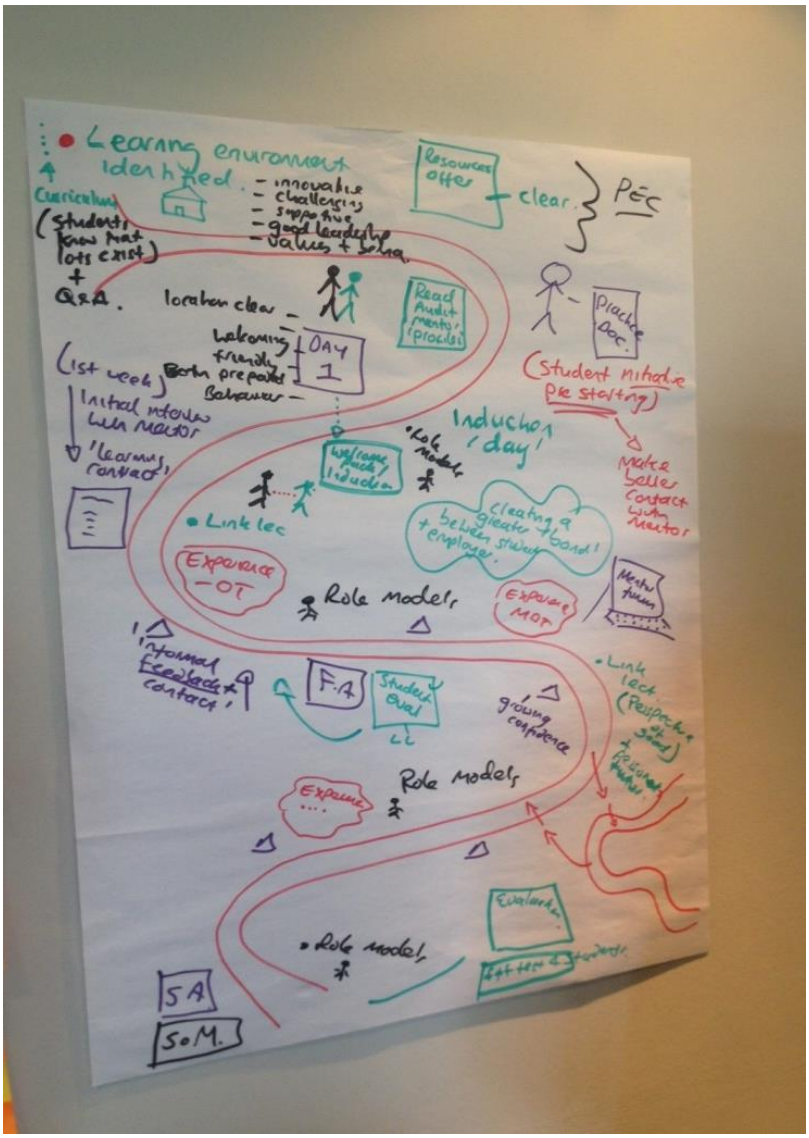
Health Education East of England

Health Education East of England

Fundamental Review of Pre-Registration Nursing

Interim Report

17 September, 2014



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1.0 Introduction to the Fundamental Review

Health Education East of England (HEEoE) currently commissions 23 pre-registration nursing programmes per year at 6 partner Higher Education Institutes in the East of England and a small number of commissions at the Open University at an annual cost of £37.7 million. As pre-registration nursing is predominantly a three year programme, the total annual commission is in excess of £100m.

The fundamental requirement to deliver high quality nursing care integrated with essential person centred care and high level technical skills, as identified in the Francis Report, suggests that we need to assure ourselves that our programmes meet existing healthcare requirements now and also in the future with a drive to ensure that we "foster a common culture shared by all in the service of putting the patient first," and that "it should be patients – not numbers" that count.

The purpose of this exercise is to review (fundamentally) the pre-registration nursing provision currently funded across the HEEoE region in order to ensure high quality content, delivery and outcome and to align planning for future provision with the emerging implementation of the National Standard Contract Framework.
This interim report describes the process and findings to date.

2.0 What we know about our pre-registration programmes

The programmes commissioned by HEEoE vary in content, quality and focus across the east of England. Performance and quality of programme delivery is measured via the HEEoE Quality Improvements and Performance Framework (QIPF) and there is evidence of quality improvements in commissioned programmes over the past three years. The QIPF Key Performance Indicators are in the contract schedules, providing the commissioning levers to drive continuous quality improvement.

QIPF is a key component of the contracts with HEIs that deliver pre-registration education and with service providers who provide practice placements. The framework uses key performance indicators to assess the quality and performance of education delivery and support. The indicators are based on the nationally agreed indicators included within Education Commissioning for Quality (ECQ) but have been developed to reflect emerging local and national priorities. QIPF is focused on identifying where improvements are required and supporting the development of improvement plans as well as identifying best practice. This can feel challenging for HEIs as it intentionally tests and identifies where improvements are needed.

Programmes are commissioned based on the outcomes of the framework. This means that programmes that are identified as not reaching the required standard are decommissioned and commissions are increased on programmes that are demonstrating the best outcomes, where this is possible.

All student nurses recruited onto HEEoE commissioned programmes have been recruited against the NHS values since April 2013.

Service users are involved in selection, programme design and delivery at all of our partner HEIs and this involvement is measured via the QIPF.

Commencing in April 2014, HEEoE collected data on the level of experience student nurses have had prior to entering education programmes. The first six months of pre programme experience data shows no correlation between pre programme experience and levels of attrition

All of our programmes have placements in the community sector and some in primary care and private, voluntary and independent sector

Attrition levels on nursing programmes average 14.5%[1]. Rates vary across education providers and branches of nursing but it is possible to demonstrate a decrease in attrition rates as a result of QIPF. The focus has been placed on understanding the detail behind the numbers and identifying the underlying causes of attrition and how these can be addressed by developing improvement plans based on sharing of good practice.

