The Quality Assurance Agency for Higher Education

QAA report on the evaluation of Prototypes 2004-05

Evaluation of the Prototypes for Ongoing Quality Monitoring, and Approval, including the evaluation of the Standards Template and Evidence Base

The Partnership Quality Assurance Framework

ISBN 1 84482 373 3

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Acknowledgements

The Quality Assurance Agency (QAA) is extremely grateful to all the staff, students and service users at the prototype sites, including the practice placement areas connected with these sites.

Approval

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Coventry University/West Midlands South SHA

University of Teesside/County Durham & Tees Valley SHA

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University College Chester/Cheshire and Merseyside SHA

Middlesex University/North Central London SHA

University College Northampton/Leicestershire, Northamptonshire and Rutland SHA, Bedfordshire and Hertfordshire WDC, Thames Valley SHA

University of Teesside/County Durham & Tees Valley SHA

All participants have actively and positively contributed to the considerable amount of information and feedback that we have gained during the prototype experience. We hope that colleagues can recognise some of their experiences of the last year and their significant contribution.

Skills for Health are working in partnership with the Nursing and Midwifery Council, the Health Professions Council, Strategic Health Authority Workforce Directorates, higher education providers and other stakeholders to streamline and make more effective quality assurance arrangements for professional healthcare education. The Quality Assurance Agency is working with Skills for Health and their partners under contract.

Contents

Executive Summary

The Partnership Quality Assurance Framework (PQAF) proposes that there are three inter-related quality assurance processes - major review, approval, and ongoing quality monitoring and enhancement (OQME) - supported by a shared evidence base, and benchmark and quality standards. Major review was tested through prototypes in 2002 and is in the second year of a three-year cycle, due for completion in December 2006. From August 2004 to May 2005, seven prototype sites tested the proposed approval and OQME processes, the evidence base and the standards template. Two sites prototyped the approval process, four sites the OQME process, and one site both approval and OQME. Each site consisted of one or more Strategic Health Authorities and a higher education institution in partnership with NHS Trusts and other practice placement providers. The PQAF and its constituent parts will be the subject of further review and debate following the evaluation of the prototypes.

This report outlines the findings from the evaluation activities for each of the four elements of the PQAF tested through the prototypes in both campus and practice-based learning settings. Issues are highlighted and recommendations made. The prototypes tested the relevant PQAF elements with the following disciplines: nursing (all branches); midwifery; specialist community public health nursing; physiotherapy; occupational therapy; dietetics; operating department practice; radiography; clinical psychology; and podiatry. As the PQAF was initiated and developed in England, the prototypes did not explore placements outside England. Disciplines that were not included were prosthetics and orthotics, orthoptics, speech and language therapy, and paramedic science.

The report identifies the issues that arose during the prototype process, the elements of the PQAF that worked, the strengths expressed by participants and the recommendations for change. The conclusions and recommendations are detailed and we urge interested parties to consider Chapter 6 fully. However the following points encapsulate the key messages arising from the QAA evaluation.

1 Practice placement staff and their organisations were enthusiastic about their active involvement in the self-evaluation of standards. They saw that practice had a formal, meaningful partnership in the consideration of placement learning and standards of healthcare education. They welcomed the responsibility and the ownership.

2 There was a perceived benefit of enhanced partnership relations and more interprofessional collaboration facilitated through completing the standards template and enabling a broader range of those in practice to be involved in quality assurance and enhancement.

3 The number of standards needs to be reduced and the quality assurance processes to be less cumbersome and resource intensive.

4 Approval needs to fully recognise and take on board the HEIs own approval/validation processes, while making the outcomes of self-evaluation of standards meaningful to approval panels.

5 OQME needs to be less burdensome and resource intensive.

6 Students and service user representatives need to be specifically invited and involved in agenda setting and decision-making in both processes.

7 The principle of using exception reporting was welcomed. However, much greater clarity and guidance is needed to make the process more consistent, particularly in the meaning of good practice.

8 More explicit guidance is needed on the type/sources of evidence required to support the self-evaluation, the level of detail required, and what constitutes sufficient evidence.

9 Whilst there was considerable reassurance about the rigour of the self-evaluation processes at local level, there remains a lack of explicit, visible evidence and detail for external stakeholders. If integration and streamlining is to be achieved, external stakeholders need reassurance as to the robust evidence base and less generalisation.

10 Achieving self evaluation in 100 per cent of placements cannot, and indeed should not, be the aim in any of the processes. Further consideration needs to be given to targeting of placements, with a fresh perspective on assurance of standards of learning in practice. This perspective would move away from an HEI-centric and discipline-specific approach to placements to one of partnership between placement providers and all relevant HEIs.

11 Terminology needs to be clarified and be more user-friendly. For example, there is considerable reluctance, particularly at approval, to state that standards are not met or at risk.

Chapter one

Introduction

1 Partnerships were established at both strategic and operational levels between the Department of Health England (DH), the Nursing and Midwifery Council (NMC), the Health Professions Council (HPC) and its predecessor body, higher education institutions (HEIs), the National Health Service (NHS) and other stakeholders to develop a more streamlined and integrated quality assurance system for healthcare education in England. This work continued with Skills for Health, a sector skills council, under a service-level agreement from the DH, working in close partnership with the Strategic Health Authorities (SHAs)/Workforce Development Confederations (WDCs), NMC, HPC, HEIs, Trusts and other stakeholders to develop the PQAF. The PQAF establishes that there are three quality assurance processes - major review, approval, OQME - supported by a shared evidence base, and benchmark and quality standards. Major review was tested through prototypes in 2002 and is in the second year of a three-year cycle, due to complete in December 2006. From August 2004 to May 2005, seven prototype sites tested the proposed approval and OQME processes, the evidence base and the standards template.

2 The five elements of the PQAF for healthcare education are:

- approval
- OQME
- major review
- benchmark and quality standards
- evidence base.

Figure 1 shows how it is proposed that the elements fit together within the PQAF to ensure continuous quality improvement of NHS-funded healthcare education in England.

Continuous quality improvement of healthcare education

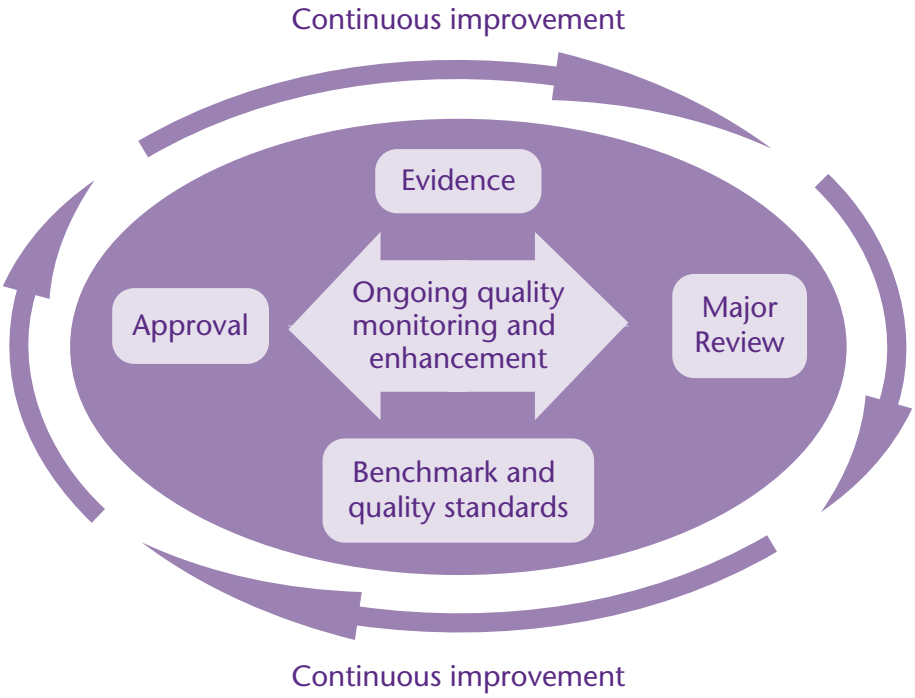

Figure 1 The Partnership Quality Assurance Framework

3 After significant collaborative work, with input from a wide range of stakeholders, a proposed framework, the PQAF, was developed. QAA was contracted to organise the process of consultation on the PQAF. This consultation took place between March and June 2004. After a number of amendments in response to the feedback received, a *Prototype Document* (see www.qaa.ac.uk/health/framework/default.asp) was prepared and published, setting out the processes and principles to be tested. This *Prototype Document* contains a glossary of terms agreed by the working groups with representation from partners and stakeholders, and these terms are used within this report. QAA was contracted to coordinate the prototypes of two of the processes of the PQAF: OQME and approval, in the academic year 2004-05, as well as the evidence base and the standards. Seven sites were selected as prototypes, each involving the relevant SHA(s) and HEI. Two sites prototyped the approval process, four sites the OQME process, and one site both approval and OQME. Prototype activity took place between September 2004 and May 2005. The prototypes tested the relevant PQAF elements with nursing (all branches); midwifery; specialist community public health nursing; physiotherapy; occupational therapy; dietetics, operating department practice; radiography clinical psychology; and podiatry.

Role of the QAA

4 QAA's role related to the preparation, implementation, coordination and evaluation of the two processes, the evidence base and the standards (including the templates). To help with the implementation of the processes, QAA facilitators were allocated to each site. Each prototype could draw upon one facilitator to provide support for the HEI, the SHA/WDC and the practice placement providers. Ten facilitator days were available for the OQME prototypes and five days for the approval prototypes. How the facilitator time was used was directed and discussed by the HEI and SHA/WDCs.

5 QAA has undertaken a significant amount of work in coordinating, preparing and supporting the prototypes. Activities included:

- finalising all documentation for publication (in a range of formats) and use by the prototype sites (documentation developed and agreed by the OQME and approval working groups)
- undertaking initial scoping of the provision to be included, with related practice areas, in August 2004
- subsequently holding detailed planning meetings with stakeholders at each site in September and October 2004
- preparing the communication protocols and agreed channels
- organising and chairing the NMC/HPC Operational Group meetings, attended by Skills for Health
- organising and delivering the one-day briefing event for NMC and HPC Visitors in November 2004
- organising, in response to requests from the prototype sites, a one-day forum to enable the sites to meet and share experiences in December 2004
- responding to many queries from the prototypes
- attending and providing input to a variety of prototype stakeholder events
- monitoring prototype activity against timescales and goals and undertaking appropriate action in order to ensure that targets were achieved.

Evaluation methodology

6 QAA is committed to reflecting on all its activities. Therefore, it has undertaken a formal evaluation of the prototypes. The aim of this evaluation is to provide systematic analysis of the prototypes to examine the approval and OQME processes, the usefulness of the standards template and the value and appropriateness of the evidence base in supporting the two processes to determine if they:

- provide an effective standard mechanism for assessing quality and promoting enhancement

- streamline quality assurance requirements, thereby reducing the burden for stakeholders
- provide outcomes that meet the needs of both stakeholders and partners
- engage HEI and practice placement staff in quality assurance processes effectively
- make a positive impact on the monitoring and enhancement of quality assurance of healthcare provision
- provide an opportunity to highlight good practice to share with the sectors.

7 The evaluation was undertaken in accordance with QAA's evaluation framework (see Appendix 1). The framework ensures a consistent and robust methodology in accordance with QAA's standards. A two-stage evaluation methodology was used, examining the preparation, facilitation and delivery of the two processes, the evidence base and the standards template. The data collection strategies have been designed to ensure that meaningful qualitative and quantitative data were collected and analysed. Sources of data include:

- documentation - including communications, preparatory material, reflections from facilitators and QAA officers, documentation prepared and used by the prototype sites, for example, a *Prototype Document*, an overview of practice-based learning and the PQAF document
- observation of aspects of the process (in essence this was participant observation by QAA officers and QAA facilitators)
- QAA postal questionnaire to all prototypes
- QAA postal questionnaire to NMC and HPC Visitors
- QAA focus groups - participants from Trusts and other practice placement providers, SHA/WDC staff, HEI staff, QAA facilitators, NMC, HPC, the British Psychological Society (BPS - the professional regulator for psychology) and Skills for Health senior quality assurance coordinators.

Appendix 2 outlines in more detail the evaluation techniques/approaches that were identified at the beginning of the prototypes.

8 The first stage of the evaluation was to gather and analyse data from the observations, communication and documentation. In the second stage, postal questionnaires were developed, one for those involved in the prototypes and one for NMC/HPC Visitors. These were distributed through the main HEI and SHA contacts for each of the prototypes and sent to each of the Visitors directly. Thirty-three questionnaires were returned (35.8 per cent return rate overall, 35.7 per cent return rate from Visitors). This stage then explored all analysed data further through focus groups involving each of the groups of participants in the prototypes: HEIs, SHAs/WDCs, Trusts and other placement providers, and the QAA facilitators. Two focus groups were held on 18 and 24 May 2005 in London and Leeds respectively, with a total of 53 participants (see Appendix 3).

9 In total, 86 contributions were made either through the questionnaires (see Appendix 4) or attendance at the focus groups. Of these, five contributed to both fora and all prototype sites were represented at HEI, SHA and Trust level, with the exception of one HEI which neither replied nor attended.

10 This report outlines the findings from the evaluation activities for each of the four elements of the PQAF tested through the prototypes: the evidence base; the standards and the template; the approval process; and the OQME process. Issues are highlighted and recommendations are made.

11 Skills for Health and their partners also commissioned an external evaluation, the contract being awarded to Homerton School of Health Studies, Cambridge. The external evaluation report is available on www.health-homerton.ac.uk/research/pqaf

12 The NMC considered that it would be informative to undertake an NMC Visitor verification exercise. This consisted of the Visitors spending one day meeting with clinical staff who either had undertaken, or were in the process of undertaking, the self-evaluation against practice standards. The NMC Visitors were given written guidance for this exercise and the reports were all anonymous and non-attributable. This enabled the NMC to explore the process from a regulator's perspective and to gain feedback. The activity was restricted to one day, mostly in December 2004. The report was structured around the relevant standards statements and the visits were in placements relevant to the Part of the NMC Register and the provision under scrutiny, either through approval or OQME.

The prototypes

Background

13 The eight prototypes were undertaken by seven HEIs and their partner SHAs, a lead SHA being identified for each prototype. One HEI/SHA undertook both an approval and OQME prototype.

Table 1 Scope of the prototypes and dates of main process events

Prototype	Process	Provision - disciplines	Annual Review Meeting or Approval Event
Prototype 1	Approval	Graduate entry to nursing - adult, mental health and childrens branches.	10 March 2005
Prototype 2	Approval	Nursing, midwifery, physiotherapy, dietetics, occupational therapy, and operating department practice.	w/c 9 May 2005
Prototype 3	Approval	Midwifery, nursing, occupational therapy, physiotherapy, radiography, and specialist community public health nursing.	7 December 2004 - Allied Health Professions 8 March 2005 - Return to Practice Nursing, and RTP Midwifery, Adaptation programme for overseas nurses 22 March 2005 - Promoting Practice Effectiveness (community pathways)
Prototype 4	OQME	Nursing and specialist community public health nursing.	15 March 2005
Prototype 5	OQME	Midwifery, nursing, and nutrition and dietetics.	16 March 2005
Prototype 6	OQME	Midwifery, nursing, and specialist community public health nursing.	23 March 2005
Prototype 7	OQME	Nursing, midwifery, occupational therapy, and podiatry.	15 March 2005
Prototype 8	OQME	Clinical Psychology, midwifery, nursing, occupational therapy, operating department practice, physiotherapy, radiography, and specialist community public health nursing.	17 March 2005

HEIs and their partner SHAs were invited to volunteer to be prototype sites, and a group of partners then agreed which sites would go ahead against an agreed set of criteria. The choice of sites ensured that rural and urban areas were included, with a wide variety of student and service-user populations. Placements available included Acute Trusts, Primary Care Trusts (PCTs), the independent sector, the social services sector and the prison services. Placements were distributed across England, the majority relatively local to the HEI and some at a considerable distance. The prototypes did not explore placements outside England. Disciplines that were not included were prosthetics and orthotics, orthoptics, speech and language therapy, and paramedic science.

