on the ability of educators and employers to deliver healthcare apprenticeships. Ultimately this could result in programme withdrawal, particularly for smaller and more vulnerable allied health professional apprenticeship programmes.

Postgraduate routes

Postgraduate entry to pre-registration nursing and allied health programmes is part of the strategy for sector growth. Increased use of this route will be helpful in reducing the gap between supply and demand going forward. Postgraduate pre-registration students should receive more support for maintenance costs and Government should pay their tuition fees upfront, which we believe would substantially boost recruitment, particularly if we also promote this lesser-known route.

Research

Clinical Academic Posts

Clinical academics operate across the university and healthcare landscape. These individuals are vital to improving healthcare outcomes by producing world class research that leads to evidence-based practice. Despite this only 0.1% of the nursing, midwifery and AHP workforce are clinical academics. It is therefore essential that the number of clinical academic posts amongst these professions is increased to advance evidence-informed practice and innovation in healthcare.

Research demand and supply

The future of safe, effective, and innovative practice depends upon a professional workforce that is research confident. Research capacity building is required at all career levels to ensure that we have a healthcare workforce that is evidence informed. Clear career pathways and an inclusive way of engaging in research is needed, as well as protected research times in contracts, recognition of accrued benefits from other positions, and support through mentorships schemes and masterclass programmes.

There is inequity of investment in research across England with opportunities for nurses, midwives and AHPs to engage in research varying depending on their locality or region. A wider range of funding bodies should also make their grants accessible to a wider range of health and social care researchers. Complementary to this would be a targeted approach to building capacity amongst certain professions that have lower research bases such as paramedic science.

Please provide any web links to supporting evidence below. Additionally, please do send information such as documents via email to strategicframework@hee.nhs.uk

N/A.

In 15 years' time, what one key thing do you hope to be able to say the health and social care system has achieved for its workforce, including students and trainees?

CoDH supports HEE's ambition 'to support the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place.'

The Council's strategic priorities for influencing over the next five years include: sector sustainability, agile regulation, research capacity, diversity and inclusion, and pedagogy and innovation. We suggest that HEE should also focus on these areas to deliver its overarching objective.

CPD and Advanced Practice Opportunities

Continuing professional development (CPD) amongst registered professionals takes many forms and often involves provision delivered by universities. This additional training is already helping to fill existing skill gaps in the healthcare system and can help individuals to progress in their careers. Over the next 15 years it is vital that these routes are expanded and made available to wider groups. Advanced practice programmes similarly represent a significant step in additional training but have not always been available to all who wish to undertake them. Within the next 15 years funding for registrants to access CPD and advanced practice options should be expanded.

Research Supported

The value of research undertaken by nurses, midwives, and allied health professionals has finally begun to be recognised. However, within the next 15 years genuine support for research amongst the workforce can be achieved. Significant gaps including improving clinical academic pathways and the inequity of funding opportunities need to be addressed to ensure healthcare research and researchers are better supported.

Further Comments

Please provide any further comments in the space below. Please use this space to add information on factors you felt unable to add under the six drivers of change categories including suggesting a new category the factor(s) would sit within if applicable.

The Health and Care Bill which is currently progressing through Parliament considers strategic workforce planning. It legislates to put Integrated Care Systems (ICSs) on a statutory setting and abolishes Local Education and Training Boards (LETBs). Universities are committed to working in partnership with their local communities to deliver on the healthcare workforce needs of their communities. Alongside continued working with regional HEE, they must be involved in Integrated Care Systems (ICSs) to ensure effective and sustainable workforce planning.

For more information contact:

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