Report from the pre-registration nursing stakeholder consultation

March 2018

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1. Introduction

The OU currently delivers the BSc (Hons) Adult Nursing and the BSc (Hons) Mental Health Nursing, qualifications that have been established since 2002 and have a consistently high student retention (>90%). The qualification is delivered in Northern Ireland, Scotland and England in a successful partnership with a substantial number of employers. From 2018, the programme will be delivered in Wales too. In England, the OU is actively leading the nursing degree apprenticeships agenda with the Registered Nurse Degree Apprenticeship now being offered as an apprenticeship.

The Nursing and Midwifery Council (NMC) regulates the nursing qualifications, which currently meet the 2010 Standards for Pre-registration Nursing Education. In 2016 the NMC started the process of developing new proficiencies and an Education Framework: Standards for Education and Training. These new standards, which will replace the 2010 standards, are published in draft and a consultation has been completed. The NMC will publish the final versions in spring 2018 and all UK pre-registration nursing degrees must use the new proficiencies and Education Framework from September 2020, at the latest. There will be an NMC approval event for the new OU nursing degrees in spring 2019. Due to interest across the UK, we will be offering a BSc (Hons Learning Disabilities Nursing, as well as the current qualifications. The new requirements necessitate extensive curriculum changes and we are taking a partnership approach to our curriculum development.

2. Consultation activities

From September 2017-January 2018, we ran seven multi-stakeholder events, with 195 people participating (see Appendix 1 for details). The events were held in: Nottingham, Belfast, Leeds, Newcastle, Exeter, Tunbridge Wells and Winchester. A good mix of stakeholders attended the events, including employer representatives, mentors, OU practice tutors (PTs) and module tutors (MTs), service users/carers, students and alumni. Nation/locality and central academics attended each event. We also held an afternoon session at the Annual Nursing Partnership Meeting in Scotland, conducted 2 skype meetings with PTs/MTs from across the UK, conducted four individual phone calls with service users/carers and alumni in Scotland; see Appendix 2 for a summary of two telephone conversations. We also received additional comments/suggestions from individuals, some of whom collected information from local, practice-based staff. Event participants completed evaluations at each event with very positive results (see Appendix 3). They commented that they enjoyed the discussions, learnt more about the NMC's proposed changes, and appreciated the chance to network. Suggestions from earlier events influenced the later events and all feedback will influence any future events organised.

Each event started with an overview of the nursing programme at the OU, including numbers of students and locations, and a synopsis of the NMC's planned new standards for pre-registration nursing education. During the rest of the event, there were a series of table-top discussions, which were captured on flipchart paper, and subsequently written up and sent out to attendees at each event. This report provides a summary of all these discussions combined with information from the additional consultation activities.

3. Discussion area 1: strengths, Weaknesses, Opportunities, Threats

Discussions took place focused on:

- What do we do well? (Strengths);
- What could we do better? (Weaknesses);

- What do the proposed new NMC standards and changes in healthcare and education pathways and funding offer? (Opportunities);
- What are the pitfalls and challenges ahead? (Threats)

3.1 Strengths

There were many strengths of the current OU programme identified, which relate to the following areas: accessibility of the programme; recruitment process; programme structure, materials and content; benefits for employers; student support and development; and personal benefits for students.

3.1.1 Accessibility of the programme

- Entry for students who would not be able to access other provision, including those with disabilities and people from different backgrounds
- Online delivery: easier access, reduced travel costs, works around family
- Enables diversity: recruitment from the local community, attracts mature students due to flexibility.
- Lower entry requirements [OU requires only minimum NMC requirements]

3.1.2 Recruitment process

- Effective and robust recruitment and selection process, which impacts positively on retention
- Service user input through the application process
- Motivation and experience of applicants

3.1.3 Programme structure, materials and content

- Flexibility of the programme: adaptable, offers opportunities not otherwise available, the model is able to 'flex and morph'
- Aligns with apprenticeships
- Offers scale and bespoke dimension/individualised provision
- Library resources, 'amazing' website and materials, access to Clinicalskills net
- Gradual educational development throughout stages 1-3, progressive, setting goals, and supportive review points, developing topics across the programme
- Comprehensive programme; current level of expectation feels positive
- OU programme combines experience/value of fundamental care/nursing skills with academic/professional.
- Module structure: well organised, ideas develop, helps understanding, supports development at each stage, regularly reviewed
- Presentation of content: clear written materials (good for students with dyslexia), video clips breaking up the text,
- Good use of technology to support learning – students develop excellent IT skills, which they can apply in their workplace

3.1.4 Benefits for employers

- Work based approach with continued growth of employee/student skills
- Employer ownership and support: students are known to employers and they feel valued; employers have a vested interest in student success and provide support to learn
- Supports staff progression: opportunities to develop healthcare assistants, 'grow their own' staff, retaining students as staff
- High student retention rate
- Calibre of students: resourceful and use initiative, understand role, understand NHS culture, come prepared with experience and 'resilience' of the environment, positive mentor feedback about the students
- OU's independent learning approach pays off in quality and proficiency of practitioners developed: their initiative, good self-discipline and determination, organisational skills, confidence

- Individualised practice learning: placement areas are known and employers can influence placements
- Partnership working between trusts and OU very good: very good communication and positive relationships, practice tutors support mentors

3.1.5 Student support and development

- OU very supportive: good resources and infrastructure of support with allocated tutor support for practice and theory
- Associate lecturer and practice tutor roles and their liaison
- Student centred support: email, telephone contact and visits.
- Staff tutor offers support and relationship building
- 'Outstanding tutors': know their group of students and take responsibility, follow up on students not engaging, available for 1:1 on phone to address difficulties, readily available
- Practice tutor role very positive: cohort sizes, student support, Individualised/personal approach, visits by practice tutors
- Processes in place to support student with additional support needs (e.g. dyslexia) and to support students at risk of failing
- Module Tutor materials - excellent support when there are problems, issues dealt with quickly.
- Employers' investment in OU students provides additional and robust support (own staff – 'inside' organisation)
- Students very well supported with personal difficulties: '*like a family network, able to cope with students with learning challenges – not just a distance learning university – went the extra mile'* (Alumni, Scotland)
- OU programme builds on work and life experience of students, promotes independence, develops ability and confidence, promotes resilience as a result of challenges/addressing weaknesses.
- Students are eased into study which builds confidence and find information easy to understand

3.1.6 Personal benefits for students

- Work/life/study balance: can maintain income, work alongside study and '*live your life while learning*'
- Flexibility within practice learning periods enables students to work and study alongside family life
- Very good for mature students
- No debt in the end, no travel.
- Current and own employment improves employability

3.2 Weaknesses

The weaknesses identified included specific issues related to: structure and content, tuition and assessment, practice learning and placements, students' practice experience and role. There were solutions suggested too and other points were posed as ways for improving the programme.

