Nursing & Midwifery Council

Staffordshire University: Extraordinary Review - Summary

24 June 2020

Introduction

Since Jeremy Hunt's announcement in April 2017 of an independent review led by Donna Ockenden into the tragic circumstances of 23 baby and maternal deaths at Shrewsbury and Telford NHS Trust, alongside further concerns into the Trust's emergency departments we have been monitoring the education institutions that have student practice placements at the Trust.

In January 2020 we made the decision to ask for an extraordinary review to be undertaken into Staffordshire University and its pre-registration nursing and pre-registration midwifery placements at the Shrewsbury and Telford Hospital Trust.

This document is a summary explaining our Quality Assurance (QA) process for monitoring education institutions and their practice learning partners. We also explain why we commissioned an extraordinary review by independent visitors earlier this year, its findings and the action plan we have since put in place. For the full independent report please click here.

Throughout this period we have welcomed the cooperation of Staffordshire University and the Shrewsbury and Telford NHS Trust.

The NMC

As the professional regulator of nurses and midwives in the UK, and nursing associates in England, we work to ensure these professionals have the knowledge and skills to deliver consistent, quality care that keeps people safe.

We set the education standards professionals must achieve to practise in the United Kingdom. When they have shown both clinical excellence and a commitment to kindness, compassion and respect, we welcome them onto our register of more than 700,000 professionals.

Once registered, nurses, midwives and nursing associates must uphold the standards and behaviours set out in our Code so that people can have confidence that they will consistently receive quality, safe care wherever they're treated.

We promote lifelong learning through revalidation, encouraging professionals to reflect on their practice and how the Code applies in their day-to-day work.

Our role in the quality assurance of education

We set the standards of education and training[1] that enable students to achieve our standards of proficiency[2] before joining the register. We approve education institutions to deliver nursing, nursing associate or midwifery programmes.[3] As part of our ongoing educational quality assurance, we monitor all of our approved education institutions and their practice learning partners to ensure they continue to meet our standards. Our QA framework and accompanying QA handbook provide detail on the QA process and the evidence[4] education institutions need to demonstrate to satisfy us that they meet our standards for education and training. Where we have significant concerns that an approved education institution is not meeting our standards, we may seek an independent QA visitors' report by way of an extraordinary review and we may even decide to withdraw approval[5] of the programme and institution. Internally we have set up a QA Board which provides oversight of our ongoing education QA activity and our Professional Practice directorate provides regular updates to our Council in relation to our QA activities.

Background

In 2017, Jeremy Hunt ordered a review into maternity care relating to the deaths of 23 babies and mothers at Shrewsbury and Telford NHS Trust. The review, led by Donna Ockenden on behalf of NHS England/Improvement, into mother and baby deaths and injuries at the Royal Shrewsbury is now examining more than 1,170 cases.

The CQC has rated the Trust as inadequate including both the Royal Shrewsbury Hospital, and the Princess Royal Hospital. In September 2018 the CQC raised concerns about both the maternity services and the emergency departments and set out urgent enforcement plans.

The CQC has published subsequent inspection reports which highlighted improvements in the services, but that there remain ongoing concerns.

Our actions

As concerns emerged about the maternity services and the emergency department at Shrewsbury and Telford NHS Trust we began communicating with Staffordshire University who use the Trust as a placement setting for their nursing and midwifery students. We required regular reporting as part of our exceptional reporting process[6]. The concerns raised were identified as 'critical concerns' as defined in our QA Handbook. We therefore held regular phone call and face to face meetings with the University and Trust as part of our ongoing critical concerns processes and sought assurance around the student learning environment. We also sought assurance from

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[1] Article 15(1) of the Nursing and Midwifery Order (2001) ('the Order)
[2] Article 5(2) of the Order
[3] Article 15(5)(b) of the Order
[4] Article 15(8) of the Order
[5] Article 18 of the Order
[6] When risks emerge Approved Education Institutions (AEIs) and their practice learning partners must respond swiftly to manage and control risks appropriately. AEIs should email exceptional reports to us. We'll take action when these risks are not being effectively managed and controlled locally.

the other Approved Education Institutions who use Shrewsbury and Telford NHS Trust however they do not place nursing and midwifery students within the maternity services or emergency departments.

As part of our ongoing assurance for a critical concern, and following a meeting with the University in May 2019 we requested a contingency plan from them outlining how they continue to seek assurance around the student learning environment, what indicators would trigger removal of students from placements at the Trust, and what arrangements were in place to allow them to implement this, should it be necessary. The University submitted a contingency plan, to which we provided feedback. Subsequently another contingency plan was submitted to the NMC in October 2019. The plan submitted by the University lacked sufficient detail and failed to provide assurance that the university was able to appropriately identify risks to the student learning environment in a timely and appropriate manner, and had the appropriate plans in place to mitigate any risks that might be identified. We also continued to ask for further clarification of the contingency plan in relation to the CQC reports and other publically available information in relation to the review being carried out by Donna Ockenden.