Employment data shows that of nursing students completing in 2013/14, 72% of completing students entered employment in the NHS in the east of England, with 85% entering employment in the NHS regardless of location.[2]

We currently commission Apprenticeship Programmes for HCA preparation and Foundation Degree Programmes for Assistant Practitioner preparation. Some, but not all, of our HEIs will APEL this learning into their degree programme, reducing the time required to complete the degree.

[1] This is based on attrition for all nursing programmes completing between 01 April 2013 and 31 March 2014. 6.4% of students on this programme are yet to complete.
[2] This is based on 1,345 completing students and a 77% response rate

3.0 The Design of the Fundamental Review

The review design is built upon HEEoE's principles:

- Patient-focused
- Provider-led
- People-centred

The review is therefore designed and conducted using a consultative methodology using the principles of action research and analysing the data though grounded theory methodology (see Appendix 1). All groups with an interest in pre-registration nurse education are being consulted about their views and the findings are collated and supported by research in the field.

The review focuses upon four key lines of enquiry:

- How do we determine what excellent nursing education should look like and how it should be delivered?
- How do we ensure the right learning environment?
- How do we ensure that we have the right applicants onto nursing programmes?
- What is the optimum commissioning pattern for nurse education?

The review has three key strands of work:

- Engagement and consultation will key stakeholder groups
- Literature review relating to key emerging themes
- Collation of best practice evidence collected during fieldwork

The HEEoE review design is flexible and responsive to emerging themes. The review has made explicit links to the national Shape of Caring Review, commissioned by HEE and NMC and independently chaired by Lord Willis of Knaresborough. As the national review plans to focus on taking actions to deliver improvements to education, the adoption, spread and evaluation of best practice will also form part of the HEEoE review.

The director accountable for the review reports on progress to the acting Managing Director of HEEoE and the Director of Education and Quality. The review is further supported by an expert reference group with representation from lead nurses in provider organisations and Area Teams, medical (including Primary Care) and AHP representation and from key national bodies, including NMC, Council of Deans, and RCN. The reference group advises on both the design and the delivery of the review.

4.0 Stages of the Fundamental Review

The review is scheduled from January to the end of the year 2014 and is working with national project teams, including the Shape of Caring review, in order to enable integration of the EoE findings with national work. From November 2014 to March 2015, the review will focus upon implementation, with adoption and spread of best practice initiatives.

Phase One (Jan – Feb 2014) **Project design and launch**
• Project planning and design • Sign off by HEEoE Executive • Launched with DONs and HEIs • Set up reference group
Phase Two (March – April 2014) **Collecting initial evidence**
• Fieldwork: 8 all day workshops in 7 locations • 191 participants from a range of nursing backgrounds • KLOE: What does excellent nurse education look like?
Phase Three (April – May 2014) **Analysis & testing**
• Analysis of workshop data into key themes • Testing themes with DONs, reference group, Directorate of Education & Quality
Phase Four (June – July 2014) **Refining the themes**
• Fieldwork: Testing and refining themes • 3 service user events. 42 Participants • 1 HEI event for our 6 partner HEIs. 19 Participants • 4 student events. 86 Participants
Phase 5 (July – September 2014) **Sharing the themes with key stakeholders**
• Presentation to DEQ team • Presentation to Lord Willis and team • Presentation to reference group • Interview with Ruth May – Regional Chief Nurse • Presentation to HEEoE Executive Team

5.0 Communication and engagement

In addition to the engagement at workshops we developed a communication plan to ensure on-going communication and feedback with stakeholders:

- Webpage with monthly blog http://eoe.hee.nhs.uk/our-work/fundamental-nursing-review/
- Twitter site and chats @HEEoENurse
- Interviews with key senior stakeholders

6.0 The Key Themes from the Fundamental Review

The themes that have emerged from the workshops in this review are those subjects cited frequently by the nursing participants (themes derived from repetition). They provided us with a taxonomy of key descriptors for the elements that constitute excellent nurse education. These themes are extracted from the nursing workshop contributions, but have then been refined in further workshops with students, service users and HEI staff, and by discussion and presentation with key stakeholders. They derive from those who are currently involved in the teaching and learning of pre-registration nursing. The key themes are:

1. Mentorship
2. Core skills, competencies and knowledge
3. Values; care, compassions and resilience
4. Service user, patient, carer involvement
5. Preparation for working in a range of settings
6. Selection of future nurses and routes into nursing

Analysis of workshop discussions revealed rich themes and considerable agreement across HEEoE. The main themes of the discussion are presented by theme and by stakeholder group as follows:

6.1 Mentorship

Mentoring proved to be the most frequently cited theme in the first stage of our investigation into pre-registration nurse education in the East of England. Workshop participants from nursing, HEIs and existing students emphasised the need to investigate the demands and uncertainties of current mentoring practices in the training of pre-registration nurses.

Mentoring is the point at which the practice environment supports and works with the formal classroom teaching programme delivered by contracted HEIs. Yet there is not a formal descriptor of practice for the work of the mentor and there is not generally an evaluation of the outcomes of this category of mentoring work. In fact, in the programme of pre-reg nurse teaching and learning, the mentor generally operates without precise formal guidelines and this is the case in nurse education programmes in other countries as well as those in England.

