



ROBERT GORDON UNIVERSITY•ABERDEEN

**The Development, Implementation and Evaluation of
Demonstration Projects of New Approaches to Providing Practice
Placements in Pre-registration Nursing Programmes:**

A whole course hub and spoke approach in mental health nursing

Final report

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**Debbie Banks, Senior Lecturer, RGU
Dr Colin Macduff, Reader, RGU
Dr Mary Addo, Lecturer, RGU
Ann Ogle, Lecturer, RGU
Elaine Ross, Staff Nurse, NHS Grampian
Angie Wood, Nurse Consultant, NHS Grampian
Lesley Alexander, Staff Nurse, NHS Grampian
Eugene Bienek, Clinical Nurse Manager, NHS Grampian
Jenny Gibb, Head of Mental Health Nursing, NHS
Grampian**



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ABBREVIATIONS

CAMHS	Child and Adolescent Mental Health Services
CLET	Clinical Learning Environment Team
CPN	Community Psychiatric Nurse
HEI	Higher Education Institution
NHS	National Health Service
NMC	Nursing and Midwifery Council
PEF	Practice Education Facilitator
PEL	Practice Education Lecturer
RGU	Robert Gordon University

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ABSTRACT

This report presents details of one of three national demonstration projects focused on new approaches to providing practice placements in pre-registration nursing. The initiative has involved the development, implementation and evaluation of a "hub and spoke" model within mental health nursing in North East Scotland. Students are now based in two key practice placements (hubs) for their whole programme of study and undertake a range of "spoke" learning experiences in related practice settings. The new approach commenced in September 2009, and implementation and evaluation activities have continued during 2010 and 2011.

The evaluation primarily used qualitative methods to elicit the experiences of the main stakeholder groups such as students, mentors, managers and academic staff. This has enabled lessons to be drawn about the preparation needed to implement such a model and the key factors influencing its progress and impact.

The evaluation found promising initial evidence of benefits for students and staff in terms of enhanced continuity of relationships and learning experiences. Moreover there was some evidence that students were able to obtain deeper understandings of patients' experiences by following their journeys through care. However the 2008 student cohort tended to see the introduction of the model half way through their programme as restricting the breadth of learning that would help them obtain subsequent employment. This was much less marked in the 2009 cohort who were generally very positive about their hub and spoke experiences. Mentors mostly shared the latter view, but a number of operational issues were raised as points for improvement (e.g. more guidance needed on processes around spoke placements).

The study makes a number of recommendations for enhancing the continued implementation of the model locally. Moreover it identifies factors that would be important for others to consider if implementing this type of hub and spoke model. In particular the tensions between breadth and depth of learning experiences and between regulation of student placements and flexibility are explored. Finally the need for more longitudinal research to follow students' experiences over a whole programme is advocated.

PREFACE

This document presents the final report on this demonstration project. It has been structured in sections to enable ease of engagement for readers with different levels of familiarity with the project. The first section will be of particular value to those who are unfamiliar with the projects' origins, rationale and early development. The second section provides the reader with a summative account of the implementation work taken forward between early 2010 and the time of writing (June 2011). The middle sections focus on the evaluation in terms of its design, conduct and especially findings. The meaning of these findings is then considered in the discussion section. Relevant literature is brought to bear in order to consider implications and potential future work. The latter aspect is formalised in the final section's recommendations.

SECTION 1: PROJECT ORIGINS, RATIONALE AND INITIAL MODEL DEVELOPMENT

1.1 Origins in context: national and local developments in the pre-registration nursing curriculum

Development work around pre-registration mental health nursing education has been taking place at both national and local levels since the publication by the Scottish Government, of the National Review of Mental Health Nursing in Scotland (2006). The School of Nursing and Midwifery in Robert Gordon University (RGU) has been involved with the national work on a consistent basis and locally, an Action group was set up in 2007, to enable education and service staff to work closely together on the National Review's Actions specified for HEIs.

During this time, the pre-registration nursing programme at Robert Gordon University was also undergoing a critical review as part of the curriculum development process and new proposals for the programme were subject to University and NMC approval in April 2009. The new programme was approved and commenced in September 2009.

The benefit for the mental health nursing branch programme of these two major work streams occurring at the same time has been the whole systems approach that has been implemented and the associated opportunity to develop the curriculum in a holistic and integrated manner rather than in a piecemeal fashion. The outcome is the development of a curriculum where many strands of work have been brought together to produce a coherent, robust and student-centred programme.

The curriculum emphasises four key purposes,

- Outcome – responding to professional requirements and drivers defined by external agencies such as the Scottish Government.
- Professional preparation – ensuring students are immersed in and experience nursing as a professional discipline rather than a set of modular learning units.
- Culture – preparing students for the future rather than the present and embracing the challenges that are created when the present value-base

does not match the vision for the future and the resulting impact on the student experience.

- Transformation – realising students’ potential, adding value to students’ lives and empowering them to achieve their goals.

The curriculum, theory and practice, aims to:

- deliver an integrated and meaningful learning experience that empowers students and prepares them as confident, professional registered nurses
- positively impact on the patient experience through the provision of a curriculum that inspires and motivates students to deliver best practice.

The new curriculum is based on the following philosophy and principles:

- Learning communities to be established in theory and in practice as a conceptual approach to small group learning – promote socialisation, belonging, commitment, ownership, taking responsibility for personal and group development.
- Protection and well-being of the public, service users and carers underpins the curriculum design.
- Incorporation of an appropriate values base, namely the 10 Essential Shared Capabilities
- Service-user engagement and patient outcomes a key consideration in all aspects of teaching and learning.
- Better integration of theory and practice learning.
- Fewer practice placement periods and increased length of time within placement locations across all years/stages.
- Built in time during placement learning for reflective learning facilitated through on-line learning activities such as live chats, discussion forums and a range of directed learning activities (30 hours clinical practice per week / 7.5 hours per week for on-line learning).
- Need to enable mentors to deliver more transparent evidence-based assessment decisions in relation to student achievement and development in practice.
- Need to introduce more rigorous moderation of practice assessment.

- Student-centered support through offering flexible options and ongoing supportive relationships for academics and mentors.
- Depth of learning (deep learning) rather than breadth (surface learning)
- Learning focussed on professional development and personal development for professional practice.

1.2 Rationale for the new practice placement model

Within the context summarised above, the School was approved to deliver a new approach to placement learning for the mental health nursing programme based on a hub and spoke placement model. Although there are varied formats, hub and spoke models usually involve students being allocated home/base placements (hubs) which they revisit over a period of time during their education. They also have opportunities to visit spoke placements which are related to the hub in order to maximise relevant learning experiences.

A number of factors contributed to the decision to develop and implement this type of model:

- This approach seemed consistent with national work being undertaken in Scotland in relation to Facing the Future, the National Framework for Pre-registration Mental Health Nursing in Scotland (2008)
- Campbell (2008)'s review suggests benefits from adopting a hub and spoke model, such as increased consistency of experience for student, service staff and possibly service users/carers
- Review of local placement provision for the RGU mental health nursing branch programme (Addo 2008) showed areas of strength and where there was scope for improvement. A hub and spoke approach seemed to offer a way to build on success, encourage improvement and increase practice placement capacity at a time when healthcare provision is changing in nature, scope and location
- The model could help to realise the concept of students' belonging to learning communities that may combat isolation, enhance collaboration and ultimately improve retention (Anderson and Burgess 2007; McKegg 2005)

- The model could improve integration of theory and practice
- There was an opportunity to integrate it at the start of the new pre-registration programme and to adapt it in the light of progress

As such, the overall aim was to develop an innovative approach to placement learning designed to enhance the quality of the mentorship experience and promote good quality, appropriate and patient-centred learning experiences. In turn it was felt this would enhance the recruitment, retention and preparation of mental health nursing students and assure their fitness for practice on completion of the pre-registration nursing programme.

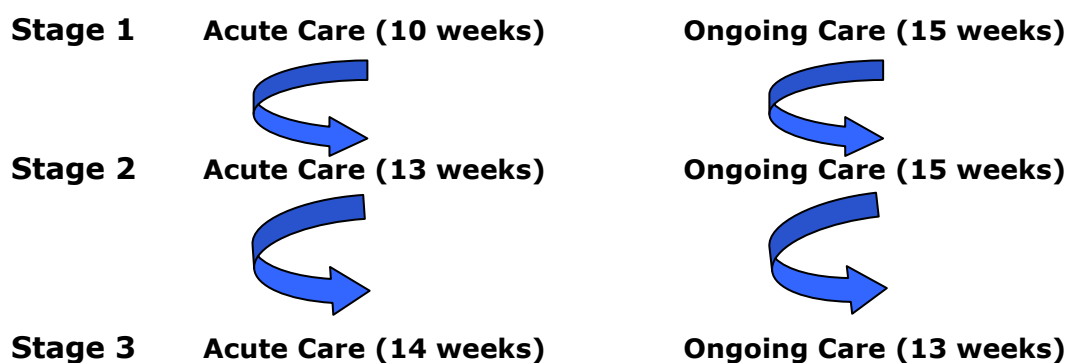
1.3. The model as envisaged

The principles and envisaged processes of the new model are now described.

In terms of principles, the notion of learning community is emphasised within the whole curriculum. Within the University, learning communities are established within the students' personal tutor groups. Students will work and learn together with their personal tutors, in these groups for the duration of their programme.

Within practice the learning community principle will be applied through a number of proposed processes. Students will be based within two key practice placements – the hub or base placements, for their whole programme of study as indicated below in Figure 1.