As part of our normal process for dealing with 'critical concerns' our QA Board reviews ongoing assurance at its monthly meeting. At its meeting on 7 January 2020 it reviewed the ongoing assurance we had received from the University and Trust including reports and contingency plans. This was alongside public protection concerns about the reported high vacancy rate within the Trust and the potential impact of this on student supervision and learning. The QA Board also considered the ongoing concerns which have been reported in relation to patient safety and the culture of caring, which could negatively impact the student learning experience in the CQC reports and media reports regarding the ongoing review. The QA Board also took into account the increase in midwifery students at the University of 50 percent within the space of a year. Following consideration, the Board instructed Mott MacDonald, our quality assurance delivery partner, to carry out an extraordinary review of Staffordshire University's pre-registration midwifery and nursing programmes, in particular focusing on their oversight and support of students on placement within Shrewsbury and Telford NHS Trust's maternity service and emergency department.

An extraordinary review enables us to seek further assurance by visiting the University and their placement learning partners providing the opportunity to discuss how students are being supported, alongside speaking to students themselves and staff at the Trust. An extraordinary review is undertaken by a team of visitors who are independent of the NMC, and their report outlines their findings on whether our standards are met or not met.

The review was focused on five key risk themes: effective partnership working: collaboration, culture, communication and resources: selection, admission and progression; practice learning; assessment, fitness for practice and award; and, education governance: management and quality assurance which were reviewed across academic and practice settings.

Extraordinary Review Findings

Mott MacDonald appointed a review team consisting of a lead QA visitor, lay visitors and registrant visitors with due regard for the programmes under review. The extraordinary review's methodology included group presentations, individual interviews and focus groups. The full methodology and list of people spoken to can be found in the full report.

The review team triangulated what they had been told over the three-day period of the extraordinary review (11–13 February 2020) with documentary evidence supplied by the University and Trust.

As part of the review the team reviewed whether the pre-registration nursing and midwifery programmes met our standards, focusing on the five key risk themes.

Their findings concluded that the University has systems and processes in place to monitor and control the following risk themes to meet NMC standards and assure protection of the public:

- Effective partnership working: collaboration, culture, communication and resources
- Selection, admission and progression, and
- Assessment, fitness for practice and award

They found the following NMC key risks are currently not controlled:

- Practice learning, and
- Education governance: management and quality assurance.

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Extraordinary review findings – risk themes not met:

Risk Theme	**Risk Theme Not Met**	**Extraordinary Review Findings**
Practice Learning	3.2 Programme providers fail to provide learning opportunities of suitable quality for students 3.2.1 Practitioners and service users and carers are involved in programme design, development, delivery, assessment, evaluation and co-production.	The review team found no evidence that people who use services and carers are involved in the evaluation of the pre-registration midwifery programme or in the overall management of the programme. SUCs are involved in some aspects of programme delivery of the pre-registration nursing programme. However, the review team found no evidence of SUC involvement in the programme management teams for the pre-registration midwifery programme and the pre-registration nursing programme. The school and programme management teams must therefore develop and implement an action plan to ensure there is appropriate SUC involvement at strategic and operational levels in the pre-registration nursing and pre-registration nursing programmes
	3.2.2 Academic staff support students in practice learning settings	The review team found that academic staff support students in practice learning settings in the pre-registration nursing (child) programme and pre-registration midwifery programme. However, the roles and responsibilities of university staff supporting students learning in practice settings were not clearly understood by adult nursing students. The university must ensure students understand and student facing documentation details the roles and responsibilities of adult nursing academic staff in practice learning settings
	3.3 Assurance and confirmation of	The review team identified that the key risk is not met for the pre-

	student achievement is unreliable or invalid 3.3.2 Systems are in place to ensure only appropriate and adequately prepared mentors/sign-off mentors/practice supervisors/assessors are assigned to students.	registration midwifery programme, as they found that the intrapartum practice learning areas at Shrewsbury and Telford NHS Trust are insufficient to accommodate and support students' learning and assessment of competence due to the increased number of midwifery students. An urgent action plan must be put in place to ensure intrapartum practice learning areas support the numbers of student midwives to ensure EU birth requirements are met
Education governance: management and quality assurance	5.1 AEI's internal QA systems fail to provide assurance against NMC standards 5.1.1 Student feedback and evaluation/ programme evaluation and improvement systems address weakness and enhance delivery	The review team identified that there was limited evidence to demonstrate how students are informed of actions taken as a result of student evaluations of their practice learning experiences. The university and trust must establish a process for informing students of feedback from practice evaluations and actions taken to enhance the practice learning environment. The review team also found no evidence that Shrewsbury and Telford NHS Trust receive timely evaluations of external examiners' engagement and reporting of assessment of practice. The university and trust must ensure a process is in place to share external examiners' reports relating to practice engagement and assessment and action and any relevant findings.

Action Plan and Next Steps

The full report of the extraordinary review was shared with Staffordshire University on 6 April 2020 and they were given a month to provide observations. Staffordshire University made no observations to the report[7].

As a result of the finding that some of our standards are not being met the University has identified and must implement an action plan to address these key risks. We continue to review their progress at our monthly QA Board meetings to ensure that they make appropriate progress and meet our standards.

We have also placed their pre-registration nursing programme which has recently been approved against our new standards under enhanced scrutiny. Enhanced scrutiny requires institutions to provide us with more regular updates on their programmes which we will review and monitor.

If insufficient progress is made against the action plan, then we have the power to withdraw approval of the programmes[8].

If you have any questions in relation to the extraordinary review then please contact Dr Alexander Rhys, Assistant Director (Education) at Alexander.Rhys@nmc-uk.org.

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[7] Articles 16(9),(10) and (11) of the Order
[8] Article 18 of the Order