Output from Clinical learning Environment Workshop
18th October, Center Parcs Elveden

Using the lens of the Clinical Learning Environment the workshop aimed to:

- Provide the opportunity to explore the new education funding and quality management systems
- Develop a better understanding of the new quality and funding system and influence local implementation
- Identify the support required to manage transition and implement the new arrangements

Delegates came from service and education across the East of England and worked in groups aligned to their STP footprints, to explore the future and what it could mean to them. The detail of discussions in STP footprints is attached in Appendix 1. A high level summary is as follows:

What has changed in education funding and how might the new system work?

There were seen to be a number of challenges:

- Apprenticeship levy- HEIs re-mapping and risk to level 2-3 apprenticeships
- Recruitment, particularly to vulnerable programmes such as LD
- Geographical challenges for some organisations
- How do you manage students expectations
- How do we relate numbers to our future workforce needs
- Working as a system – how do you prepare the system to work differently
- Bursary and non-bursary students working alongside each other

And a number of opportunities were identified:

- Move to apprenticeship levy, more focus on work based learning
- Financial modelling – ensure effective use of tariff and levy
- Collaborative approach to recruitment, so students don't just gravitate to acute trusts but are 'owned by the system'
- Freedom to work in collaboration across STPs
- More work with schools, FE, offering work experience, careers guidance etc
- More clarity about the employment offer to students – this should be a system wide offer to prevent gaming

Good work already going on was identified as:

- The Nursing Associate test bed in C&P
- The DoN business model in Norfolk & Waveney, Suffolk & NE Essex
- The Thames Valley & Wessex work using local study centres to market and recruit to local areas

Improving the Clinical Learning Environment

Kathy explained that the genesis of this work was:

- The Fundamental Review of pre-registration nursing where mentorship was the most frequently cited theme
- This led to the piloting of a range of models (CLiP, PEBLS, Enhanced Mentorship Framework) to improve the quality of the CLE
- The evaluation of all the new models showed many similarities and these were drawn into a set of principles

The Principles for improving the CLE were discussed in the STP groups. Key messages were:

- There was a lack of clarity about the relationship between the principles and the national quality framework
- There were questions about whether the indicators measure quality or are just a tick box exercise

As there were so many questions regarding the principles it was decided the team would review the approach. It has now been decided that:

- A guidance document would be developed capturing the learning from the pilots and evaluations which would be shared with service providers
- Service providers will decide whether to implement guidance

Appendix 1 - The detailed discussions captured on feedback forms and tapes

Group work 1 - What has changed in education funding and how might the new system work

Suffolk & NE Essex

What are the challenges	What are the opportunities	Examples of Current Work
Recruitment - retention/attrition - change in student (age etc.) Student expectations (shifts, hours) Providers needing to provide more WBL, moor mentors Placements/mentors - decreased workforce - increased students Alternative caps - placements/tariff Return to practice - contingency plan?	Different methods of funding - student support Financial modelling - apprenticeship framework	Trailblazers looking at national standards for apprentice framework DoN approach to recruitment on commencing training Using coaching methodology to mentoring Trusts and HEI developing new working frameworks

<u>Challenges</u>

Myriad of challenges main one is recruitment – all recognising that this is a significant challenge for us. Part of that is retention – big issue articulated in some of the slides – really big issue – how do you manage student's expectations once you have them in the door in first place particularly with hours and expectations of a pre-reg student.

From a provider perspective real issue is how do you prepare system – if there really are this number of students waiting to join the join the courses and pay the fees how do you manage it in an effective way – how do you get the mentors in place, the opportunities properly aligned and how maintain that level of quality.

<u>Opportunities</u>

Exciting time in regards of different methods of funding – apprenticeship levy, self-funding, flexible routes all sorts of ways we can get students to registration for nursing and for all AHPs. How do we prepare the system that when we are looking at apprenticeship levy we are all moving towards that in a timely fashion in an appropriate way. There is a trailblazer group looking at the pre-reg nursing standards and tying those to an apprenticeship standard – how does that work and how do we make sure NMC and other regulatory bodies for all our programmes are coming with us.