Figure 1: Hub placements in the new model



As can be seen, the hub / base placements will reflect nursing care that is acute in nature and care that is ongoing. It is recognised that such classification is somewhat arbitrary as the boundaries of care delivered within services are often blurred. However the key aim is to ensure students have contrasting hub placements.

It is intended that students will have the same named mentor in each of the hub placements for the duration of their programme of studies. This mirrors the students having the same personal tutor at the University for the duration of their studies and supports the building of learning communities where familiarity, involvement, collaboration, shared experiences, and a sense of belonging are some of the important constituents of effective learning environments.

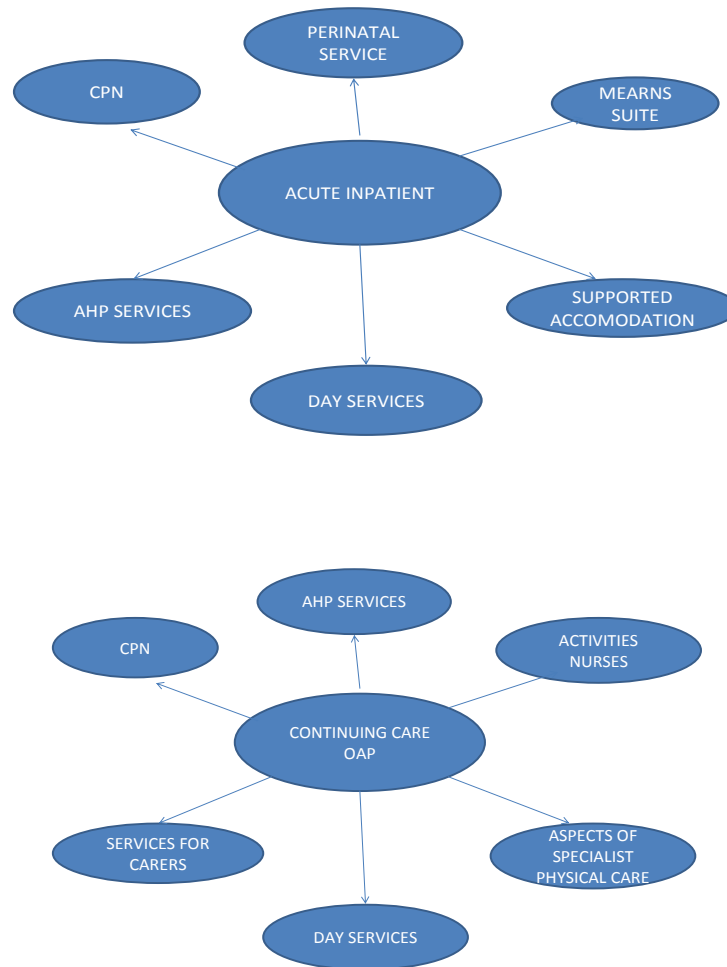
The named mentors will work with the students in each stage of the programme facilitating investment in the development of students over a long period of time. This enables the development of relationships between students and the mentoring teams that will be based on increasing knowledge and understanding of each other. It is expected that the establishment of close and ongoing connections with the hub / base placements and the people therein will promote a deeper involvement in nursing practice, a deeper involvement with service users and their families, and deeper learning and development as well as better informed assessment of performance.

Spoke experiences/exposures will be identified for hub placements and it is intended that students will access these spokes throughout the duration of the programme. Access to the spoke experiences may be planned or may arise as a result of services users' journeys through various services. It is expected that both approaches will become the norm as the new model is embedded. Guidelines will be drawn up to ensure there is clarity around the model and its flexibility to ensure core NMC, University and Service requirements are met.

It is anticipated that students will be involved in the planning process and will have input to their choice of hub placements, taking account of their interests and circumstances. This will be work carried out within the learning communities in the University and will emphasise the need for ownership, collaboration and negotiation in the learning process.

Examples of characteristic hub and spoke combinations are depicted in Figure 2.

Figure 2: Characteristic hub and spoke combinations



1.4 Initial development work preparing for implementation

During the latter part of 2008 and the first half of 2009, the following development processes were commenced in preparation for full implementation:

- Initial dissemination of information on the proposed model to practice staff
- The involvement of student representatives
- The initial identification of hub and spoke placements
- Discussion with the general manager and the mental health operational group
- Obtaining the support from executive nurses and the Head of School
- The development of the curriculum in a manner that better integrates practice learning and theoretical learning;

- The introduction of long thin modules
- The creation of time for students to engage in learning activities during placement periods – 30 hours per week clinical practice and 7.5 hours per week reflective learning activities e.g. on-line
- The development of the practice learning and assessment documentation to ensure a robust ongoing record and promote the need for evidence-based assessment of students' performance.

1.5 Inception as a national demonstration project

In August 2009, RGU was successful in obtaining funding from NES for the project to be one of three national demonstration sites where different hub and spoke models would be implemented and evaluated. This afforded potential to:

- Give further impetus to the development and implementation work of the whole course hub and spoke model for practice learning
- Enable the appointment of an NHS secondee (one day per week) to support the implementation of the project with a particular emphasis on the identification and development of spoke experiences and the establishment, re-establishment or refreshment of learning opportunities for students with voluntary sector organisations
- Enable the appointment of an NHS secondee as a research assistant to support the evaluation of the project (one day a week)
- Raise the profile of pre-registration mental health nursing preparation at RGU and NHS Grampian, NHS Orkney and NHS Shetland
- Enable systematic learning of key lessons so as to inform both local and national sustainable development.

As the latter point suggests, one of the main benefits from national funding was the enablement of a systematic evaluation. From inception the evaluation research study was set up as a distinct element of the project and was undertaken by staff with no ongoing individual involvement in pre-registration programme design or mentoring input to the students involved. This approach sought to minimise any possible conflicts of interest and to yield benefits that may accrue from a slightly more distanced perspective. As such the project had two distinct but related workstreams: the implementation work and the evaluation work. The following section now describes how the former aspect progressed.

SECTION 2: IMPLEMENTATION WORK 2009 -2011

This section provides the reader with a summative account of the implementation work taken forward between early 2010 and the time of writing (June 2011)

The development and implementation elements of the funded project commenced in Autumn 2009.

2.1 Internal Project Steering Group

Development and implementation was overseen by an internal project Steering Group. The membership and remit of this group was agreed at the first meeting held on the 7th October 2009. This report's authors comprised the membership. In the initial stages, monthly meetings were agreed, progressing to meetings every three months once the model had been implemented with current cohorts of students. The remit was to:

- Provide leadership and drive for the project
- Promote the positive engagement of stakeholders with the project
- Monitor the development and implementation of the practice learning model making decisions for change where and when required
- Ensure appropriate evidence is gathered to inform the implementation and evaluation of the practice learning model
- Ensure effective use of financial and other types of resources
- Appoint and support individuals to undertake the development and implementation support role and the evaluation assistant role
- Disseminate information on the progress of the project as widely as possible
- Report to NES formally on the status of the project at agreed points

2.2 Appointment of secondees

The appointment of the secondees took longer than anticipated because of the vacancy control process that was in operation within NHS Grampian. The decision was made that the Research Assistant post would be of one year duration rather than the planned 18 month duration. The Implementation post was shortened to 11 month duration to allow it to be passed by vacancy control.

Elaine Ross was selected to undertake the Research Assistant secondment and took up post March 2010. Elaine worked one day per week with Dr Colin Macduff to take forward the evaluation research. Elaine is an experienced mental health nurse who has completed a Masters in Nursing.

Lesley Alexander was selected to undertake the Implementation post and took up post in May 2010. Lesley worked one day per week with the Practice Education Facilitator, identifying and establishing spoke placements. Since the Practice Education Facilitator changed role in September 2010, Lesley has collaborated with the Practice Education Lecturer for mental health, Ann Ogle. Lesley works within the in-patient setting and this allows her exposure to a high volume of students on placement and therefore increased understanding of practice learning and associated issues.

2.3 Implementation – Hub placement developments and student cohorts

The PEF for mental health nursing along with the project lead and practice education lecturer launched the new model through a series of sessions during August and September 2009. These were held in Aberdeen and Elgin, and teleconferences took place with Orkney and Shetland.

The launch workshops, which were well attended, provided mental health practitioners and students with the opportunity to explore the new model and have questions and concerns addressed. Initially the hub placements reflected acute mental health care services and ongoing care services as this was believed to provide students with contrasting experiences.

New hub placements have emerged over the last 18 months through a process of self-identification by some practitioners and clinical teams and through work undertaken by the PEF and PEL. Once a new PEF is in post, a review of hub placements will take place and services where there is potential for offering a hub practice learning experience will be supported to develop in this way.

Details of implementation work with the various student cohorts now follows.

2.3.1 September 2008 intake

The September 2008 intake progressed to their mental health nursing branch programme in September 2009. A review of this cohort's Stage 1 practice placements was carried out and where possible and/or feasible, the hub placements identified for their branch programme were based on their Stage 1 allocations. The aim was that at least one of the hub placements would be an area the students had previously had a learning experience in.

The project leader and the PEF for Mental Health met with this cohort following the initial identification of the hub placements for the branch programme. Students were introduced to the model and had the opportunity to ask questions, raise concerns and explore the potential of the model for them. Following this meeting, a small number of amendments were made to the allocation based on capacity of the identified hubs and students' personal circumstances. The outcome for the 20 students was as follows;

No hub placements reflecting Stage 1 placement allocation:	1 student
One hub placement reflecting Stage 1 placement allocation:	14 students
Two hub placements reflecting Stage 1 placement allocation:	5 students

Within this cohort one student requested a hub that would enable a spoke placement to be undertaken in Orkney or Shetland. This student was allocated a hub in an acute ward which receives patients from Shetland and Orkney. This student has subsequently undertaken two spoke experience in Orkney from her hub in Stages 2 and 3 of the course.