Timescales

14 The prototypes ran from September 2004 to May 2005. Initial meetings to establish the scope of each prototype were undertaken by QAA in July and August 2004, followed by formal detailed planning meetings in September and October 2005. The prototypes were conducted in a shorter timeframe than would normally be used in the two processes. Therefore, it has been important in this evaluation to identify when an issue arose from the timeframe of the prototype, when it might not have arisen within the time available for the planned, normal process. The timescales were challenging and influenced the approach taken by the prototypes, determining for example, which placement areas were sampled for the self-evaluation process and the amount of evidence that was available.

Selection of placement areas

15 In all prototypes, there was a varied approach to the selection of placement areas chosen to undertake the self-evaluation of standards. The discussion on which placements were to be included commenced in the planning meetings. As the timescales for the prototypes were set by the external requirements, prototype sites were encouraged to consider a choice of placements relevant to the disciplines and quality assurance activity. In the *Prototype Document* (section 3.3) it is expected that all placements undertake self-evaluation 'at unit level'. Considerable debate started at the planning meetings about the meaning of unit and the feasibility of self-evaluating across all placements.

Approval prototypes

16 The *Prototype Document* (section 2.1) states that there are three reasons for approval:

i the development of new provision

ii a significant change in existing provision which partners agree requires approval

iii a result of OQME and/or major review processes.

The provision considered in the three approval prototypes was eligible for the first two reasons.

Prototype 1

The provision considered in this prototype was existing provision that had been revised significantly in the light of changes to NMC regulatory requirements for 'postgraduate shortened pre-registration' programmes. The prototype also included new provision, as two additional branches had been added to the programme. The approval event was conducted over a single day.

Prototype 2

This prototype included four allied health professions (AHP) and nursing and midwifery pre-registration programmes. The AHP programmes were all existing programmes that had been revised substantially. The HPC considered, in line with its own processes, that the revisions were 'significant' enough to require the presence of HPC Visitors at the approval event. Five HPC Visitors attended, accompanied by an HPC Officer. The HEI/SHA, at their own discretion, also invited representatives from the relevant allied health professional bodies.

The nursing and midwifery programmes included new (a learning disabilities branch of nursing pathway) as well as existing provision that had undergone significant revision. NMC Visitors attended, each representing one Part of the Register.

The approval event was conducted over a period of one week. The curriculum development included a significant element of interprofessional learning and represented a considerable conceptual and cultural change for the HEI and its practice partner providers. The sheer number of programmes for approval meant that the event would have been complex and logistically demanding, even without the approval prototype.

Prototype 3

Three separate (single-day) approval events were undertaken. The first event was held in December 2004 and was for AHP provision, occupational therapy, physiotherapy and radiography. After some consideration, HPC stated that, under its own approval process, there had not been sufficient significant changes to the provision to require approval by HPC, and therefore no HPC Visitor attended the event. An HPC officer and an HPC Visitor did attend as observers. The HEI/SHA, at their own discretion, invited representatives from the relevant allied health professional bodies.

The second one-day event, held in early March 2005, considered two nursing and one midwifery programmes. Two NMC Visitors from appropriate Parts of the Register attended.

The third one-day event, held in late March 2005, considered one specialist community public health nursing programme with a number of different pathways. This programme was existing provision but with sufficient revisions to warrant participation in the approval event. Two NMC Visitors from the appropriate Part of the Register attended.

OQME prototypes

17 Two of the OQME prototypes contained provision in the nursing and midwifery areas only, while the remaining three included both nursing and midwifery and the AHPs. The programmes considered were both at pre-registration and post-registration levels, and the range of awards was from certificate of higher education to doctoral level. The provision was delivered on campus and/or at a distance and/or work-based activity. All of the provision was to be included in the OQME process. The NMC made the decision that all NMC-approved programmes would be scrutinised by the NMC Visitors through the OQME process (NMC annual monitoring presently is 100 per cent with 20 per cent sampling for in-depth scrutiny once a year over a five-year cycle). The NMC agreed to receive the initial action report as the annual report from the programme provider, the NMC encourages providers to use their own internal reporting mechanisms to inform this report. NMC Visitors, where appropriate, were part of the Annual Review Meeting (ARM), the third stage of the OQME process where the initial action report produced through self-evaluation is verified. However, as the HPC does not have a separate annual monitoring process, preferring to link with HEIs' existing internal quality assurance procedures, there were no HPC Visitors present at the ARM. The HPC had agreed that it would receive, and if necessary act upon, the documentary outcomes of the ARM.

Chapter two

Evidence base

18 The *Prototype Document* (section 4.1) states that the purpose of the shared evidence base is to:

a provide a set of shared, transparent, measurable data, acceptable to all stakeholders that can be used to:

- give validity to statements and thus invite confidence in claims
- allow consistent judgements to be made against quality standards
- allow improvement and enhancement of quality standards to be measured

b suggest appropriate sources of qualitative evidence that might be used to support/verify claims

c ensure commonality/consistency of the evidence base for the PQAF.

19 The evidence base being tested includes all information and data offered by the HEI and practice placements in support of their self-evaluation and, in the case of approvals, for use by the approval panel in order to verify the quality of provision. The evidence base proposal is that it is made up of core evidence (mainly quantitative data) and additional evidence. The evidence should always be existing information or data, not especially prepared for these processes.

20 One issue that was consistently raised in all the evaluation activities was that of providers (HEI and their placement partners) requiring additional guidance on:

- what constitutes sufficient evidence for the standards
- the level of detail required
- potential sources of evidence mapped against the standards
- how and when evidence should be available during the two processes, particularly at the ARM and the approval event
- how external bodies, including Visitors, should access the evidence.

21 The prototype sites largely failed to include core evidence in the Initial Action Reports (IARs) or approval events. This may have resulted from the apparent lack of understanding about the evidence base by the prototypes. Different parts of the *Prototype Document* have conflicting statements about evidence, that core evidence is both essential and available on request only. There are also differing claims for the purpose of the evidence base in the sections on evidence and on OQME. The written guidance on the evidence base needs to be clearer and more precise.

22 Annex 5 of the *Prototype Document* was noted as having shortcomings in relation to the particular kinds of evidence that are relevant to providers' circumstances. Hence, one SHA produced its own list to assist staff completing the templates. The more general point is that, should the PQAF be rolled out, providers would need more help identifying relevant evidence than is currently given in Annex 5 of the *Prototype Document*.

23 It was apparent from the qualitative data received, and the observations undertaken that there was a perceived lack of evidence available for the ARM and approval events, and this raised some questions about the rigour of the processes. However, Trust staff noted that often a large amount of data/evidence had been gathered prior to the ARM and approval events but this was not explored or requested explicitly by panel members during the process. A minority expressed concerns that aspects of the evidence base for smaller (student numbers) disciplines could be lost during the preparation of the IAR. A small number of the Visitors and observers did note that discussion of the evidence base had taken place during the meetings, but in relation to oral evidence rather than specific documentation. Observers also noted variable linkage, by the prototypes, to evidence available from other external quality assurance processes such as major review reports and action plans. Active mapping and checking against standards is necessary in order to ensure there is continuity and no conflict. Documentation from other processes such as major review should be the full published documents and not selected excerpts.

24 Visitors noted that it was difficult, without visiting practice placement areas or talking to providers and students, to confirm the evidence base provided by the HEIs and their partner placement providers. At the Visitor briefing day, it was emphasised that the NMC verification exercise was not to be used in the OQME or approval processes as a direct form of evidence on standards or quality. However, in practice, most Visitors did directly draw upon this experience to inform their professional judgements as Visitors. In the NMC reports from practice, it is clear that evidence to support the self-evaluation of standards was available and this appeared to reassure the Visitors about the rigour of the process. Interestingly, the verification activity confirmed the consistently expressed need for Visitors to continue to have direct access to placement areas, and preferably students, as key sources of evidence.

25 The provision of quantitative data as part of the core evidence was deemed to be unclear and still awaits guidance from the DH about the standard model contract. However, there were contrasting views from two SHAs in relation to the inclusion of financial data, particularly in the OQME process. One SHA stated that the consideration of financial data should be separate from the OQME process, whereas the other SHA thought it should be an integral part of the process.

26 It was noted that a benefit of the approval and OQME processes is that they enable the structured gathering of evidence at Trust and unit level and also give the opportunity for providers to consider a wider range of evidence gathered by all the areas (disciplines) working together.

Chapter three

The standards template

27 The standards template provided the prototypes with a standardised format for the self-evaluation against the standards, within the 10 aspects (see Appendix 5). The template included colour coding to identify, within each of the 10 aspects, the locus of responsibility for each standard - HEI, placement providers or both. Feedback during the prototypes and at the focus groups indicated that some of those involved in the prototypes found the template cumbersome and would have preferred the document to be split into three smaller documents for each of the loci of responsibility. Unsurprisingly, the prototypes illustrated the need for some changes, particularly in relation to the exception reporting and the identification of standards at risk and good practice. However, overall the template was deemed workable, if cumbersome. A large majority returning questionnaires found the preparatory documentation (see Appendix 7) helpful.

28 The template was to be signed off at local level, that is unit or programme(s), and then at organisational level. The template needs to be structured to reflect this two-tier process of signing off. The present structure for signatures means that externals/members of the ARM or approval event cannot be clear as to the nature of 'the unit', the person responsible and where to ask for the evidence if wanted. Signatures at organisational level worked well in the Trusts, particularly where there was a clearly identified lead such as a clinical practice facilitator (CPF) or practice placement facilitator (PPF). The Trust board or equivalent body was rarely able to receive the organisation's self-evaluation document for formal signature. However, participants are very clear that this principle needs to be maintained and that this needs to be more explicitly built into the timescales for the PQAF processes.

29 A recommendation from participants is that suggested evidence should be referred to within the standards template so that the links are more explicit. The danger is for the evidence to become formulaic and a gathering of policy statements, rather than evidence that the policies are implemented with effect. During the prototypes, both commentary and some of the documentation reflected this concern; opportunities were not taken to test out the application of policies claimed as evidence.

30 The present layout/presentation of the self-evaluations is also a constraint. The task could be streamlined and given a clearer focus, and help discourage repetition, if exception reporting is linked to clusters or groups of standards, rather than the overall report approach. Some participants would find 'visual triggers' helpful in stimulating thought around the wide range of possibilities to consider as evidence for the self-evaluations.

31 There was some variability in the approach to completing the standards template at the practice level. Some practice areas responded in detail, with considerable critical analysis, whilst others used a tick-box approach. There is also some confusion regarding definitions of 'at risk' or 'good practice', and the need for greater guidance on terminology and completing the standards template in order to ensure consistency

of approach was a key theme from the focus groups. It was suggested that it would be helpful to have 'exemplars' of the completed standards template to share with HEIs, SHAs, Trusts and other practice placement providers.

The standards

32 The standards were developed to integrate learning and quality assurance in both HEIs and practice settings and to address all key stakeholders' requirements. A specific locus of responsibility was indicated, while demonstrating the partnership between HEIs, SHAs, regulators and individual placement providers. The standards are meant to enable stakeholders' requirements for monitoring to be met but also to provide a focus on enhancement. Each standard applies to pre-registration and learning beyond registration provision.

33 In total, there are 104 standards listed in the standards template (see Appendix 6), of which 13 are evidenced through QAA institutional audit. These would not routinely be considered in the approval or OQME processes by the HEI, if that organisation was deemed successful in QAA institutional audit (*Prototype Document* section 5.1).

Number of standards

34 Of the 29 respondents to the questionnaire, 12 thought that there were too many standards, 17 that the number of standards was about right, and no one thought that there were too few standards. There was a consensus in the focus groups, discussions at the prototype sites and through observation, that there were too many standards. Merging of standards that were repetitive could help to rectify this. For example, standards 5.11 and 5.15 need to be combined in order to avoid suggesting that there should be two policies, one for the HEI and one for the Trust. There should be an agreed, shared policy to address students' poor performance. Other suggested standards that should be merged include 1.13 and 1.14, 5.5 and 5.17, 10.5 and 10.7.

35 In terms of the number of aspects, the consensus of the questionnaire data indicates that all the aspects should be kept. However, this consensus is not reflected in any other fora. One of the focus groups suggested that aspects 1 (Management and organisation) and 10 (Values, equalities and diversity) could be merged; another that the number of aspects should be reduced to six. One participant suggested adding an eleventh aspect, attrition and student mix, across pre-registration programmes, including ethnicity and diversity of recruitment 'to ensure rigour and to meet commissioning requirements'. In approval, many of the standards statements in Aspect 1 were dealt with long before the approval event. Table 2 in the *Prototype Document* shows the relationship between the 10 aspects and the eight elements in major review. If the number of aspects could be reduced, and achieve greater consistency between all three processes, then eight aspects could be identified: combining management and organisation with quality enhancement and

maintenance (replacing maintenance and enhancement of standards and quality in major review), and integrate student support as part of student selection, progression and achievement. Keeping values, equalities and diversity as an aspect/element for all three quality assurance processes in the PQAF would reflect wider health policy.

36 There was also some suggestion in the focus groups that the locus of responsibility for certain standards could be modified. For example, standards 1.14, 3.7, 7.8 and 9.8 should all change from being the responsibility of placement providers to the responsibility of the HEI. One focus group suggested that all the standards should have joint responsibility. It was suggested that, if the approach of identifying the locus of responsibility was maintained, it would be easier operationally if the standards template were split into three separate documents based on the locus of responsibility; one for HEI standards, one for placement provider standards, and one for standards that have joint responsibility.

37 Three Visitors suggested that the standards should reflect regulatory requirements more explicitly or that a separate standard should be included to ensure that regulatory requirements are met. Another Visitor considered that the standards should be completely re-evaluated and significantly reduced for them to be of any worth. Although both regulators' requirements had been mapped against the standards, this lack of an explicit link did cause concern to many stakeholders. This was particularly the case for the HPC. The requirements of the allied health professional bodies were not part of this mapping process, this will need further consideration. This is needed particularly where the allied health programmes seeking approval do not include awards leading to eligibility to register with the HPC.

38 It is evident from the questionnaires, focus groups and observation that there is significant concern about the amount of paperwork that the self-evaluation against the standards generates, the resource required to undertake this part of the process and the consequent cost.

Language

39 All the data gathered, highlighted the need to review the style of language used in the standards. The consensus was that the language:

- did not fully reflect post-registration provision or AHP provision, the terminology being too nursing-orientated
- was too jargonistic and the statements too long.

40 A consequence of the latter was that the standards were open to interpretation which did not help consistency within the process. This was further exacerbated by the perceived generality of some statements. Examples of standards to be reviewed include:

- 2.8 which 'caused some difficulty' and 'some confusion' in two prototypes. While this does not suggest an argument for removing it, it may suggest strengthening the wording

- the definition of standard 6.4 is unclear because of the lack of definition of timing
- 8.9 - one provider considered that mentoring abilities should feature within individual appraisal as part of mentor updating.