3.2.1 Structure and content

- Differing nature of OU programme (compared with other nursing degree programmes) - different programmes of study at different universities create employer/mentor confusion
- Biology content (Adult nursing): too intense and not sufficiently applied, not spread across the whole 4 years
- 'Research' module [KYN316]: difficult, i material should be introduced earlier in 'bite-size' chunks
- Module overlaps: reduce where possible

- Programme length: 4 years too long for employers, course could be shorter (3.5 years) to balance employment and student commitment

3.2.2 Tuition and assessment

- Module Tutors and Practice Tutors could link more: need to know if students are struggling so can support.
- Greater continuity of practice tutors for students across the programme
- Practice tutor role: could be expanded, e.g. greater involvement in placement such as observation of practice rather than involved at a distance.
- Practice tutors: some appointed 'last minute', need more student contact from the beginning of the placement, better to have practice tutors for a group of students in a Trust
- Practice tutor report: a live document online which could be updated as needed rather than a monthly update
- Lack of consistency re timeframe for module tutors/practice tutors responding to email
- Lack of involvement of module tutors in initial induction of students
- Module assessments: some inconsistent expectations e.g. content presentation
- Module wide forums: students may be anxious about posting on a large forum
- Delivery of course materials: some silo module delivery
- Online tutorials: can be isolating, only know tutors online

3.2.3 Practice learning and placements

- Alternative placements may be too short
- No formal clinical skills sessions or simulation
- Managing placements for trusts working with several HEIs: other HEIs' full time students might be prioritised over OU students, OU's role in audits and placement office
- OU programme considered complicated as placements so individualised for students
- Field-specific competencies: some skills can be missed out/developed late (important that key skills are developed)
- Combination of physical and mental health experience not always easy to achieve
- Case by case management required: challenges of students' changing rotas
- Lack of placement reviews in each placement - missing opportunities for evidence; Issue of stage 2: 3 reviews over 4 placements
- Identification of students: local interpretations of uniform
- Different contractual arrangements: levels of support/seconded.
- IT access in placements not always good: user name and password access
- Need protected time for practice meetings
- Uncertainty re placement requirements (e.g. how long maternity and child experience needs to be)
- Importance of placement preparation: pre and during programme
- Core placements (several issues, though solutions also offered):
    - Good for employers to have flexibility but need OU guidance/support too
    - Risk of mentor/student collusion on core placements (but can be managed with practice tutor support),
    - Student not recognised by other team members as being a student (need confidence to be assertive and mentor to advocate for student),
    - Can impact on 'student' status - risk of reverting back to healthcare support worker role, need to allow time to develop into student role.
    - Students (and colleagues) dealing with student being 2 days as a healthcare assistant and 2 days as a student
    - Could be better to start on alternative placement - core placement needs to be right length (is it too heavily weighted?). Examples offered of students

having first placement on non-core ward, which worked well, returned to home ward as third placement in Stage 1.

- Students need confirmation of non-core placements at sufficient notice to enable students to plan child care etc.
- Mentor preparation: limited time and support for mentors, mentors need greater notice for induction sessions at the beginning of each stage
- Staff may assume OU students know more than they do so they miss learning opportunities
- Peer support: students isolated at times, lack of group identity, no critical mass, small student numbers in any one area, students can 'get lost'. Solutions offered: one Trust set up a local study group; another facilitator set up a Facebook site for local OU students
- Students may not have the right IT equipment and access needed or have necessary skills.
- Students need more encouragement to use external resources
- Students need to be autonomous - some students may not be proactive enough
- Students need resilience: role requires multitasking and can be stressful as managing various elements: healthcare assistant; student; home
- Students; understanding how much work is involved: can be a culture shock

3.2.4 Mentorship and assessment in practice

- Access to and identification of mentor for each experience
- Mentors/supervisors may lack sufficient awareness of OU programme requirements, process and expectation (e.g. making sure they work 40% with the student), not always aware how to access information, may not always understand students are also healthcare assistants and are juggling both
- Students' and mentors' perspectives about how 'competent' the students actually are e.g. perceptions that student is 'already doing a nurse's job' and the programme is a formality (particularly in core practice base where students work) and may be assessed at levels higher than they are at because they are a 'good' band 4 healthcare assistant
- Practice tutors can face difficulties in contacting mentors as they may not have Trust emails
- Portfolios: paper portfolio – needs to be electronic, repetitive signatures and over-wordy, expectations of evidence inconsistent

3.2.5 Other areas

- Recruitment: Interviews – lengthy application questions, could be a smoother process; different selection process for OU (than other HEIs)
- Loss of employee (backfill issues), which limits number of staff who can be released
- Apprenticeship levy issues
- Marketing and employer engagement more in partnership with the curriculum team

3.3 Opportunities

The opportunities identified related to: curriculum development, structure and content; programme delivery; recruitment and access; partnerships; practice learning; practice assessment and supervision; for students.

3.3.1 Curriculum development, structure and content

- Increased service user, student and tutor involvement in curriculum development
- New ways of delivering provision e.g. blended approaches
- More even workload (exams earlier in year rather than at end)
- Standardisation of taught clinical skills
- Specific skills and learning objectives to achieve

- More creativity in curriculum and assessment
- New fields/courses e.g. Learning disability field, dual registration
- Aligning Mental Health and Adult Nursing
- Module 'chunks'
- Reduce theory and theoretical assignments in practice modules (increase focus on learning in practice)
- Less essay writing and more practice skills – practice experiences helps with understanding the concepts
- Learning biology and pharmacology related to practice would be better (e.g. pain, nausea)
- Opportunities to step off the programme and onto another if nursing is 'not for them' at the end of stage 1 – also enable employers to understand this option
- Topics developed across the qualification (all stages): safeguarding, evidence-based practice, professionalism (including challenging) and self-awareness
- Important topics to include: pain, sepsis, assessment, care planning

3.3.2 Programme delivery

- Tutor forums and tutorials: improve format and build into curriculum, more creative use of Adobe Connect (OU's online system) to engage with active learning, setting up expectations from outset (e.g. adobe connect, support mechanisms, students' ownership of their learning)
- New assessment process
- Individualised approach: less restrictive/self-directed learning
- Improve peer support: bring students together (e.g. Whatsapp), arrange meetings for students online/'face to face' for more support, Create small cohorts in employer organisation – peer support
- Practice tutors to be move involved in skills: expanded PT role might attract recruits
- Interprofessional learning

3.3.3 Recruitment and access

- Increasing access options, more career prospects, opportunity to promote an alternative pathway into nursing – starting as a band 3.
- Apprenticeships – could be available at all levels – follow funding, use Apprenticeship Levy
- Self-funding? Secondment two days a week from their job?
- Equal opportunities for all – more accessible.
- Engagement and marketing with employers to 'sell' what's on offer - 'home grown' talent, more stable workforce:
- Marketing for post-registration opportunities (mentors/employers not aware).
- Could use Adobe Connect within recruitment process to prepare expectations

3.3.4 Partnerships

- Build on existing partnership working.- increase collaborative ways of working and conversations, opportunities for co-creation/co-production, strengthen links with employers further
- Joint learning and learning culture - communities of practice - online tutorials trust-based
- Strengthen employer understanding of course and course structure
- Organisations can train the numbers they need and create training groups together locally
- Increased partnership working with service user and carer led groups: involvement at earlier stage of programme design and from point of induction
- Work together to celebrate learners' achievements

3.3.5 Practice learning

- Inter-professional learning contexts
- Possibilities for increasing placement capacity: opening up alternative placement areas e.g. use of independent sector, well women clinics, sure start, de-categorise placements - change of mindset.
- Greater collaboration between different practitioners
- Responsive to student need: flexible core base at each stage
- Stages 1 and 2 not in HCA base as a Student Nurse
- Development of bespoke practice learning opportunities
- Simulated opportunities for knowledge acquisition
- Consider how to remove barriers for transferable competencies
- Recognising importance of context/perspective and placement planning e.g. stay in directorate but on an alternative ward.
- Enhancement of clinical skills learning opportunities
- More emphasis on learning in practice: reduce theory, relate biology to practice

3.3.6 Practice assessment and supervision

- Portfolio; standardisation of portfolio across universities; electronic document
- Open opportunities for experienced nurses to supervise students: remove the barrier of having to have completed the mentorship programme.
- Clarify practice supervisor role [relates to NMC proposals]
- Full time placement toward end not in core practice base
- Gain a variety of views e.g. assessor clinics
- Review the assessor/supervisor split - ensure good communication between practice supervisor(s) and assessor
- Credit practice modules and assess them in practice only.