Financial modelling in particular – we have to make sure we are being really creative with our tariffs. There is going to be a squeeze on CPD – we know this – can we use the tariff, can we use the financial models in a different way to evoke not just a change for HEIs but for the providers as well and make a real difference for patient care making innovative use of the different financial models.

Examples of current work

DoNs group for N&S doing some good work about drawing together a unified approach that will mean that for the entire county we have a joint offer in terms of employability – very positive. Also looking at variety of coaching models we are using. Have lead mentor approach, PEBLS and CLiP we are already doing creative things to maximise capacity however they are not a panacea for all we still have to be really creative with coaching to make sure that we are being critical about our system and we have preparedness in there.

Mid & South Essex

What are the challenges	What are the opportunities	Examples of Current Work
Relating prospective numbers and placements to the future workforce needs financial challenges - apprenticeship levy/employer tax - getting health related education labelled and mapped	To work in collaboration across FE, HEI & placement - whole career pathway - health employment offer? (5-7 years?) Footprint - learn from other areas to reduce competition and increase collaboration (e.g. DoNs agree no postcode poaching?)	Enhanced practice supervision framework - sharing the responsibility across all registrants for the CLE Nursing networks already coming together - formalising this Corporate support teams coming together - formalising this Rotation programmes across pathways - acute/MH/commissioners and acute/community

Challenges

How do we relate our prospective numbers in this climate to our future workforce needs – we are dealing with a changing workforce environment, collaboration and the fact that services are going to be moving very rapidly within the footprints across different areas. Maintaining that with the student environment and managing expectations is going to be a challenge. We linked it to the opportunity that we can really have the freedom to work in collaboration, almost from the start of healthcare, schools, FEs, HEIs and placement providers we should be saying this is a job offer for the next 5-7 years and actually you will do A, B and C your pay will change. We use that to draw down against the other challenge which is the apprenticeship levy.

Apprenticeship levy is a huge financial challenge and our HEIs will be under pressure to work to almost remap, to call things an apprenticeship will enable us to say that fits in that bit of the pathway to draw down the funding to cover that to support the workforce agenda. Big challenge because of the timescale this will hit us for registering in Jan for our digital accounts and from April we will have our own employer tax which is significant.

Linked to that is the footprint. Look at other areas where they have been successful as well. In Essex chief nurses do we hold our colleagues to account do we say we will stick to a postcode agreement – we will not put ourselves in direct competition – we put ourselves into collaboration within the system. Recruitment is looked at from a postcode perspective via collaboration - they are more likely to stay. If we can turn that into a job offer then we might have more hope of retaining workforce.

Examples of current work

Linking to enhanced practice supervision framework – not panacea it is working at moment for our areas taking lead mentor approach because it builds in the responsibility of the CLE goes across all registrants so they become coaches and then they jointly share with the lead mentors the responsibility for the whole of the CLE for our learners – it is worth rolling it out but not one fits all. Community have been doing this informally for years.

Herts and West Essex

What are the challenges	What are the opportunities	Examples of Current Work
Accommodation pre-reg to qualification Recruitment to STP Difficulty for some recruitment of students that are vulnerable groups	positive recruitment for STP - more local candidates Build on collaborative trusts and providers Greater school engagement with employers/HEIs Progression pathways - talent for care - work experience Greater grow your own local workforce - Bands 2-5 Explore usage of levy Explore return on investment job opportunity/offers Opportunity for sense of belonging/senior nurse parenting/buddy system Induction for students within STP	Sharing best practice from other areas i.e. work with London LETB Resourcing implication for HEI & students outside STP`

Opportunities

Talent for care - going into schools trying to capture the children so they make right choices, offering work experience and bringing them on so these children potentially have got a career pathway from Band 2 up to Band 5.

Whole collaboration within STP looking recruitment for STP as opposed to working in silo with HEIs directly and by recruiting for the STP we are hoping to capture a lot more local people.

With the levy is there scope to employ students so we can draw down the levy. The students would then belong to a trust within that STP.