Exception reporting

41 Exception reporting is an important part of the self-evaluation process. It is a supportive commentary included at the end of each cluster of standards with a particular locus of responsibility in each aspect. It provides additional details where standards have yet to be met fully, or where attainment of the standard is at risk, or where there is good practice that should be recorded for further dissemination. However, it was apparent from the evaluation data that not all those involved in the prototypes were clear about the purpose of exception reporting and there was a request for greater guidance on this area, particularly in relation to what was deemed good practice. A varied approach to exception reporting was seen in the prototypes with variable levels of critical self-evaluation (see Table 2). Exception reporting was extensive in practice settings but far less so in the campus settings. This difference reflects a larger and more fundamental issue that (with one prototype site exception) the campus-based activity/programmes were not visible in the self-evaluation/IAR/approval documentation. Exceptions were not identified as either at risk or in good practice for programmes in documentation that went to ARMs and/or approval events.

42 While all the prototypes undertook some self-evaluation, one prototype in approval did not undertake any exception reporting, noting that the *Prototype Document* did not make it clear that this should be done. Where exception reports occurred, there was a positive and constructive discussion and an identification of possible solutions in the majority of cases. There was evidence that, where exception reports highlighted difficulties, these were often resolved at the local level very promptly. However, the exception reports were not always visible during the approval events or ARMs. Indeed, there were clear examples of where the exception reporting was ignored in these activities. HEIs need to consider how they might demonstrate the rigour of their self-evaluation processes and their willingness to make a critical self-evaluation of standards available for external scrutiny. Placements generally grasped this opportunity with enthusiasm and their willingness to be reflective and critical should be recognised and built upon.

Table 2 Amount of exception reporting by the prototypes

Exception Reporting in Approval Prototypes

Approval Site	Standards not met	Standards at risk/ difficulty	Good practice
1	0	15	31
2	0	31	23
3	Nil return	Nil return	Nil return

Exception Reporting in OQME Prototypes

OQME Site	Standards not met	Standards at risk/ difficulty	Good practice
4	0	2	22
5	2	19	50
6	0	7	6
7	0	13	7
8	2	15	41

43 Table 2 outlines the number of exceptions reports made against standards that were not met, standards that were at risk/difficulty and good practice. The small number of items in the 'not met' column probably demonstrates an unwillingness to record an unmet standard. Such exposure could be regarded as risky. However, it may also reflect that action has immediately been taken, as it should be, in response to a 'not met' judgement. Proper transparency should allow a record of such action, which shows rapid and effective response to perceived shortcomings. Positive and constructive discussion and identification of possible solutions occurred in the majority of cases. A number of the participants indicated that they would have been more comfortable with exception reporting against 'emerging issues' rather than standards at risk. This understandable concern, about stating a standard is not met, must be recognised and other categories need to be identified but without a proliferation of options.

44 The wide variation in the number of exceptions in the good practice column indicates there was uncertainty about the definition of good practice as evidenced through the observations and focus groups. There were consistent comments across all sites, from the meetings at prototype sites, by Trust staff and by external representatives, that there was a lack of shared understanding of the term 'good practice'. The glossary of terms in the *Prototype Document* identifies that good practice 'relates to strengths, good ideas and innovations…' (Page ii). It also says 'usually, good practice means that one or more standards have been met at a higher level'; however, no indication is given

about the meaning of 'higher level'. Some participants observed that a considerable amount of filtering was necessary to remove what would be better defined either as 'standard, sound practice' or 'strength'. Whilst such items are always worth recording locally, they may not be worthy of specific dissemination.

45 Another issue that arose from the data is the organisational level at which particular standards need to be considered. For instance, it would be helpful to differentiate between those that need to be addressed at local or programme level and those that require a higher-level Trust or HEI response.

46 Some standards need re-writing to clarify whether they relate to students or staff or both.

Chapter four

The approval process

47 Approval is the recognition of a programme by the regulator(s), where appropriate, the commissioner and the programme providers (*Prototype Document* section 2.1). The reasons for approval may be:

- the development of new provision
- a significant change in existing provision which partners agree requires approval
- a result of OQME and/or major review processes.

48 The approval process enables a decision to be made about the ability of the proposed programme to meet the requirements of a variety of stakeholders:

- regulatory bodies
- programme providers (practice and campus based)
- health and social care providers
- service users
- education commissioners.

All judgements must be supported by appropriate evidence (*Prototype Document*, section 2.6).

49 Within the approval process there are four key questions that must be answered.

- Does the education, training and assessment meet the requirements for the award, the requirements of regulators, the requirements of commissioners and the needs of the student?
- Is there evidence that the providers' systems and processes meet the requirements of the Partnership Framework for OQME and for major review?
- Do the providers' systems and processes operate in a fair, just and open way?
- Is there evidence that the provision is sustainable?

50 A central part of the approval process is the self-evaluation against approval standards within the 10 aspects. The standards relevant to approval are designed to address the four key questions identified above and represent: academic award requirements, the requirements of education commissioners through contractual arrangements, and relevant professional, statutory and regulatory bodies' requirements.

51 The stages of approval identified in the *Prototype Document* (2.4) are as follows:

Stage 1 Commissioning

Stage 2 Programme development

Stage 3 Approval

Commissioning

52 Commissioning involves both service and programme providers and results in a decision to commission a programme of healthcare education and training. This decision should be informed by clear evidence that the programme reflects service-user and carer needs, wants and expectations. The approval prototypes were set up after the originating commissioning process was complete. However, there was evidence from the approval documentation provided in two of the prototypes that consideration of local workforce needs had been taken into account, and it was not always clear whether the developments reflected service-user and carer needs, wants and expectations (*Prototype Document* page 12).

53 As each of the prototypes had provision that included qualifications leading to eligibility for entry to a professional register, the appropriate regulatory body had been notified. Both the NMC and HPC agreed to participate in the prototypes in line with their current procedures. In relation to AHP provision, the HEIs/SHA also invited relevant professional bodies to attend the approval events. The decision to invite allied health professional bodies is at the discretion of the HEI and their partners. Within the approval process, the professional bodies have a specific role in curriculum development. The prototypes were taking place at a time of HPC implementation of their new processes, and some of the uncertainties experienced by prototype sites reflected this period of change. Further discussion is needed to clarify the role of the professional bodies in relation to the standards and the integration of the standards to approval events. A practical issue for providers was the number of panel members, which appeared disproportionate to the activity. This was exacerbated by the HEI/SHA decision to invite professional body representatives.

Programme development

54 The second stage of the approval process is programme development. Here the commissioner and the programme provider should jointly convene a programme development group (*Prototype Document*, page 12) to produce and sign-off documentation for submission to the approval panel. The *Prototype Document* (section 2.5) recommends that the membership of the programme development group be:

- HEI 'host' faculty, department or school
- expert/professional advice, eg the relevant professional body(s)
- service users
- commissioner representatives
- service management representative(s)
- practice learning providers
- representation from students.

55 Although not formally set up, equivalent programme development processes were undertaken prior to the beginning of the prototypes. It was evident that all the prototypes had gained some input from the groups above, and a considerable amount of development activity had already taken place. There was little evidence of service users and carers having a significant input to all of the provision in two of the prototypes. However, this was not the case in the third prototype, where there was clear evidence of active and effective involvement by service users and carers in the development phase.

56 It was apparent from the documentation submitted that the development group (or equivalent) had given due consideration to appropriate professional body curriculum guidelines (for AHP provision), HPC Standards of Proficiency and Standards of Education and Training (for AHP provision), NMC Standards of Proficiency (for Nursing, Midwifery and Specialist Community Public Health Nursing) and the elements of QAA's academic infrastructure: subject benchmark statements, the *Code of practice for the assurance of academic quality and standards in higher education*, and the Framework for Higher Education Qualifications (FHEQ).

Self-evaluation against the standards

57 The *Prototype Document* (page 12) stated that the programme development group should also use the approval standards as a point of reference. This requires both the programme providers on campus and the associated practice placements to undertake self-evaluation against the standards, which results in exception reporting of issues, standards 'at risk' and good practice or innovations. The self-evaluation and the documentary evidence to support the identified 'exceptions' should form the basis of discussions during approval, along with other documentation. It was the expectation that the placement self-evaluations should be then incorporated (with a direct link to the proposals, rather than as an adjunct) into the documentation to be considered at the approval event.

58 Two out of the three prototypes undertook programme development in the manner required by the process. However, one HEI/SHA did not undertake exception reporting, although a sample was undertaken of self-evaluation by practice providers and by the central quality assurance department in the HEI. This prototype noted that the *Prototype Document* gave no indication that exception reporting was required in the approval process. Therefore, a recommendation of the evaluation is to make more explicit the need for exception reporting in approval. Where self-evaluation against the standards was undertaken (prototypes 1 and 2), there were some very positive comments about their use. The completion of the self-evaluation 'had been a very helpful exercise for both the University and the Trusts concerned'. One practice manager reported that they found the standards difficult to work with at first but they were easier to understand with increasing familiarity. The collection of evidence through areas working together was reported as 'inspiring' by two Visitors. The process was useful for identifying gaps and creating action plans for all levels within partnerships. It was noted that one prototype had envisaged particular difficulty in

engaging and undertaking the self-evaluation of placement providers in the independent sector and community placement areas and therefore these had not been included in their sample for self-evaluation.

59 The questionnaire data (both qualitative and quantitative) indicated that respondents considered that the self-evaluation process generated a significant amount of paperwork, far more than in other approval processes, and required additional resources. It was noted by HEIs, SHAs and Trusts that there were too many standards in the template. Four Visitors commented negatively about the amount of paperwork generated and the time available to read it, and for two Visitors there were concerns about the cost of the process. One Trust undertook a cost analysis of the exercise. Although useful, it did not undertake a comparative cost analysis with previous QA activity. The labour intensiveness of the self-evaluation process was highlighted in the questionnaire responses and the focus groups as a negative aspect of the process. However, this was tempered by the perceived benefit of enhanced partnership relations and more interprofessional collaboration facilitated through completing the standards template and enabling a broader range of those involved in practice to have the opportunity to be involved in and take responsibility for the approval process.

60 There was some concern amongst the respondents that the process of concatenating the self-evaluations into a single document to be considered at the approval event could result in the dilution of issues for verification at the approval event and in small disciplines being lost, particularly where a large number of programmes are approved at one event or where one discipline is dominant. Ensuring sufficient specific detail in the original standards templates could prevent this.

61 It is evident that those involved in the prototypes recognised the importance of undertaking significant development work with practice in preparation for the self-evaluation. Leadership of the process, including developmental work and implementation, was found to be crucial. In Trusts, the leadership was provided by the PPFs and CPFs, or equivalent roles in Trusts. There is no apparent consistency in titles; however, PPFs, CPFs or their equivalent take responsibility for supporting students and assessors/mentors, and for promoting a positive learning environment in practice.

62 An issue that arose from the data analysis was responsibility for the signing off of standards. Two prototypes noted that it was not always clear who should be signing off the standards and at what level of seniority, and thus confirming that the evidence is available to support the self-evaluation.

The approval event

63 Membership of the approval panel followed the *Prototype Document* recommendations in the main. It was noted that there were many participants at meetings and that meetings tended to be long. One Visitor noted that this could be 'very

tedious', although the inclusion of course teams, when this occurred, was felt to be a very positive feature. One prototype noted that setting up the panels took a great deal of organisation and administrative time, particularly where the panel was large. One respondent to the questionnaire and one observer noted that the dual role of SHA staff meant that they could be a member of both the approval panel and the programme development group, and considered that this could lead to a conflict of interests.

64 User involvement was evident in some meetings. Two of the prototypes (prototypes 1 and 3) had users and/or user representatives on the programme development group equivalent, and one prototype had a former student on this group. On other programmes, user and student input did not seem to have occurred or it was not clear how input had been achieved. In one case, student meetings were held before the main approval event but were not particularly productive, mainly because the number of students was too small and the meetings were dominated by professional body concerns. In the remaining events, meetings with students took place during the approval event and these had been very informative.

65 In most cases, panel members had not received, or only received shortly before, the standards template and exception reporting documents prior to the approval event, and this was identified as a problem, particularly by the Visitors.

66 None of the approval events followed the prototype methodology in full. In some instances, the methodology had not been sufficiently adopted at earlier stages in the process to allow the approval meeting to use the exception reporting outcomes. In other cases, the initial work had been completed but at the meeting the prototype methodology was put on one side and the HEI's normal validation processes utilised. With one exception following a QAA prompt, it would seem that the validation Chairs did not explicitly direct the panels to discuss standards or the exception reporting. More guidance is requested on the logistics of running an approval event.

67 Even though discussion in the meetings did not specifically refer to the standards, all approval events followed the principles of the approval methodology. The four key questions were discussed briefly and it was recorded that they had been met, although detailed discussion did not take place. In one case, an account of how the provision met the standards was appended to the approval documentation after the approval event.

68 Although the prototype methodology was not used to its full extent, most approval events were observed to be efficient, comprehensive and thorough, with a good level of debate. An NMC Visitor reported that the approval process was rigorous and there was an opportunity to see the completed standards template and the evidence used to make the judgement. Another Visitor reported that it was an enjoyable experience and a learning experience for all involved. However, three approval events were reported as being 'bogged down in minutiae' or too focused on technical detail that could have been dealt with elsewhere.

69 The HEI undertook the responsibility to write up the minutes of the approval event and produce the subsequent action plan. These were circulated, with the exception of one prototype, to all stakeholders for agreement. In one prototype, there was some initial confusion about the role of the NMC in accessing and agreeing the minutes, the HEI determining that the document was for internal use only. The prototype documentation did not comment on the reports produced from an approval event. During the prototypes, it became clear that such advice was needed. QAA provided that advice, identifying that there were two sets of documentation that stakeholders need to agree. The minutes/notes of the approval event and the outcomes of the approval event in terms of actions agreed. Future guidance is needed to clarify the responsibilities of members of the approval panel following the event.

Fit with HEI/SHA quality assurance processes

70 Two respondents to the questionnaire felt that the approval process fitted completely with the existing university/SHA quality assurance processes. The remainder, including the Visitors, felt that there was a partial fit. However, all the observers noted that the prototypes still used the HEIs' 'normal' approval/validation process to a greater or lesser extent. One observer considered that the prototype approval process was not consonant with HEIs' 'normal' validation procedures and that this might be part of the reason for it not being wholeheartedly adopted. Generally, all parties represented at the approval meetings felt safer with their tried and tested methods. The culture of approval from an HEI's perspective may be to adopt a defensive position; for example, one HEI produced a written response to the exception reporting which was very defensive in tone. The notion of a standard being 'at risk' runs counter to the notion of a secure base from which to launch a new programme. This would suggest that adoption of the new process would require more development effort to initiate a culture change and alter the terminology/categories to make them more user-friendly.

71 It was observed that, although meetings did not make explicit reference to the PQAF standards, the standards template could have covered all issues that were discussed. At one meeting, an intervention by a QAA observer demonstrated how exception reporting had already identified an issue and described steps that would be taken to remedy it, which the approval panel were considering to be the basis for a condition/recommendation.

Verification

72 One purpose of the approval event is to verify the quality of the provision as demonstrated through the self-evaluation and approval documentation provided. While there were no explicit requests to see the supporting evidence by the approval panel, verification was undertaken orally. However, 75 per cent of the respondents (including the Visitors) considered that the evidence was not explored fully in the approval event, and 66 per cent considered that it had not been verified.

However, 66 per cent of the Visitors thought the evidence base sufficient to enable them to undertake their role as a Visitor, but with some instances of Visitors requesting additional documentation prior to or at the approval event.

