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| 26 April 2019  Lee McDonough  Director General, Acute Care and Workforce  Department of Health and Social Care  39 Victoria Street  London  SW1H 0EU |  |  |
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Dear Lee

**UK Healthcare Education Advisory Committee update**

The UK Healthcare Education Advisory Committee (UKHEAC) met on 19 March 2019. This letter summarises key items of discussion and feedback arising from that meeting for the benefit of system leaders in healthcare education. A similar letter is being sent to appropriate policy bodies in each of the UK nations.

The Committee discussed recruitment across the UK and reviewed data which showed trends in recruitment to pre-registration nursing, midwifery and allied health disciplines over the last few years. (Annex A shows recent trend data for recruitment to these subjects in England). The Committee remains extremely concerned that strategies that could mitigate the risks to the intention of increasing the number of nurses, midwives and allied health professional have not been implemented and there are concerns that recruitment still needs more support and intervention in England, particularly for challenging to recruit professions (including nursing and in vulnerable allied health professions such as podiatry and therapeutic radiography).

The Committee suggested that there may be cross-national learning opportunities that could help inform each nation’s approach to recruitment (for example from 2015-16 to 2017-18 there were increases to mental health nursing from Scottish and Welsh domiciled students). It was suggested that consideration needs to be given to targeting demographic groups (such as mature students) when addressing recruitment concerns, but the Committee also noted the importance of treating all students equally. It also recognised the value and opportunity afforded through using school-leaving age students to help grow recruitment, as this will represent the majority of entrants to the NHS and these students will offer a long career on graduation. The Committee reiterated the importance of pre-registration undergraduate training as the main route to workforce supply, and noted the risks posed to successful recruitment through this route from an over-emphasis on new routes in policy development. For those health professions where strong growth in the number of individuals in training has been achieved such as physiotherapy, children’s nursing and paramedics; the Committee advised that there could be learning as to the factors that drive high demand for these courses to understand how demand for highly qualified individuals in other programmes might be generated.

The NHS long term plan for England was discussed at the UKHEAC, with particular regard to cross-system impacts and likely challenges in developing the workforce implementation plan. The Committee indicated that care should be taken against putting too much emphasis on initiatives that do not recognise the long term trajectories of the workforce, with members recommending that the most important issues relating to capacity and resources should be prioritised. The Committee also recommended that there should be more cross-UK discussion to form a consensus on the required balance between generalists and specialists in the UK health workforce, thereby ensuring complementary education systems accross the UK nations.

Additionally members suggested that there needs to be more discussion on technology use and digital advances in healthcare, to ensure that the recommendations in the workforce implementation plan are well-adapted for the future in terms of use and awareness. The Committee also recommended that the workforce implementation plan needs to recognise the close relationship between the health higher education systems and in particular should have more detail on the role and involvement of academic staff. There was a concern that health workforce planning and academic planning could otherwise be divergent in terms of goals and delivery. This is especially important at the current time when the higher education system in England is facing significant change with the impending publication of the Augar Review of tertiary education funding, with potential associated impacts on other countries of the UK.

The Committee discussed the arrangements for university outcome agreements introduced by the Scottish Funding Council (SFC) in 2012-13. These agreements are intended to align university contributions to the Scottish Government priorities of: high quality learning and teaching, widening access, world-leading research, and innovation. The agreements are intended to encourage Scottish universities to demonstrate their distinct contributions against the public investment toward sector level impacts while complementing and support their institutional strategy. Specific targets have been set for health provision in Scotland, including:

* + Encouraging more young doctors to enter GP and other shortage specialties by seeking to increase the percentage of teaching that takes place in general practice to at least 25% of the clinical curriculum, and providing evidence that all students are regularly taught by GPs (e.g. clinical skills teaching or leading seminars) from the beginning of first year
  + To increase the retention and completion rates in nursing and midwifery: aiming for a percentage point increase on retention and completion of nursing students
  + To improve the gender balance across all fields of nursing: aiming for 1% annual increase of men entering nursing studies across all nursing programmes.

The UKHEAC discussed the different approaches being taken by each of the UK nations to ensure delivery of key health education objectives with a view to understanding and learning from each nation and identifying and sharing good practice, and the transferability of the Scottish approach. Caution was advised around the use of targets in general, particularly noting that any regulatory approach should recognise the nuances and differences between different providers and hold them to account accordingly. Members also highlighted the risks for unintended consequences when utilising targets and suggested clear articulation of aims, with built in flexibility to take different approaches to delivery, would help mitigate against this. Finally members noted that tackling any deep seated issues (such as widening access and participation) will need engagement across a range of organisations and levels, as many issues are not solely under HE provider control.

The UKHEAC considered and discussed the findings from a recent OfS investigation into healthcare apprenticeships in England (see Annex B). The Committee recommended that the approach to the end point assessment for apprenticeships leading to professional registration should be reconsidered or removed as other regulatory process that are in place to assure that required standards have been met should be sufficiently robust. There was concern expressed for the sustainability of the funding approach to clinical practice placements and members also noted some tensions between NHS Trusts and HE providers over perceptions on suitable student activity while on placements. It was suggested that the NHS long term plan could articulate more clearly the expectations and targets for students on apprenticeships.

I trust that you find the above points useful in ongoing discussions and that due consideration is given to the issues raised. We will share any response to this letter with our members at the next UKHEAC meeting in June 2019. In the meantime, if it is helpful to meet to discuss this letter and the next steps in the delivery of the workforce elements of the Long Term Plan, please do let me know.