Challenges

Not only recruit to STP is an opportunity it's also a challenge. Very much collaboration within STP. Potential challenge of building on momentum of collaboration from today.

Recruitment of vulnerable groups i.e. LD

Examples of current work

Thames Valley and Wessex within wide national system of using local areas study centres in Southampton and Reading we have intel on how we can market and recruit to local areas

Beds, Luton & Milton Keynes

What are the challenges	What are the opportunities	Examples of Current Work
Increased no of students require and increase in mentors ?if there will be an increase or will it be a dip. The age range may change therefore students ability to pay Will the cap lower the 'bar' for applicants? Given the range of providers & commissioners how do we create a sense of belonging Geographical challenges with placements which may be more costly & inconvenient	Changing models of mentoring More cohesive messaging at early stage at schools GCSE option level. Link to talent for care joint offers - system offers & rotational posts	coaching model: prep starts at pre-reg year 3 into preceptorship year Joint system offers with unique selling points (not in place yet - under discussion)

Challenges

Number of students will they increase? It will require us to invest in mentorship and if the coaching model takes off in a faster way than currently. We recognise that although students tend to gravitate towards acute trusts with the changing workforce needs we talked about a collaborative approach to recruitment as well. If the model works in one area how can it be adapted for others? Working with coaching model in community settings – like to hear how it works differently there.

Whether or not the increase of numbers might lower the bar for entry points – it's an unknown. There are quite a few unknowns and how you plan for that if numbers dip or increase the age-range and if that changed. Talent for care and getting into schools at an earlier point to ensure that we grab children at GCSE when they are choosing options and guiding them on right path. Giving range of providers and commissioners and creating sense of belonging to an organisation of conglomerate.

Geographical challenges of some orgs and students having to travel and how costly and inconvenient for family life and the safety issue around this – will they chose to do that if they have choices – how can we help to develop the opportunities for them in a partnership approach to make it easier for them.

Opportunities

Models of mentoring and how soon we start – start at pre-reg year 3 and develop through preceptorship and consolidation before they can do mentorship training but get really good coaching
More cohesive messaging with schools about opportunities in health care and joint offers

Examples of current work

Coaching model and joint system offers with their unique selling points.

Norfolk & Waveney

What are the challenges	What are the opportunities	Examples of Current Work
working collaboratively together with HEIs/provider in partnership	Development of 'joint offer' in partnership including HEIs - career pathways	Work of DoNs group - their business model with 4 workstreams
Development of a recruitment strategy shared HEI/provider - joint recruitment offer	Ownership of students/belong to clinical institutions - identify to clinical organisation not HEI	Offer - recruitment 'joint offer'
Understanding the future workforce requirements - generic roles etc./integration (modelling)	Re-model the 50% clinical practice element	New Band 5 roles
Opening up CLiP/PEBLs model to all professions	Apprenticeship levy	Preceptorship/coaching models
Timeframes/call to arms		Placements …… into CSR
Student placements/quality of placements/clinical learning environment		

Challenges

Need to get on with it time is running out. Working collaborative and building trust and relationships, joint recruitment strategies- do things more jointly. Can't worry about what we don't know. To be open about what we have done with CLiP PEBLS and Lead Mentor with other professions – it's a call to arms.

Opportunities

Career pathways, joint offer, ownership of students. Need to think about remodelling clinical placement – we only get students for short period at certain time and possibly not at the best time in their pathway.

Examples of current work

DoNs work across the 2 STPs – some significant workstreams from that we are all involved in they include recruitment, development of Band 5 roles, placement, CSR and coaching models.