73 There was some confusion regarding the NMC Visitor's role in verification and how this could be achieved. Two Visitors reported that they would want to visit practice areas before the event to meet students and staff to help ensure that regulatory requirements were being met. Others reported that taking part in the verification visit was helpful and necessary. In one prototype, it was not clear that the verification visit was a single-day event, with Trust staff anxious that there might be further visits. NMC officers helpfully allocated the same Visitors to both OQME and approval processes for prototype 3, the aim being to see if this helped in the dialogue and verification process. Where possible, NMC also arranged the allocation of the Visitor who had previously undertaken annual monitoring of the provision. The benefits of continuity clearly outweighed any potential disadvantages. Regulators need to consider how this continuity may best be achieved.

Statutory regulatory bodies

74 Both the NMC and HPC agreed to participate in the prototypes in a manner appropriate to their current approval procedures. For HPC, this meant that HPC Visitors were present at the approval event for an AHP where new provision was being approved or where there was a significant change to an existing curriculum. In prototype 3, the HPC deemed that, in accordance with their procedures, there had not been sufficient change in the curriculum of two programmes to warrant the presence of the HPC; note would be taken of the final approval documentation. Therefore, five HPC Visitors were involved in one prototype (prototype 2). The HPC reviewers who commented found the documentation to be too lengthy and complex and so used HPC documentation and procedures. An explicit cross-referencing of PQAF standards to HPC standards had been carried out, which should have facilitated more explicit involvement of the HPC in the approval process. However, this cross-referencing needs to be widely shared and made visible to participants in the PQAF.

75 NMC Visitors were involved with all three of the approval prototypes, with Visitors from the appropriate Parts of the Register in attendance. The majority of the Visitors who completed the questionnaire felt that their role was clear and as expected (83.3 and 71.4 per cent); 66.7 per cent noted that the QAA/NMC/HPC briefing day was clear and helpful, and 83.3 per cent that the preparation received prior to the prototypes was clear and helpful. However, one Visitor felt that their role in the approval event was unclear and as a result they could not wholeheartedly report that regulatory requirements were being fully adhered to. The lack of understanding about the role of the Visitor from the perspective of the HEIs, SHAs and Trusts was also apparent from both the questionnaire data and focus groups. One Visitor noted that some HEIs had little understanding of the importance of the Visitor role and lacked appreciation of the

expertise of the Visitor. More clarity about what is required from Visitors, and what evidence regulatory and professional bodies require, is needed.

76 Two of the six Visitors who responded to the questionnaire felt that their role worked well within the approval process, and the rest felt that it worked in part. There was a mixed response as to whether the evidence base for the approval event was verified and whether it would allow them to fulfil their regulatory role. However, the observers commented that the Visitors tended to revert to their known NMC mode of working during the approval event. This might be a result of the HEI's traditional approval processes being utilised rather than the nature of the prototype approval process itself. In two cases, it was observed that the Visitors dominated the approval meetings. Overall, none of the Visitors who responded to the questionnaire felt that they were able to fulfil their role as a Visitor in full.

Student and service-user involvement

77 The approval process includes specific roles/involvement for the students and service users in the commissioning and programme development (see paragraphs 48 and 52). While there was evidence in the prototypes that there had been student and service-user involvement in two prototypes, the degree of their involvement was not always clear. It was also noted from the focus groups that the timeframes for the prototypes did not enable full engagement with students or service users.

78 In three of the prototypes, service users or service-user representatives participated in the programme development, making a positive contribution to the approval (see paragraph 64). All the prototypes included, more usually as part of the standard HEI approval process, meetings with students (see paragraph 64). One prototype approval event included a former student on the subject panel.

79 The quantitative data arising from the evaluation questionnaire noted that 62.5 per cent of the Visitors who responded to the questionnaire agreed that stakeholder involvement was facilitated by the approval process, compared to 55.6 per cent of the respondents from HEIs, SHAs and Trusts.

Partnership

80 A positive outcome of the self-evaluation against the standards, noted by a significant number of respondents to the questionnaires and by the focus groups, was the strengthening of partnership between the Trusts, the SHAs and the HEI. There was a very strong message that the approval process facilitated the stakeholder involvement and that it enabled practice placements within Trusts to take responsibility for the education provision. There was some difficulty in ensuring that the independent sector had an input to the process.

Leadership

81 It is recognised in all the evaluation activity that strong leadership in the Trust or placement organisation encourages the appropriate completion of the self-evaluations and, as one observer suggested, would ensure that the evaluations hold a central place in the approval process. Whilst not all of the prototypes had this strong leadership, the role of the CPFs/PPFs, where they were in place, appears to be crucial for the process to work well and to ensure full participation from the practice areas.

82 Strong leadership in the HEI both at the faculty/school or departmental level, and close links with any central quality assurance department, are essential for the process to be carried out appropriately. Where these were in place, concomitant with a thorough grasp of the process by those with leadership responsibilities and those chairing the approval event, the approval process followed the prototype approval process more closely.

Resources

83 The approval process appears to demand a significant resource input and a suitably planned lead-in time. Almost all Visitors agreed that the large amount of paperwork, numbers of participants and potentially the number of programmes approved meant that a significant amount of time was required. There was concern that this might be costly and place the supporting infrastructures under strain. This was demonstrated through the perceived late production of documents. However, this might be predominantly because of the shortened timescales available for the prototypes rather than as a result of the process itself. The process was reported as being very labour intensive by the HEIs/SHAs/Trusts and by participants in the focus groups. However, the quantitative data from the questionnaire would indicate that the respondents considered the workload to be either about the same or less than previous methods. Almost all felt that the processes could not be undertaken within existing resources.

Facilitation and communication

84 There was a mixed response as to whether the prototype documentation was helpful in preparing for the prototype and completing the self-evaluation. The NMC visitors found the *Prototype Document* helpful, while the HEIs/SHAs/Trusts thought it unhelpful in explaining exception reporting and running the approval event. It was felt that the process was explained but interpretation was vague, leading to difficulty and misunderstanding. Further guidance was published by QAA in March 2005 on the use of the self-evaluation against the standards and exception reporting.

85 Evidence indicates that the prototype sites did not have a clear understanding initially of the role of the QAA facilitators. In time, the facilitators were used predominantly for briefings and as sounding boards and, while welcomed, were not always used to full advantage. This would indicate that a rigorous programme of briefing prior to any future rollout is required.

86 The prototype sites recognised that clear communication was crucial for implementing the approval process; where clear channels of communication were in place there was better involvement and engagement with the process. Communication between the Visitors and the prototype sites was variable; however, where a CPF/PPF was in place, communication was strengthened.

Chapter five

Ongoing quality monitoring and enhancement

87 OQME is a process by which education commissioners and regulators satisfy themselves that the quality of education programmes provided by HEIs and placement providers is maintained and improved (*Prototype Document*, section 3.1).

88 The four stages of the OQME process are as follows:

Stage 1 Self-evaluation in the local learning environment

Stage 2a Authorisation at organisation/institution level

Stage 2b Production of Initial Action Report (IAR)

Stage 3 Annual Review Meeting (ARM)

Stage 4 Final Action Report (FAR)

Stage 1: Self-evaluation in the local learning environment

89 Evidence serves three purposes (*Prototype Document* page 21):

- it gives validity to the claims being made, supporting local judgements
- it enables comparisons to be made between different placements or programmes
- it provides a means of measuring quality.

90 A key decision to make early in Stage 1 is how to choose what to sample in the local learning environment and where evidence should be sought. Different approaches were taken by prototypes within the framework. For placement areas, a sampling approach, for example 50 per cent, was taken by some and a clustering approach by others. In the latter, rather than looking at a very large number of individual placement areas, including some that because of the short time-scale were unable to accommodate a new process, placements were clustered into larger groupings. This raises the questions: what does a placement unit consist of, and at what level? It became clear that, because of the time constraints, placements deemed too difficult to embrace in the sampling were avoided. These included those spread widely on a national scale and also most of those in the independent sector. It will be important to include these in the future. Some participants pointed to the need to determine a standard sampling procedure that precludes the need for self-evaluation of all programmes and all sites every year. Others, however, emphasised the need to meet contractual obligations on an annual basis at the same time.

91 Sampling in the campus environment poses similar problems. It is important to give appropriate weight to post-registration as well as to pre-registration provision. It is also important to link campus and practice evaluation. The prototypes showed a lack of explicit evidence of this link taking place.

Exception reporting of evidence

92 The *Prototype Document* (page 17) gives guidance about exception reporting. This is fundamental to the process and involves reporting only for those standards judged at the level of the local unit to be:

- at risk
- demonstrating innovation and good practice
- showing change since the last review.

93 The definition of exception reporting was often not clearly understood. This points to the need for developmental work as part of standard practice. Participants suggested that it would be helpful in future to distinguish good practice from at-risk reporting by using an appropriate form of coding.

94 The *Prototype Document* emphasises that it is not necessary for evidence to be produced, but that it should be available for scrutiny if requested. However, the OQME prototypes have thrown up a challenge for clinical placement staff. Participants commented that many clinicians do not routinely generate evaluative evidence in relation to their own practice, nor the learning of students on placement. This means that there is a significant challenge in ensuring the effective completion of the standards template by clinical staff. The initial and effective briefing of clinical staff is critical to the successful implementation of the process.

95 Self-evaluations showed some indication that clinical participants found it easier to identify shortcomings and more difficult to see strengths and good practice. To give equal weight to both positive and negative requires a shift in culture. Variations in reporting meant that some Trusts identified good practice that others consider a routine part of their work. This points to the need for a decision-making process to determine what is good practice, new ways of identifying it, and a process for disseminating it.

96 Overall, Trusts were enthusiastic about the self-evaluation process. They saw it as allowing them to gather evidence in relation to their responsibilities that they would otherwise be unable to do. Evaluation events showed that most staff approve of the idea of self-evaluation. It promotes explicit recording and Trust staff felt they could be more open and give explicit detail.

Completed templates

97 There was wide variation in the quality of the locally completed templates for OQME. Clinical areas made a very positive effort to abide by the intended spirit of the process. Several participants noted that it gave them a feeling of actual significant involvement, of having 'a say in the provision for the first time'. HEI involvement at the programme level, on the other hand, was generally less clearly visible. The lack of reference to external examiners' reports and to the academic infrastructure in exception reporting underlined this. On both sides, there was often a lack of sufficient detail or

specificity to allow the particular location, programme or sub-discipline to be identified, other than at local level. The logistics of completing a template for each placement were found not always to be straightforward. Some were completed peremptorily, suggesting the need to scrutinise the evidence upon which the judgements were based. This might be the kind of trigger for requests to see the evidence in order to overcome a perceived lack of rigour. However, many were filled in precisely the way intended and needed.

98 A point of significant concern is the progressive generalisation of the self-evaluation exceptions in moving through the IAR stage to the FAR stage. This 'filtering' process inevitably resulted in a loss of specificity of the exceptions reported to programme and unit, and precise responsibility for taking subsequent action. For example, in one prototype, there was a complaint made at an interim meeting that the detailed self-evaluation work that had been undertaken had not been utilised fully. In another, good practice from Trusts was criticised as being under-represented in the amalgamation process. This suggested a conflict about the need to keep documentation tight and economical while not running significant risk of conveying the impression of a lack of rigour. One provider noted the rigorous way in which those locally responsible completed their templates.

99 The emerging evidence base is proving very useful to Trusts. It has been found to be directly related to standards and would not have been assembled through existing procedures. In one subject area, for example, after producing their local self-evaluations, staff were reported as having already shared their exception reporting and were in the process of implementing action plans. However, through the process of reducing the commentary to manageable proportions, this excellent and reliable work had become invisible. This reflected the common experience of core evidence not generally being identified at IAR level. One participant commented that the templates simply did not reflect the reality and depth of what had been achieved. Therefore, visibility of the evidence is an issue that needs to be addressed. Ways of mapping and signposting evidence could be developed in line with increasing engagement with electronic means of collation.

100 A simple device to increase the visibility of the evidence is to reinstate the self-evaluation template column that was present in the draft *Prototype Document*. This required a list of evidence sources for each standard. However, the judicious use of this column is important. It is not sufficient here to point only to policies and strategies in place. Rather, the ways in which such policies are enacted provide the quality of evidence required. It will be important to give further clear guidance on what is needed in this additional column. The key outcome here is to ensure that robust verification is facilitated.

101 It will continue to be important that one particular area of evidence is not over-summarised. This is the quantitative evidence in statistical form of students' progression and achievement. These statistics are essential to the Teaching Quality Information needs of the HEIs as well as the contract monitoring needs of the SHAs.

102 Experience of the prototypes also points to a clear need for significant staff preparation and support for self-evaluation and appropriate use of reference points. For example, consistency of practice in relation to adequacy of clinical placements at Trust level is an important issue but does not mean much to the individual practitioner who does not have wide experience and specific preparation for the exercise.

103 Student views of standards are captured, generally by their HEIs, through a number of established mechanisms, such as module, programme, placement and exit questionnaires. However, it is acknowledged by participants that the input from service users on the standards of healthcare education is both unclear, unsystematic and in its infancy.

Stage 2: Authorisation and the Initial Action Report (IAR)

> 'self-evaluation should result in an **initial action report** which the Annual Review Meeting should then consider in depth' *(Prototype Document 3.2)*

104 Local self-evaluation is confirmed by a signature from the named person in each local area. The named person within the HEI might be a programme leader for a specific programme. For placement providers, the named person could be a ward or department manager or an individual healthcare practitioner. The signature indicates that there is evidence that the standards are self-evaluated accurately in the local environment. If standards have not been met, a supportive commentary is provided, on the reporting sheet for each cluster of standards, on the basis of exception reporting. The self-evaluations across the whole standards template then need to be signed at an organisation-wide level by the HEI and Trusts to indicate that the appropriate standards have been achieved with reporting on an exception basis. In the case of some Trusts, good practice was demonstrated in an iterative process of dialogue between directorate and lead level to produce the IAR content.

105 The timescale for the completion of the self-evaluation process was set for early December. Providers sought various ways of ensuring that the project was on track to meet the various deadlines agreed. In one case, this involved a networking day, half-way through the project, for all Trust Leads and Chief Executives. Another prototype instituted a critical reading day with key stakeholders, including the facilitator, in preparing the IAR. By mid-December, sharing of information and consolidation of evidence with the assistance of NMC Visitors was well advanced. The IAR needed to be completed ready for distribution to stakeholders four weeks before the ARM (this timing was a concession for the prototypes; in real terms, external stakeholders need the reports earlier).

106 With the production of the IAR, emerging themes became apparent from the exception reporting. Where providers produced a thematic analysis based on exceptions, this was perceived to be very helpful. The following eight themes were articulated by one prototype but were also common to many of the others:

- mentor preparation, mentor updates and live registers
- practice learning capacity
- monitoring and managing underperformance of students
- Trust involvement in curriculum development and setting learning outcomes
- partnership working in recruitment and selection
- sharing and using student feedback on practice placements
- practice assessment and inter-assessor reliability
- the role and value of PPFs/CPFs.

107 The emphasis on the practice part of the provision is obvious from these themes. However, named responsibilities do also include exclusively HEI ones, such as learning resources in the academic environment. 'At risk' exception reporting was balanced by commendations of good or innovative practice. However, the need for clarity around these definitions was apparent. For example, in one case, some strengths were identified also as good and innovative practice. Later, in this instance, it was telling that the FAR indicated 'no action' against all of these.