6.1.1 What the nurses said

Nurses reported that to act as a mentor is not always seen as a 'badge of honour', either by mentors themselves or other nurses. They reported that there is often seen to be little choice in becoming a mentor and that it was 'simply something else to do on top of an already busy role'. Nurses who did not work as mentors were reported to sometimes be 'happy to leave all the education to the mentors'. The mentorship development programme was not seen by all mentors as an opportunity for personal development.

Nurses reported that there is a perceived lack of organisational support or value for the mentor role and it was unclear if the non-medical tariff allocation to Trusts was spent on infrastructure support for practice based learning. There were reports of a lack of system capacity for supporting practice based education, and mentors reported having to find time for students out of their own personal time, as time for mentorship activities was not protected as part of their daily work.

Some mentors reported that they had experienced difficulties in failing a student on placement and a lack of clarity from the HEI with the process governing placement sign-off….'I failed the student and they (HEI) just placed her somewhere else'.

Despite a number of concerns regarding the support for the mentor role, a number of participants were clearly committed to providing excellent mentorship and described a range of innovative approaches in practice.

6.1.2 What the service users said

It was difficult for service users to fully understand the role of the mentor and their discussion was greatly occupied by questioning whether a degree level qualification was required for nurses. However, service users did emphasise the need for learner nurses to have clinically competent role models, who exemplified compassion and good customer care skills.

6.1.3 What the HEI staff said

HEI staff also reported awareness of the variable quality of mentoring in practice and were concerned about their ability to implement 'quality control' processes. Much of their effort appeared to be put in when things had gone wrong. HEIs also reported that the quality and performance processes required effort to measure 'compliance with NMC rules', such as mentor registers, rather than measuring quality practice based education. The interpretation of NMC guidance regarding 1:1 mentorship was perceived as giving rise to constraints in practice education quality and capacity, in that almost every nurse who qualifies to be a mentor has to work as one, whether they value the role or not.

6.1.4 What the students said

Students reported that the role of the mentor is of significant importance to the quality of their learning, however they also reported experiencing mentorship of very variable quality. Good mentorship was seen to include clarity about learning outcomes, the opportunity to practice clinical skills under supervision and a welcoming approach to questions and challenge. Students reported a number of excellent examples of mentorship they were aware that their mentor had had to 'put in extra hours' in order to deliver this. The degree to which the mentor, and the learning environment, valued the importance of learning appeared to impact significantly on student outcomes, both in terms of learning and the desire to stay on the course (attrition).

Students described examples where mentors were unsure about what learning outcomes should be achieved on placement and a lack of clarity regarding signing off outcomes, practice assessment documentation and the grades that could be achieved. Students felt that there was a lack of clarity about skills acquisition and the partnership between HEI and practice on deciding this.

There were examples of very poor mentorship cited, where students described their mentors as stating 'your job is to watch and not ask questions'. In this context, these mentors were reported to be dismissive of new clinical evidence, 'this is the way we do things around here'. However it was more common for students to report that nurses were aware of the need for evidence based practice, but to state that they didn't have the time to implement it, thus role modelling unsafe practice to students e.g 'I know you have been taught to use a slide sheet, but we don't have time for them here'. Where mentorship was very poor students were conflicted over whether they should report it, as they needed to get the placement signed off, 'I reported my mentor, and they just placed me with her for longer'.

6.2 Core skills, competencies and knowledge

The International Council of Nurses (2009) identified that 'the capacity of educational programmes to prepare clinically safe competent nursing graduates is often jeopardised by insufficient emphasis and time allocation for clinical learning; the absence of clearly defined clinical education outcomes; use of ineffective clinical teaching methodologies; unsuitable, poor quality or crowded clinical learning places; and a lack of good clinical role models', which was in accord with some of our findings.

The discussion on mentorship (above) proved to be key to developing additional insight into the theme of core skills, competencies and knowledge; in that it appeared unclear about which players in the system took ownership of, and placed value upon, the development of core skills and competencies, and how partnership working within the system could support this area.

6.2.1 What the nurses said

The nurses described a lack of clarity about the partnership arrangements governing the practice based element of education, 'HEIs 'own' theory; service 'owns' practice'. They did not always experience clarity about process or outcomes in terms of acquiring clinical skills and there appeared to be a 'dislocation' between theory and practice. By 'dislocation' we mean that theory and practice did not appear joined up in the curriculum to the nurses in the workshops. More concerning still, they believed the HEIs did not place equal weight upon theory and practice; valuing theory more than practice. This gave rise to the belief that there is a 'theory/practice gap', with theory and practice being 'pulled apart', rather than being integrated as required for the development of graduate professionalism.

There was also a lack of clarity regarding the infrastructure support for practice based education. The levels of support to mentors, link lecturer activity in practice based education and lectures linking to practice were not understood overall and this coupled with the lack of clarity regarding how practical clinical skills are acquired, measured and assessed in practice, led to a further feeling of de-value for the importance of practical learning, (and for the mentor role overall).

It was not uncommon to hear senior nurses stating that newly graduating nurses were not 'fit for purpose'. This linked to skills acquisition, but particularly related to management skills; although we did hear stories of nurses graduating who had never given an intra-muscular injection. Nurses felt that at the point of registration, student nurses should be able to demonstrate capability in the role, underpinned by a set of core competencies and transferable skills, 'they need to be able to manage a case load, work safely and assess risk'.

One other area where there was lack of clarity and a perceived lack of join up between theory and practice was how student nurses learn about leadership. There was some evidence that some curricula are linked to the NHS Leadership Framework, yet it appeared that student nurses focused on leadership towards the end of their programme i.e. in the third year. Nurses described the importance of 'personal leadership', that is understanding self-management and responsibility linked to accountability as well as learning to be leaders of care and service improvement.

