

# **Funding and Commissioning issues for undergraduate and postgraduate healthcare education from 2013**

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## **Introduction**

The model of healthcare training whereby the National Health Service (NHS) has responsibility for provision, is disappearing with the future direction being that of education providers needing to respond to commissioners' requests and being able to evidence the capability to train (1). The intention is to establish a clear linkage between the educational needs of the future healthcare workforce and improved patient outcomes, along with developing a flexible approach to providing quality patient centred care (2). Training institutions will have greater accountability for the education of the future healthcare workforce, particularly with regard to quality metrics. There will be a requirement for an innovative approach to be adopted in terms of learning, teaching and assessment pedagogies, and the training provision will have to constantly evolve to meet the changing needs of the healthcare workforce. Individuals being trained now will need to be flexible, willing to continuously learn and develop, and be more comfortable with technology and change than any previous set of graduates (3). Education providers of the future will need to lead the way in improving the quality of education and developing innovative training. Radical changes to the way the service is commissioned in the past have resulted in similar requirements to adapt educational provision, and providers will need to learn from these experiences. The requirement to move towards a more commercial model, and apply this to the NHS educational setting, will mean that examples from the private sector will need to be reviewed.

Providers of education for the Allied Health Professions (AHPs) will be required to recognise the need to support the whole workforce, from assistant to consultant level, mapping against the clinical domains outlined in the NHS Outcomes Framework publication (3). This will involve clear identification of preceptorship, mentorship and lifelong learning in the form of Continued Professional and Personal Development (CPPD). Importantly, Radiography as a profession will need to model future workforce education and training around the adoption of new technology, research and innovation, and further promote itself within the realms of academic and clinical practice. The introduction of Local Education Training Boards (LETBs) and Academic Health Science Networks (AHSNs) will also have integral roles in the translation, development and provision of new curricula, whilst ensuring involvement and appropriate scrutiny from the relevant regulatory professional bodies.

## **Background**

The abolition of the ten Strategic Health Authorities (SHAs) in England has significant implications for NHS workforce planning and for the future education, training and professional development of NHS non-medical staff. Prior to 2013, nursing, midwifery and allied health profession education in England was provided via a national standard contract between the SHAs and individual universities which ran faculties or departments that specialised in particular NHS professional education and training, and were approved by the relevant professional body (4). The SHAs were therefore the planning and awarding bodies for these education and training contracts in England.

Funding for nursing, midwifery and allied health professional education (NMET) was one component of the 'Multi-Professional Education and Training' (MPET) budget

which was included in Department of Health (DH) funding of the SHAs. Other components provided funding for postgraduate medical and dental education (MADEL). MPET funding was allocated for NHS workforce education and development for all areas other than for medical training and courses. The Higher Education Funding Council for England (HEfCE) allocated student numbers to universities for medical training and courses, as well as for dentistry, pharmacy and healthcare science (5). MPET funding for nursing, midwifery and allied health profession education provided for pre-registration education, post-registration education, and continuing professional development (CPD).

The SHAs managed MPET budgets according to national, regional and local requirements in terms of workforce planning. Universities were contracted to provide courses and had to meet certain criteria. For their part, universities would plan and manage the viability of course programmes, and ensure their staffing by appropriately clinically qualified and academic staff and associated clinical placements. They were also required to meet standards and regulations set by the relevant professional health bodies, and they had to match these requirements with commissioned numbers (6).

MPET funding covered allied health professions such as radiographers, physiotherapists, and podiatrists, where specific arrangements related to registration apply. For example, radiographers must be registered to work in the NHS. For this, they need a degree in radiography from an education centre approved by the Health Care Professions Council (HCPC) (formerly the HPC). All qualifying radiography courses since the early 1990s have been at degree level, and most are three-year courses. Students are normally based in a university and in hospital departments for an equal amount of time.