3.3.7 For students

- Opportunity to shape future and develop their roles – influencing profession and practice
- Learning from people who are really focused and inspirational – nurses with different views and goals
- To be a student out of health care assistant role
- Student representation: local representative in each area with group representative meetings in adobe connect; a single point of contact, so students can raise issues or concerns in a safe environment
- More involvement of students in curriculum development

3.4 Threats

A number of threats identified concerned a range of external factors. There were also threats concerning: funding issues, employers, the new NMC standards, practice learning, and some OU-specific factors.

3.4.1 External factors

- Congruence between Nursing and Midwifery Council, higher education, patients and Trusts
- Coping with constant change including reorganisation within the NHS and other providers.
- Changes to community care e.g. moving into councils and managed by non-professionals, health visitor and school nurse roles merged
- Business model: changed approach, service needs flexibility.
- Disconnect between policy and practice
- Political issues: Brexit, independence in Scotland

- Impact of media and PR about OU on student perceptions
- Quality assurance
- Confusion between Nursing Associates vs Registered Nurses vs Assistant Practitioners – confusion for employers/finance
- Challenges to NHS workforce and funding for staffing
- Current media image of nursing
- Loss of identity as nurses

3.4.2 Funding issues

- Apprenticeships: Levy money will be used for lower levels of programme/training, not paying salary
- Changes to funding (England): student loans and impact on recruitment of students
- Self-funding students and implications
- Funding arrangements not always understood by employers
- Transparency about funding

3.4.3 NMC standards

- Lack of clarity in some areas
- Proposal for increased simulation: no clarity around simulation and what it will mean in practice, lack of simulation centre, simulated practice skills (impossible to portray real context).
- New supervisor/assessor plans and implementation: misinterpretation of supervision/assessment – potential drop in standards
- New NMC Standards procedures list: extra skills required to be achieved/extra level of skills' tick box exercise; impossible to achieve all skills? Focussing on task outcomes and losing qualities of reflective practice
- Tick box approach to inter-professional learning

3.4.3 Employers

- Time of change: resistance and uncertainty
- Losing skilled band 3s/HCAs/support workers
- If students not employed promptly after programme they become de-skilled.

3.4.4 Practice learning and assessment

- Securing placements and availability of placements in a stretched NHS, particularly with the clear differentiation for practice supervisor and separate practice assessor
- Pressure on clinical areas to provide placements for students, number of learners, time to support students, supervise and record.
- Clinical support due to staffing levels and capacity of staff to support new pathways.
- Maintaining a patient centred focus and patient expectations
- Changing attitudes of existing registered nurses
- Different opportunities in different trusts
- Achievement of practice learning opportunities dependent on relationships/goodwill
- CQC status and impact on learning opportunities
- Changes within practice e.g. review of Mental Health, funding
- Fundamentals of nursing care may not be seen as important.
- Requirements for: maternity/learning disabilities/mental health – four fields experience
- Mentors' lack of understanding about assessment (Bondy levels) and confusion between objectives vs outcomes (difference in portfolios).
- Team members may be struggling themselves e.g. new staff, lacking confidence
- Access to IT from working environment (also for mentors). Students may not have the necessary IT skills.

3.4.5 OU-specific

- Loss of OU regional offices: loss of presence, need to ensure we can maintain face to face inductions
- Marketing of OU programme: being aware of our competitors and what they are offering – offers of blended learning, identifying our USP
- Students training to work in 'region' and 'cultures'
- Flexibility of national provision
- Length of current programme and flexibility with life changes
- Communication of changes: to practice tutors, students and mentors (practice supervisors/assessors): ensuring all have an equal understanding of changes and rationale

4. Focused discussions

A further focus of discussions related to: enquiry-based learning; virtual simulation; practice learning and assessment; and ideas for Stage 1 of the new programme

4.1 Enquiry-based learning (EBL)

In EBL, learning is triggered by scenarios representing real-life situations, which increases application of knowledge. EBL encourages students to find more information, make decisions and suggest solutions, while stimulating independent learning and developing transferable skills. There was a very positive response to the proposal for an EBL approach for the stage 2 and stage 3 theory modules of the new curriculum. For example, it was thought that EBL would encourage person-centredness and students would better understand the relevance of subjects, such as biology, when directly applied to a scenario. . Discussions revolved around three areas:

1) How to implement EBL effectively
2) Core areas of learning that EBL could facilitate
3) Specific scenario ideas

4.1.1 How to implement EBL effectively

- Needs a blended approach, carefully constructed, supported package using rich media, exciting graphics, healthcare resources, virtual families (could link with simulation)
- Important to portray real life experiences – 'bigger picture' scenarios – what do students need to know?
- Needs setting up properly and recording: need to understand the work required to set up and manage EBL (resource)
- Service user focus/involvement opportunities (e.g. peer support workers could support with scenario development)
- Facilitator's skills important: use coaching principles, students need to develop a plan of what they need to learn
- Delivery: consider face-to-face, online, interprofessional education
- Online tutorials using Adobe Connect: with students in groups, work as a small group, decide who will find out what,
- Be mindful of UK wide regions: facilitates rich learning experience if students learning in groups across UK
- Could be student led from practice experience with peer exploration and inquiry, could discuss actual incidents/reflect/take on different roles/rotate group roles
- Assessment: 10% of grade could be teamwork contribution
- Adapt some of current OU resources e.g. scenarios in modules
- Increase complexity across curriculum: staged to allow for progression/building skills, synthesis of learning

- Build in flexibility: change/update themes in line with societal change, bank of scenarios
- Adaptability to situations: follow the patient journey
- Scenario repeated and developed: not a ‘right’ or ‘wrong’ – feedback to guide certain aspects
- Explore consequences and wider consequences
- Promote transferability of learning
- Technology: reliable technology essential (awareness of firewalls/blocked network issue), data protection – VPN, virtual simulation rooms, Whatsapp groups – security issues
- Build skills across stages: e.g. stage 1: focus on detailed case study in core placement to foster person centred care & develop core skills; stage 2: community profile; stage 3: exploration of an area of practice to critically appraise and identify strategies to develop and implement and evaluate change

4.1.2 Core areas of learning that EBL could facilitate

- EBL scenarios mapped across NMC skills/proficiencies (e.g. health promotion) and (patient focused) learning outcomes, address EU directives
- Illustrate practicalities of different interventions and outcomes
- Compare and contrast skills based scenario with different patients
- Underpinning epidemiology, psychology, biology, anatomy, physiology, pathophysiology, pharmacology, microbiology
- Public health/promotion including making every contact count
- Social issues e.g. Food bank
- Carers: including complex carer issues (example: young carer of someone with dementia)
- Leadership
- Management skills: e.g. alerts about risks, professional response, accessing help, budget control/economic planning
- Culture, equality and diversity
- Accountability, professionalism and trust (attitudes and behaviours, revalidation), role modelling
- Model of nursing: holistic assessment and care (whole picture, including social aspects), person-centred (including family dynamic, carers)
- Care pathways and sectors: interdisciplinary, integrated care, dynamics of community/acute interface, voluntary, discharge planning
- Inter-agency working and team working: multidisciplinary teams, interactions with different teams including social care
- Understanding context: political context, policy drivers (local and national), local management of care: policy, governance structures
- Risk assessment and learning from incidents/accidents, human factors
- Ethical issues and conflicting situations (e.g. being told confidential information)
- Safeguarding (abuse, neglect) and serious incidents
- Health and safety
- Medication management
- Investigations and diagnostics
- Communication skills: questioning skills, and different communication styles, empathy/compassion - appropriate responses; difficult conversations/conflict resolution; dealing with aggression; delivering bad news/sensitive communications
- Care planning, Implementation and evaluation
- Prioritisation, delegation, coordination, decision making
- Fostering curiosity, problem solving and critical analysis
- Escalation and referral