6.2.2 What the service users said

Service users were focused on values and communication skills and the importance of fundamental care (see next section). However they were also very clear that nurses need to understand the whole patient pathway and be able to treat the patient as a whole, not just a physical or mental health condition. They felt that more training in the community and social care sector would help this. Service users felt that focusing the first few months on practical training and fundamental care would be beneficial.

6.2.3 What the HEI staff said

HEIs also expressed the view that there should be more clarity around the requirement for, and acquisition of core skills, and clarity about what constitutes core skills. HEIs felt that practice can see core skills as specific technical skills i.e. 'a procedure', whereas they focused upon developing transferable skills for students. This was further exacerbated by the differing expectations of specific clinical areas and the differences in interpretation of policy and service delivery in practice. HEIs felt that 'frontloading' fundamental care skills in the curriculum could be beneficial.

HEIs were aware that the acquisition and assessment of skills was unclear for mentors and expressed the view that HEEoE HEIs should work towards developing a common assessment documentation (CAD), they did however feel that this needs to be underpinned by a common understanding of skills acquisition (ie what skills, when and why) and their contribution to the nursing degree.

HEIs talked about the importance of developing the University/learning 'without walls' approach, with improved integration between theory and practice but recognised that more work was needed on the practice education support infrastructure and the role of the link tutor. It was felt that link tutors may not have specific clinical skills and therefore not feel confident to work alongside students in the practice education environment, they do however have transferable skills which should be taken into practice.

HEIs were particularly concerned about the management of placements and the need to develop capacity and quality in practice education. HEIs cited examples of poor placement management by service, when students were unexpected or unwelcomed and the affect this had on learning. HEIs felt that service should have more of a role in placement management and aligning theoretical learning to practical learning. HEIs recognised the benefits of having strong relationships with local trusts.

6.2.4 What the students said

The importance of practical clinical skills; how these are acquired and assessed was a key theme from the student workshops. Students reported a perceived imbalance between the importance of theory and practice from the HEI perspective, ' I can just pass placement and no one in the university takes any notice, but if I just pass my theory assessment, there is a lot of fuss and I am told I may fail my course'. Worryingly students reported that it was possible to 'scrape through practice but not theory', which suggest theory and practice are not valued equally by HEIs.

This was further compounded by the perceived lack of clarity regarding the measurement and assessment of clinical skills. As reported above, mentors are unclear about what clinical skills they should be teaching and this lack of clarity was reported by the students also. The HEIs all have different approaches to assessing clinical skills and some HEIs do not assess these as assessed grades towards the final degree award. Students reported that the paperwork for clinical assessment is different by HEI, by programme and sometimes by branch; creating confusion for students and mentors. Overall, students reported that they wanted to practice clinical skills more, and have better access to skills labs in the HEIs. Students described the ability to carry out a practical skill with confidence as being the foundation of then carrying out that skill with compassion.

Students felt placements could be better organised; in that they should relate to theoretical elements of the programme, but also that practice learning environments should plan for the student. Students reported turning up at a practice placement, with no-one expecting them, thus reducing the quality of the learning. Students were also unclear about the support they could expect from link lecturer and other HEI staff, with some reporting good support and others none.

6.3 Values: Care, compassion & resilience

6.3.1 What the nurses said

Nurses said that it should be explicit both within the pre-registration programme and within service that the 'fundamentals of care' are held in high esteem. By this they appeared to mean that the 'fundamentals' i.e. washing patients, feeding them and giving them drinks and taking them to the toilet, should be seen as high value caring nursing activities that underpinned clinical skills and theoretical learning. Nurses talked about how clarity and confidence regarding practical skills would give students the confidence to deliver skills with compassion. Nurses also talked about the fact that although graduate nurses should be able to delegate some fundamentals of care to the skill mix team, they should still hold these tasks in high esteem and understand that delegation also meant good supervision of skill mix staff; linking to the learning and practice of clinical leadership.

Resilience was a key theme in the nursing workshops and this closely related to values; however nurses also expressed the view that they did not have the time to reflect when things had gone well and to discuss with colleagues the issues described above. Some nurses in the workshops talked movingly of the occasions when they felt they had only been able to deliver 'bronze standard' care' due to staffing levels and patient mix, and described the effect this had on their morale. Students at these workshops expressed surprise and pleasure to hear experienced staff talking in this way and felt that conversations of this nature helped them developed their own resilience. However, there was also the suggestion from nursing participants that part of the culture of nursing was to not make the time to reflect on care quality issues. A supportive team and value for learning and reflection was seen as key to supporting reflective practice and developing nurses' resilience.

Nurses discussed how we ensure the patient remains at the 'front of our thinking' and related this to the ability to deliver care to the whole person and across care pathways. The inability to do this, because of time constraints and staffing levels, seemed to lead nurses to deliver 'task related' rather than 'person centred' care, impacting on the demonstration and role modelling of care and compassion. Nurses felt that the NHS and service environments should support a positive learning culture and the NHS values and behaviours should be clear within this; including the need to value and support staff. Demonstrating value for staff, students and their learning was seen to clearly articulate the NHS values and behaviours.

Nurses also talked about the importance of courage and the need to be able to challenge and raise concerns. Developing a culture that supported raising concerns was seen as linked to leadership skills and professional and personal accountability. Not all nurses recognised that addressing concerns or changing culture was their job, and saw this as the responsibility of 'management'

6.3.2 What the service users said

Service users discussions were mostly focused upon this area. Service users appeared to feel confident that the care they received was clinically effective and usually safe, but gave many examples of poor communication and customer care skills which was key to their experience of care. These comments fell into three main areas; good communication skills, the delivery of fundamental care, and being treated as an individual.