The September 2008 are completing their first Stage 3 hub placement and they will shortly be undertaking the final, 2nd hub placement of their course. Fifteen students are on target to complete in September 2011 with one student currently on a temporary suspension of studies.

2.3.2 September 2009 Graduate Access Students

Two students commenced the advanced entry for graduates route. These students joined the September 2008 intake students in January 2010 following a 3 month access module which included an 8 week placement. One of these students expressed an interest in having Orkney or Shetland as a hub and this was planned for however, once the student examined the financial impact of a

hub placement in Orkney for a period of 15 weeks in 2010 and again for 13 weeks in 2011 she concluded she would not be able to afford to undertake the placement as she would not be able to continue to work part time to ensure she could pay her monthly outlays for her mortgage and such like. One of the graduate access students is currently on a temporary suspension of studies but the second student is on target to complete in September 2011.

2.3.3 September 2009 intake

The September 2009 intake was the first to have the new approach from the outset of their course. Recruitment to this intake was extremely healthy and 36 commenced. This was the biggest cohort for mental health nursing that the university and NHS Grampian, NHS Shetland and NHS Orkney has had to support in many years. During semester 1, September – December 2009, which is based within the University, work was undertaken with the students during their personal tutor group, personal development sessions, to identify any areas of personal interest within the mental health care sector. Where possible, attempts were made to match one hub placement with an area of student interest. All students had at least one hub that reflected an area of interest for them. This cohort commenced their first hub placement on January 4th 2010. Currently in Stage 2 of the course, this intake have returned to their first hub placement for the second time and will be returning to their second hub on the 25th April 2011. There are 27 students active on the course at this time; 3 students transferred to adult nursing during Stage 1, 3 students are on temporary suspension of studies and 3 students discontinued from the course during Stage 1.

2.3.4 September 2010 intake

Thirty two students commenced their studies in September 2010. A similar process was undertaken with these students to enable the hub placements to be identified. However, as a result of key project team members being absent during this time, the process was not a smooth as it could have been. As a result, the process for identifying hubs and then matching students with hubs has been reviewed and clarified and this will be implemented for the September 2011 intake.

The September 2010 intake commenced their hub placements in January 2011. At present this cohort is not part of the evaluation.

2.4 Implementation - Spoke Placement Developments

During her time in the Implementation Secondment post, Lesley has been working closely with hub placements and their mentors. She has supported mentors to identify and develop possible spokes linked to their clinical areas. The hub placements have been encouraged to produce written information detailing spokes for students to access in order to plan their learning experiences. This work is progressing along with collation of the information as part of the process for matching students with hub placements, and also for preparing students for their practice learning experiences.

Where areas have been more limited in available spokes, Lesley has explored possibilities within the voluntary sector. There has been success in making connections with services such as;

- Dee View Court funded by Sue Ryder Care, providing residential care to people with neurological conditions,
- SHAPE funded by Turning Point Scotland, a community based housing support service for adults with neurological conditions,
- OPUS funded by Turning Point, a picture framing workshop promoting social enterprise and employment for people with mental health problems
- Momentum Aberdeen, a community out reach brain injury service
- SACRO Aberdeen (Safe Guarding Communities Reducing Offending) which provides criminal justice services, restorative justice services and community mediation services.
- Pinpoint and Square One, projects that supports individuals with mental health problems to have choice and control in their lives through the development of work skills.
- Corrieneuchin, a Children's 1st and Aberdeen City Council jointly funded project providing services to help children recover from abuse.

Lesley is continuing to work with hub staff to identify and nurture relevant spoke placement experiences for students that reflect the journey of service users. She also continues to build a database of hub and spoke information which will be used both in practice locations and in the university to prepare and enable students to achieve breadth as well as depth of experience. Examples of three individual student pathways followed during hub placements are presented in Appendix 2.

2.5 Impact of NHS contextual and personnel changes on implementation

The implementation work has been taking place at a time of considerable pressure on NHS budgets, with related service changes that include ward closures and staff redeployments. Within this context, the Practice Education Facilitation role has had limited enactment since the former full time postholder became a Nurse Consultant in October 2010. The role is currently advertised. Moreover key senior NHS personnel involved in the project's inception such as John Donaghy, have now taken up posts where they will have no input to the project. As such, there has been considerable strain on the infrastructure that supports the development of NHS practice placements in recent months and those involved in the project have been striving to minimise any possible related negative impacts.

2.6 Other challenges as seen by the implementation team

Other key challenges that have emerged to date are:

- The number of students that require mental health placements or exposures. The move to a single intake and a new structure, two instead of three placement periods per year, for the pre-registration nursing programme, coupled with healthy recruitment to the September 2009 and 2010 intakes has presented some challenges in the capacity of the NHS mental health placement providers to support the number of students requirement placements at any one time. This includes FE colleges HNC students and adult nursing students requiring exposure for both NMC requirements and EU requirements. A new approach to providing exposure experiences for some adult and children's nursing students to mental health nursing care and practice is being piloted within Aberdeen city and will be reviewed as the project progresses. This involves the students spending one day within the hospital setting, hearing presentations from both adult and older adult community mental health teams. The afternoon is spent in workshop activities using reflective templates. The students are then asked to use these templates to reflect on their experience of mental health issues throughout their placements. It is hoped that this reflective work will deepen the student's understanding of the impact of mental health issues in all areas of health and wellbeing.

- The exposure of mental health nursing students to the three other fields of practice within Stage 1, the common foundation programme, as required by the NMC. During Stage 1, 2nd placement, an exposure day facilitated by the PEF was arranged. This brought the students together with Nurses from the three other fields of practice. This allowed the students to deepen their understanding of the fields. The day was positively evaluated by the students.

2.7 Highlights of the project so far as seen by the implementation team

While there have naturally been many challenges, these have been more than balanced by a number of very positive formative experiences, namely:

- The opportunity to continue close partnership working between RGU, NHS Grampian, NHS Shetland and NHS Orkney mental health practitioners.
- The integration of practice, education and evaluation research that the project is facilitating.
- The enthusiasm and willingness of mental health nursing practitioners across NHS Grampian, NHS Shetland and NHS Orkney, to engage with the new model and the emerging opportunities they are identifying for learning and development of the students.
- The establishment of hub placements in services that previously only supported students for relatively short exposures within the branch programme, for example, substance misuse services, CPN services, forensic services, eating disorders service, CAMHS, Shetland and Orkney community mental health teams.
- The students cohorts' willingness to engage with the new model
- Anecdotal evidence emerging that mentors are anticipating student's learning needs for when they return to hub placements. Mentors comment that they have given students guidance into areas that they may wish to develop before returning to placement.
- Press reporting about the project and the presentation to the International Network for Psychiatric Nursing Research Conference Oxford 23/9/10

SECTION 3: EVALUATION RESEARCH DESIGN AND METHODS

3.1 Evaluation questions and design principles

As indicated in Section 1, the evaluation work comprised a distinct element of the project that ran concurrently with the implementation of the model. The evaluation study sought to address the following questions:

1. What are the key developmental and preparatory processes involved for the HEI and its NHS partners when introducing this hub and spoke placement model?
2. What are stakeholders' experiences of the implementation of this model and how does this develop over an initial 18 month period?
3. What are the key factors that appear to influence the success of implementing the model? (e.g. in terms of local placement related factors, NHS strategic management related factors, and HEI related factors)
4. In light of the strengths and weaknesses identified, what are the implications for possible wider application of this model?

The evaluation design was informed by the stakeholder approach of Guba and Lincoln (1989), the work of Stern (2004) focusing on explanation and development, and the work of Pawson and Tilley (1997) seeking to understand what works for whom and why. The study methods were qualitative in nature with a view to understanding the initiative in context. Under this ambit the aim was to elicit perspectives from the main actors in the hub and spoke development and those affected by it.

3.2 Sample

The main stakeholders who were identified as the target sample for the evaluation were:

1. HEI nursing academics (in particular four key post-holders)
2. Practice Education Lecturers and Practice Education Facilitators (four key post-holders)

3. NHS strategic and service level managers (approximately 10 key post-holders from Grampian, Orkney and Shetland)
4. Practice placement mentors (total of 105 identified through liaison with the Clinical Learning Environment Teams)
5. Practice placement staff i.e. clinical workplace colleagues of these mentors (exact number unknown; see below for access strategy)
6. RGU mental health students involved in new placement approach (approximately 56 comprising the September 2008 and September 2009 cohorts)
7. Representatives of users of NHS mental health services (up to five particular local service user/carer groups identified for possible approach)
8. NES and wider learning communities (those interested in the development and evaluation lessons)

3.3 Methods of data collection

The main methods used are summarised below:

- Individual interviews with Practice Education Lecturers, Practice Education Facilitators and strategic/service level managers (groups 1-3 above). It was envisaged that 10 such interviews would be conducted in the course of the evaluation. The aim here was to gain more insight into experiences of managing the roll-out of the development in a range of settings. This would help to understand key processes and influencing factors.
- Questionnaires to mentors and clinical workplace colleagues (groups 4 and 5 above). The questionnaire aimed to gather perceptions of the introduction and establishment of the model, highlighting any positive or negative experiences. Due to data protection considerations the evaluation team had to rely on key NHS contacts for initial distribution to some of the 105 mentors. The aim was that mentors would pass on a clinical colleague questionnaire to two of their workplace team who had involvement with the nursing students (e.g. other staff nurses or AHPs). Following consultation with the Clinical Learning Environment Teams, however, it became clear that this would not be possible in all cases and in the end a total of 102 questionnaires were given to key contacts and mentors for distribution to workplace clinical colleagues. Due to time constraints it

proved possible to distribute questionnaires to mentors and colleagues on one occasion only (August 2010) rather than the two originally planned.