108 The way in which the IARs were pulled together from the self-evaluation evidence varied significantly. One example succeeded in retaining the detailed and comprehensive evidence at programme and placement level. However, in the majority, the core evidence was not apparent, making it difficult to sign off the IAR reliably. The key message here is that clear and consistent verification of the standards is paramount. Some providers developed very efficient electronic means of grouping the self-evaluations of Trusts together, compiling, cutting and pasting exception reports on screen to provide a summary of the evidence. One SHA (not a prototype site) is currently piloting an electronic shared-practice database that may in the future provide an effective and timesaving tool. This links with the perceived need by many placement providers for a standard placement educational audit tool that could be used with economy of effort throughout the country.

109 An important point emerged in relation to timing. Is the standard met once the actions are specified? A number of actions resulting from self-evaluation may well have been clearly dealt with by the time of the ARM. These should be signalled in the version of the IAR that goes to stakeholders attending the ARM.

Stage 3: The Annual Review Meeting

> 'self-evaluation should be subject to rigorous **verification** in the Annual Review Meeting…and supporting evidence be made available if needed' *Prototype Document*

110 The aim of the ARM is to focus on quality enhancement and to meet the need for quality monitoring by the stakeholders. It therefore needs to accommodate the requirements for quality monitoring of each stakeholder. Overall management of the prototype ARMs was in accordance with the protocol. They were coordinated and chaired by the lead education commissioner or their representative in agreement with the NMC and in collaboration with the HEI. Representation by individuals from placement providers was at an appropriately senior level although, in one case, was inadequately small. It is important that representation is equitable to help enhance shared ownership and genuine partnership.

111 It is clear from feedback and observation that the kind of robust debate that is perceived as essential to the rigour of the OQME process was difficult to achieve in the ARM. It is important to clarify the expected ethos of the event. The five that were held varied across a wide spectrum from a kind of formal contract review to participative problem-solving. All formats had strengths and weaknesses. There was a lack of testing of the evidence base in all. In two cases, the lack of disagreement in the ARM was identified as a consequence of it appearing too risky, with debate therefore being kept to a minimum. In most cases there was a filtering of issues thought to be significant enough for the ARM. Therefore, not all those that were important to those stakeholders present were considered. Moreover, practice learning featured strongly in all the ARMs, sometimes to the detriment of consideration and verification of claims made about campus learning.

Table 3: A summary of the ARM process across five prototypes

Provider	Process	Strengths noted	Weaknesses noted
Prototype 4	32 attendees. Chair: SHA nominee, supported by four SHA staff who acted as recorders and facilitators. Plenary, followed by six workshops, followed by plenary. No students or service users present. Each workshop group discussed the relevant standards and exception reports from the IAR and then fed back recommended actions. NMC not consulted about agenda. They were unable to confirm at the end of the meeting whether or not their needs had been met.	• collegial and open discussion among partners • permitted the review of supporting evidence, although no-one present availed themselves of this opportunity • central role of the shared standards was evident throughout • discussion encouraging as linked to fitness for purpose as well as practice	• not all output from workshops was discussed before being agreed at the plenary • no verification activity • lack of critical appraisal by the HEI; practice learning dominated the discussion
Prototype 5	33 attendees. Chaired by partner Trust Chief Executive. Each agenda item addressed, with opportunities for partners to contribute. No students present. NMC Visitors actively involved by Chair and confirmed their needs had been met.	• ethos of testing continued throughout the meeting • specific discussion of issues (mainly) and good practice (a few) by nominated reps • joint strategy to resolve attrition (Standard 5.16) agreed by partnership	• specific programmes not identified, at least not in initial documentation • affirmation of need to continue to work hard at ensuring number of of placements of adequate quality

Provider	Process	Strengths noted	Weaknesses noted
Prototype 5 (cont)		• Standard 5.17 - inconsistency, but formally raising profile of jointness. Policy being reviewed and consulted upon • communication between partners improving	• Trusts and the HEI differed in their interpretation of whether the detailed work carried out had been fully recognised • route for sign-off and corporate ownership of self-evaluation not identified
Prototype 6	25 participants, including observers; 2½hr meeting chaired by SHA nominee. Agenda carefully set in relation to the comprehensive IAR. All stakeholders represented except students and users. NMC Visitors did not shape agenda but confirmed their needs had been met. Discussion led by HEI Lead.	• IAR very comprehensive • effective IAR discussion at a strategic level, • IAR provided an appropriate, critically evaluative basis for discussion, • quantitative data presented in support of contract • ethos of testing evidence throughout the meeting	• none, though outcomes possibly skewed in favour of issues as opposed to good practice and innovation for dissemination • lack of visible verification
Prototype 7	Workshop format, with about one hour devoted to one, two or three aspects together; introduced by Ambassador; followed by discussion of risks, action plan, time scales and responsibilities. Ambassadors were appointed per aspect prior to the event	• ARM format unconventional and ambitious. Successful in promoting an attitude of enhancement • all stakeholder groups present confirmed it had met their monitoring requirements	• asked for three key risks associated with exceptions, but not good practice • exceptions, proposed actions and criteria for evaluation were more like wish lists

Provider	Process	Strengths noted	Weaknesses noted
Prototype 7 (cont)	and, before each discussion, they were asked to brief the group regarding the aspect and what they would like them to consider. All feedback from each table taken away and taken into consideration in the production of the FAR.	• mixed group discussions intensive, informed and constructively involved all participants. The opportunity to share across the professions and organisations was clearly valued by the participants • awarded those exceptions that demonstrated innovation and good practice with certificates of recognition	• specific programmes/ placement areas/Trusts/HEI committees/boards not identified • not clear how the ARM would have addressed any serious exceptions - separate out into less interactive format? • meeting inconclusive in undertaking its formal duty to confirm the FAR
Prototype 8	43 participants. Very minimal attendance by partner Trusts. Lecture theatre layout. Chaired by WDC Senior Officer. NMC participants in general audience. Therefore, question and answer format: panel, chaired by SHA and including observers facing ranked attendees. Well-managed meeting, with high standards of discussion and scrutiny.	• clinical staff were helpful in nuancing some of the proposals • did seek to verify evidence	• only four Trust staff attended out of a potential 15 Trusts, 3 at PPF level; one Asst Director Nursing

112 Prototype 6 illustrates one possible model of good practice in enhancement. The stakeholders felt strongly that the ARM should be used as a developmental activity, in addition to its function as a rigorous monitoring event. They considered that it should be used to promote cross-organisational and interprofessional discussion, the sharing of good practice and the search for solutions to issues. To ensure that each item in the IAR was given due consideration and debate, and that stakeholders were able to shape the FAR and gain ownership of it, they were asked the following.

- Do you recognise the exception in the IAR?
- What are the three key risks associated with this exception?
- Do you believe the suggested action in the IAR is appropriate?
- What other three suggestions do you have for action?

113 The lack of a student voice at any of the ARMs gave cause for concern, as did the absence of service-user representation. Representatives need to be specifically invited and involved in agenda setting. The absence of clear student feedback to support the achievement of standards is a significant problem for some clinical areas.

114 In closing the ARMs, the timing and route for the FAR were not always clear and agreed in the way that they need to be.

Stage 4: The Final Action Report

> '...discussion at the Annual Review Meetings should result in a **final action report**, which is shared and agreed by all stakeholders' (*Prototype Document* 3.2)

115 An integral function of the FAR is to identify and disseminate good practice. All partners need to sign off the document. There is a need for action plans to be formalised at Trust and HEI departmental level if the process is to be effective. Shared ownership of the FAR by all the stakeholders is an important principle.

116 A number of significant shortcomings were identified in four of the five prototypes at the interface between the ARM and the FAR. In one, hardly any of the exception reporting and planned actions focused on the HEI or the standards for which it was responsible. In this case, it was also noted that the FAR was identical in content to the IAR. This would indicate that the ARM served no significant function here. Also, the lack of evidence base and verification in the FAR meant that it would not serve adequately as a SED for major review. It is important to recognise precisely who takes responsibility for action on what.

117 In two other prototypes, the material for the FAR was derived directly from the IAR. There was 'no action' indicated in relation to anything labelled as good practice. In one of these, a number of exceptions (issues) are listed for development during 2005-06 and the roles of those responsible for actioning these are named. In two

others, there was a lack of specificity to programme, location and responsibility. This made it difficult to know whether the high level of generalisation in the FAR will influence or impact on the necessary specific action at the local level.

118 The quality of the FAR in one prototype was exemplary. Exceptions were specific down to programme level, criteria for evaluation were given, responsibility for actions was identified and review dates were stated.

119 Following the ARMs, an emerging need became apparent for meetings to be held through the following year in order to verify that issues within the FAR were being addressed appropriately. This is particularly important where issues are considered 'high risk' in terms of student achievement, public safety, and fitness to practise.

Partnership working

120 Before Stage 1 could commence, key decisions needed to be made and protocols clarified to ensure a well-integrated and effective process to achieve the objectives of the OQME process.

121 Key guidance in the *Prototype Document* (section 3.2) about self-evaluation includes the following:

> 'self-evaluation should be subject to rigorous **verification** in the Annual Review Meeting…and supporting evidence be made available if needed;'
>
> 'self-evaluation should take place against agreed standards from the shared Approval and OQME Standards Template.'
>
> 'self-evaluation at local level should be authorised by each organisation;'

122 About three-quarters of those returning questionnaires considered that stakeholder involvement and partnership were facilitated and promoted by the OQME process.

Partners and named leads

123 There was a significant effort made to engage all Trusts and stakeholders in the independent sector. Initially, for logistics and engagement reasons, the numbers of Trusts and SHAs involved needed clarification. In most cases, the sound practice was adopted of using named leads in each placement provider for receiving and actioning documents. By the time of the planning meetings, those responsible for leading the prototype, whether from the HEI or SHA, were clearly identified. Where this was bipartisan, it clearly emphasised the key principle of partnership between HEI and practice components of the education. It will always be important that named leads are clearly identified in advance of self-evaluation commencing.

124 The importance of engaging Trust Chief Executives to help with the initial engagement with the process within the SHAs was noted. In one case, this was true from the start with, for example, an assistant director of nursing holding a joint appointment with the HEI. Good practice was evident in the production of two information sheets, one for clinical staff and one for Trust educational leads. These are two and three sides long respectively and provide succinct, explanatory summaries of OQME and the staff roles within it. This HEI/SHA partnership has developed further good practice by providing individual briefings for every Trust, so that clinical staff know exactly at what level they should be working. Link lecturers became involved with clinical staff as part of their ongoing partnership process as they, the link lecturers, have a wider experience of what contributes to a quality practice learning environment.

125 The evaluation events also identified another key partnership link that was enhanced by the OQME process. This was between health visiting, midwifery and nursing on the one hand and AHPs on the other. They discovered that working more closely together resulted in greater accountability.

Roles and communication

126 There were a significant number of partners and stakeholders involved in the OQME and approval prototypes. The communication protocol stressed the importance of effective, focused and clear communication and outlined the communication principles and channels agreed by the partners and other organisations. The principles were stated as follows:

- communication channels should be as simple and clear as possible
- wherever possible, the communication between partners and stakeholders should be through identified lead person(s)
- prototype organisations should experience as little disruption as possible
- prototype coordinators (QAA) and the external evaluators will agree specific processes.

127 A lack of clear and effective communication between key stakeholders was apparent in some prototypes at the start. Strong leadership is required to ensure that adequate communication is maintained between the key players in the HEIs and SHAs. Evaluations showed that the OQME process brought the positive benefit of putting education at the forefront in Trusts, particularly at board level. Participants welcomed websites to facilitate communication where these were developed by prototypes. However, a worthwhile attempt by one provider to use electronic communication to elicit self-evaluations from distant sites was unsuccessful. In this case, none of the five providers of one AHP submitted a self-evaluation.

128 The quality of communications remained a key ongoing theme throughout the prototypes. In one case, relating to academic development, discussion showed that differences of opinion between Trusts and the HEI were still evident at the ARM.

In another case, a senior academic clearly felt isolated in the task of preparing the IAR. It had been difficult to translate the plethora of detailed and location-specific exceptions in the templates into a coherent set of messages for the IAR. Evaluation events showed that, where channels of communication and support were in place, there was widespread involvement and returns of self-evaluations.

129 However, a clear message also emerged that the OQME process led to improved communication between partners at Trust level. In one prototype, many partnerships were formed, building on strong collaborative working within the educational provision since major review had taken place. In one HEI, subject staff had not previously had the level of contact with supervisors that the OQME process now required. They stated that, 'Once started, this is a very positive dialogue that will help staff relationships and students.'

The QAA facilitators

130 The QAA facilitators were QAA contract reviewers with significant experience in the review of healthcare programmes. The facilitator role was to work with the HEI, SHAs/WDCs and Trusts to help coordinate the implementation of the prototypes. Each was allotted 10 days for this role. However, without exception, providers and partners found it difficult initially to engage effectively with this role. One facilitator commented early in the process that the partners had 'not sought to involve me as QAA facilitator except when they thought it was a specific requirement,' and found himself party to a very limited amount of communication. Later, facilitators were used increasingly effectively in providing briefings for clinical staff and for chairs of panels, and became active in early planning and discussion. In several cases, the facilitator was used effectively in helping to clarify aspects of the process and to support the lead persons with specific issues arising or at times of uncertainty.

131 Perhaps particularly valuable was the use of the facilitator in strategic meetings and, more informally, as a critical independent friend. In at least one case, working relationships between partners were so effective that the facilitator role was largely superfluous. Nevertheless, one of the facilitator's functions was to receive copies and monitor all the documentation generated by the prototypes. This did not take place systematically, with the provision of documentation being minimal in some areas. Self-evaluations were received in very few instances. This point is important, not for the prototypes or QAA, but because a constant theme in the prototypes was the level of reassurance external stakeholders can receive. If the rigorous and robust forms of verification are not visible to external stakeholders, integration and streamlining become difficult.

132 Overall, a majority of those returning questionnaires found the facilitator role helpful. There may be value in each provider being supported by a person in the role of 'external critical friend' during the first year of the new process, should it be rolled out, but it should not be essential thereafter. This role might be restricted to

correspondence in support of the lead HEI and SHA and/or could involve attendance at early-stage planning meetings.

Practice placement facilitators/clinical practice facilitators

133 The successful completion of the self-evaluation templates at local level was the crucial underpinning of the whole OQME process. The effectiveness of this part of the process in practice areas was most notable in those where PPFs/CPFs provided the support and monitoring needed by the clinical staff. PPFs/CPFs were involved from the outset in giving support to clinical staff and in helping to ensure an even quality of self-evaluation. They may be funded by the SHA, but are Trust-based. In one prototype, the CPF delivered a 90-100 per cent return of self-evaluations from clinical staff. In another case, the CPF carried the heavy workload in successfully producing the collated composite Trust report. However, some SHAs and Trusts have not established these crucial posts, particularly in PCTs. Many that are in place do not have an SHA commitment to continuation of funding. A leadership role is essential for pulling staff together in the maintenance and enhancement of quality. For some placement providers, this role was undertaken by staff in education lead posts; these tended to be separated between allied health and nursing.

The statutory regulatory bodies

134 As the HPC does not have a separate annual monitoring process, preferring to link with existing HEI internal quality assurance procedures, there were no HPC Visitors present at the ARMs. The NMC role is as regulator and stakeholder. The NMC Visitor could ask for any additional evidence they needed to enable them to verify the standards of programmes. Ideally this request would be in advance of the ARM, however this required them to be informed of the ARM and the proposed agenda. The NMC has the right to request further visits after the ARM if it is not satisfied that it can sign off the FAR. It was made clear at an early stage that there could be further NMC visits if concerns about the self-evaluation arose during the NMC Visitor verification visits scheduled for all the prototypes during the December period. This option was not taken up in any prototype.