Service users placed high value on good communication and inter-personal skills. They gave examples of nurses not making eye contact or smiling, and how this made them feel. They wanted nurses to be kind, gentle, informative and friendly, but also to have the 'correct attitude and behaviours', which meant to be empathetic and demonstrate respect and compassion.

Service users placed high value on the fundamentals of care as the route to dignity and respect. They gave examples of being made to wait 3 hours to be taken to the toilet and having food or drink placed out of reach. They wanted nurses to be able to admit to mistakes, identify poor practice and have insight into the needs of, and advocate for patients.

Service users wanted nurses to notice people's additional needs e.g if they are blind or deaf and to also see the person as an individual and not just as an illness or disability.

Service users recognised the value of good nursing and wanted nurses to take pride in being a nurse and delivering nursing care. Service users told us it was the little things that counted most and these are illustrated below:

6.3.3 What the HEI staff said

All of our HEIs are involved in values based recruitment and recognised the importance of the NHS Values and Behaviours; with care and compassion being identified as transferable skills relevant to all setting. The HEIs felt that 'frontloading' the fundamentals of care, and other lessons from PNEP, into the pre-registration programme was worthy of consideration.

HEIs raised concerns about how practice culture and role modelling impacted upon learning about care and compassion. In a practice setting where staff and students were not valued and learning was not supported, it is hard to ensure students understand the importance of NHS values. HEIs struggled to address these issues due to the need to maintain learning environment capacity.

6.3.4 What the students said

Feedback from student workshops also focused on the fundamentals of care. Students felt it was important to be clear about developing and practising clinical skills as these skills confidently practised were linked to compassion. Students also stated the importance of focusing upon the fundamentals of care and embedding them throughout the programme of education.

There was the suggestion from current students, that there may be students on programmes today who are 'too posh to wash'. Students described examples of students stating 'I have done that once, I don't have to do it again'. The students at the workshops felt very strongly about this issue and some sent in additional evidence in the form of a plan to mitigate against this (see supporting section) Broadly speaking, the students felt that 'compassion cannot be taught, but must be demonstrated' at selection and through regular assessment of personal care delivery during the programme

Students linked the NHS values and behaviours (or 6C's in nursing) to resilience and felt that they should commence 'resilience training' from the commencement of their pre-registration programmes. Lessons from the pre-nursing experience pilot (PNEP) in terms of focusing on fundamentals of care, linked with learning about self-management, self-awareness and reflection, were seen as beneficial and adding value to the way we train nurses today.

6.4 Service user, patient, carer involvement

6.4.1 What the nurses said

Nurses recognised the need to ensure patients and service users are involved in, and their needs reflected in, practice. However the nurses who worked as mentors expressed feelings of conflict regarding patient need versus student need. This appeared to relate to the view that patient and student need are two separate and distinct needs and there is not enough time in the day for both.

Although nurse participants expressed the view that patients should be at the centre of their care, they also articulated some conflict regarding the paradox of nursing associated with this. For instance, taking a coaching approach to support a patient to deliver self-care, may result in that patient deciding to take high risk decisions, which the nurse might be accountable for. Nurses described the need to make all patient encounters meaningful, while the speed of patient throughput made this more difficult. Nursing is increasingly governed by best evidence and standardised protocols and yet there is the need to tailor this to individuals.

Nurses expressed concern about their ability to communicate with people with mental health issues or learning disability, in the acute setting, and nurses in mental health were concerned about physical health. Overall, the participants seemed to be saying, that as nursing has become more specialised, it has become harder to deliver person-centred nursing in the general sense. There was surprisingly little discussion about the expert role that patients, service users and their carers play in the planning and delivery of care, particularly from nurses in the acute sector, and there was recognition that nurses in the mental health sector work more effectively with users and carers.

Nurse participants were clear about the power of the patient story in nurse education, in that it enabled students to understand peoples' lived experience. Nurses felt the patient voice must be heard and responded to throughout pre-registration education and beyond.

6.4.2 What the service users said

Service users felt that nurses should be curious about them as individuals and curious about their patient journey. They should not just focus on the illness or task in hand, but to see the person as a skilled individual, who has a life outside of the care setting. Service users were concerned about being labelled 'difficult' if they asked too many questions or were assertive about being involved in their care. They wanted to talk about this to students.

Service users said that nurses need to understand that they have a lot to learn from service users and their carers. They need to acknowledge the fact that most people manage their own health for most of the time and recognise their level of expertise. Service users felt they were lucky to be *informed* about their care, it was more unusual to be *involved* in it.

Service users felt that nurses should be able to work with individuals, whatever their requirements. They did not expect nurses to have all of the technical skills and knowledge required for every condition, but they did expect them to be able to communicate. This was particularly vital if the service user had a communication problem or a mental health condition or learning disabilities. Service users told several stories of where communication had broken down e.g. a father of a girl with profound learning disabilities and appendicitis, who was admitted A&E and told by the nurse that she was 'not qualified' to communicate with his daughter; a highly intelligent man with a speech impairment following head surgery, who heard himself described in nursing handover as learning disabled. Service users acknowledged that it took time and patience to communicate with people with a range of needs, but it was clear that they had a very valuable contribution to make to the planning and delivery of both education and care.

6.4.3 What the HEI staff said

HEIs feedback was that they actively welcomed working with service users and carers. They discussed how they could further this work in areas of recruitment and programme delivery, and how to put the service user at the centre of the conversation about nurse education. This means, to empower patients, service users and carers in planning for the future, both in education and their health care needs.