Cambridge & Peterborough

What are the challenges	What are the opportunities	Examples of Current Work
Counteract negative media messages and misinformation around new system through consistent messaging	Potential increase student/workforce numbers	Enhanced practice support framework (;lead mentor)
Managing student expectations - especially around placements - be specific at recruitment and marketing phase	Greater collaboration across STPs and beyond	Close monitoring of retention rates and alignment to employment contracts
May need to reshape/refocus prog to ensure 2300 hours are met and no extra hours	Ability to evaluate and evolve the process	Collaborative HEI/service work on marketing (incl nursing Associate)
Will there be extra placements to support extra numbers	Chance to identify what programmes are care provision and what is luxury that can support prioritisation	General collaborative approach to areas such as QIPF, nursing associate bid
If additional simulation is used to support practice - how will quality of the this be assess.	Recruitment opportunities from non-usual HEI providers	Collaborative working provides a good platform to build on
How will HEIs ben able to support extra provision?		
Need to give clear and consistent message to staff and mentors around student expectations and needs	Ability to sell service side from a placement perspective and market all the really good work going on locally	
How do we manager both students (funded and self-funded) consistently	Collaborative work with HRI and placement providers to market/recruit to healthcare/workforce/programmes	
How do we manage placement needs of all areas (e.g. acute, PIVS, GPN)	Students to be given more choice in placements (e.g. towards chose career pathways - e.g. placement pathways (older people, acute care); use of areas accessible to student (e.g. staying with friends/family); risks for AHPs in being pigeon-holed to a practice area.	
Need to focus more on the high number of high quality placements rather than the low number of poor quality (marketing/media)		

Clear offer/messaging around travel, accommodation, childcare Recruitment - actual numbers/interest not known Ability to recruit to and manage regional (non-nursing) programmes How to support new programmes (e.g. Phys Assoc, Nursing Associate) if no extra tariff funding available		

Challenges

Consistent messaging – lot of national negative media around change – need to turn it round – have done lot media work locally to make it a positive thing.

To have 2 different systems will be a challenge bursary and non-bursary alongside other different systems. One example some HCAs on flex nursing pathway and some on open uni pathway some doing 3 and some doing 4yrs.

Opportunities

It is a real opportunity to refocus – have a look at what we are doing to refocus and reshape to make this fit for our patient pathways. Discussion around alignment to system transformation. Some of our HEIs partners do not align directly with our system transformation work – we work close with them we think it is about the patient pathway system transformation will change year on year patient pathways are something we should focus on.

Re-framing the programme allowing these new system changes and using these opportunity to really look at the programmes.

Examples of current work

Successful site for Nursing Associate pilot site – good opportunity and fits perfectly into this with that successful bit as a system have done more collaborative working and that will put us in a good position going forward. We are doing a lot around positive marketing we also monitor our recruitment and retention very closely and work to make sure we can then retain our medical and non-medical students.

Group Work 2 - Improving the Clinical Learning Environment

Beds, Luton & Milton Keynes

Principle 1: A sustainably funded infrastructure is provided to support a high quality and positive clinical learning culture that enables and involves the wider workforce to support excellent clinical learning

Conclusion first 3 words are 'sustainable funded infrastructure' – we didn't feel indicators measured sustainability, funding or infrastructure. It is important that the focus should be on the structure of organisations such as policy, staffing, capacity, culture – the wider issues not just the CLE itself. The language felt very nursey focussed need to be adapted to encompass all learners – not just nurses

The assessment to this principles should ensure we use tools to assess culture and both the learners experience and the experience of those supporting providing the learning – value in that. Looking at the wider organisations approach to quality improvement. We challenged how does this lead to improvement we shouldn't just be focussing individually on the CLE but on the whole wider organisation – their approach.

Include all learners not just students.

What should be added or removed	How will they be useful to you in improving the quality of CLE?	What is missing?
Indicators do not measure sustainability - how do you measure How will we capture all learners - could there be widened evidence Not sure indicators answer principle Language adjusted to encompass all learners/multi-professional tools to be added to How do you ensure sufficient metrics/education - reports? Do not do this Should not be prescribed Important to measure 1.3, 1.4 and 1.5	1.3, 1.4 and 1.5 - some indicators are useful Essential student/mentor/education feedback	Measure for sustainable funding Mentor/education voice missing
What will they do/comments: will test with desktop exercise within education team. Principles not wrong would have liked national standards first		

Suffolk & NE Essex

Principle 1: A sustainably funded infrastructure is provided to support a high quality and positive clinical learning culture that enables and involves the wider workforce to support excellent clinical learning

In agreement the principle needs changing. It should be sustainable infrastructure. How can we talk about funding when we don't know what it will be going forward so a sustainable funding infrastructure is not possible but a sustainable infrastructure is.