135 The role of NMC Visitors in the OQME process was a new one, limited to the verification of the effectiveness of self-evaluation at the local level. The role was not perceived to be clear by about half of those returning questionnaires. Visitors were keen to remind subject staff of their need to be assured that signing-off of standards was verified. Indeed, at one site, while the process was deemed to have proceeded effectively, NMC Visitors asked for evidence to support the self-evaluation. It was acknowledged that this level of scrutiny needed to be robust while, at the same time, a shift in the culture of the NMC and Visitor from gathering their own primary evidence and talking directly to individual students needed to be achieved, in line

with the intentions of the OQME process. However, visiting practice areas is a key part of their involvement and allows verification of the summary provided by the IAR. Some Visitors reported finding that what happened in practice was much better than the impression they had gained from the documentary evidence.

136 There was some confusion and concern about the expectations of the NMC in relation to the ARM. It is important to ensure that SHAs actively involve the NMC, as well as other stakeholders, in the ARM agenda setting. It was noted that some of the NMC Visitors who had attended the briefing day had still retained the culture of previous NMC processes, despite being briefed. Briefing of Visitors was felt to be a positive feature by the Visitors themselves.

137 While the NMC had a clearly-defined approach to and involvement in the OQME process, the HPC only visits the education providers annually in exceptional circumstances. If the HPC needed to visit, it would have indicated its intention to do so. This option was not taken up in any of the OQME prototypes.

Student and service-user involvement

138 Students and services users, as one of the stakeholders in the OQME (and approval) process (*Prototype Document*, glossary of terms), should be involved either directly or indirectly (through other sources of evidence) in the self-evaluation process and the ARM. As highlighted in paragraph 103, students' views are often captured through established HEI mechanisms. However, one focus group noted that greater guidance in the prototype documentation on how student input should be gained in OQME would be welcomed, for example, a separate section as in the approval process. This might be particularly helpful in addressing the issue raised in paragraph 113 about the lack of student voice and service-user representation in any of the ARMs.

139 The quantitative data from the evaluation questionnaire noted that 62.5 per cent of the Visitors who responded to the questionnaire agreed that stakeholder involvement was facilitated by the approval process, compared to 72.7 per cent of the respondents from HEIs, SHAs and Trusts.

Timescales

140 The sites achieved the overall goals of the prototypes within the timescales. This is a positive feature and deserves congratulation. The timescales for the prototypes were tight, effectively a 7-8-month year. There was less time for stakeholders to prepare than there will be if an agreed version of the PQAF is implemented nationally. This meant that the time needed for gaining the necessary understanding of the process was short. It also meant that most prototypes made a slow start while deadlines for the completion of Stage 1 were looming. The challenging time-lines

meant that many placement providers were not able to participate in the OQME process. This underlined the need to ensure that placement providers are given sufficient forewarning for any future collaboration. Planning and progress meetings during the September-October 2004 period formed an important part of the clarifying process for staff centrally involved in it. They brought partners together and began to address decisions that were required.

141 It will be important for any future roll-out that the timing of the process meets the needs of all stakeholders in an equal partnership. All need to be fully involved in order for the production of 'joined-up' evidence. It was suggested by some participants that reconsideration should be given to the frequency of the ARM but that self-evaluation should be annual. However, others considered that there was a continuing need for an annual OQME process, a biennial one would not meet the needs of all stakeholders. In practice areas, the face-to-face audit process that already exists could be enhanced through workshops set up to define exceptions, rather than being the result of individual working. This would help satisfy the need both for enhancement and annual monitoring. There was clear understanding of the time costs of developing and becoming familiar with a new process, although respondents to the questionnaire noted that the process could not be implemented using existing levels of resource.

142 The timescale was tight for all partners, involving much extra work for all. In particular, the timescale of the prototypes did not fit the annual programme review processes of the HEIs. It therefore proved difficult to test the extent to which the OQME process could replace the standard institutional annual monitoring process for the healthcare provision. One institution was clearly committed in principle to replacement. Others have shown an intention so far of running OQME in parallel with their own established quality assurance procedures. This is against part of the spirit of the process which is to reduce the overall burden of quality assurance.

143 If a full year is adopted, it will be necessary to plan the OQME process fully before the start of the annual cycle. Planning should:

- commence at the end of the cycle with publication of the FAR
- build in time to confirm drafts and sign them off
- set the date for the ARM
- plan and identify time to view evidence
- identify the last date for completion locally of self-evaluations and reports by exception
- plan for the receipt of initial action plans by each organisation's formal committee structure and timetable of meetings
- set the date for the receipt of the IAR
- agree the ARM agenda with all stakeholders
- afford the time necessary to update the IAR in preparation for the ARM

- plan the dates for the distribution of the notes of the IAR and the draft FAR
- agree the date for publication of the FAR.

Perceived impact/influence of OQME

144 Providers and stakeholders identified a number of significant positive outcomes within the prototypes in which they were involved. These included:

- a need identified for educational audit to cover all professions in placements. OQME provided a lever that helped to take this forward
- the opportunity to have contact with and learn from different parties participating in the prototypes
- participation in the OQME process enabled better communication between the HEI and placement providers and highlighted the possibility of further improvements in collaboration
- the process points to the need for a standard placement educational audit document used by all providers. It would appear sensible for the standard template to become that document so that: a) there is one document across England, with each placement area completing one self-evaluation of all the HEIs who place students in that environment; and b) that the standards should be evaluated for that practice placement environment, not by the use of separate audit tools for each profession.

Outcomes of the overall process

145 One provider noted that the contributing stakeholders took the process seriously and worked hard to use and test the OQME arrangements effectively. They were very involved in the emerging IAR and the format of the ARM and offered many constructive ideas. Also noted was the complex and, possibly, conflicting role of SHAs. They are an integral partner in OQME, yet they hold the contract. They are responsible for compiling the overall OQME FAR, but have limited control over its content. While this could be difficult, this programme provider did not regard it as problematical because they recorded having 'fantastic support from the SHA and Trusts', not least in coordinating the NMC Visitor verification day.

146 The *Prototype Document* (page 21) stresses that balance must be sought between ensuring the rigour of the OQME process on the one hand and excessive monitoring on the other that is likely to detract from opportunities to enhance quality. Opinions varied about the comparative weight of work involved, as the following table of questionnaire responses shows.

Table 3: Questionnaire responses about the OQME workload (20 returns)

How would you rate the workload for the following against previous quality assurance methods?	More than previous methods (%)	About the same (%)	Less than previous methods (%)	Not applicable (%)
1 self-evaluation against the standards	11	11	78	0
2 preparing the documentation	12	23	65	0
3 preparing for the ARM	27	39	27	7
4 preparing for the post-event documentation (eg Final Action Report)	14	43	43	0
5 getting documentation signed off	14	33	53	0
	Yes (%)	No (%)	N/A (%)	
6 was it possible to undertake the prototypes with existing resources?	56	38	6	

147 The workload needs careful monitoring. Providers agreed that the new processes must be sustainable. Some participants regarded it as unmanageable and unsustainable, while others found little to complain about in terms of any excessive burden. Figures in Table 3 suggest broad overall support for the latter view, however the level of representativeness of the small number of respondents needs to acknowledged. The HEI lead and the PPF/CPF workloads were noted as being particularly onerous.

148 One prototype commented on its experience of the way in which the partnership process facilitated productive partnership working: 'We thought we were engaged, but now we're married!' It was felt that Trust placement providers, having found that voice, would take up the outcomes and act on them. Free and frank discussion, they concluded, will influence the sense of ownership of the education and action in relation to it. This has much to do with the development of a culture that embraces organisation for the development and management of change.

149 A clear message emerges that the success of OQME is dependent on clear and established lines of communication within and from the Trusts. There is a need for named contacts to provide clear guidance, support, monitoring and progress chasing.

150 Another prototype site intends to establish an integrated and comprehensive yearly review cycle to include six-monthly interim updates, informed by reports from relevant subgroups as appropriate, and that will meet the requirements of all

stakeholders. They regard it as an important step in working towards the Government's agenda of providing a rigorous but more cost-effective approach to quality assurance and enhancement within the HE sector and DH-funded provision. This institution clearly built on the momentum of a 'much richer feel of the partnership' generated by major review, with the action plan items carried forward. Their major review helped them to establish effective partnership relationships and processes and to identify where further developments were needed. An element of their good practice is that they have devolved the work to those staff in placement areas who are at the cutting edge of the provision. The alternative, of an HEI small team going into practice, would have been contrary to the already established principles of partnership working.

Links with other QA processes

151 There was general agreement that OQME must use the established protocols of NHS clinical governance as an operating mechanism if it is to be a sustainable process. However, to shift emphasis in the way needed by OQME was seen as being a big challenge. The stakeholders were broadly of the view that clinical governance systems should be the formal means by which OQME is ensured, but that the hands-on, practical means of prosecuting the self-evaluation processes would be better delegated to the Trust Development Groups (or their equivalent). Some concern was expressed among Trusts that PQAF documentation might become public and affect future Healthcare Commission reviews. It will be important for Skills for Health to test out these issues in its discussions with the Healthcare Commission.

152 Those responding to questionnaires were asked how well the OQME process fitted with existing HEI and SHA quality assurance processes. Thirty-five per cent recorded 'completely', 41 per cent 'partly' and 24 per cent 'not at all'. Clearly there is much ground still to be gained in integrating quality assurance and thereby reducing the overall burden.

153 Stakeholders encountered much suspicion about the process within some HEIs which regard themselves as already having well-established quality assurance and enhancement procedures. In one case, the main exception to the commitment, cooperation and response of partners was seen to be the HEI, which was demanding full compliance with the institutional annual monitoring and refusing to accept OQME in lieu of any part of its established process requirements. It is essential that OQME be integrated with the existing QA systems of all the partners. One senior HEI administrator participant suggested that they 'can live quite happily with their School of Health using a somewhat different annual monitoring process.' They discovered through the prototype that 'the roof had not fallen in'.

Chapter six

Conclusions and recommendations

154 All the prototype sites managed to complete the prototypes within the challenging timescales set; this reflects the significant amount of work and commitment by those leading the activities and all those involved at each site.

155 The prototypes provided an invaluable opportunity to test the two processes, the evidence base and the standards template.

156 The aim of this evaluation was to examine the approval and OQME processes, the usefulness of the standards template and the value and appropriateness of the evidence base in supporting the two processes to determine if they can meet six key statements (see paragraph 6), and it is appropriate to return to these.

- provide an effective standard mechanism for assessing quality and promoting enhancement

157 From this evaluation, it is possible to conclude that the approval and OQME processes and the standards template do provide a standard mechanism for assessing quality and promoting enhancement. However, there are still a significant number of developments to be undertaken before it can be deemed to be an effective mechanism. Not least, convincing HEIs and SHAs to adopt the processes in their entirety and not use them in parallel with existing quality assurance processes. There remains some uncertainty regarding the evidence base, what constituted the evidence, how consistency of content can be ensured, and how the valuable and extensive evidence gathered at the level of the individual units that undertook the self-evaluation can be used effectively in the approval event or ARM. In the prototypes, the sites did not generally utilise or identify explicitly core and additional evidence, and documented evidence was not explored fully in either the approval events or ARMs. Clear and consistent verification of the standards is paramount.

158 Practice placements and Trusts welcomed the opportunity to undertake the self-evaluation to demonstrate, in writing, the quality of what is provided, to gather the evidence base and to take greater visible responsibility in the quality assurance processes. Indeed, during the self-evaluation and the production of the approval documents and OQME IAR, there was a greater emphasis placed on the practice part of the provision. A point of significant concern is the progressive generalisation of the self-evaluation exceptions in moving through the IAR to the FAR in OQME and in the production of the approval documentation.

159 The standards template provided some standardisation in approach, although there was a wide variation in the quality of locally-completed templates. However, the prototypes highlighted a number of areas for review; for example, the number of

standards, the relevance of the language used in some disciplines, and the specificity of a standard in the context of potential interpretation.

- streamline quality assurance requirements, thereby reducing the burden for stakeholders

160 There remains some debate about whether the processes, standards template and evidence base streamline quality assurance requirements, thereby reducing the burden for stakeholders. There were mixed responses from participants about whether streamlining had taken place, but this may have been influenced by the adherence in a number of prototypes to traditional quality assurance mechanisms. There arose an interesting debate in relation to the frequency of the OQME process, with some Trust staff advocating annual self-evaluation but with the full OQME process (the ARM and FAR) being biennial. This may prove more problematic in meeting the needs of the SHAs and the statutory regulatory bodies. A strong message from the evaluation was the need to provide appropriate resources, particularly in relation to the self-evaluation process, where it is critical to brief clinical staff fully, and where significant amounts of paperwork are generated.

- provide outcomes that meet the needs of both stakeholders and partners

161 The analysis of all the evaluation data indicates that, while the prototype sites were able to complete the two processes within the timescales set, the ability of the processes, the evidence base and standards template to meet the needs of both stakeholders and partners is less clear.

162 There was little visible use or testing of the evidence base in either of the prototypes and, with one exception, no inclusion of the core evidence in the approval event or IAR, although Trust staff did indicate that evidence had been gathered and was available. Significant additional guidance is required by providers on the level of detail required, the potential sources of evidence as mapped against the standards, how and when evidence should be available during the two processes, particularly at the ARM and the approval event, and how external bodies, including Visitors, should access it.

163 The principle of Trust involvement in the two processes, particularly through the self-evaluation against the standards, was welcomed and deemed a positive feature. However, the number of standards was generally considered to be too large, with much duplication. The template itself was deemed workable but rather cumbersome, and dividing the template into three separate documents to mirror the locus of responsibility was advocated. A significant issue raised by participants was the extent to which placements are self-evaluated and at what frequency. In the prototypes, the starting point was that sampling of the placements would have to happen because of the timescales of the prototypes. However, even without these timescales, undertaking self-evaluation of every placement each year seems unlikely and indeed unhelpful. The NMC does not require annual learning environment audits, and one of the frequently expressed concerns from HEIs was that OQME has the potential to be 'an annual major review'.

164 The approval prototypes did not test out the approval process as set out in the prototype document but rather used established HEI approval processes with fleeting reference to the requirements of the processes. It is crucial that the concept of self-evaluation against the standards is clearly understood and embedded within the quality assurance departments at the centre of the HEI and not just within the faculty/school, if stakeholder and partner needs are to be met.

165 The prototypes did undertake the OQME process more closely to what was required. However, the lack of student and service-user involvement, two key constituents of the stakeholders, in the ARMs is of significant concern. The process was considered unwieldy, with many suggesting that it was not sustainable on an annual basis with existing resources.

166 There is still concern by some of the Visitors about how approval and OQME can link with existing NMC and HPC processes to ensure that statutory regulatory body requirements have been met and accomplished in a more streamlined way. Further consideration needs to be given to a national picture of QA activity, reducing the requirements for a review of all provision every year.

- engage HEI and practice placement staff in quality assurance processes effectively

167 The prototypes clearly demonstrated positive engagement of HEI and Trust staff in the quality assurance processes. Indeed, the enhancement in partnership working was identified as one of the key benefits of the processes. This is further advanced by having strong bipartisan leadership and PPFs/CPFs in place and freed to undertake the crucial briefing and engagement of practice staff. What has been less clear from the prototypes is the level of engagement by HEI staff with the processes, both locally and within the central quality assurance departments. Another key learning point from the prototypes is the importance of ensuring that senior staff, including Trust Boards and Chief Executives, are signed up to and committed to the two processes. Where this has occurred, the prototypes, particularly OQME, have helped to raise the profile of the quality assurance of healthcare education much higher up the strategic agenda. This is particularly important in relation to the self-assessment against the standards and the monitoring and implementation of the final action plans.