HEIs discussed a range of innovative approaches already in place to involve service users in the selection of future nurses. They discussed the value of having service users at interview as a means of getting underneath standardised responses and assessing how candidates interfaced with service users. HEIs were clear about the importance of involving service users, both child and adult, from a range of settings and with a range of conditions; not just involving service user stereotypes.

HEIs were enthusiastic about the role service users played in delivering education through patient stories, case studies and delivering expert sessions. Some HEIs provide training and support to develop service user expertise still further in delivering education to student nurses. It was felt that service user involvement in the planning and delivery of education must be the norm, and not a bolt on.

HEIs expressed the view that they taught the involvement of service users in the planning and delivery of care as well as education. They did also express the view, however, that this is not always role-modelled in practice.

6.4.4 What the students said

The majority of the student comments in this section related to the level at which students felt prepared to understand and communicate with patients with a range of needs. Students felt that there is lack of shared learning between the adult, mental health, learning disability and child branches of nursing, which left them un-prepared to deliver person centred care. This theme is considered in more detail in (see 6.5.4)

The second theme has already been discussed in 6.1.4 and 6.3.4 in that if students do not see their mentors role modelling the behaviour that demonstrated service users and carers are engaged in the planning and delivery of their care, they will often not be encouraged to practice this behaviour (the NHS Values and Behaviours)

6.5 Preparation for working in a range of settings

6.5.1 What the nurses said

There were three main themes identified by nurses in the workshops:

Firstly, they felt that the way nurses were educated currently was in preparation to be specialists rather than generalists. That is nurses learned how to work with adults with physical problems, or people with mental health problems, with little recognition that people will have both a mental and a physical health problem. Nurses felt that pre-registration should be a more *general* training, without the rigid demarcation between branches of nursing, and that nurses should graduate being competent to practice but needing to *consolidate* their skills, not ready to specialise. They also felt that a more general training would prepare nurses to work in community, primary care or hospital settings, with the focus on development of skills transferable to any setting.

Secondly, Service users expressed the view that they wanted nurses who understood the patient pathway, and nurses also felt that education should follow the patient pathway. There were some examples of where education did allow students to follow pathways, but this was rare, due to the difficulties associated with organising and planning patients. Although all of HEEoE student nurses have placements in a community setting, not all health systems work together to maximise learning across pathways and not all systems work with HEIs to integrate practice and theory.

Thirdly, there appears to be an expectation that we are preparing nurse to work primarily in the acute sector. In one sense nurses felt this was not unreasonable, as the acute sector is the biggest employer of graduating student nurses. However there was also the expressed view that if we should be developing a health system that delivers care closer to home, are

we effectively preparing future nurses to work in, and lead this system? Nurses expressed the view that students should be educated to work in teams and across agencies in order to more effectively provide and plan care closer to home, but also they felt that routes into nursing in the community and primary care sector should be clearly signposted.

6.5.2 What the service users said

Service users were particularly clear about their view that nurses need people-centred training first. They felt that nurses needed a more general training to be able to care for people as a whole and not as a single condition. They also identified that for service users there is no division between hospital and the community; it is one pathway of care to the user, and they expect it to join up. They felt that as people are living longer, and have a range of chronic conditions, this approach becomes even more vital. End of life care was seen as a key component of nurse education, not a specialist area.

Service users stated that in order to work in a range of settings it is important for the nurse to be aware of the service users expertise and the range of support systems around them. Nurses need to ask for, and read, care plans and health books, as these follow service users care in all settings. By doing this, the nurse will recognise that they are part of a team, and value the contribution made by carers and domiciliary workers.

Service users felt that all members of the team had something to contribute to nurse education, 'including cleaners', and that this approach would assist the nurse to value and understand the whole team contribution.

6.5.3 What the HEI staff said

The discussion focused on the variety of the setting and the need for transferable skills. By this it was meant that if a placement is in the community setting, the student nurse can still learn the skills required to work in the acute setting. The debate should centre on skills as much as settings. There was also debate around the need for transferable skills between branches of the nurse education programme and care closer to home may require a different skill set, as there was the view that current education programme prepare nurses to work in the current system and not the future one. It was felt that more effective placement management with a focus on 'hub and spoke' models of placement would facilitate patient pathway based learning.

There was some discussion around the notion of newly qualified nurses not being fit for purpose. HEI staff felt strongly that newly qualified nurses have a set of transferable skills (for any setting) and a good understanding of a range of areas as an expert student, but novice level qualified nurse. Whereas service expects nurses to qualify fully formed and able to 'hit the ground running', which does not recognise the need for preceptorship by service and the need to consolidate skills, before developing new ones.

6.5.4 What the students said

Students felt that current training was too specialised and there needed to be more insight into other branches of nursing, 'there is too much separation between branches'. It was generally felt that child branch and mental health branch students received a broader based education than adult nurses. Students on the adult branch stated that mental health 'appeared to be an afterthought' and lecturers didn't necessarily have knowledge in this field. Students felt the range of learning opportunities, in university and in practice placement, for joined up learning was limited. Students expressed concern that this way of learning impacted upon patient care, 'nursing is becoming less and less holistic'.

6.6 Selection of future nurses and routes into nursing

6.6.1 What the nurses said

The discussion focused on two areas that are closely linked: are we selecting the right people to come into nursing, and should we have a broader range of routes into nursing that would entice a greater selection of people?

The learning from the PNEP programme was considered valuable by the nurse workshop participants. It was felt that prior experience of care delivery was vital and that working as a HCA gave insight into employment within the healthcare sector as well as delivering fundamentals of care. This coupled with greater practice and service user involvement in selection and value based recruitment, was felt to give the best chance of selecting the right people. Ensuring that pre-registration education programmes focused on assessment of skills and personal care delivery was felt to be essential to 'weed out' the wrong people from programmes.