- Documentation and record keeping
- Fundamental care and practical/advanced skills
- Emotional resilience/awareness
- Reflection/self-awareness – in and on action
- Challenging practice – what went wrong?
- Evidence sourcing/independent research skills (OU library, journals, assessing research/evidence, national guidelines)
- Teaching skills

4.1.3 Specific scenario ideas

- Across settings: start with family/street scenario > GP surgery > hospital
- Family example:
    - Recognising care at home issues – keeping people at home, care in the family environment etc.
    - Opportunity to look at all generations (family tree, genetic issues) and lifespan, individual with issues and impact on whole family
    - Example: grandmother with alcohol issues, grandfather confused, physical deterioration, admitted to hospital (a smoker, has chronic respiratory disease), mother is in a carer role, one child has a learning disability (e.g. autism), a daughter has sexual health issues, pregnancy, safeguarding issues, mental health issues (depression, self-harm), frequent A&E attendance
    - Range of physical/social issues and services working with family: explore bigger picture, different perspectives, e.g. financial impact on health (lack of money for heating, food), family and lay ideas about health, family involvement in decision making and best interests
    - Emotional support and evolution of family circumstances as scenarios unfold and dynamics change
- GP surgery as basis with different clinics and people accessing: referral to other services/disciplines, variety of clinics (health visitor, children), explore child not being brought to clinic (DNA-pattern emerging, case review, root cause analysis), incident reporting and trend analysis, include diversity e.g. transgender/neutral, different health issues e.g. post-traumatic stress syndrome
- Hospital-based scenarios: handing over a group of patients, prioritising care, delegation, rationale, cardiac arrest, link to fitness to practice, leadership, managing situations, supervision
- Operating department scenario: prioritising patients, environment fundamentals including roles, conflicts (legal, ethics, family views and pressure), safety (check list, processes, physical positioning), people with learning disabilities, privacy, dignity and confidentiality, anxiety and loss of control, communication challenges, conflict resolution and behaviours, pre theatre visit, post-operative care
- Road traffic accident scenario: start with the obvious and bigger picture emerges e.g. alcohol factors, spinal injury and paralysis, link in with support services and multi-disciplinary team (physiotherapy, occupational therapy, social work)
- Community scenario: complex patient with palliative care needs, clinical skills e.g. catheterisation, admission and discharge, resources needed for care at home, communication across hospital and community (integrated care), ethical dilemmas, legislation
- Older people and frailty, falls, dementia, delirium
- Recognition/care of confused/deteriorating patient
- Mental health: mental state awareness, Isolation/anxiety, suicide prevention and awareness, managing risk of self-harm, initiating and monitoring seclusion, eating disorders, recovery, dual diagnosis, short term memory loss
- Learning disabilities

- Infection control, wounds, pressure area care
- End of life care, palliative care, bereavement,
- Chronic long-term conditions and care: diabetes, chronic obstructive pulmonary disease, bipolar disorder, paralysis, osteoarthritis
- Co-morbidities
- Stroke/neurological scenario
- Public health: flu, lifestyle choices/conditions, travel health – globalization, immunisations
- Nutrition and hydration
- Acute conditions/pathways, including sepsis, cardiac
- Surgical interventions and care
- Data, serious incidents, multi professional experts related to scenario involved
- Hypertension
- Lifespan: adolescents, maternity, older age
- Hearing and visual impairment
- Sexual health, sexuality and body image (e.g. cosmetic surgery)
- Post-discharge care and self-management
- Services: transitions between ages and services, primary/secondary care

4.2 Virtual simulation

Currently, under the NMC's 2010 standards, 300 hours of practice learning can be in simulation. The NMC has proposed increasing the proportion of simulation to up to half of the 2300 curriculum hours of practice learning. The NMC's definition of simulation is: 'an artificial representation of a real world practice scenario that supports student development through experiential learning with the opportunity for repetition, feedback, evaluation and reflection'. The Nursing team have scoped the literature on virtual simulation and found the following definition: 'an interactive reality technology that recreates real-life scenarios' (Duff et al. 2016). A review of studies that investigated virtual simulation concluded that it is comparable or superior to traditional simulation methods (Duff et al. 2016[1]).

Generally, most people considered that virtual simulation could play a useful role and there were many areas identified as suitable for virtual simulation. However, there were limitations identified and there was little support for it replacing much practice learning. There was an emphasis on the use of simulation having good rationale and adding value. The discussions about the role virtual simulation might play in our new curriculum were around the following areas: 1) General considerations; 2) Care settings; 3) Clinical skills; 4) Communication skills 5) Professional and management skills

4.2.1 General considerations

- Role/proportion – varied views, which included: rehearsal for real practice but should be as well as not instead of; simulation needs to be appropriate and not just tick-box or working to a percentage, but used to fill/enhance gaps in theory/practice; overall, should not lose too many practice hours - no more than 20%; it has to be the best way of learning not a stop gap for practice support; need physical real world scenarios to demonstrate competence; could be less actual practice: 70/30 practice: simulation;
- Assessment: award credit/marks for 'contribution', consider marking if contributing to practice hours, consider shared assessment and peer review skills

[1] Duff, E., Miller, L., Bruce, J. (2016) Online Virtual Simulation and Diagnostic Reasoning: A Scoping Review. *Clinical Simulation in Nursing* 12, 377-384

- Use forums to facilitate virtual simulation: could use role play
- Open access and flexible: not time limited so that students can access learning relevant to particular placements e.g. wound care when with district nurse
- Some scenarios in current modules (e.g. in KYN237) could be adapted for virtual simulation
- Provide robust feedback on development - learning from debrief – needs to be competent and comprehensive for maximum impact, students need feedback on areas where they have not met outcomes/not achieved
- Provide in 5-10 minute chunks: 'bitesize'
- Should be easy to update when there are new changes
- Need to be clear about what skills must be performed in practice and which in simulation
- IT skills necessary (healthcare staff already do online training)
- Gamification and virtual reality suites (e.g. project hospital – new game could be made 'serious' and 'realistic'), goggles for virtual reality and use of sensors for touch
- OU could access funding for technological developments
- Fits in with EBL and is a way of making learning 'fun'
- Appropriate for some clinical skills development: useful repetition of skills practice, allowing safe testing of skills – students can access exposure, develop confidence
- Link with online tutorials to make more interactive e.g. discussion with tutors, then move to outcomes of decision making
- Use for reflection, to consolidate practice and bring an individual perspective
- Ensure diversity across simulation
- Bridging theory and practice gap
- Use for anatomy and physiology

4.2.2 Care settings

- Include day-to-day scenarios, not just emergencies and avoid over-dramatisation of scenarios – be realistic
- Use to cover shortage of placements: show visualisations of units/theatres, wards, maternity or learning disability experience, children; unpredictable environments
- Family/home situation: students going into patients' home [the actual state portrayed and coping with shocking situations], identifying risks
- Insight into fields of practice: child, learning disabilities, mental health
- Health prevention/health promotion (mother and child, breast feeding support, advice/guidance, signposting, boundaries)
- People with rare situation/rare condition, diagnosis, Interaction