Yours sincerely



Professor Dame Jessica Corner

Chair of UKHEAC

cc Matthew Toombs, Department for Education

Nicola Dandridge, Chief Executive, OfS

Gavin Larner, Department of Health

David Sweeney, Executive Chair, Research England

**Annex A**

English recruitment in NMAH from 2016-17 to 2018-19 from HESES and HEIFES data

The data shown below is from the HESES/HEIFES18 survey data and equivalent tables in previous years. The data is limited to students studying on both full-time and part-time (unless otherwise specified) undergraduate courses only. The percentage changes are compared to the number of starters in academic year 2016-17 (as opposed to a year on year percentage change).



**Annex B**

**Health Degree apprenticeships**

1. In November 2018, OfS staff carried out interviews with 12 providers of healthcare apprenticeships. The majority delivered the Registered nurse (adult) apprenticeship, the Nursing associate apprenticeship, or both. Between them, the providers were delivering or developing 18 other healthcare apprenticeships. While there is strong demand for apprenticeships from potential students and employers, and positive engagement from universities, numbers remain relatively modest.

1. The summary below has been shared with stakeholders, including the Department of Health and Social Care, the Department of Education and Health Education England. It has also informed a recent OfS briefing discussing apprenticeships more broadly, which was published alongside the evaluation of the Degree Apprenticeship Development fund. Both can be found here:

<https://www.officeforstudents.org.uk/publications/degree-apprenticeships-a-viable-alternative/>

Main Positive findings

1. *Strong demand from prospective students and strong widening participation potential*. Apprenticeship opportunities, when advertised by Trusts, have attracted more (sometimes many more) expressions of interest than Trusts were able to fund. The majority of health apprentices are mature and have been working in the health sector. Apprenticeships are attractive to people who may not otherwise have engaged with HE. For some, the flexibility of studying for a level 5 nursing associate qualification and then potentially progress to the registered nurse degree was key to making higher education accessible.
2. *Strong demand from employers.* Employers see apprenticeships as a way to recruit and retain employees. They also report that apprentices demonstrate increased confidence and independence, which in turn improves patient care. Employers were keen in particular on the nursing associate role as meeting a workforce need. They had also been able to afford to fund more apprentices in this role thanks to additional funding from Health Education England and flexibility in the use of the levy.
3. *Positive engagement from Universities.* Interviews were conducted with universities currently developing or offering apprenticeships, so willingness to engage with this agenda was a given. Interviews however highlighted the commitment universities had demonstrated in developing apprenticeships. In particular they had shown considerable flexibility to accommodate timescales which were much shorter than universities normally require in order to meet the needs of employers, and resilience in persisting with these developments in the context of repeated changes in ESFA guidance.
4. *Positive feedback.* Interviewees were very complimentary about this student group, indicating that they bring a professional attitude to their studies, strong experience of patient care and well developed communications skills. Retention so far is high, although some highlighted that they had had to revise their entry requirements to ask for level 2 maths and English to be completed before the course started.

Main challenges identified

1. *Excessive regulatory burden*. The development of higher education apprenticeships is challenging because they have to comply with multiple quality standards frameworks: ESFA, the University’s own and the OfS, and for nursing, midwifery and allied health, there is the additional requirement of complying with Health Education England’s quality framework as well and meeting standards set by the regulatory body, either the NMC or the HCPC. In the case of Level 5 apprenticeships, Ofsted is also a regulator. Requirements are not all cognisant of one another. Universities also have to engage with procurement processes to obtain the contract to deliver a curriculum they develop. This is time consuming and creates uncertainty.

For universities, these mean:

* significant workload implications, which translate into costs
* financial and reputational risks

*Simplifying and coordinating requirements would reduce both risks and costs for education providers, making it more viable for universities to deliver training opportunities that support widening participation without compromising quality.*

1. *Mandatory qualifications and end point assessment.* Completion of the End Point Assessment (EPA) triggers final payment of the apprenticeship levy, however there has not been agreement from the IfA that the EPA could be included in the registered nurse qualification, and students therefore need to submit an additional module after they have qualified. There is no incentive for apprentices to comply with this requirement as their university degree enables them to register with the NMC. The separate EPA t is perceived as unfair to students, out of touch with professional requirements and adding unnecessary financial and reputational risks on employers and universities.

*Securing an integrated end point assessment for all nursing, midwifery and allied health apprenticeships, including the nursing associate apprenticeship, would remove an unnecessary risk on education providers and reduce the burden on students.*

1. *Funding and student numbers.* The primary reason given for lower numbers of apprentices in training than planned is backfill, which is the shorthand for the cost of training for employers. These costs were often not clear to employers when they started developing apprenticeships. The cost of backfill for the registered nurse apprenticeship is significantly greater than any other because of the requirement that 50% of the course is placement and the NMC stipulates that this placement needs to be supernumerary. The development of apprenticeships was therefore in a number of cases based on higher numbers than employers were eventually able to support. There is ongoing uncertainty on future numbers, making it challenging for universities to plan delivery.
2. Funding bands have not been calculated on the basis of actual cost of delivery by universities or colleges, and in particular have not included capital funding. The decision that some of the levy funding for the nursing associate apprenticeship could be veered back to employers has further reduced income for education providers.
3. Incentives from Health Education England have successfully enabled employers to support apprentices for the nursing associate role, leading to higher numbers in training, but this funding remains unconfirmed for 2019 and can create an artificial imbalance between numbers of students trained as NAs rather than assistant healthcare practitioners or registered nurses.

*Securing additional funding to support employers with supervision of students and backfill, through the levy or otherwise, would contribute to maintaining numbers of nursing associates being trained and would encourage the development of other health apprenticeships.*