- The questionnaire packages contained an invitation to take part in a follow up interview. The plan was to undertake a total of 10 of these with consenting mentors and 5 of these this consenting workplace colleagues. The aim here was to elicit experiences of the development in more depth, covering a range of settings.
- Questionnaires to the two student cohorts involved in the development (group 6 above) at two different time points. The Time 1 questionnaire aimed to gather perceptions of hub and spoke experiences and the model as a whole. The Time 2 questionnaire used the same format, but added more fixed choice response questions. It proved possible to use both questionnaires with the September 09 cohort, but time and student programme constraints prevented follow-up of the September 08 cohort.
- The questionnaire packages for the students contained an invitation to take part in a focus group interview. The aim was to elicit experiences of the development in more depth, covering students' perceptions in relation to a range of settings. It proved possible to conduct three focus group interviews (one with members of the September 08 cohort and two with the September 09 cohort).
- Individual interviews (or a focus group interview) with representatives from mental health service user and carer groups (group 7 above). The aim was to explore whether users and carers had any perception of changes in the way they experience contacts with mental health nursing students (e.g. any change in perceived continuity of contact). It was initially envisaged that this might involve five such representatives. It proved possible to conduct individual interviews with two.
- Analyses of relevant documentation such as guidelines and/or portfolios for spoke placements. These were studied as available on an ongoing basis throughout the evaluation

The data collection tools referred to above were developed by customising tools which had been previously tested and successfully used on similar evaluation projects (e.g. Macduff et al 2009; 2010). The main tools used are included as Appendix 1.

3.4 Ethical approvals and study conduct

In 2009 we sought advice from the NHS North of Scotland Regional Ethics Committee as to whether this educational evaluation project would be seen as research. The advice was that a full research ethics application was necessary. This was subsequently submitted early in 2010 and final NHS Ethical approval was granted in April 2010. The project also underwent ethical review within Robert Gordon University and received approval. Management approvals from the three NHS Boards involved were also necessary. In two cases these were obtained relatively quickly and involvement of their NHS staff was possible by July 2010. In one case, however, the delay in receiving management approval lasted for over five months despite no issues being raised by that Board. The authors would contend that the extensive ethics and governance procedures visited on the project were well out of proportion to the risks involved.

The study was conducted on the principal that all involvement of participants was voluntary. NHS staff could choose whether to return a completed questionnaire and/or an interview consent form as they wished. Questionnaires to the RGU students were distributed in the classroom setting by the evaluation team following an explanation of the study. Students were able to return the questionnaire and consent form at a time of their choosing (using a FREEPOST envelope) and were not be asked to make an immediate decision on participation in the classroom setting.

Individual interviews were conducted by telephone or in-person at RGU, depending on what suited participants and ensured confidentiality. The former setting was used for the focus group interviews. Informed consent was sought from all interview participants prior to interview. This involved them receiving the relevant study information sheet and returning a completed consent form before any such data collection.

All data was stored in a secure environment within RGU, with confidentiality a paramount concern. In this context we undertook to report the findings in such a way as to avoid identifying any specific named individual outwith the immediate project team.

3.5 Data analysis procedures

Data from the questionnaires was entered in an anonymised, coded format onto a password protected SPSS database. The minimal amounts of quantitative data were collated and summarised through descriptive statistics. Respondents' textual comments were collated for each question and printed out. Content analysis facilitated the identification of themes and sub-themes (Bryman 2001; Priest et al 2002), and key quotes which encapsulated these.

The individual interviews were digitally recorded as an aide-memoir. The recordings were listened to several times and selectively transcribed in an anonymised format. Again qualitative content and thematic analysis approaches (Bryman 2001; Priest et al 2002) informed our handling and interpretation of this data. Key verbatim quotes were collated in relation to the thematic areas of the prepared interview schedule and thematic content that emerged from the interaction as a whole.

The focus group interviews were also digitally recorded. The recordings were listened to several times and fully transcribed in an anonymised format. Analysis procedures were broadly similar to those described above, but were also informed by the "Framework" method of Ritchie and Lewis (2003) and by ideas from the narrative tradition (e.g. considering how ideas are shared as well as the ideas themselves).

Findings from each of these main data sources were then drawn on and combined as appropriate in order to better understand the experience of key groups and to address the study objectives.

SECTION 4: EVALUATION FINDINGS

4.1 Overview and response details

Presentation of the main findings is structured around the evaluation questions. As a major part of the evaluation focused on stakeholders' experiences of the new model (question 2), these are presented first. A substantial amount of insight-rich qualitative data was generated in this part of the research, and this is reflected in the weighting and detail given to these findings. This in turn enables consideration of findings in relation to question 1: i.e. what are the key developmental and preparatory processes involved for implementing the model. From this basis, the final sub-section reports on the key factors that appear to influence the success of implementing the model (question 3).

Before looking in detail at the findings, it is useful to give a summative overview of the participation achieved in this evaluation (Tables 1 and 2)

Table 1: Response details for questionnaires/interview schedules

	Number distributed	Number returned	% response	Notes/Comments
Questionnaires to Mentors August 2010	105	36	34%	Due to data protection considerations, some of the questionnaire packages for mentors were sent to key contacts for distribution. (i.e. not possible to send all direct to mentors). This method is associated with reduced responses rates (Macduff et al 2009).
Questionnaires to Colleagues August 2010	102	19	19%	Due to data protection considerations, the questionnaire packages for colleagues were sent to key contacts and mentors for distribution. (i.e. not possible to send direct to any colleagues). This method is associated with reduced responses rates (Macduff et al 2009)
Questionnaires to Sept 09 Students April 2010	33	10	30%	Questionnaires were distributed to 25 students in class. Remainder given to class members to pass to students who were not present on the day. Denominator may be less than 33.
Questionnaires to Sept 08 Students November 2010	20	9	45%	Questionnaires were distributed to 11 students in class. Remainder given to class members to pass to students who were not present on the day. Denominator may be less than 20.
Questionnaires to Sept 09 Students January 2011	27	13	48%	Questionnaires were distributed to 23 students in class. Remainder given to class members to pass to students who were not present on the day. Denominator may be less than 27.
Interview schedules to key HEI and NHS staff March 2011	12	8	67%	It was originally anticipated that these staff would be interviewed individually in person or by telephone. Due to strictures of time, the interview schedule was e mailed to potential participants, and textual responses were received.

Table 2: Participation details for individual and group interviews

	Number invited	Number consented	Number interviewed	Notes/Comments
Mentors (August 2010)	105	16	5 (individual by telephone)	Although all who consented for interview were contacted, some did not subsequently respond to invite to suggest an interview time. In other cases it was not possible to find a mutually feasible time.
Colleagues (August 2010)	102	8	4 (individual by telephone)	Although all who consented for interview were contacted, some did not subsequently respond to invite to suggest an interview time. In other cases it was not possible to find a mutually feasible time.
Sept 09 students (April 2010)	33	7	0	Students were only at university for a short time in April 2010 and it was not possible to hold the focus group. Decided there was merit in postponing until this cohort had returned to their original hub placements and then to university
Sept 08 students (November 2010)	20	4	3 (one focus group)	One student who returned a consent form did not attend on the day.
Sept 09 students (January 2011)	27	12	12 (two focus groups)	Well attended groups (5 and 7 people).
Service user representatives (January 2010)	10	3	2 (individual in person)	Some of the invitations were given to other representatives to pass on to colleagues. Therefore denominator may be less than 10.
NHS managers (December 2010)	6	0	0	Invitations distributed at a time of major change at managerial level (service strictures) and informal feedback from NHS colleagues suggests that service delivery concerns took precedence over study participation.

As the notes/comments in Tables 1 and 2 explain, a number of factors made it difficult to obtain optimal access to, and response from, the various target groups. The varied participation rates and generally small numbers mean that some caution is needed in relation to the representativeness of the findings and any associated generalisations.

4.2 Stakeholders' experiences

4.2.1 Mentor and clinical colleague experiences

These findings stem from two data sources: questionnaire responses and follow up interviews. Around three quarters of mentor and colleague respondents worked in a setting that was used both as a hub and as a spoke placement. Almost a half of mentor respondents were CPNs (42%) and hospital based staff nurses (38%) were also well represented. Experiences of preparation for the introduction of the model were mixed, with a fairly even split between those who felt they had good prior information and explanation, and those who perceived lack of guidance on structures and processes:

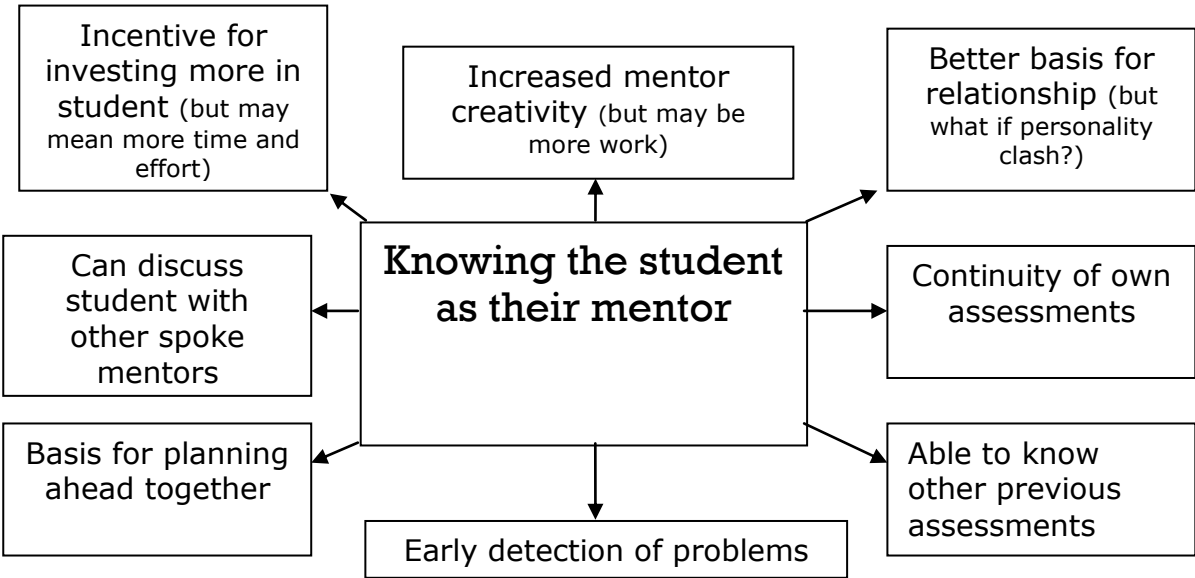
"No, no real information about the changes were made clear, we learned most from the students themselves" Staff Nurse, Hospital, Hub and Spoke placement setting

"Yes, I attended a couple of roadshows etc and felt this very helpful in grasping changes" CPN, Hub and Spoke placement setting

Analysis of the main content of participants' perceptions identified three substantive themes, each with a number of sub-themes.

4.2.1.1 Knowing the student as their mentor

This theme is presented schematically in Figure 3 below:



As can be seen, this theme reflected a predominantly positive view of the early impact of the model on the nature and scope of mentors' knowledge of their students. The responses below illustrate some of the constituent sub themes:

"You know the student well, you know their capabilities you didn't get that insight before. I was sceptical to be honest to start with but now I'm quite optimistic about it." CPN, Community Old Age Psychiatry, Hub and Spoke placement setting

"I feel that the student returning to the same area is a great idea as you can assess exactly how they have improved or not, also continuity of care" CPN, Hub and Spoke placement setting

"Still early days, however I feel positive about concept and idea of following/mentoring students from start to finish of training. Also good to have assessment documentation in one booklet to be able to see previous performance" CPN, Hub and Spoke placement setting

"Knowing the student will be returning allows forward planning, spacing of specialist experience" Staff Nurse, Hospital, Hub and Spoke placement setting

"Longer placement, knowing student will be returning means you want to invest more" Nurse specialist, Hospital, Hub and Spoke placement setting

"The work you put in with the student i.e. knowledge & skills. You will benefit on their return" CPN, Hub and Spoke placement setting

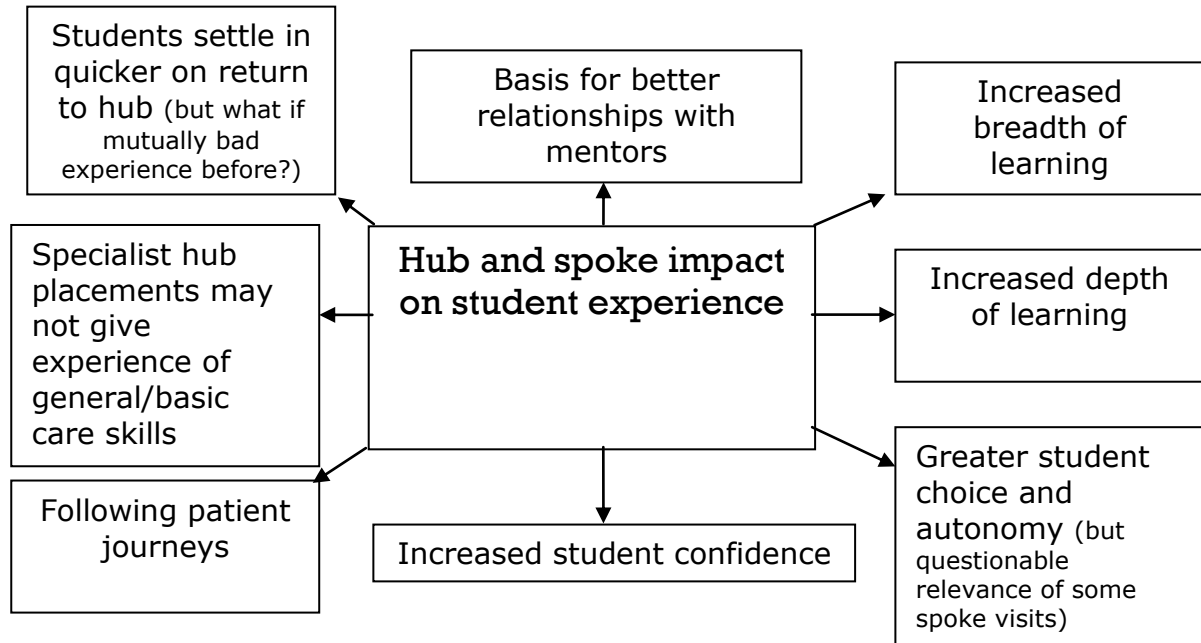
"The main thing is I actually had to organise little placements out of the ward which I tried to do on a weekly basis." Ward Manager, Hospital (Dementia Care), Hub and Spoke placement setting

"I have an anxiety with regards to their being a clash of personalities! However, with the hub student I have, this is not the case" CPN, Hub and Spoke placement setting

"It has been beneficial to be able to discuss placed students with other spoke mentors to get a clearer picture of their progress" Staff Nurse, Hospital, Hub and Spoke placement setting

4.2.1.2 Hub and spoke impact on student experience

This theme is presented schematically in Figure 4 below:



Again, this theme reflected a predominantly positive view of the early impact of the model on students' learning experiences. The responses below illustrate some of the constituent sub themes:

"Main positive would be students can choose areas that they are really interested in" Staff Nurse, Hospital, Hub placement setting

"More in depth knowledge gained and focus on recovery. Felt more part of the team. The longer placement was better for experiencing community nursing" CPN, Hub and Spoke placement setting

"Has made me more responsible for arranging experiences outside the ward. The placement is more interesting for the student and she has a full understanding of the patients' whole journey" Staff Nurse, Hospital, Hub placement setting

"First placement students who have now returned for second year appear to be doing well. The settling in period is much reduced. These students are more confident in their abilities" Staff Nurse, Hospital, Spoke placement setting

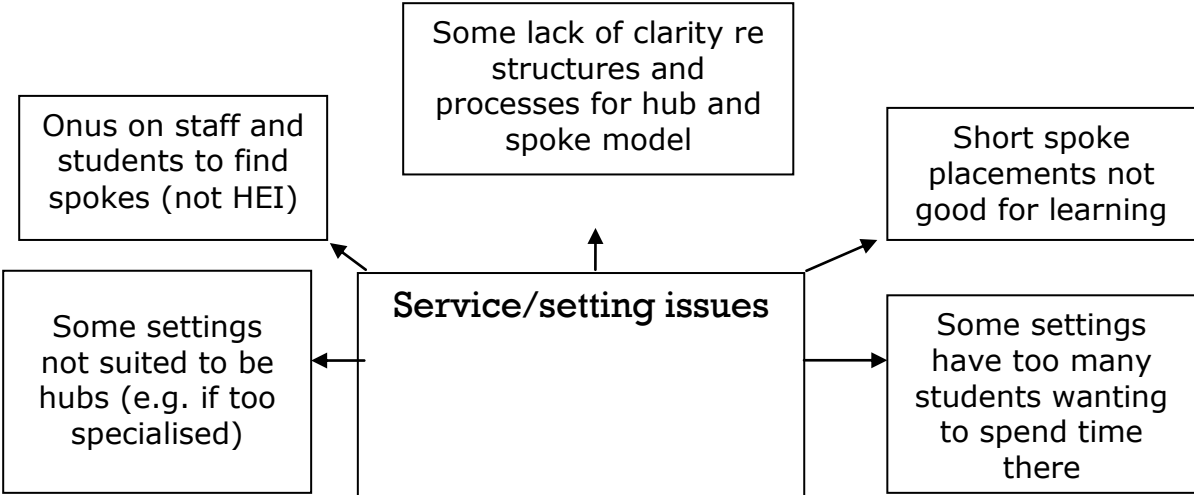
"It gives the student a bigger picture of what is involved in caring for the elderly." Ward Manager, Hospital (Dementia Care), Hub and Spoke placement setting

"We have experienced students from other areas/wards requesting and attending the unit for a 5 day period who are unsure if there is any relevant to themselves, but feel obliged to fulfil a variety of and hoc placement opportunities" Staff Nurse, Hospital, Hub and Spoke placement setting

"Have some concerns that a hub placement in a specialist service means the student gets less general experience. however, we endeavour to minimise this by arranging sufficient spokes" Ward Manager, Hospital, Hub and Spoke placement setting

4.2.1.3 Service/setting issues

This theme is presented schematically in Figure 5 below:



As can be seen there were more concerns voiced about contextual and procedural issues relating to the service settings:

"1) the extra workload is arranging spokes. 2) Spoke placements that were not under NHS were good but could not monitor how they practice and whether student was exposed to bad practices" CPN, Hub and Spoke placement setting

"Lack of clarity, communication, onus on ward staff to find appropriate learning opportunities for spokes" Staff Nurse, Hospital, Hub and Spoke placement setting

"Places need to organize better with one & other re spoke placements. Some spokes over subscribed to, so no availability" Deputy Manager, Hospital, Hub and Spoke placement setting