4.2.3 Clinical skills and situations

- Clinical skills which students may have less opportunity to complete in practice e.g. PEG feeding
- Sensitive issues' that not all students may experience, or that they should have exposure to before 'doing' (e.g. never events; outbreaks; violence and aggression; end of life issues; children and young people; safeguarding; serious case review; alternate fields of practice; drug interactions/errors)
- Drug interactions and effects: e.g. impact on physiology – blood pressure
- Needs assessment – person-centred, holistic whole body assessment, observation, thinking through evidence, physical history/holistic history
- Assessment skills: physical and mental health and co morbidities, identification of anomalies (like driving test video)
- Assessment tools e.g. wound and selecting products
- Challenging scenarios e.g. alcoholism
- Mental health issues: actors playing different mental health roles: different presentations e.g. eating disorder

- Interpretation of results, differential diagnosis (e.g. ECG, blood),
- Problem management: what now choices
- Deteriorating patient (mental health, adult): increasing symptoms, National Early Warning Score, triaging,
- Emergencies e.g. road traffic accident, hyper/hypoglycaemia, crash call scenario, resuscitation and emergency care, first aid, basic life support
- Inter-relationship between psychological and physical issues through scenarios
- Risk assessment e.g. self-harm/suicide risk, mental/emotional distress) and near misses, through game playing/gaming
- Prioritisation/sequencing of activities
- Medication: regulations, administration, management, calculations, preparing for intravenous therapy and injections, including emergency administration
- Clinical skills: health and safety, wound care, aseptic technique, venepuncture and cannulation, blood glucose monitoring, catheterisation, fundamental nursing care, feeding pumps and other equipment – error checking, infection control, nutrition and dietary requirements,
- Care planning and patient management

4.2.4 Communication and interpersonal skills

- Developing communication skills: active listening, summarising, paraphrasing etc.
- Non-verbal communication and body language
- Communication barriers
- Empathy
- Motivational interviewing,
- Human interaction and understanding e.g. cognitive impairment,
- History taking,
- Communication across the lifespan and at end of life
- SBAR tool (Situation, Background, Assessment, Recommendation)
- Self-awareness/reflection
- Dealing with distress e.g. ‘upset’ relatives
- Managing incidents/conflict (de-escalation, aggression management),
- Supporting others and delivering bad/difficult news
- Developing emotional resilience e.g. preparing students for death and de-briefing
- Observation/interactive skills
- Dealing with challenging behaviours

4.2.5 Professional and management skills

- Moral and ethical dilemmas,
- Using and applying the NMC Code
- When care goes wrong and trouble-shooting: how to resolve and manage mistakes, simulate errors e.g. medicine errors, serious untoward incidents, unexpected occurrences
- Dealing with complaints and governance
- Major incidents and unexpected scenarios
- Development of problem solving skills
- Complex decision making and rationale for clinical decisions
- Skill mix, roles and responsibilities
- Leadership skills and teamwork using gaming
- Principles of teaching, teaching/coaching skills, supervision, peer and MDT learning
- Service improvement
- Ward rounds and handover: setting out priorities and delegation
- Record keeping and documentation
- Caseload management: prioritising workload and resources, delegation and managing unexpected changes in demand/need

- Case conferences, tribunal preparation,
- Safeguarding (use Talking Heads)
- Multidisciplinary team meetings, interagency/multi professional/ service user/carer, best interests decision making e.g. complex needs, Inter-professional/multidisciplinary learning and working, integrated care
- Referrals for a range of people including children

4.3 Practice learning and assessment

The NMC's proposed Education Framework includes general principles about practice learning and a number of changes to how practice assessment is conducted, including that the 'mentor' is replaced by two separate roles: the supervisor, who provides day-to-day supervision and can be any healthcare professional, and a named practice assessor (a different one for each stage of the programme), who must be a registered nurse and with assessment skills. The NMC has proposed that there will not be NMC process standards on who, what or how supervisors and assessors are trained, providing freedom for organisations to develop their own models to suit local circumstances. In terms of practice learning, the NMC standards set out that we must provide practice placements that will allow students to:

- develop and meet the proficiencies to deliver safe and effective care, to a diverse range of service users, across all fields of nursing practice;
- meet the technical and communication skills within their field of nursing practice
- experience the variety of practice expected of registered nurses to meet the mental, cognitive, behavioural and physical needs of people across the lifespan.

We discussed how we can ensure students gain the range of practice experiences they need, how the proposed new practice supervision and assessment arrangements might work, how supervisors and assessors should be prepared for their roles, and practice assessment (the portfolio).

4.3.1 Practice learning experience

- Flexible framework in place and scaffold across the years – students need to be on a 'pathway'
- Support for equal weighting between university and practice learning (theory/clinical)
- Who should manage practice learning and assessment needs and organisation of placements – whose responsibility? Placement pressures and other universities needing placements too are a challenge
- Should be 'practice experiences' rather than 'placement' – highlight specific experience/practice area that should be met. How long is an 'experience'?
- Strengthen links between university and placement areas: employer links would welcome ownership and partnership with the university
- Coping with challenges of healthcare in future and impact on students' learning
- Emphasis on leadership/management skills and patient safety
- Additional skills – how will they be taught? Skills focus in new NMC standards could mean less emphasis on values/communication
- Empower students to find opportunities for the skills they need to acquire through 'hub and spoke' approach, guidance/examples of where skills can be acquired
- Practice tutor role – great link between OU and employer/placements
- Student's coach/practice supervisor feeds back evidence against their learning objectives they have met on each shift. E.g. developing skills in leadership/medicines management
- Consider access to skills labs for OU students
- Link policies to practice – policies that enable students' learning/development
- Better prepare students for practice, develop levels of practice to that of student nurse before going on placement, enhanced understanding of accountability and

responsibility, ensuring knowledge and experience of therapeutic interventions as part of nursing practice and therapeutic use of self

- Ensure diversity of experiences, e.g. for students with a core placement in a specialist outpatients or hospice
- Core placement: reduce length of core placement, ensure that the student remains a student when back in their own workplace as some students (or their colleagues) struggle with the student being an HCA on some days and a student on other days (this issue can be overcome). Should the first placement be an area that is not the student's 'home ward' to avoid challenges with core placements?
- OU needs to set criteria for practice learning requirements e.g. surgical experience
- Consider extended practice placements to develop relationships with supervisors
- Timetabling of practice learning opportunities
- Clear mapping of skills, proficiencies and expectations: defining topics/themes to determine specific practice learning within broader parameters
- Competencies to be more practice based
- 'Core' placements for 'core' competencies with specialist skills: adult, mental health, child, learning disability, maternity and consistent opportunities for skills development across various practice fields
- Quality driven: challenge practice placements suitability
- Widen exposure: include short placements across variety of locations as well as some longer ones – acute, community, care of older people and insight placements – make all specialist areas accessible to students e.g. eating disorders, psychiatric liaison
- Inclusion of non-traditional/cross disciplinary learning to facilitate student appreciation of breadth/diversity of nursing provision
- Mandatory independent sector placements to provide variety of experience and fundamentals
- Interagency working – private/voluntary sector (but not as final placements) and build links with community/services (insurance may limit opportunities offered)
- Scope for inter-professional/disciplinary learning – emphasis on transferable skills
- Placement exchanges with other trusts
- Private, voluntary and independent organisations: own apprenticeships – could be positive
- Role of virtual simulation for increasing exposure to different settings: less actual practice: 70/30 practice: simulation; 1500 practice learning hours over Stage 2-3 or one placement in Stage 1 e.g. 12 weeks only. Model: Theory > simulation > practice
- Use virtual simulation for experience and assessment and across field: some skills will always require simulation e.g. IVs in mental health
- Virtual learning experiences increase confidence and offer parity but reduce real experiences and real practice learning
- Online knowledge development and virtual discussions led by experts