Much discussion around their different exemplars and evidence the overall feeling was this actually is no different from our current model it doesn't give us any SMART measures so we need to look at this in a totally different way. Also it doesn't measure quality in any shape or form. We felt it was uni-professional very 'nursingy'. It should be across all learners and be multi-professional.

There should be much more focus on avoidable attrition, educational responsibilities, who owns them within organisations, national indicators that we are currently using are already there around nursing hours per patient there is loads of national indicators we are already feeding into that would fit into this standard nicely – would want to work on that.

<u>Missing</u>

We didn't feel the mentors or coaches' voice was there much. there is a lot about the student we needed to hear from the mentor as well and we felt would want to reduce tick-box- layout not helpful – would rather have narrative with word count so people could do critical reflection like the HEIs already to when feeding back to NMC that would be more robust

Education governance should be clearly defined.

What should be added or removed	How will they be useful to you in improving the quality of CLE?	What is missing?
concern with exemplars - they do not indicate quality - just tick-box	Support retaining students	Consider for how it can be used multi-professional
No different from current model for evidence, how does it measure quality over and above different model	Increase board focus on training, raise priority during financial difficulty	Need to focus on avoidable attrition
Not true measure of quality	Link education to workforce - focus on grow your own / 5 yr workforce planning	Clarity on who own educational responsibilities in organisation

standards need board accountability - standard is not SMART so cannot be used to measure standard Need to be meaningful so seen as an equal quality indicator for board level link with FFT/quality staff/indicators of quality Indicators or exemplars need changing	linking organisations within STPs Measure outcome of training - fit to practice	How are national indicators currently used (linked to these standards i.e. staffing levels a mechanism to cross-reference to current indicators what is a sustainable level of infrastructure - - needs defining 1.5 very difficult to evidence especially in current climate of high stress in practice nothing for students & mentors to assess quality of their mentoring Valuing work of mentors, positive affirmation - encouraging mentors to keep on register how do you measure organisation where staff are valued, feel they belong, want to stay more narrative evidence rather than attaching documents
What they will do/comments: signed up to the principles but will wait on quality metrics to come out of Newcastle University and reflect on what they will mean. The principles will act as a measure in their quarterly reviews using critical reflections as evidence based against the standards		

Cambridge & Peterborough

Principle 2 - Supporting and Empowering Learners to be an integral part of the clinical team delivering patient/service-user centred care.

We are all very committed to championing and delivering a good education. We found this a challenging piece of work. We found it hard to match the ideas of the principles that we were asked to look at against the actual 6 six domains of the quality framework and the 24 standard within those. 'We are in danger of a huge industry in the culture of shrinking resources.' This is a national standard we felt there are 6 domains and 24 standards and the evidence should be matched through to those and these principles are excellent as principles in guiding where we are going and what we need to be doing but actually the evidence requirements are already listed in those standards. From our perspective we would like to see those worked on - the specifics locally. We felt it was hard with the heading where they were similar but principle 2 matched to standard 3 thee were bits of standard 5 and standard 1 – it was hard to match them through. Felt there was good value in principles that guide the discussions that you would require around

the standard – that would be valuable – we would want to have our evidence reflective of the 24 standards.

Nursing Associate pilot site in Peterborough hospital – they suggested that this get tested out with the hospitals which are pilot sites they can work with everybody to map some of this further to make it a live ongoing piece of work.