"Greater clarity, regarding the suitability of proposed 'spoke' could have been achieved if staff had been supplied with guidelines. For example, how relevant the spokes had to be to the hub? Did they have to admit into or be discharged to, or was the spoke wider?" Staff Nurse, Hospital, Hub and Spoke placement setting

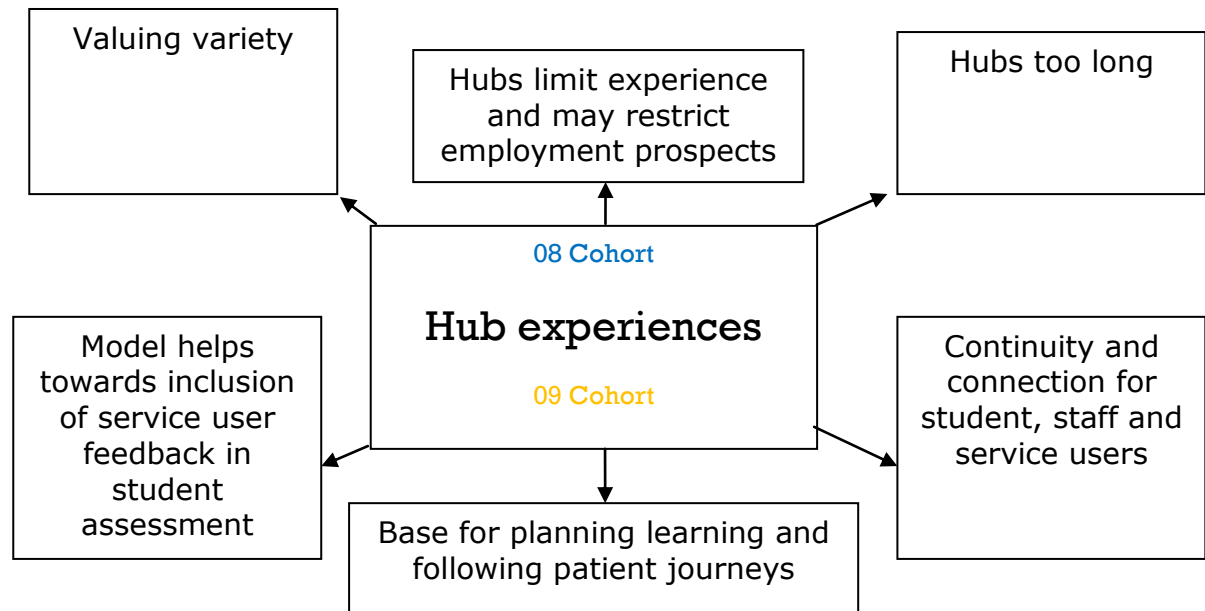
"Lengthy placements make shadowing repetitive for students and overwhelming for patients. No opportunity for any further learning style than shadowing whilst in this area" Specialist Nurse, Substance Misuse, Hub and Spoke placement setting

"Spoke placement not enough for students to develop learning/relationship/knowledge in that area" CPN, Spoke placement setting

4.2.2 Students' experiences

Students' perceptions are reported now under five main thematic headings.

4.2.2.1 Hub experiences



As Figure 6 above suggests, there were generally marked contrasts between the student cohorts in their perceptions of hubs, although neither cohort had a monopoly on any of the sub-themes.

"I don't think that the longer 15 week placements are necessary because I feel like the old 8 week placements were long enough to form relationships and have an in depth learning experience. I don't think it will be very beneficial to return to hub placements for the same reasons" (student 08 cohort)

"15 weeks is too long. I feel I have had little experience with the change to hub and spoke. I have had no old age placement which I feel is very poor. I think it is more important to have a variety of placements to broaden your experience. I would be happier if you could choose your placement hub areas" (student 08 cohort)

"While I have gained a lot from both placements, particularly building good relationships with staff and patients, I feel my experience is severely limited to

OAP, which will effect my prospects of gaining employment and post-reg”
(student 08 cohort)

“I’ve been lucky in that my mentors have seeked out the opinions of the service users and because my community placement is a fantastic placement. And actually lucky they gave me a lot of independence to go in seeing patients myself. They did ask before the final assessment. But that’s really because my mentors were so enthusiastic and interested and engaged. And I was the only the student there as well because it’s a really small team so it was just me”
(student B, 08 cohort; focus group)

“Excellent, due to small team I had 2 mentors and benefited from seeing their approach and discussing their views. They both spent a lot of time answering questions and discussing cases. Great opportunity to improve communication skills and learn about diagnoses ”(student 09 cohort Time 1)

“I feel hubs are good as you return to a familiar environment, although I think having 2 hubs both adult acute, will in the long run limit my knowledge & experience on other areas of mental health as spokes are not always long enough” (student 09 cohort Time 1)

“Going back to my 1st placement Hub was great as no settling in period was required and I feel comfortable with them” (student 09 cohort Time 2)

“I was able to catch up with the patients. I had met in 1st year to see how they had progressed who's been discharged” (student 09 cohort Time 2)

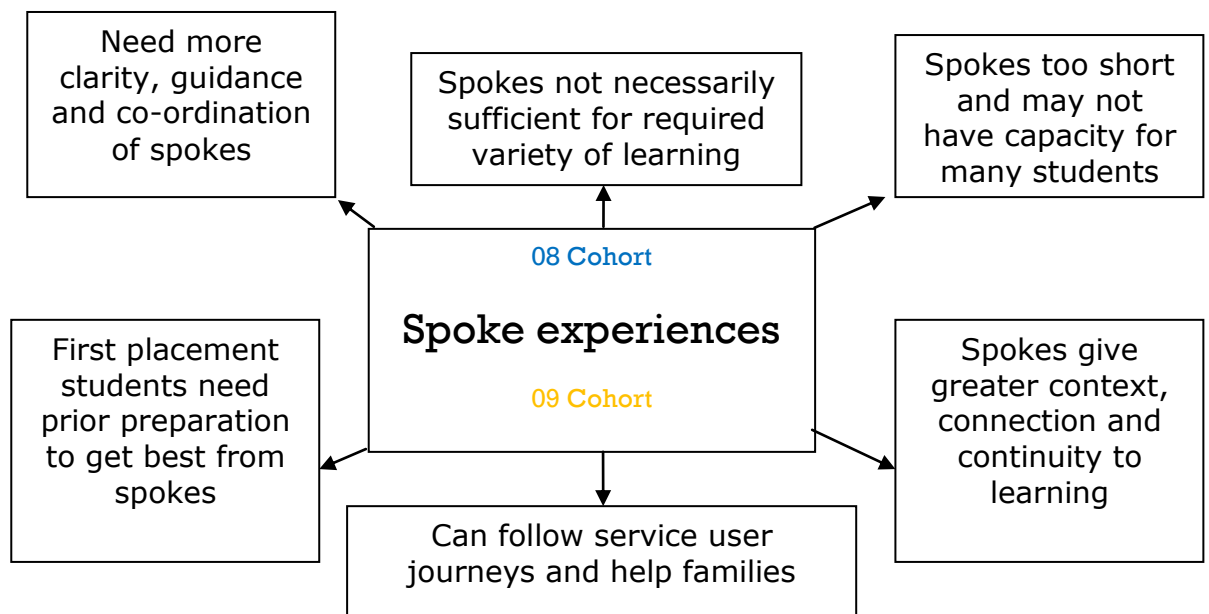
“Very positive has allowed me to consolidate good clinical practices and use Hub as base to extend learning. This learning extends and follows patients journey often to spokes great for continuity of care” (student 09 cohort Time 2)

“The hub has enabled me to build solid relationships with both staff, service users and cares/families. I do feel that the placements are now longer, we would benefit more from going to 6 different placements over the 3 years instead”
(student 09 cohort Time 2)

" they've never had a first year student before, but they were open to it and still are, compared some negativity I experienced in other places. They realised the benefits of the Hub & Spoke model, and it was a new experience, so we kind of learned together, what things I could and couldn't do, what experience I would need, especially going back the second time, they had prepared a lot of spokes that added value to what I would need to know because I got good grounding in what they do. Also what they are doing to progress to 3rd year too" (student A, 09 cohort; focus group 2)

"My mentor did ... now you mention it, in my final grade, in the bit they write about, he did actually specifically say 'the clientele on this ward is not that can be of any input' but he can tell by the body language between me and the patient and the patient and me, how well I was doing" (student D, 09 cohort; focus group 1)

4.2.2.2 Spoke experiences



As Figure 7 above suggests, contrast in perceptions between the cohorts was rather less marked in relation to the experience of spokes, but was nevertheless evident. While 08 cohort students perceived benefits, they saw limitations in terms of duration, scope and co-ordination of spoke experiences.

"Have attended many spoke placements within the rehab placement. My mentors were very flexible to allow me to do this. Some were more beneficial than others. Loved the time (1 week) with the CPN would have preferred/benefited from a whole placement. Spoke ok but don't compensate for lack of variety and broad experience to be gained during training" (student 08 cohort)

"Spoke placements were beneficial as they allowed me to gain an insight into other areas of mental health and the services used out with the hospital, although feel too short to grasp proper in-depth insight" (student 09 cohort Time 1)

"No centre co-ordination of spokes, mentors and students organise themselves. 'Spokes' had been operating informally anyway before the introduction of new system, many students would have enough initiative to seek out further experiences related to their placement anyway" (student 08 cohort)

The 09 students also highlighted a need for better guidance, especially before their first placement.