Nurses felt that there was a need to develop a range of flexible pathways into nursing. They felt that currently the entry gates were not well signposted and it is difficult for HCAs to progress through the healthcare system to registration. The approach to APEL onto nursing programmes was not clear and different HEIs took different approaches. There was also recognition that more work need to be done to develop a clear practice education support offer for work based learning programmes, as staff in Band 1-4 groups were more disadvantaged in this area.

6.6.2 What the service users said

Service users felt they must be involved in all parts of selection. 'Observing how candidates work with service users and carers tells you a lot about them'. Currently some HEIs work closely with service users on selection and some use them at arm's length.

Service users supported flexible routes into nursing. They cited many good HCAs who they felt would make good nurses. Service users also expressed the view that better nurses have experience of practice before going on to a degree.

6.6.3 What the HEI staff said

All HEIs in HEEoE currently use values based recruitment and service user involvement in parts of the selection process. There was recognition, however that there is best practice to be shared in this area and some HEIs do it better than others. HEIs recognised the value of learning from the pre-nursing experience pilot but there was concern about where this would sit in the process as students are currently selected via the UCAS system.

HEI staff felt that mixed models of educating nurses provide a range of options and widening participation however they stated there was a need to 'thrash out' standardised approaches for routes, practice support, APEL, commissioning cost and quality. HEIs stated they could develop programmes for part time programmes and open learning programmes if these were to be commissioned and there was an appetite to discuss this further. HEIs felt there was a need for Masters programmes but there needs to be a clear commissioning strategy.

HEIs expressed one concern regarding grow your own programmes which was regarding the quality of care. If a hospital has poor quality of care and finds it difficult to recruit staff, then growing their own may be an option. However those students would work and learn in an environment that provides poor quality standards, thus increasing the likelihood of the students learning to deliver poor quality care after registration.

6.6.4 What the students said

Students recognised the value of being able to have prior experience and being able to work as a HCA before entering the programme. However they did feel that with the current lack of emphasis upon practice skills that a learner HCA may have had more practice than a 3rd year student, which would need to be addressed.

The students were also concerned with selection and ensuring the right people get into nursing. The response from a group of students at the University of East Anglia describes their thinking:

'I put the question you asked regarding students being 'too posh to wash' to my colleagues and some recurring themes became apparent in terms of safeguarding against this issue;

- *The health care assistant programme pre training would certainly help to eliminate some of this attitude, as it would give students the opportunity to garner whether or not they felt comfortable taking part in personal care before they committed to the full nursing course.*
- *With this in mind, perhaps incorporating more practical skills into the interviewing process would help to give interviewers a good indication of whether or not the student would be prepared to partake in the washing and dressing (etc.) of a patient. (We did also acknowledge that this would be difficult to achieve within an interview setting, but the general consensus was that the interview was a good opportunity to set a precedent for the rest of the training programme in regard to engagement in personal care).*
- *Another suggestion was that it might be a requirement within the assessment of practice documentation (universally) that student nurses must show evidence of regularly taking part in the personal care of patients on each placement.*
- *And, lastly, it was felt that better liaising between the school of nursing and the placement setting (via 'link lecturers', perhaps) to oversee students involvement in the personal care elements of the course would create an incentive for students to engage in this aspect of nursing, and also provide another form of regulation/assessment.*

I hope that our ideas provide some assistance in combating this problem. As a group we all acknowledged that this is something that needs addressing, and is also something we feel very passionately about.'

7.0 Additional themes

7.1 Commissioning levers

"*The regulatory landscape of health services and higher education are highly complex, and even more so where they intersect in matters that influence the education of health professionals. They will become even more complex in England as responsibilities devolve to LETBs, with education commissioners requiring universities to satisfy expectations for quality and contract value*." (Report of the Willis Commission 2012, p. 22)

When Lord Willis came to HEEoE on 22nd July, 2014, he set us the challenge of developing more effective commissioning levers to manage the quality of pre-registration programmes. He was particularly interested to see if levers for outcome based commissioning could be developed, as we currently commission for input.

It became evident from discussions with service and HEIs that if we are to successfully develop a 'grow your own' nursing offer with a range of routes and step off points, that commissioning standards for cost and quality will be important; so that HEIs can confidently APEL candidates onto programmes and so that candidates get the right offer to support practice based learning. There is a need to cost this model for comparison with the current model of benchmark price, bursary and non-medical tariff.

7.2 Workforce planning & development in nursing

Workforce planning and the role of the Director of Nursing was a key theme to emerge in the interview with Ruth May, Regional Chief Nurse.

Ruth felt that the role of the DON in workforce planning and development had become less apparent over the years and was likely to be delegated to a deputy ('or deputy's deputy'). However the focus upon safer staffing levels has thrown the role of the DoN in workforce planning and development into sharp relief.

Ruth felt that DoNs were taking more responsibility for the 'finished product' of nurses graduation today, however there was more work to be done by ensuring that service plays a key role in recruiting and selecting students, ensuring they had quality mentorship and practice based learning and forming close relationships with partners in universities to establish how graduate nurse could be more fit for purpose.

It was felt that we should work to establish pride in the quality of our locally graduating nurses and the responsibility for developing them further post registration with preceptorship and CPD programmes.

There also needs to be more join up between the need to train additional numbers to deliver safer staffing levels and DoNs responsibility for workforce planning and development. It could be argued that the current nursing shortage may have been minimised if DoNs had commissioned the right numbers of nurses, ensured the practice education capacity and quality for them, and most importantly retained and developed existing staff.

A further theme which emerged from the workshops was the importance of the DoNs role is supporting the development of a learning culture as an environment where reflection and compassion can flourish.