What should be added or removed	How will they be useful to you in improving the quality of CLE?	What is missing?
Need to make links clearer - different language used for principles & framework	Unsure but want to be involved with the testing of the using pilot sites (PSHFT)	Exemplars discuss what students demonstrate but need to consider how the placement providers can demonstrate their part.
Do these principles cover all standards?	Excited about national standards	Needs to be clear that these are principles that will guide the collection of evidence
There is a risk of duplication of work	Could be a huge industry with shrinking resources	If measured against principles (locally) how can a national standard be measured (nationally)
Language should be same as nat standards		Use for multi-disciplinary?
Principles are statements not examples - need to be descriptive about evidence		
What they will do/comments: need more time to absorb new framework. Pilot sites to be used once incorporated today's feedback to map principles to drive forward - providing 'evidence' suggestion. Timeline for metrics		

Herts and West Essex

Principle 3 - Executive ownership of practice education The organisation provides effective senior leadership and direction demonstrating a clear commitment and accountability to the delivery of high quality clinical education

Decide there some that need words added. The word education is used we felt that needs to change to be more reflective of academic and training strategies we felt that would capture all disciples not just nurses. Education is implicit but it neds to be explicit for fear of getting lost. Resources and including this in business planning and is a key feature of business planning.

How does it work collectively and the monitoring of that – not just about producing evidence but the impact of the education strategy of whatever we call it will actually have. Representation of the voice – not just the nurse but voice of every discipline needs to be multi-layered from professional staff in trust right up. Education is everyone's responsibility and everybody needs to take ownership of that. The learner

voice being represented at board level not just in a report something visible and tangible and is making a difference. We saw the impact being a cultural shift. The org becoming a learning org and therefore a learning culture which would have direct impact on patient care.

STP sharing their education strategies across different STP working collectively and collaboratively onto developing that in conjunction with their HEIs as well.

What should be added or removed	How will they be useful to you in improving the quality of CLE?	What is missing?
3.1 - indicator is fine - already happening - wording to be broader e.g. Academic & Training strategy Education implicit / explicit in business planning - not an add-on Is it one person - named executive? How does it work collectively? 3.2 = operational 3.1 Variance in remuneration for role - moves outcomes ……. Embedding - proactive,, quality indicators slipping 3.3 single oversight framework - good learning culture - good organisation culture - good patient care	3.1 Impact & - patients, learning environment, individual staff Influence - future workforce Linking backward - culture The learner voice' - multiple layers Represented shared governance models measured collaboratively - recruitment, retention, commonalities of STP/HEI's education strategy	
What they will do/comments: Will look at strategic objectives across the STP footprint and will have a multi-disciplinary pilot across AHP, medical and Bands 1-4		

Mid and South Essex

Principle 4 - Clinical Learning Environment learning resources The organisation has resources and facilities to facilitate the development of clinical competences and membership of a positive clinical user centred community.

4.1 a couple of exemplars needed re-visiting engagement and recruitment – we wanted to clarify it is recruitment to programmes rather than recruitment per se that we need to have engagement with. Widening the exemplar to a wider engagement with healthcare practice careers pathways and wider engagement in relation to curriculum development events – not just recruitment the wider education perspective

Placement feedback to be captured and used to inform whether the organisation did present a positive clinical user sense of community we weren't sure the exemplar would really be measuring that in its entirety. We wanted to see inclusive engagement of all areas which support learners as an exemplar.

KPI/exemplar around supernummerate clinical teaching staff a better exemplar would be how education funding from tariff is used to support clinical teaching roles we didn't feel supernumerary clinical teaching staff would be achievable or sustainable.

Missing

Wanted some clarification on who local leaders are – is it the local lead who is regularly dealing with practice education and clarification around clinical leadership structure which could be different dependant on the organisations.

Wanted to see inclusion of learning from medical colleagues they do somethings very well in terms of having clear metrics for every visit, have more consistency across board and in relation to quality and update of appraisal processes which we don necessarily have consistently for non-medical quality assurance.
4.2 Some exemplars were repetitive 1 and 4 could be merged both around IT. Considered having an increased use of simulation learning suites. Not everyone has access to those to have sharing of those resources across STPS as a learning resource would be a useful KPI in terms of the learning environment.