4.3.2 Assessment process

- New assessment model: different ways of assessing adds objectivity and has potential for more staff to have responsibility for supporting students, but less standardisation
- Some concerns about the proposed lack of NMC mentor (supervisor/assessor) standards (particularly in private or primary care services) - more autonomy/flexibility could cause issues with consistency and quality assurance of programmes
- Mentors support students over long periods of time so 'more than just skills' – also attitudes/values: will new model provide this or just be skills based?
- Consistency of assessment process for different styles of education/training for students and consistency in application to make the process work (be aware of risks of failing to fail)

- Quality Assurance: set out fundamental expectations, regional quality assurance needed
- Capitalise on existing assessment process models
- Apprenticeships: end point assessment required, organisations need to be apprentice assessment registered
- Flexibility of when assessment takes place
- Practice assessor should have the opportunity to supervise students to ensure the students meet the practice requirement, rather than solely relying on feedback from practice supervisors
- Assessment timing: assess student at the end of each placement/practice period rather than at the end of each year, duty to protect service users/ patients so students need interim assessments
- Opportunities for assessors to discuss each student
- Trust policies: risk assessment, assessors going out into different settings may need honorary contracts, practicalities of releasing staff to go out as assessors

4.3.3 Assessor role

- New nursing and educator roles – upskilling workforce to meet new workforce assessment need and support new proficiencies
- Having enough practice assessors and supervisors in place to support students – how will they be supported in practice? (keeping up to date)
- It should be nurses assessing nurses: assessor should be a nurse with minimum requirements set regionally and nationally, and assessor must be clinically based – clinical credibility
- Assessment/supervision: Identified supervisor for each placement should continue, continuous assessment by same nurse/assessor
- Credibility of practitioner assessing in a different setting (not always field of expertise)
- Who might assessors be? Likely to be qualified mentors so could be upskilling for existing mentors. Practice educators could be assessors. Also, use the transferable skills of Advanced Nurse Practitioner for assessing patients, for assessing students. Assessors register needed
- Assessor preparation: needs to be robust and equitable with updating and equity across assessors, for foundation degrees too
- No funding for practice assessor preparation
- A regional approach for training supervisors and assessors and ways to induct supervisors and assessors (criteria needed), workshops for practice assessors in trusts.
- Opportunity for OU to develop current mentorship course to be an online free resource with open access to support preparation of practice assessors.
- Clearer guidance for mentors, supervisors and assessors. Clarification required on supervisor and assessor. Should it be the same person or not?
- Shared teaching partnership approach in training/preparation across HEIs – regional approach
- Briefing for those supporting students re virtual learning necessary
- Need some guidance and training for supervision and assessment, updates and refreshers
- Assessor should work alongside supervisors
- Hub and spoke model: assessor stays put and uses evidence from supervisors
- Issues with mentors ‘knowing’ the student as an HCA and ‘difficulty’ with failing students in this context, or over assessing Bondy levels (e.g. level 4 at stage 1) – important role of practice tutors in helping them to understand what levels mean
- Mentors need an understanding of standards and OU programme
- Need more opportunities for mentors and managers to access a mentor induction (mentors are so busy) – could be online

- Practice tutor role in supporting mentors is very important
- Availability of mentors: impact of Brexit, reduced funding
- Apprenticeship in student support roles
- Build supervision and assessment into the student programme

4.4.4 Student support in practice and supervision

- Student nurses must have a “go to” professional (e.g. nurse, manager/deputy manager)
- Use of ‘coaching’ models to address ‘flexible’ standards proposed
- Interaction in practice between service user and student and involving service users in supervision
- Supervision should be a requirement in every job description
- Student ‘buddies’ and peer mentorship in Year 3 to play a transition role
- Concerns that other professionals acting as supervisors will not understand values of nursing – need to maintain professional identity of nursing
- Need benchmark for supervisors
- Concern that students are supervised by clinical staff with no assessment skills
- Students in core base could potentially choose friends as practice supervisors

4.4.5 Documentation

- Some mentors struggle with the documentation but others know the programme and expectations; OU documentation is different than other universities – more in-depth and intense but is manageable
- Bondy levels: student feedback: the levels are clear, helps students’ awareness of where they need to focus and improve confidence and competence
- Consider introduction of a grading system for assessment
- Standardisation of practice assessment e.g. London universities have agreed requirements/principles/outcomes: promotes consistency and based on outcomes
- National document: regional approach with national aspirations; need a national common core to enable measurement of quality, standardised document would be better
- Portfolio: user friendly, co-designed portfolio, provides a range of evidence (needs standardising) to support the practice assessor rather than focus on direct observations; enables professional discussion; evidence of actual hours/practice/theory of practice/simulation, consider how portfolio can be constructed to reflect actual practice;
- Skills book/skills record/passport over 3 years/4 years with criteria to ensure skills are signed off and demonstrating their understanding
- Formative/summative process currently works well in OU assessment
- Students should be able to seek service user feedback for assessment. Service user view: giving feedback to student directly has greater impact, indirect feedback (i.e. through mentor) ‘feels like going behind the student’s back’

4.4 First year (stage) of the programme

The final area of discussion was about ideas for the first year (Stage 1) of the new programme. There will be two new 60-credit modules developed for Stage 1, one focused on theory and the other module focused on practice. The information gathered was grouped and mapped against the NMC’s proficiencies. The module teams for level 1 have since reviewed the suggestions, identifying whether material fits best in the theory module, practice module or will be included in both, from different perspectives.

4.4.1 Introducing:

- Introduce key areas/topics at Stage 1 (and then develop during Stage 2) and increase complexity over time,
- Communication skills: develop across Stages 1 and 2
- Balance of essential and technical skills: use a checklist
- Introduce range of client groups at Stage 1 and all fields of nursing; adult, mental health, learning disability, child

4.4.2 General points and ideas:

- Balancing generic with field – specific knowledge
- Preparing for Stage 2 - Understanding Bondy requirements for Stage 2
- Could use a 'core structure'/scaffold in each stage to build on with novice to expert approach
- Scenarios in year 1: enquiry-based learning and use of role play.

4.4.3 Placements: (range of suggestions)

- Mix of placements
- More community nursing: shift focus from acute care in year 1 to care at home, using day care, outpatients to focus on discharge/homecare, need access to effective community placements (other HEIs compete for placements)
- Early experience in new environments
- Emergency care experience (but avoid critical care placements at Stage 1)
- Multidisciplinary learning
- Core placements: shorter placements in core settings or lose core completely, move away from core being HCA workplace to facilitate role transition
- Explore block placements (but don't have students as HCA in between or near end of module assessments)
- Prepare mentors (assessors/supervisors) better for their role
- Treat OU students the same as other students but with recognition that they are Trust staff: they are students/nurse apprentices
- More peer support within community e.g. use of WhatsApp group for students within same Trust
- Understanding of placement area e.g. mental health key principles for mental health placement

4.4.4 End of Stage 1: achievements

- Communicate effectively
- Understand scope of practice of a student nurse
- Evidence based practice
- Reflect and use reflective tools and techniques, self-reflection
- Questioning approach and problem solving skills
- Competent in fundamental skills
- Eager to do year 2: motivated and enjoying course and prepared for stage 2 challenges
- Adaptability
- Understand other fields (Adult/Mental Health/Learning disability/Child)
- Advocate for profession and professionalism e.g. timekeeping, respectful, correct uniform, answering phone
- Gained confidence
- Active and proactive learner
- Understand the importance of documentation