Since the transition of healthcare education into higher education institutions (HEIs) universities have had significant resources (staff) and capital investments in NMET/MPET contracts, and have employed academic staff who were experienced practitioners in their field. However, the DH in England signalled that the MPET budget would be cut by up to 15% over three years, commencing in 2011/12. SHAs in England confirmed that the number of training place commissions was likely to decrease by around 10-15% and that these cuts would be 'front ended' i.e. with the greatest reductions in year one (2011/12). Within this overall reduction, there were considerable variations amongst the SHA regions and within individual professions, with some areas (such as physiotherapy) receiving even larger cuts over the period. At present there appears to be a wide level of variation in the number of students being commissioned in different regions (5).

Prior to 2013, some universities received approximately 25% of their total income from NHS funded health professional courses. Uncertainty about the arrangements for the commissioning and award of these contracts from 2012/13 created a financial problem, which coincided with the introduction of the new fees and funding regime for other undergraduate courses in England. With further anticipated reductions in student numbers, many universities had no option but to implement redundancies for well-qualified and experienced staff.

### **The new model from 2013**

The Government launched its white paper 'Liberating the NHS: Developing the healthcare workforce' in January 2012 (7) and this set out proposals to establish a new framework for workforce planning. This was to ensure high quality education

that supports high quality and safe patient care. In preparing its white paper, the Government had several objectives:

- Value for money;
- Widening participation of those accessing the education;
- Ensuring that there are the correct numbers of people being trained with the appropriate skills;
- Increasing responsiveness to patient need and changing models of delivering healthcare;
- Delivering high quality education and training;

Various regional consultations were subsequently held on the workforce white paper, with stakeholders from the NHS, education providers, local authorities, patients and the public. The outcome of these consultations supported the proposals in the paper to create a new provider-led system with greater autonomy, and local trusts were given responsibility for planning the education and training of their workforce. The new model consists of an overarching board associated with each Trust, known as a *Local Education Training Board* (LETB) (7). These boards are accountable to Health Education England (HEE).

SHAs remained accountable for education and training until 31 March 2013, after which they ceased to exist. HEE was established as a special health authority in June 2012, became operational from October 2012, and fully functional from April 2013. This newly formed HEE is intended to provide a multi-professional oversight of the new system. It replaces Medical Education England (MEE), (which previously covered medicine, dentistry, pharmacy and healthcare science), the nursing and midwifery professional advisory board and the allied health professional advisory board. This proposal has potential risks for the smaller AHP group, which could potentially be subsumed by the interests of the larger medical education and nursing bodies.

The LETBs nationally have common terms of reference. Ten principles were established to enable LETBs to develop locally appropriate arrangements whilst operating within a nationally consistent framework (8). These Operating Principles are designed to reinforce autonomy for local areas, whilst enabling high quality education and training for the workforce to ensure best outcomes for patients and service users.

The ten principles consist of:

1. Local decision making
2. Inclusive approach of providers
3. Good governance
4. Sound financial management
5. Stakeholder engagement
6. Transparency
7. Partnership working
8. Quality and value
9. Security of supply
10. Accountability

## **Concerns**

There are considerable concerns as a result of the abolishment of the Strategic Health Authorities, and what is seen by many as the failure of DH to assign clear responsibility for the future planning and commissioning of MPET and NMET education and training. The policy framework set out in the document, *Liberating the NHS: Developing the healthcare workforce* (7) on the future of education and training in England failed to dispense these concerns. In addition, there are significant concerns that the DH has proposed that the MPET budget for nursing, midwifery and AHPs should no longer fund post-registration and continuing professional development (CPD) provision, and that it will be restricted in the future to pre-registration programmes. This poses a further risk to the future viability and availability of this provision. Funding for CPD will not be ring-fenced and may understandably not prove to be a high priority for Foundation Trusts and GP consortia during a period of radical structural change. Healthcare providers will be required to deliver efficiency savings over a four year time-scale, and CPD will be an easy target to cut. It is very unclear therefore how well the DH's proposals will serve the future needs of the NHS in terms of CPD, and particularly the skills training required to keep pace with developments in care and technology. This may potentially have serious implications for the training and development of the future healthcare workforce, in terms of being equipped and flexible to deliver quality care.