"Spokes are a great way to get a flavour of other areas, but I do feel that there are unclear guidelines as to how we do them. Some areas are not as enthusiastic about having you for short spaces of time = more pressure on us. If you do really enjoy your spoke two weeks etc is not enough time" (student 09 cohort Time 2)

"I don't think I did any spokes in my first placement (two other students voice assent)..... Looking back I am a bit regretful of it. With the mentor it was even approached, and I was a kind of a little bit blind, not sure about it and on the second time, I did more on the second. When I went back into the first placement for the second time, I did quite a few spokes because I saw the benefits of them and I wanted to broaden my experience. I was almost managing more learning as well. But first year I didn't" (student F, 09 cohort; focus group 2)

Nevertheless, there was a substantive emphasis on the mutual benefits of spoke experiences for students, staff, patients and their families.

"Spoke placements have been extremely good and show how related services "join-up" with hub placement. This enhances relationship with staff and families and of course service users as there is a wider shared knowledge base" (student 09 cohort Time 2)

"I was able to follow patients' journeys when they attended other mental health service areas" (student 09 cohort Time 2)

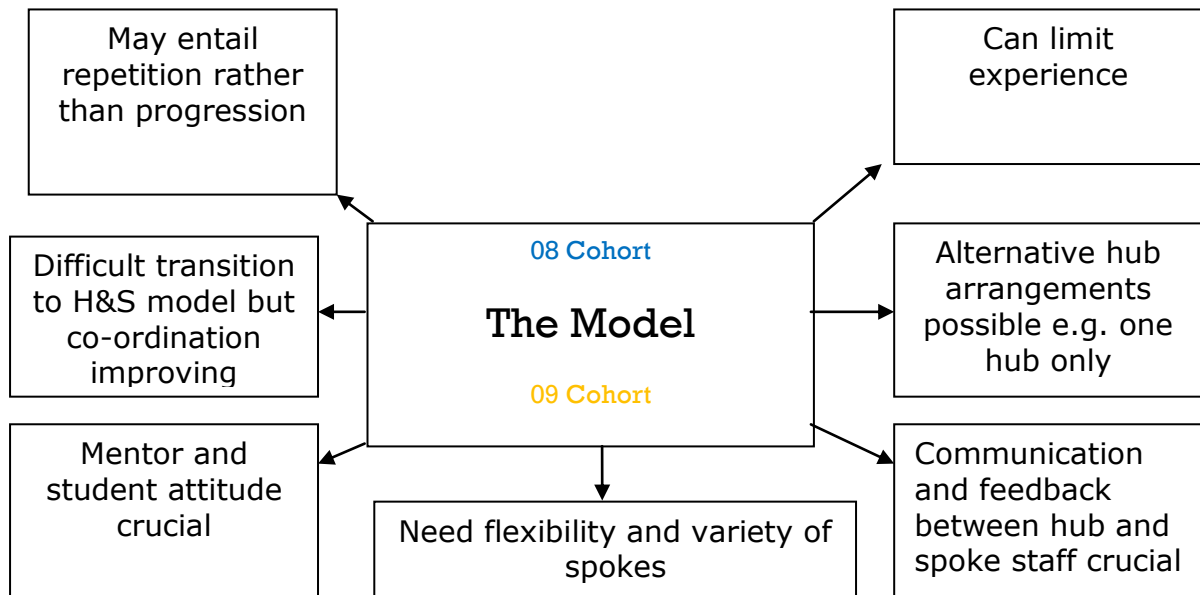
"So I got to do that and follow this patient. The patient was involved in the presentation. She gave me her version of events, then I did it versus the notes version of events and then she got a copy of the presentation at the end. Then my mentor and her had a discussion about me. So yes, she was actively involved the whole time but I know her from first year...." (student E, 09 cohort; focus group 1)

"Some ward patients I met on CPN/outpatient appointment. Relationship already developed" (student 09 cohort Time 2)

"I was able to take up the relationship from the ward, and use it fruitfully so much so, even I had a one to one with patients' mum, patient's mum while the CPN was talking to the patient. Because I could see it was quite an emotional experience for the mother. And you know one of the research shows most patients have like almost trauma when they are first admitted as an experience, and you imagine that for the family it is quite traumatic as well also. So I was able to pick that up on the general , and go and talk to her in the kitchen, as a one to one person, I was able to, you know, built up a therapeutic relationship with the mum and leave the CPN to it. And the family had that experience in an acute. And I was able to take it from there so it was very fruitful" (student C, 09 cohort; focus group 2)

4.2.2.3 The Hub and Spoke Model as a whole

Although there was some polarisation between the cohorts, students generally were able to reflect not only on the strengths and weaknesses of the model as experienced to date, but also on factors that could optimise its success (Fig 8).



"I can see the benefits of the hub and spoke model, but I think it is more important to get a variety of learning experiences in different placements rather than going back to the same hub, as there are only so many spokes related to your placement you can go on" (student 08 cohort)

"very much what I did in first year, I did again in second year.....there is not really much difference in what you are really doing. When I go back in 3rd year, I will be doing pretty much doing the same kind of stuff to what I was doing already" (student A, 08 cohort; focus group)

Undoubtedly the transition to the new model was most difficult for the 08 cohort.

"because the new system was coming in – there was a big transition, it took a lot of organising. I appreciate that. But I don't think that anyone of us felt, was really consulted about it before hand. And I think we don't, came on a course, we applied for a course that is essentially different to what we are doing now"
"I've talked to some people the year below - they work on the bank as well. It seems to be a bit better coordinated and administered. But ours seemed to be

two weeks before we go - "there you go" and we went "oh" (student B, 08 cohort; focus group)

".....there just doesn't seem to be any feedback much from your spokes back to your mentor and I think all of those experiences need to be taken into consideration" (student C, 08 cohort; focus group)

The key linking role of the mentor was also recognised by the 09 cohort who tended to emphasise the student's own contributory role in making the model work.

"A supporting mentor who is interested in your learning is vital to making the Hub & Spoke model a success" (student 09 cohort Time 2)

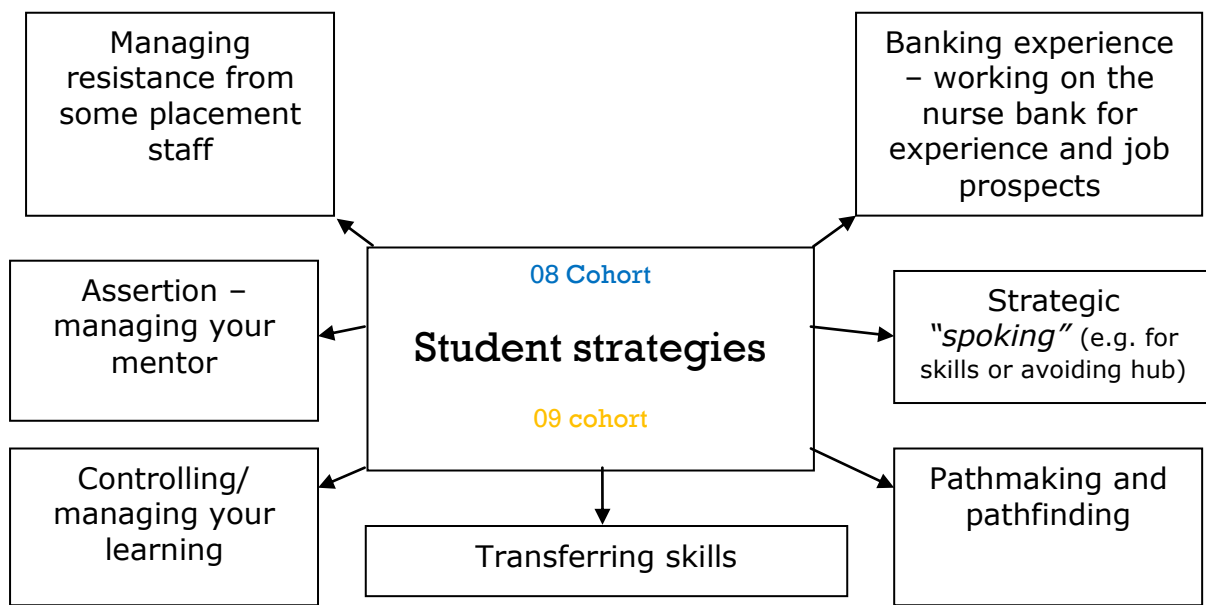
"I like the hub & spoke model. The rooting relationships with staff & patients have been firmly cemented and as we return in 2nd and 3rd year to the same hubs, these relationships can be built upon with consistency of same mentors. Great for following patients journey. Also a great sense of 'belonging' for students" (student 09 cohort Time 1)

"you get out of the model what you put into it, so if you are keen and want to experience opportunities you can do" (student 09 cohort Time 2)

"I think flexibility is the key" (student C, 09 cohort; focus group 1)

4.2.2.4 Student strategies

In addition to the more predictable thematic areas that have been described above, one of the key themes to emerge related to students' own strategies towards their learning in general, and more specifically to negotiating the hub and spoke model (Figure 9 below).



"Although it's a good idea (hub and spoke) it limits gaining experience. I have had a chance to work on the nurse bank at (main hospital) but some don't when a job comes up, they take the known faces with experience on the bank" (student 08 cohort)

"All these different areas in a hospital that I have not really had much chance to utilise, but I mean we have all made a big effort to get those opportunities in other ways like working with the hospital and the nurse bank and things like that. But a lot of us have done that, yea. Perhaps about half our class are on the bank and that's how I have managed to get forensic experience, and acute experience, and so it has been challenging but fortunately both my placements are incredible. My mentors are really good and I have learned a lot and I have tried to make the most of it" (student B, 08 cohort; focus group)

In addition to "banking for experience", students had some proactive "spoking" strategies to obtain skills and/or avoid particular settings.