4.4.5 Study skills and becoming a student

- Transition to nurse/nursing student

- Understanding the role of the student nurse, managing expectations of the role, role boundaries and assertiveness skills:
- Doing 'Health Care Assistant' skills but with student eye and focus – understanding what they don't know
- Ownership of learning and being a student, self-management
- How to get the most out of practice placements: being curious, talking to patients, questioning why care is being given and what results mean, developing a questioning approach, asking 'why' e.g. why do we need to do observations, what does the blood pressure measurement mean, understanding results,
- Basic academic skills: writing / referencing, preparation of students for academic skills necessary for Stage 2
- Core study skills: understanding how you learn – self-awareness, IT skills, navigating OU and OU website
- Learn how people learn and learning how to learn: managing study:: Time, Place, Organisation
- Academic skills – critical thinking/literacy, critical analysis e.g. of websites
- Numeracy: theory and application (e.g. medicines)

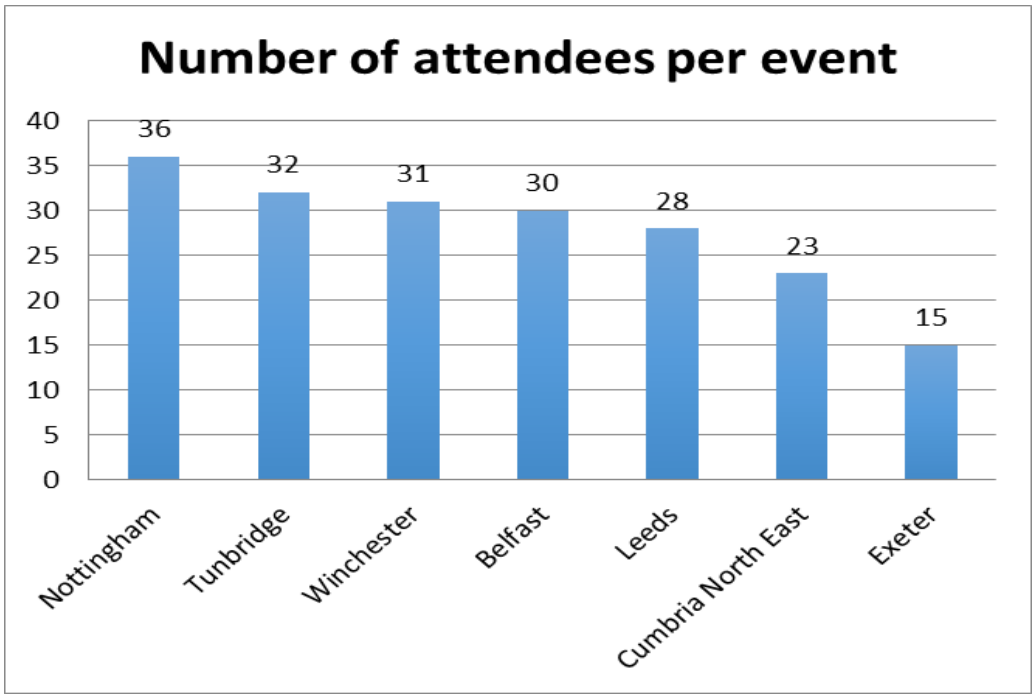
4.4.5 Mapping against NMC proficiencies

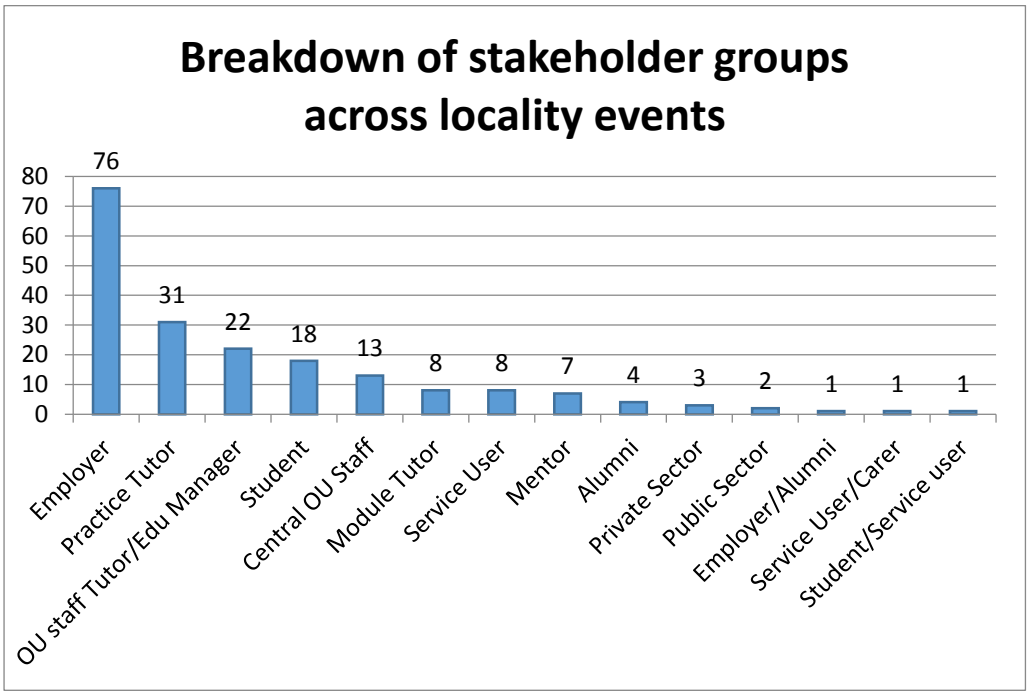
NMC proficiency	Topic areas
Be an accountable professional	**Accountability** **Values** • Values: compassion/empathy, confidence, personal value base and impact on care • Embedding of fundamental values, behaviours and patient experience • NHS Constitution/Nation equivalents and values **Interpersonal** • Conflict and difficult situations, conflict resolution skills, • Resilience – coping strategies • Challenging practice • Cultural awareness/skills • Emotional intelligence, questioning (readiness for challenging) **Self-awareness and reflection** • Reflection and reflective practice, reflection on practice and learning • Self-awareness and self-reflection: what you bring to the role • Knowing limitations and dealing with feedback **Law** • Introduction to Law and legal aspects of care • Basic understanding of key relevant legislation (all nations) **Ethics** • Introduction to Ethics **Professionalism** • What is a profession? Professional identity, professionalism • Understanding what is nursing and role of the nurse • Professionalism (e.g. confidentiality, health and safety assessment, self-discipline)