There remains uncertainty over the responsibilities of providers (GP consortia and Foundation Trusts) to participate in the LETB process, and how they will co-operate to identify future national workforce requirements. Numbers of healthcare professionals being trained each year requires a careful balance of oversupply, leading to unemployed graduates, and undersupply, leading to shortages in the workplace. A strategic approach is therefore crucial to ensure accurate forecasts are made, particularly in relatively small areas such as radiography.

MPET funding previously included NHS professional development and courses for those such as healthcare assistants who wanted to enhance their skills. The DH proposal to remove funding for these activities from the future MPET budget, and to restrict the latter to pre-registration training, conflicts with the life-long learning agenda which has been identified as being of importance by the Government (9).

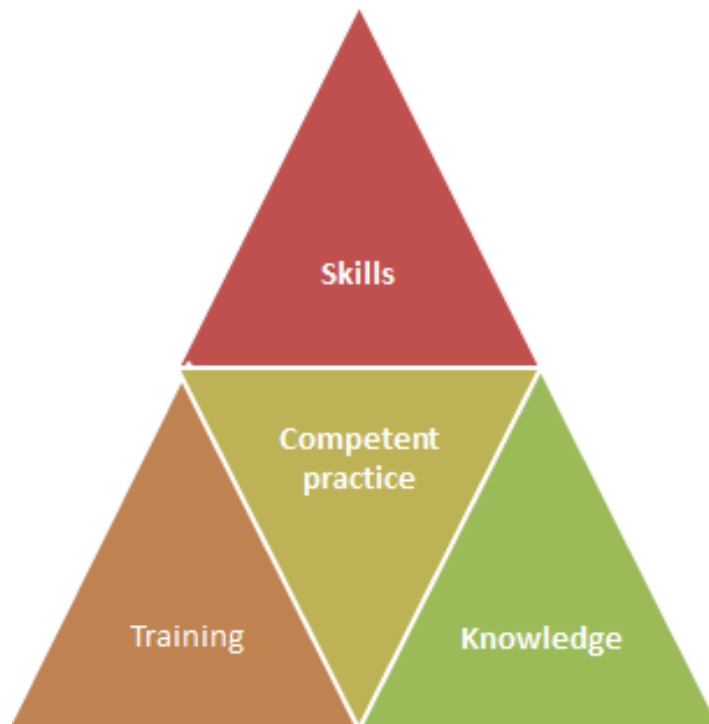
The transfer of the current planning and commissioning function of the ten Strategic Health Authorities to a plethora of local skills networks is a cause of further uncertainty in the future planning and commissioning of MPET / NMET provision. There is a requirement to make effective and efficient use of HE facilities and infrastructure, and the need to avoid unnecessary bureaucracy and transaction costs within the NHS and higher education institutions. Neither of these concerns appears to have been addressed. Universities have been given little time to respond to these changes and many may not be ready for a transfer in responsibility. As a consequence they risk being left behind by more commercially aware independent providers. This raises concerns that the quality and scope of the education and training for NHS staff that will be available, may be very different if driven purely by commercial concerns.

It is also difficult to see how the proposed arrangements will be cost-effective, add value or improve the quality of patient care. There is concern that the new provider skills network arrangements will create another costly layer of bureaucracy, and therefore future commissioning and funding arrangements must be transparent. This is particularly important for universities engaged in contracts related to nursing, midwifery and the professions allied to health, since medical numbers will continue to be allocated by HEfCE.

## Opportunities

Given the impending changes to the commissioning of future healthcare workforces, it may appear difficult to identify new opportunities for training and education. However greater modelling of the future workforce requirements is now being undertaken by the Centre for Workforce intelligence, which aims to provide commissioners with greater clarity around future required numbers of healthcare practitioners. This will include the mapping of particular 'at risk' specialist roles, such as nuclear medicine and ultrasound, which according to the Migration Advisory Committee (10) are not recruiting sufficiently to adequately provide a supply of clinical imaging services for the future healthcare needs of the population.

The mapping of knowledge, skills and training will need to be further integrated, in terms of Higher Education Institutes, clinical healthcare environments, professional and regulatory bodies and Academic Healthcare Science Networks. There is also the need for clinical practitioners to be cognisant of their responsibilities and accountabilities, particularly with regard to lifelong learning, to facilitate an adaptive and progressive platform for competent practice (figure one).