Role of CLE to assess students' digital competencies – that will be big going forwards in r elation to NMC. Linking library facilities to the LQAF outcomes. Potential risk from that how will some of the other areas have access to digital resources such as nursing homes as they may not have good IT access currently. In terms of how it might be useful to us it was in relation to the use of tariff funding and identifying through the orgs that it is actually linked to those particular outcomes.

What should be added or removed	How will they be useful to you in improving the quality of CLE?	What is missing?
4.1 - clarify recruitment programmes broaden engagement to wider engagement with healthcare and practice careers/pathways widen engagement (e.g. include curriculum development etc)	Align use of tariff funding to CLE and support for board priorities (e.g. DoFs)	Clarification of who the 'local' leaders' are. Is it local lead who regularly engages with practice education? Clarification of clinical leadership structure - evidence of involvement in education at every level include learning from medical colleagues (e.g. clear and consistent metrics for every visit)

ensure placement feedback captured and used to inform whether the organisation does resent a positive clinical user centred community need inclusive clinical engagement for all areas that support learners supernumerary clinical team staff - should be 'how education funding (tariff) is used to support clinical teaching roles'. 4.2 - 1&4 could be merged (repetitive Add use if simulated learning suites (share across STP) as a learning resource Role of the CLE to assess students digital competence link library resources to LQAF *potential issue of access to digital resources in some areas* (e.g.. Nursing homes, community)		No process measures for 4.1 (what forums are in place to support learning and sharing of best practice around the CLE? E.g. how is ownership for student learning demonstrated? Length of placement - students being on placement long enough to feel like they belong and gaining enough experience to be able to deliver hand on care. Additional Principle: additional exemplar around all staff having educationally focussed objectives included in their appraisal.
What they will do/comments: Could it be a methodology to be used as a guide to the national framework that can be utilised by placement providers? It will be used to support peer review in critical challenge. It must not be an extra process to the national standards. It needs to be made easier to implement and understand - could form the next QI handbook. Needs to use data easily found which actually measures quality (e.g. not just number of mentors).		

Norfolk & Waveney

Principle 5 – Partnership Working - The organisation has effective structures and processes in place to promote and implement strong partnership arrangements, such as service planning, the sharing of information and quality improvement activities.

Strong feelings if there was a need for these principles. Were they going to add value or not – tried to be positive and looked at evidence if they would add value. Clear beliefs the language we use needs to be simpler and user friendly and friend also for service users. Took on task of re-writing every one (see below) to give value to organisations and partnership working. Would it give value with our service users, with our partners, universities and learners?

Missing

Focussed on multi-agency multi-professional.
Multiagency and system wide agreements in place to ensure the maintenance of student placement experience (*not practice experience*) and capacity, including during un planned events across the systems.

The following are changes that group 5 at the CLE meeting requested
5.1

- Through governance structures, there is a timely and effective approach between practice and education partners for the preparation, allocation and evaluation of practice experience
- There is a named individual with the authority and responsibility who formally liaises wit relevant educational partners
- All parties are empowered to raise concerns about the practice experience, which includes clearly identifies processes and systems to address those concerns

Extra
Multiagency and system wide agreements in place to ensure the maintenance of student placement experience and capacity, including during un planned events across the systems.

5.2
Interprofessional working and learning opportunities aligned to the patient journey are promoted and identifies
General comment: was they felt that the work of the 3 pilot mentorship projects, e.g. CLiP, PBLS, and Lead mentor, were not highlighted and represented enough. They felt this was the work that had been championed and needed to be more evident

What should be added or removed	How will they be useful to you in improving the quality of CLE?	What is missing?
Group re-wrote each statement and added 1 on 'multi-agency and system-wide agreements) - *see separate document*	They need to add value to natural system	Multi-agency and system wide agreements in place to ensure the maintenance of student experience and capacity, including during un-planned events across the systems
mentor models	They need to be linked more specifically to the mentor work i.e. CLiP, PEBLS, lead mentorship	
What they will do/comments: engage with HR group to share the work undertaken on mentorship and the principles of CLE to explore opportunity of raising at STP Board. Continue to work with DoNs to continue to explore mentorship models and work in partnership with the university to explore more effective ways of using the tariff		