- make a positive impact on the monitoring and enhancement of quality assurance of healthcare provision

168 The prototypes demonstrated that the processes, evidence base and standards template did provide a method of monitoring quality assurance. There were also clear examples of how the process could aid the enhancement of healthcare education, but these were often related to rectifying a problem area rather than identifying and taking forward dissemination and implementation of good practice. Different approaches were taken between the different prototypes in relation to ARM in OQME. Many stakeholders felt strongly that the ARM should be used as a developmental activity, in addition to its function as a rigorous monitoring event. Others noted that the kind of robust debate

that is perceived essential to the rigour of the OQME process was difficult to achieve in the ARM. A number of significant shortcomings were identified in four of the five prototypes at the interface between the ARM and the FAR.

- provide an opportunity to highlight good practice to share with the sectors.

169 The processes did provide an opportunity to highlight good practice to share within the sectors. Indeed, one SHA awarded certificates in recognition of good practice. However, there needs to be further refinement and dissemination about what is good practice to ensure consistency of approach. It was apparent that what was one placement provider's good practice was another's standard practice.

Recommendations

170 The evaluation activity generated a wealth of recommendations from all the constituent groups involved in the prototypes, HEIs, SHAs, Trusts and Visitors. The recommendations listed below are grouped into the four elements of the prototypes, the evidence base, standards template/standards, approval process and OQME process. Those recorded are ones that have been raised in more than one forum and, unless otherwise stated, reflect the consensus views.

The evidence base

i More explicit guidance (signposting/mapping) on the type/sources of evidence required to support the self-evaluation, the level of detail required, and what constitutes sufficient and relevant evidence (paragraphs 20; 94, 99; 101).

ii Visitors need access to placement areas and students as key sources of core evidence (paragraph 24).

iii Clarify, when appropriate, the content of the core evidence in light of the standard model contract (paragraph 25).

The standards and standards template

iv The signing off of the standards by Trust Boards and the involvement of the Chief Executives need to be maintained, and needs to be more explicitly built into the timescales for the quality assurance processes (paragraphs 28; 124).

v The number of standards should be reduced (paragraphs 34; 40; 59; 163).

vi The number of aspects should be reduced (paragraph 35).

vii The locus of responsibility for the standards should be reviewed (paragraph 36).

viii The standards should explicitly cross-reference to regulatory and professional requirements (paragraphs 37; 74).

ix More guidance on the purpose of exception reporting, the amount of detail expected, and how it should be used in the approval event and ARM (paragraphs 31, 41, 44, 93, 108).

x The term 'at risk' should be reviewed to determine if 'emerging issues' might be more appropriate, reflecting operational reality (paragraphs 43; 70).

The approval process

xi Appropriate involvement of students and users should be more explicit in programme development and evident in the approval event (paragraphs 55; 77).

xii Thought should be given to how to engage and operationalise self-evaluation for the independent sector and other diverse placements in the approval process (paragraph 58).

xiii Achieve integration between the approval process and the HEI's existing validation mechanisms if duplication of effort is to be avoided and streamlining to take place (paragraph 70).

xiv Further guidance needs to be developed on the role of the Visitor in approval to ensure that all participants including Visitors are informed fully and that there is a culture shift away from previous processes (paragraphs 75; 76).

The OQME process

xv The self-evaluation task could be streamlined and provided with a clearer focus if exception reporting is linked to clusters or groups of standards (paragraph 30).

xvi Sample placements including those spread widely on a national scale and those in the independent sector (paragraph 90).

xvii Determine what is good practice, new ways of identifying it, and a process for disseminating it (paragraph 95).

xviii Review how to address the perceived dilution of self-evaluation exceptions in moving through the Initial Action Report stage to the Final Action Report stage (paragraphs 98 to100).

xix Students and service user representatives need to be specifically invited and involved in agenda-setting and decision-making (paragraphs 103; 113).

xx Balance must be sought between ensuring the rigour of the OQME process on the one hand and excessive monitoring on the other that is likely to detract from opportunities to enhance quality (paragraphs 111; 141).

xxi Clear and effective communication between key stakeholders from the outset of the process is vital for an effective process (paragraphs 127; 128).

xxii There may be value in each provider being supported by a person in the role of 'external critical friend' during the first year of a new process (paragraph 132).

xxiii It is essential that OQME be integrated with the existing QA systems of all the partners, including the timing and frequency of each element (paragraphs 140, 151 to 153).

xxiv In all processes, a leadership role is essential and a named lead needs to be identified. The PPFs and CPFs (or equivalent) should be significantly involved from the outset (paragraphs 61, 81, 86, 123, 133).

If roll out of the PQAF goes ahead:

xxv Make more explicit in the documentation how the evidence base should be used in the approval and OQME processes and when it should be made available to external stakeholders including Visitors (paragraph 23).

xxvi Ensure standardisation of forms and data to help reduce interpretation of what is needed (paragraph 23).

xxvii Reports and actions plans from other quality assurance processes, for example the major review report, should be made available for consideration at the approval event or ARM. Such documentation should be provided in its full published format and not selected excerpts (paragraph 23).

xxviii The standards template should be split into three separate documents based on the locus of responsibility. That is, a template for standards that are the responsibility of the HEI, one for standards that are the responsibility of placement providers, and one for the standards that have joint responsibility (paragraph 36).

xxix The language used in the standards should be simplified and revised to ensure that it is as relevant to the allied health professions as to nursing and midwifery and also post-registration provision (paragraph 39).

xxx The documentation should make explicit reference to the need for exception reporting in the approval process (paragraph 58).

xxxi Review the structure of the amalgamated self-evaluation report and how it is used in the approval event to minimise generalisation of issues and good practice identified (paragraph 60).

xxxii Ensure clarity in guidance about who should sign off completed standard templates (paragraph 62).

xxxiii Guidance should be provided on the schedule for the process to ensure that documentation is with approval panel members at the appropriate time to enable them to prepare fully (paragraph 65).

xxxiv All stakeholders should agree both the notes from the approval meetings and actions to be taken (paragraph 69).

xxxv Develop an electronic shared practice database that may provide an effective and timesaving tool (paragraph 108).

xxxvi SHAs to actively involve the regulators, as well as other stakeholders, in the ARM agenda setting (paragraph 136).

Appendices

Appendix 1
QAA evaluation framework

Introduction

QAA is committed to reflecting on its processes by undertaking a formal evaluation of all its audit and review activities. Evaluation serves a variety of purposes, not least of which is reporting to HEFCE, and other stakeholders, as part of QAA's contractual requirements. It is conducted to review the effectiveness of processes and to inform future developments. The systematic evaluation of activities allows for identification of good practice that can be publicised and disseminated, and it helps to highlight aspects of activity where there is scope for further development.

The evaluation framework

All QAA evaluation activity is conducted within a standard framework. This provides a set of guiding principles for evaluation (see below), rather than a set of specific rules. The framework seeks to ensure consistency in methodology, while allowing for local flexibility specific to the needs of each audit or review method. The strategic aim of the evaluation framework is to provide a broad set of principles for evaluation activity that ensure consistent and robust processes in accordance with the QAA's standards.

Principles underpinning the framework

- It is essential to seek evaluative data from the participants and stakeholders.
- A holistic approach is to be taken to evaluation of the review event, for example evaluative data should encompass all stages from preparation to report publication. This will enable the negotiated, flexible nature of this model of review to be reflected in the evaluation process.
- Evaluation should draw on a variety of sources, with maximum opportunity for comparison between respondent groups.
- The evaluation strategy should complement other strategies of the QAA.
- The evaluation process is holistic, including a series of coordinated stages rather than independent data-gathering exercises. The outcomes of the early stages of the process inform the strategy and approach to the later events.
- The framework should enable issues of interest to the sector to be discussed in greater depth, the results of which are to be circulated amongst the higher education community. The framework will therefore incorporate a strategy for focused discussion, drawing upon the issues identified in the questionnaire responses.
- Evaluation should not replace or inhibit a prompt and appropriate response to concerns or issues raised.
- Evaluation does not form part of the complaints procedures *(Complaints from Institutions: Procedures)* (QAA, 2003) but it should be capable of pinpointing areas of QAA process that need improving.

- Evaluation must meet the contract requirements for regular monitoring.
- There is a need for the evaluation loop to be 'closed' through feedback to all participants and stakeholders, with appropriate follow-up on actions and responses.
- The outcomes of evaluation are intended to provide a mechanism for continuous improvement for QAA in delivering its core business.
- Adopting a multi-method approach to evaluations, it is possible to triangulate the outcomes from the individual evaluation activities and assure confidence in emerging themes.
- This framework enables both the longitudinal analysis of review and audit process and cross-method analysis. Intra-method comparative analysis and investigations have proved to be useful in identifying both strengths and weaknesses common to all processes.

Process

The principle source of quantitative data is postal questionnaires using a 4-point scale, with a number of open questions. Questionnaires by post have the advantage when a large numbers of respondents are involved. However, questionnaires have limitations, one key aspect being the problem in seeking clarification or expansion on points made which will be addressed using the focus groups (see below).

The design of the questionnaires has ensured that they are easy to use, analyse and report using SPSS.

Formal procedures for chasing outstanding questionnaires have been adopted to ensure effective and efficient evaluation activity. In addition, a reporting framework has ensured that the outcomes and findings of the evaluation activity have been fed back into the process and QAA developments, and shared with relevant stakeholder and participant groups, as appropriate. The outcomes of the evaluation have also been used to inform other activity; for example, the analysis of review coordinators' performance has been shared with those involved and has fed into the professional development programme.

Focus groups are used to provide further discussion/exploration of the issues with participants. The focus groups are undertaken using a highly structured project brief. The brief is informed by the findings of the post-visit evaluation questionnaire and designed to probe emerging themes from the questionnaire. This approach ensures consistency and comparability in the information derived from each group.

Appendix 2
Evaluation techniques/approaches (September 2004)

Questionnaires

Questionnaires, gathering of both quantitative and qualitative data through closed and open questions, will be given to each of the 'groups' of participants in the prototypes: the HEI, the SHA/WDC, the Trusts and other health and social care providers, and the QAA facilitators. The questionnaires will ask respondents to reflect on the individual/relevant process, including the preparation, implementation, workload, facilitation and outcomes. Questions about the facilitation are not intended to evaluate individual facilitator performance but rather to gather learning points from the facilitation process itself. The questionnaires will also gather information about the evidence base and the standards templates.

Observation

Observation will be used to gain an insight into specific aspects of the two processes and will be undertaken by a member of QAA's Health Team. The observation will be focused and will not require attendance at all events. The selection of what to observe will take into account the workloads of the HEIs/SHAs in undertaking the prototypes and the schedule of the external evaluators. A log of each observation will be kept and the data analysed. All internal preparatory meetings were attended and all approval and annual review meetings were observed.

Analysis of documentation

An important aspect of the evaluation is the review of the documentation used in the two processes. The QAA facilitators will gather a range of documentation used and forward copies to the QAA Health Team. Documentation will include information gathered at the planning meetings, the internal action report, submission documents for the programme development group and the approval event, minutes of meetings, and a selection of self-evaluations against the standards templates. This should prevent any additional burden for the HEIs and partner placement providers involved in the prototypes.

Focus groups

Two one-day focus groups will be held at the end of the prototypes to gather feedback from those involved in the processes. The two events will involve a mixture of Trust staff and other practice placement providers, SHA/WDC staff, HEI staff, the QAA facilitators and Skills for Health senior quality assurance coordinators involved in the prototypes. The focus groups will begin with a presentation on the data gathered and analysed prior to the groups, to check the veracity of the analysis and interpretation. Using small-group activities, the focus groups will then explore key themes, identify any further issues and, to enable participants to make recommendations for the two processes, the standards and the evidence base.

Appendix 3
Details of attendance at focus groups

18 May 2005 - Holiday Inn Regents Park

Number of participants: 38

3 x QAA Facilitators

9 x HEI staff

9 x SHA staff

14 x Trust staff

3 x NMC Visitors

Attended by 1 NMC officer and 1 HPC Officer

24 May 2005 - Novotel Leeds

Number of participants: 15

3 x QAA Facilitators

5 x HEI staff

2 x SHA staff

4 x Trust staff

1 x NMC Visitor

Attended by 1 NMC Officer, 1 BPS Officer and 2 SfH observers

Appendix 4
Details of questionnaires circulated and returned

Questionnaires were sent to:

- main contacts for prototypes at the HEIs and SHAs with request to circulate it to all colleagues involved in the prototypes
- adapted version of the questionnaire was emailed and posted to all NMC and HPC Visitors.

Questionnaires returned: 33

16 from Trusts

4 from SHA/WDC

4 from HEIs

9 from Visitors

Appendix 5
Ten aspects of the standards template

Aspect 1.0	Management and organisation
Aspect 2.0	Effective use of resources
Aspect 3.0	Curriculum
Aspect 4.0	Learning outcomes
Aspect 5.0	Student selection, progression and achievement
Aspect 6.0	Student support
Aspect 7.0	Learning and teaching
Aspect 8.0	Assessment
Aspect 9.0	Quality enhancement and maintenance
Aspect 10.0	Values, equalities and diversity

Appendix 6
The standards

Aspect 1.0 Management and organisation

Responsibility - HEI		When monitored
1.1	Our programme(s) have a secure place in the HEI's business plan. Financial control systems and allocation of resources to the programme are appropriately managed and accounted for	Annually Approval
1.2	We communicate our strategic vision, business plan, structure and organisational change information to the commissioners and healthcare providers	Annually
1.3	Our policies and practices meet regulatory body requirements including those related to collaborative/conjoint Approval of programmes and for demonstrating our accountability for programmes satellited to other institutions (franchised programmes)	Annually Approval
1.4	We have systems in place for reporting and decision-making that ensure plans for Approval of new programmes are efficiently implemented within designated contracts for provision	Approval
1.5	For each programme we develop we have a realistic plan that is informed by the needs of service and service users, through consultation	Approval
1.6	Our students and staff have access to an effective occupational health service that meets their needs	Approval
1.7	Our policies and procedures, with regard to the programme and student experience, reflect health and safety legislation and equality of opportunity	Annually
1.8	Our staff understand and manage specific risks to students and risk assessment is carried out in relevant areas of the HEI/site	Annually
1.9	For Approval of programmes, we have an achievable business case developed in consultation with commissioners (where appropriate) and service users that demonstrates that sufficient and appropriate resources are available to develop and deliver the programme	Approval
1.10	We ensure that there are sufficient numbers of appropriate qualified practice placement supervisors to support the practice component of the programme to meet regulatory body requirements	Annually Approval

1.11 Where appropriate we share a strategy for selection and monitoring of practice placements with other HEIs	Annually Approval
1.12 Our human resources management processes demonstrate current good practice in relation to recruitment, retention, development of staff and equal opportunities.	Approval

Responsibility - Placement Providers	**When monitored**
1.13 Our policies and procedures within our practice placement areas reflect health and safety legislation, employment legislation and equality of opportunity	Annually
1.14 Our human resources management processes reflect current good practice in relation to recruitment, retention, development of staff and equal opportunities	Annually Approval
1.15 Our staff understand and manage specific risks to students and risk assessment is carried out in practice placement areas	Annually Approval