Ruth felt that the importance of workforce planning and development was once again being recognised within the DoN community and challenged the review team about how to support this development.

8.0 Next steps

Having developed the themes of our work from the data collected from workshop participants, we have refined them to develop a series of work streams to be implemented:

Theme	Work stream
Mentorship	Pilot a range of new approaches to improve practice based learning – • CLIP (Amsterdam) project in Norfolk • New approaches to 'lead mentor' in Essex
Core skills, competencies and knowledge	Support HEIs to develop common assessment documentation (CAD)
Values, care compassion and resilience	Integrating practice and theory – will be part of CAD project
Service user and patient involvement	
Preparation for working in a range of settings	Survey the need for 'dual qualification' Review of pathways into community nursing
Selection and routes into nursing	Develop flexible grow your own pathway taking into account current learning from care certificate, higher apprenticeship, PNEP, Princes Trust programmes, AP programmes etc
Commissioning levers	Develop thinking
Role of the DoN in workforce planning & development	Develop thinking

The proposal is that these work streams will be developed and implemented in HEEoE, with learning shared with the national Shape of Caring team.

Kathy Branson
17th September, 2014

Appendix 1 – Process

Principles of action research and analysis of data using grounded theory methodology.

For the purpose of this project the principles of action research are utilized, and although this is not a pure research project, it was essential to use a methodology that is appropriate to the project and would give structure to explore the questions and a method to critically analysis the data.

Action research is a reflective methodology, that analyses and re analyses the organizational problem, thus allowing the exploration of the questions to progressively solve a problem. It enables people / organizations to be actively involved in participating to answer the questions within a changing, dynamic situation by engaging with stakeholders in focus groups, workshops, surveys etc. assisted or guided by a professional team. This gives consistency of approach. and in turn helps participants to come to an agreement about the nature of the problems and the changes required to be implemented and monitored.

Grounded Theory is the methodology used to analysis data collected during workshops, focused groups and surveys. From the data collected key points are coded, these are gathered into similar concepts that are then categorized or themed.

The themes are then explored further by using the same method; that of collecting further data, analyzing the problem and action planning for changes required.

Appendix 2

Evidence for Mid-Year Report

This document brings together additional evidence submitted to the HEEoE pre-registration review team, that may be of value to the Shape of Caring Review

1. Information submitted by HEIs on proposed improvements to Mentorship:

Mentor Position paper by Anne Devlin (after HEI event)

R:\Kathy Branson\Pre-Registration\Review\Key Documents\mentor position paper - AD et al.doc

ARU and UoE Mentorship Paper (an exploration of mentorship from multiple perspectives)

R:\Kathy Branson\Pre-Registration\Review\Evidence (Published)\Mentorship Report ARU & UoE 29 4 2014.pdf

Collaborative Learning in Practice (CLiP)

R:\Kathy Branson\Pre-Registration\Review\Key Documents\CLiP Paper for Conference.docx

2. Information submitted by HEIs on proposed improvements to delivering values

..\Evidence (Published)\Valuing Compassion - Dewar.pdf

I Care programme

I CARE programme.docx

University of Herts learning to Care Service Improvement Project

UoH EoE EBP Learning to care Service Improvement Project.docx

UoH Gannt chart.docx

3. Information submitted on proposals to improve Nursing Recruitment/Selection

R:\Kathy Branson\Pre-Registration\Review\Evidence (Published)\NHS London mental health nursing recruitment web.pdf

4. Information submitted by students:

UCS Student's report:

R:\Kathy Branson\Pre-Registration\Review\Data\Student Workshops\A O'Byrne Report UEA & UCS Workshop 7.7.14.docx

UEA Student - Too Posh to Wash Issue

R:\Kathy Branson\Pre-Registration\Review\Data\Student Workshops\Holly King UEA Feedback 'Too Posh to Wash' Issue.docx

5. Information submitted by service users

Positive/negative Words for nurses taken from workshops

R:\Kathy Branson\Pre-Registration\Review\Data\Service users\Positive & negative words re nurses.docx

West Norfolk Patient Group Feedback

R:\Kathy Branson\Pre-Registration\Review\Data\Service users\West Norfolk Patient Partnership Service User.docx

Addenbrookes Hospital – My Ideal Children's Nurse

R:\Kathy Branson\Pre-Registration\Review\Data\Service users\My ideal childrens nurse.docx

Service user from Essex:

R:\Kathy Branson\Pre-Registration\Review\Data\Service users\Service User from Essex.docx

6. Grow Your Own:

Assistant Practitioners

AP Education.Career Model Draft 3.pptx

Assistant Practitioner Report 25 Sept 2011 Final governance.doc

Assistant_Practitioner_Tool_Kit_NHS_Norfolk_March_2011-1.docm

7. Misc:

..\Evidence (Published)\Implementing Graduate entry registration - KB & DD.pdf

..\Evidence (Published)\Nursing towards 2015 full report - alternative scenarios.pdf

..\Evidence (Published)\Pre-reg-Education-The-Funding-Gap.pdf

..\Evidence (Published)\SFA Bridging Course between HCSW & Pre-Reg-15nov2013.docx

..\Evidence (Published)\Lancet article Nurse Education level & mortality 26 Jan 2014.pdf

8. International :

..\Evidence (Published)\Clinical Coaching to Improve Clinical Skills Training UoQ Australia.pdf

..\Evidence (Published)\Canada Generational differences among nurses.pdf

..\Evidence (Published)\Canadian Generation x-y report.pdf

..\Evidence (Published)\ICN Paper Nursing Workforce.pdf

9. Documents Supporting Design and output of Project

Communication & engagement plan v2 13.5.14.docx