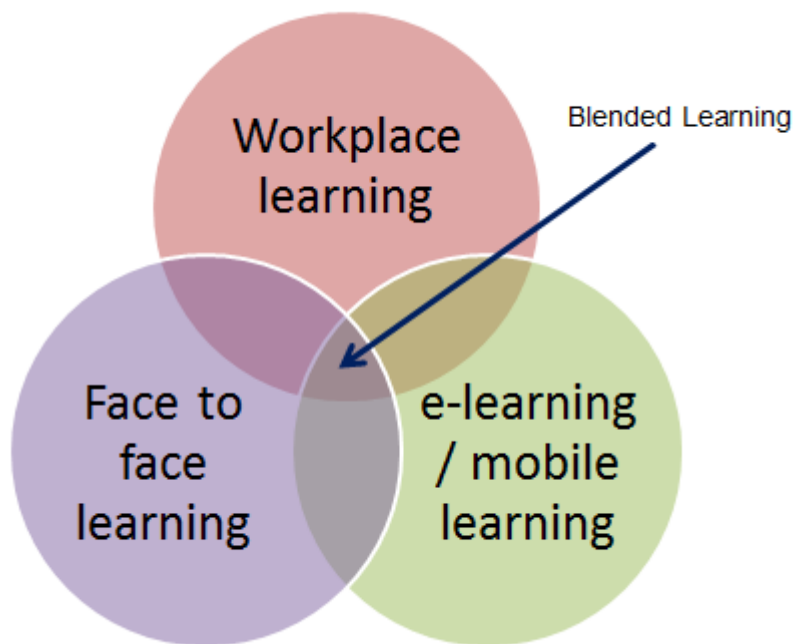


*Figure One: Requirements for competent practice*

The previous system whereby some hospitals were restricted in where they could send postgraduate students for training, due to SHA funding arrangements, will mean that the new process will be viewed by some as a positive opportunity. Competition from commercially driven providers of education may potentially increase the quality of provision, and clinical staff will have the freedom to select those providing high quality courses. However, pressures on budgets may result in managers choosing the cheapest option rather than the highest quality.

The traditional model of education delivery, which has previously mainly involved face-to-face attendance, will need to undergo a transformational change. The emergence of a culture which places innovation and sustainability at the core of the modern NHS is beginning to redefine how practitioners access learning and education. This is coupled to the finite resources now in place to provide financial support to undertake any form of post graduate training. Healthcare professionals themselves may be required to invest more of their own resources, in terms of time or funding, in order to access certain types of training. HEIs and NHS clinical sites may need to collaborate more extensively in order to offer a range of flexible learning approaches.

The provision of 'door step' delivery is an opportunity for HEIs to further develop, which provides benefits for the clinical workforce, in terms of being able to access learning in the workplace, with minimal disruption and reduced travelling time. There is also the potential for a partnership approach to educational provision, with sharing of revenue to provide income generation for both the NHS Trust and the HEI. The use of a blended learning model, which may include a combination of face-to-face and asynchronous learning (e.g. e-learning), may also offer advantages to the clinical workforce, in terms of providing access to learning within timeframes convenient to the individual learner (see figure two).



*Figure Two: Blended learning within the healthcare environment*

## **Conclusion**

The radical changes that are underway for training of the healthcare workforce, have major implications for both the providers of education and the employers of the healthcare workforce. Training institutions will have greater accountability for the education of the future quality of the healthcare workforce, and there will be a

requirement for more innovative approaches to be adopted. Whilst there are numerous opportunities presented to improve training and education of the workforce to achieve improved quality of care for patients, many concerns exist over the outcome of these changes to the commissioning of undergraduate and postgraduate education. In particular, the reduction in funding for provision of postgraduate and CPPD education are difficult to reconcile with the Government's drive to achieve a workforce which is not only competent and capable, but also sufficiently adaptable and flexible to function in a rapidly changing environment.

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