Responsibility - Both	**When monitored**
1.16 Our overall strategy for providing, managing and monitoring appropriate practice placements, for ensuring adequate resources are in place and for responding to changes, is shared between the HEI and placement providers, enables appropriate experience to be gained by our students and meets regulatory body requirements	Annually Approval
1.17 We have systems in place for honorary contracts for students and academic staff who work with students in placements	Annually
1.18 Our partnership relationships with our placement providers support the development, planning and delivery of high quality and cohesive professional education	Annually Approval
1.19 We are clear about the financial and practical arrangements for Approval, planning and implementation of programmes among all parties in the provision (ie on-site and placement-based learning providers)	Approval

Aspect 2.0 Effective use of resources

Responsibility - HEI	When monitored
2.1 The teaching resource is clearly identified and supports the delivery of each programme at the stated professional and academic level	Annually Approval
2.2 Our HEI provides appropriate administrativeand technical support for our students	Annually Approval
2.3 We have a clear organisational strategy and annual plan for research/scholarship and development that links to national and local policy and need, and influences programme delivery	Annually Approval
2.4 Our physical resources, classroom accommodation and the subject books and periodical stock and any other learning resources are appropriate to the curriculum	Approval
2.5 We ensure that technical equipment and IT facilities, including internet access, are available to students on site	Approval

Responsibility - Placement Providers	When monitored
2.6 We ensure students have access to appropriate books, journals, educational and IT facilities, including Internet access (where practicable), when they are in placements	Annually Approval

Responsibility - Both	When monitored
2.7 Our programmes are effective, efficient and demonstrate value for money as defined by the Standard Model Contract (where applicable)	Annually
2.8 Our policy for staff development for individual members of staff is adequately resourced, regularly evaluated and is intended to equip staff to meet current needs and prepare them for any future changes	Annually Approval

Aspect 3.0 Curriculum

Responsibility - HEI	When monitored
3.1 Our programmes reflect regulatory bodies, higher education requirements and QAA guidelines, and Government health and education policies, demonstrating coherence and progression to enable students to achieve the learning outcomes and to demonstrate fitness for practice, purpose and award. These requirements include: ● professional rules, standards, requirements and proficiencies (competencies) ● the Code of practice, the subject benchmark statements and produced by the QAA and the Health Professions Framework ● health policy, national service frameworks and developments in healthcare ● the FHEQ ● key skills	Annually Approval
3.2 Our curriculum development reflects input from employers, users, stakeholders and current/recent students and meets workforce requirements	Approval
3.3 Each of our programmes is under direct leadership of a programme leader who has the appropriate professional and academic qualifications and experience for this role	Approval
3.4 The curriculum is flexible and responsive to change reflecting NHS agendas, professional requirements and QAA guidelines and service and workforce needs	Annually
3.5 Each programme has an identified profile of the proposed student cohort/target group that describes the characteristics of students expected to use the provision	Approval
3.6 Where shared interprofessional learning exists we ensure that the unique needs of each professional group are addressed	Approval

Responsibility - Placement Providers	When monitored
3.7 We make a specific contribution to the development of the practice component of the curriculum	Approval

Aspect 4.0 Learning outcomes

Responsibility - HEI		When monitored
4.1	Our learning outcomes are cohesive and reflect key skills, subject benchmark statements produced by the QAA, the Health Professions Frameworkand regulatory body competencies	Annually Approval
4.2	Learning outcomes ensure fitness for practice, purpose and award	Annually Approval

Responsibility - Both		When monitored
4.3	Learning outcomes are jointly agreed between the HEI and placement providers and reflect on-site and placement-based components	Annually Approval

Aspect 5.0 Student selection, progression and achievement

Responsibility - HEI		When monitored
5.1	We have established links with local FE colleges, local schools, employers and other relevant organisations that encourage local access to health programmes	Annually Approval
5.2	All our programme Approval submissions (where appropriate) set out detailed AP(E)L arrangements that are specific to the programme and are in accordance with regulatory body and QAA guidelines	Approval
5.3	AP(E)L requirements, including maximum credit allowed through AP(E)L, are communicated to students	Approval
5.4	We have policies, systems and information related to the processes of application, selection, entry criteria and for mature/non-standard applicants	Approval
5.5	Our selection processes provide all parties with impartial guidance and the information needed to make informed choices about whether to make an offer of, or to take up, a place on the programme	Annually Approval
5.6	We provide induction programmes for our students to enable them to settle into their programme quickly, to understand their rights and responsibilities and the demands of the programme	Annually Approval

5.7 We have effective student management systems that enable us to monitor the academic and intellectual progression throughout the programme and to ensure appropriate support to students	Annually Approval
5.8 We identify accurately special learning needs of students and provide them with access to effective individual learning support from specialist services	Annually Approval
5.9 We maintain records of the patterns of numbers of students gaining employment in the local area	Annually
5.10 We offer effective career guidance about opportunities available to learners when they complete their programme	Annually Approval
5.11 We have mechanisms in place on site to recognise early poor performance of students and for taking appropriate and prompt action	Annually Approval
5.12 Those involved in selection reflect the professional discipline of the educational programmes	Approval
5.13 We have systems in place to facilitate the registration of students with the provider and with the appropriate regulatory bodies (where relevant) and for recording credits/qualifications that students have gained	Approval
5.14 We ensure that there is logical progression through the practice placements and that the placement experiences are sufficient for summative achievement	Approval

Responsibility - Placement Providers	**When monitored**
5.15 We have mechanisms in place in placement areas to recognise early poor performance of students and for taking appropriate and prompt action	Annually Approval

Responsibility - Both	**When monitored**
5.16 Our strategy for reducing attrition and promoting retention ensures that: ● objectives for retention are set and met ● attrition and completion are defined as stated in the Standard Model Contract	Annually Approval

• management of attrition/completion takes into account students who migrate from one healthcare programme to another or who 'step off' a programme with a lesser award than originally intended • action is taken on information that arises from exit interviews	
5.17 Recruitment and selection policies and processes are robust to ensure: • where possible, an appropriate diversity of age, gender and ethnicity that match workforce demands and reflect local population • that recruitment teams from the HEI work with the healthcare providers in the recruitment and selection of secondees • that candidates are measured against pre-defined agreed criteria and entry requirements (these include regulatory body requirements such as: providing most recent references from employer/place of study-including sickness records; health screening; records of previous work patterns; screening in relation to the Rehabilitation of Offenders Act (1974)) • that there are clear selection processes that reflect codes of practice for equal opportunities and the section of the code of practice on recruitment and admissions produced by the QAA • the widest possible participation in programmes • that students have appropriate information about all the requirements they must meet in order to gain their qualifications, including academic requirements and those related to their health record, character and professional conduct	Annually Approval

Aspect 6.0 Student support

Responsibility - HEI	**When monitored**
6.1 We provide students with access to relevant HEI facilities and services including: • health, welfare, counselling and pastoral care • sport and recreational facilities • student accommodation	Annually Approval

6.2	Our academic staff provide support to students and to practice placement supervisors during the students' practice placements	Annually Approval
6.3	Our academic staff provide a programme of preparation and updating for practice placement supervisors to keep them updated about changes to the curriculum	Annually Approval
6.4	Our academic staff agree a schedule for regular visits to, or communication/contact with, their link placement areas and adhere to this agreed schedule	Annually Approval
6.5	We provide opportunities for students to be prepared for practice placements and ensure that they have the appropriate skills prior to undertaking a placement	Annually Approval
6.6	Our students have a designated personal lecturer who will: ● identify learning needs with the student ● support students in the achievement of intended learning outcomes ● monitor the total learning experience of individual students ● provide feedback to students on performance at specified times during the programme ● identify special needs of students to ensure they receive appropriate support	Approval

Responsibility - Placement Providers		**When monitored**
6.7	We provide all students with a named practice placement supervisor for the duration of that placement, who is appropriately qualified and experienced and meets relevant regulatory body requirements	Annually Approval
6.8	Our practice placement supervisors are aware of the students' placement outcomes so that they are able to agree with students an individual learning contract for the placement experience	Annually Approval
6.9	We provide students with scheduled appointments with their practice placement supervisors at regular intervals to discuss their progress towards meeting their learning contract.	Annually Approval
6.10	We take action on evaluation/feedback information that students give us on the quality of their placements and practice placement supervision received	Annually Approval
6.11	We provide students with an orientation/induction to each practice placement	Annually Approval

Responsibility - Both	When monitored
6.12 We make students aware of their responsibilities and rights with regard to student support on site and in practice placements	Annually Approval

Aspect 7.0 Learning and teaching

Responsibility - HEI	When monitored
7.1 We have a written teaching and learning strategy that aims to provide quality learning opportunities, both on site and in practice placements, for students to achieve their learning outcomes and become proficient practitioners	Annually Approval
7.2 Our teaching is enhanced by a staff development strategy that is regularly updated and provides continuing staff development, updating opportunities, planned programmes of peer review of teaching, effective integration of part-time and visiting lecturing staff, team-teaching and induction/support of new staff	Annually Approval
7.3 Our teaching sessions provide appropriate depth, breadth, pace and challenge and a suitable variety of learning and teaching methods	Annually Approval
7.4 We have a research and scholarship strategy and our academic staff contribute their research, scholarship and practice to the support of student learning	Annually Approval
7.5 Learning opportunities on site are appropriate to the level and needs of the student and provide opportunities for examining interprofessional working	Annually Approval
7.6 We ensure that profiles of placement areas are reviewed in accordance with regulatory body requirements, where appropriate, to ensure that they provide what is required for effective placement experience	Annually Approval
7.7 We share placements and other curriculum approaches with other HEIs, where appropriate	Approval

Responsibility - Placement Providers	When monitored
7.8 We ensure that there are adequate numbers of practice placements to achieve effective practice learning	Annually Approval

7.9 Our placement areas ensure that provision is made for students to reflect in/on practice and link practice explicitly with their theoretical underpinning	Annually Approval
7.10 Our practice placements provide varied learning opportunities that enable students to achieve learning outcomes through: ● observing skilled professionals deliver service and care ● participating, under supervision, in the delivery of treatment and care ● teaching sessions delivered in placements ● practising in an environment that respects users' rights, privacy and dignity	Annually Approval
7.11 Our staff, who act as practice placement supervisors of students, demonstrate evidence-based teaching, assessment and practice	Annually Approval
7.12 We provide learning opportunities in placements that are appropriate to the level and need of the student and provide opportunities for interprofessional working	Annually Approval

Aspect 8.0 Assessment

Responsibility -HEI	**When monitored**
8.1 We have mechanisms in place for ensuring that assessors reflect the whole assessment process and explicitly reinforce the practice component	Approval
8.2 We have an overall assessment strategy that: ● guides programme teams ● demonstrates progression and achievement of learning outcomes and competencies ● assesses research and evidence-based knowledge and its application to practice ● integrates theory and practice ● uses a range of assessment methods	Approval
8.3 The assessment approaches and schedules that we use within each programme, including the weighting of theoretical and practice assessment, are based on clear objectives and agreed criteria that are made available to students and incorporate the requirements of: ● regulatory bodies ● EU Directives ● QAA ● the regulations of the individual HEI	Approval

8.4	Our approach to assessment is that it is a continuous process with an adequate formative function that helps develop student abilities/intellectual skills and which leads to the judgement of achievement against agreed performance criteria	Annually Approval
8.5	Our assessment criteria enable students and internal and external examiners to differentiate clearly between categories of achievement	Annually Approval
8.6	We have arrangements in place for the approval and orientation of internal and external examiners who reflect all the elements of the programme	Approval
8.7	External examiners report on practice as well as theory and we take action on the reports of our external examiners who monitor the assessment process to ensure that: ● professional and academic standards are maintained ● the assessment process is rigorous, equitable and consistent ● the conduct of the theoretical and practice assessments is in accordance with HEI guidelines and regulatory body requirements ● theoretical and practice assessments are reliable and valid ● the conduct of the examination/assessment board is appropriate	Annually Approval

Responsibility - Both		**When monitored**
8.8	Our students are actively involved in the assessment of their own progress and achievement and receive regular and timely feedback on their academic performance	Annually Approval
8.9	We work collaboratively to agree the number of placement assessors in each practice placement and ensure that these assessors are periodically updated	Annually Approval
8.10	We work collaboratively to ensure that there is inter-assessor reliability in practice assessments	Annually Approval

Aspect 9.0 Quality enhancement and maintenance

Responsibility - HEI		When monitored
9.1	We provide clear statistical and management information about our performance that is interpreted and used appropriately in the HEI	Annually Approval
9.2	Our internal quality assurance mechanisms work effectively in both the academic and practice areas	Annually Approval
9.3	We have strategies in place to deal effectively with appeals and complaints/concerns from healthcare staff, the public, clients, patients and students	Annually Approval
9.4	We seek the views of employers (commissioners, NHS and other placement providers) about our educational provision and review our provision in light of this information	Annually
9.5	Our past and current students have effective opportunities to contribute their own experiences as part of the wider process of monitoring and evaluation of the programme	Annually Approval
9.6	Outcomes of all periodic evaluation, monitoring and review of our provision are translated into action to bring about enhancement, and trends over time show maintenance or continuous improvements	Annually
9.7	We demonstrate our ability to deliver professional education to an academic standard that is measurable at local and national level	Annually Approval

Responsibility - Placement Providers		When monitored
9.8	Outcomes of all periodic evaluation, monitoring and review of practice placement areas are translated into action to bring about enhancement, and trends over time show maintenance or continuous improvements	Annually

Responsibility - Both		When monitored
9.9	We formally consider the shared action plan arising from the OQME, have structures in place to monitor our progress towards achieving the action plan, and our self-evaluation and action plan inform programme development	Annually Approval

Aspect 10.0 Values, equalities and diversity

Responsibility - HEI	When monitored
10.1 We have explicit aims, values and strategies to promote inclusion and equality for all and these are reflected in the work of our HEI within an equal opportunities policy that is periodically updated	Annually Approval
10.2 We have effective measures for eliminating oppressive behaviour including all forms of harassment in our HEI	Annually Approval
10.3 The guidance and support we offer as an education institution are sensitive to equality of opportunity, including offering learning and assessment resources and materials that meet diverse learning needs	Annually Approval

Responsibility - Placement Providers	When monitored
10.4 We have explicit aims, values and strategies to promote inclusion and equality for all and these are reflected in our work as placement providers within an equal opportunities policy that is periodically updated	Annually Approval
10.5 We have effective measures for eliminating oppressive behaviour including all forms of harassment in our practice areas	Annually
10.6 The guidance and support we offer as a placement provider are sensitive to equality of opportunity	Annually Approval
10.7 Recruitment and selection procedures for the appointment of staff are open and not discriminatory	Annually

Responsibility - Both	When monitored
10.8 There is an overall philosophy underpinning development and Approval of programmes that: • ensures that service users are at the centre of education provision • promotes social inclusion • is committed to protection of the public within a commitment of a safe and effective practitioner • uses a student-centred approach	Approval

Appendix 7 List of documentation

Provision of documentation sent by QAA in various formats to each prototype site

- covering letter
- 25 copies of the *Prototype Document* for approval and ongoing quality monitoring and enhancement (OQME). Partnership Quality Assurance Framework of Healthcare Education in England (2004) (*Prototype Document*)
- 10 copies of the OQME booklet
- 10 copies of the approval booklet
- 300 copies of the practice based learning booklet
- Contact details for each prototype
- CD-Rom of further copies

Documentation provided for the Visitors

- Prototype document for approval and ongoing quality monitoring and enhancement (OQME). Partnership Quality Assurance Framework of Healthcare Education in England (2004)
- OQME booklet
- Approval booklet
- HPC and NMC timeline for approval and OQME
- Practice-based learning booklet
- NMC Visitors only - NMC briefing sheet
- NMC Visitors only - NMC proforma for the verification exercise
- Prototype contacts sheet.

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