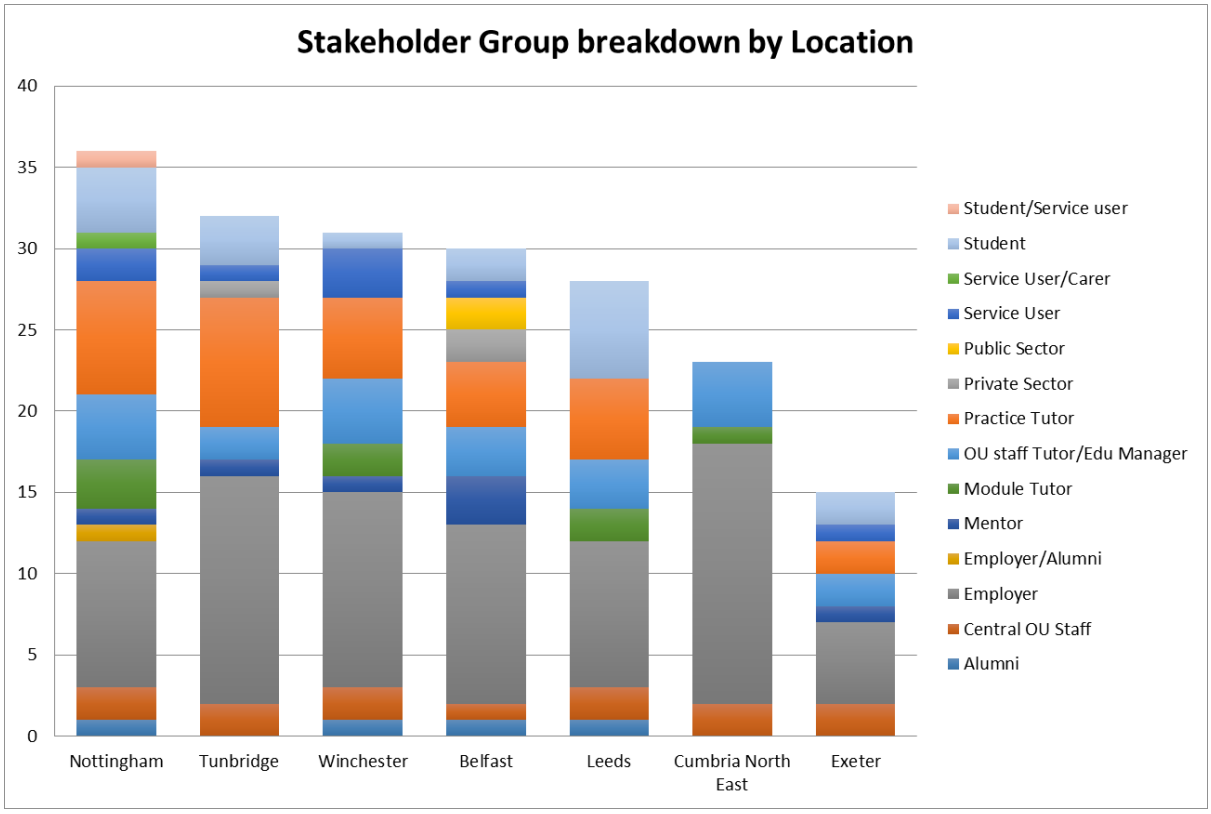
	• NMC Standards and NMC Code (professional limitations), confidentiality, documentation, proficiencies • Professional boundaries, relationship boundaries and use of social media • Safeguarding and knowing when to escalate concerns, • Recognising bad practice and reporting **Research** • Introduction to research • Accessing evidence (literature searching)
Promote health	• Introduce health promotion • Public Health introduction
Assess needs and plan care	**Theory underpinning and rationale** • Biology: anatomy and physiology with applied approach • Understanding core attributes of good physical and mental health and baselines so students can identify problems • Holistic model and approach: linking bio-psycho-social, how they inter-relate, impact of mental health on physical health (and vice versa), understanding why holistic model important, • Person centeredness • Systems approach: identifying related symptoms and diagnostics e.g. blood system, gastro-intestinal • Awareness of long term conditions to appreciate acuter conditions and underlying on-going needs • Common, less-complex mental health problems • Vital signs measurement and manual/core assessment skills e.g. blood pressure • Interpretation: understanding normal parameters and recognising the abnormal, symptoms recognition • Observation skills • Knowledge of common assessment tools and tests e.g., urinalysis, Bristol stool form chart, Early warning score systems • Working understanding of risk assessment e.g. pressure ulcer risk assessment • History taking and recording, assessment of needs • Recognising deteriorating patient: mental and physical health **Care planning** • Care planning with patients • Skills re. care planning/writing care plans (basic)
Provide and evaluate care	• Care and compassion • Safe and effective care, evidence based practice • Models/approaches to care: person-centred/client-centred, holistic, reflective, care of wider family and social aspects, context • Activities of daily living and promoting independence • Recovery (mental health): principles and philosophy • Service user perspectives (engagement) • Record keeping

	• Medications: pharmacology and key medicines linked to systems, impact of medication on body/systems • Communication skills and relationship management: building a relationship, engagement, patient focus, chatting to patients, touch, body language and non-verbal, respect, positive communication (underpinned by understanding neuropsychology) **Clinical skills** Holistic care: balance of fundamental and technical skills with underpinning theory and rationale , including: • Nutrition/fluids and impact on bowels/ infection • Infection control: Handwashing, aseptic non-touch technique • Hygiene/personal care • Safe administration of medicines: medicines management, pharmacy • Mandatory skills, e.g. manual handling. • Pain management, • End of life care/preferred place of death
Lead nursing care and work in teams	• Working with others • Understanding roles of multidisciplinary teams (and skills) and role of nurse within MDT: PM • Team working and inter-professional/multidisciplinary working • MDT approach and language • Understanding wider concept of 'community' (and hospital-community interface) • Introduction to theories of leadership • Time management
Improve safety and quality of care	• Introduce service improvement and leadership • Safety and quality of care including human factors
Coordinate care	• Understand how NHS works (+ wider health system): integrated health and social care, Understanding health care systems: primary care, secondary care, tertiary care • Context of healthcare policy • Community Nursing • New models of care

Appendix 1 Stakeholder attendance






Stakeholder Group breakdown by Location
40
35
30
25
20
15
10
5
0
Nottingham
Tunbridge
Winchester
Belfast
Leeds
Cumbria North East
Exeter
Student/Service user
Student
Service User/Carer
Service User
Public Sector
Private Sector
Practice Tutor
OU staff Tutor/Edu Manager
Module Tutor
Mentor
Employer/Alumni
Employer
Central OU Staff
Alumni

Appendix 2 Service user/carer views: what is important?

A service user/carer's views

- The most important factor in hospital care is the quality of the leadership: the ward sister/manager's role modelling is paramount, impacting on quality of care delivered by junior nursing staff and HCAs.
- Individualised, personalised, sensitive care are very important. Nurses' technical skills are generally very good but their people skills are widely variable
- Reflection: how much are students encouraged to reflect? There is not enough emphasis on reflection, which is critical particularly for personalisation and sensitivity
- Integrated health and social care: needs emphasis. Multidisciplinary working is essential
- Flexibility: can be rigidity in how technical skills are applied by newly qualified nurses – need the confidence to be flexible about care delivery e.g. giving painkillers (not making people wait till next drug round)
- Communication: feels there's a huge lack of understanding about communicating in non-standard ways, e.g. staff unable to communicate with people non-verbally using different methods e.g. charts. Need MDT input – speech and language therapists
- Has encountered nursing staff having negative and dismissive attitudes towards service users/carers
- Need to build in as many carer and service user stories and reflection as possible.
- Service user involvement in practice assessment is often lip service
- Need to involve service users in curriculum development more - really important.
- Avoid technical jargon
- Need sensitivity when working with service users and carers – recognising individual needs
- Students need help to coordinate different aspects of their learning – avoid fragmentation of learning

A carer's views about important elements for nurses:

- Empathy
- Having contact, getting to know patients/carers, building a relationship, continuity
- Speaking to carers and finding out about the person's extra needs. Ensuring the information is documented and passed on
- Seeing the person as a whole – not a set of symptoms
- Need to speak to other professionals and know when to refer
- Observation skills and showing an interest in patients
- Patient centred approach

Negative observations: nurses not leaving nurses' station, not recording information, not passing on information

Appendix 3 Evaluation of stakeholder events

Event Location	**1. Please rate how beneficial this event was to you** (1 - not at all, 10 - extremely beneficial)	**4. Please rate the organisation of the event: pre-event communication, facilities, catering, etc.** (1 - not at all, 10 - very well organised)	**5. Do you feel the event was productive for shaping the OU's future Nursing programme and enabled collaborative working** (1 - not at all, 10 - very productive)
Nottingham	9.00	8.52	9.22
Belfast	8.44	9.38	8.82
Leeds	8.33	8.61	8.55
Newcastle	8.78	8.67	9.13
Tunbridge	8.58	9.00	8.84
Exeter	8.75	9.00	8.75
Winchester	8.41	7.91	8.83
Overall average	8.61	8.73	8.88