"I do feel that only having 2 placements is restrictive in your learning and many students have joined the nurse bank to get experience in other areas, many students also use spokes just to go to other areas and not areas that are relevant to the service user" (student 08 cohort)

"I did my dementia placement. I think in the total of 14 weeks. I think I was maybe off 5 or 6 of those weeks. And I think it was because it was a placement I didn't enjoy the most. And I tried to get myself away from the ward for however many weeks. But when I came back, I felt lost because there had been new admissions, new patients had come in, didn't have clue, it was like starting all over again" (student A, 08 cohort; focus group)

The 09 cohort were particularly proactive in managing their own learning through planning and pathfinding.

"However, I have made my own path and thanks to spokes, I have had a really positive time and I've really enjoyed doing the spokes" (student E, 09 cohort; focus group 1)

"I was very lucky. I planned what I want to do when I went back, my mentors were thinking along the same lines and they had already arranged, which I am very lucky, exactly along what I had thought. They are very interested in my career and what would be of benefit to me" (student G, 09 cohort; focus group 2)

However the process was not always smooth and could involve managing staff resistance and being assertive.

"I think sometimes you've got to do that (be assertive) in order to get where you want to be. I know that sometimes, it's not easy. I had to work on a different shift pattern than the nurses and I basically had to find somebody out and say 'You, you don't know it yet but you're going to be .. to show things.. what to do .. to get into the swing of things" (student E, 09 cohort; focus group 1)

"The difference between second and first year I found is the general negativity, I mean where ever you went, they were all like, what are you thinking, because you won't get a job, you are not going to be qualified because you are not doing it and you are trying, I felt as though I was fighting. Not my mentors, but in others wards. Fighting the model itself, and going , no it does have some benefits, you know, you can do this, this and that, it's quite a good thing. But probably a fear factor because they were used to this old ways, and it worked for them and it is far better. You had to fight it constantly, though when I am, went back in second year, I didn't get that as much" (student G, 09 cohort; focus group 2)

Finally, there was evidence that students could proactively transfer skills between settings using strategic thinking about patient and family benefits.

"I found I took some skills and knowledge that I had picked up from CNPs and took them back to the wards, and they saw the benefit of me and the ward in general. People that are ready for discharge, patients we discharge, we have got bed blocking , also got people that are on delayed discharge which is basically we are waiting for accommodation, so they are sitting twiddling their thumbs in the ward till it happens. So if we have got the skills they are using the CPN, you can start taking in your WRAP and things. I can see great benefits for me following patients' journey because I can see what they do, I can give them a head start by saying I can actually start the WRAP for you in the ward. Therefore, you are going to community, you start it, like two or three meetings, and they are just asking questions, and not doing any interventions. But if you started that in the wards, they could hit the ground running" (student C, 09 cohort; focus group 2)

4.2.2.5 Balancing depth and breadth

In concluding this section on students' experiences it is insightful to listen to the 09 cohort of students talking on a "meta-theme" that inhered within and across all the other themes.

Box 1: Students' talk on breadth versus depth of learning

Student B *"I think on this last hub placement, I did get a bit of variety. The first placement I did on [X] ward, I had a different mentor who was very good but quite set in his ways and I had to really fight to get a one day spoke on an acute ward. This time, I felt I got a lot more variation because my mentor suggested I go to [Y] ward for two weeks and [Z] for one week and really, that was quite a bit of variation because I learned quite a bit about different types of dementia and particularly about activities for people with dementia because I helped the activities nurse. I enjoyed one of the spokes so much, I begged to do another week. There was plenty of variety although my original ward got a bit 'sameish' as it was task orientated. Because dementia patients can be slightly more unpredictable, you never knew what each day was going to bring. So I think there was variety from that point of view as well."*

Student C *"I don't think they're mutually exclusive. I don't think that you can have one without the other. I think you can have depth and variety together. I personally don't think I need to go on a spoke for two weeks to get a flavour of how it is. I think I can go on a spoke for a day and that can be quite sufficient to see how the workings of that spoke are undertaken. I don't necessarily have to do a big chunk of time and it can be a big chunk of time if you've only got thirteen weeks and you're doing maybe two or three weeks for one spoke. Then you may be compromising your time on the ward. So I quite like the idea of variety and doing little bits of time but getting a much wider variety, a much wider flavour, a greater breadth of what's out there and make the connections. It might not be in the depth that I would get if I were spending two or three weeks at a time but I still I feel I'm getting enough of a flavour to know whether I'll like it and that I'm actually getting something from it. It's a learning experience – I'm actually getting something from it. And of course, you can always revisit it as well in the next spoke. That's something you can re-enforce your learning on. So I like the system as it is the moment. I don't think you need large chunks of time."*

Student E *"I think I spoked more in the community than when I was in the acute ward but the community can be quite repetitive, quite a lot of, I'm not going to say sitting around because you're not, you do utilise your time. However, that time could be better utilised on a spoke. However, when I was on an acute ward, you don't know what's going to happen from one day to the next ... and you don't want to miss things like that. I think I probably wont spoke as much when I go back on this next placement, purely because I think I can get all the benefits from the ward. Whereas, in the community, it's fine to spoke about a bit more."*

(continued over)

Student A *"That's what I did, I used the community for spokes because I did find there wasn't a lot of clinical stuff to be done. When I got back on to the acute side of things, I used the time to really get these skills back in play. I've been forward planning so as long as you're keeping up those skills because I found when I went on to placement in the acute, and I felt a lack of confidence. But after the first injection or whatever, you kind of build it up so the opportunity for spoke was ... needed to keep on to the clinical side of things as well."*

Student C *"That's where I think the Hub and Spoke model becomes quite fluid. When I go back to my second placement now, I think I've done all the spokes I can possibly do which reach out from that placement...so now really, from this second hub placement, I'll be concentrating my efforts more on the therapeutic side of dealing with the patients, talking therapies and how to deal with patients on a more intense level than I have on my first placement which was obviously more superficial because I was on a more observational role. I probably won't be accessing as many spokes on this second placement of second year."*

Student D *"The thing is though, it's OK saying that but I got on one spoke and I had to fight for that spoke. I had arranged three spokes and two of them, I was pulled back because they were short staffed and one of them, I wasn't even allowed to go to. And 99% of the time, they were that short staffed, they just turned round and said 'Oh you're the unpaid member of staff' so you're not going to get on. It was the manager who was saying that, not the other members of staff. I think the hub and spoke is a good idea in theory but in practice, it doesn't work."*

Student E *"It is great if you can get the full learning experience from it and if you can benefit from it. ...You need to get the mentors and the wards ..."*

4.2.3 Perceptions from representatives of users of NHS mental health services

As indicated in Section 4.1, it was only possible to interview two such representatives. Neither of those interviewed had direct recent experience of interaction with RGU student mental health nurses and, on the basis of limited discussion with their colleagues, they were not aware of the particular change in student placement arrangements or any specific impact. Nevertheless they were both positive about the general idea of the hub and spoke model and its particular aspirations for students to follow service user and family journeys through services.

4.2.4 Perceptions of key HEI and NHS staff

As explained in Section 4.1, eight such staff contributed written responses towards the end of the project.

4.2.4.1 Perceptions of key NHS staff

The two responses from senior NHS staff involved in the development and implementation highlighted several key preparatory processes:

"Involvement with practice from early stages in development. Communication with mentors in placement. Both they and students need to understand the model and reasons for changing previous one"

"Giving staff the opportunity to comment on the model. Employing practice based facilitator to identify hubs and spokes. Ensuring staff understand the rationale for the model. Preparing existing students for the change"

The model was generally seen as a success to date.

"Both students and mentors having more control over direction they take during placements. Greater feeling of involvement in ongoing development of students by mentors. Evidence of planning over time"

"Students returning to placements yields closer staff/mentor relationships. Feel part of the team. Students gain better understanding and recognition of the patient journey and experience. Staff are more inclined to raise and challenge concerns they have with student on issues of competence and professionalism, thus students are supported earlier"

However at a time of service constraint and redesign, there were also difficulties.

"There has been problems within capacity in some of the clinical areas. These areas have also seen high levels of clinical activity. Some mentors have seen problems in providing learning opportunities to meet all of the needs of the students"

4.2.4.1 Perceptions of key HEI staff

Most of the six HEI staff who responded were supportive of the model and many of their comments echoed those of their two clinically based colleagues. Key preparatory processes had involved:

"Clear information to students regarding: placement types; placement options; procedures for any issues; spoke options. Clear information to ward managers and mentors. Hub and spoke model broken down into expectation and practicalities for each stage of programme. Identification of processes for both HEI and non NHS areas"

It was widely acknowledged within the HEI that the implementation process was developmental and ongoing:

"processes being refined for each intake and procedures in place as issues arise"

A number of areas of success were identified, and many of these had a forward orientated, prevention-focused quality.

"Students and mentors contacting each other in advance initially and prior to next placement (sometimes months in advance). Mentors given information early so can plan and notify PEF/PEL if any problems arise ie long term issues, placement/service redesign etc. Mentors quick to raise cause for concern issues to PEF/PEL so that action plans are put into place (recently change noted that stage 1 concerns have increased, dipping in stage 2)"

Moreover the student –centredness of the model could have specific benefits.

"I can see the potential positive benefits of this model; the opportunity for the student to develop closer working relationships with clients and staff; the greater opportunity for the mentor and team to assess the students competence; and from a disability perspective, the potential for the student to have a more positive experience. For example, some students with dyslexia need longer to orientate themselves to the practice area and learn the names of staff and clients, along with the types of common medications, conditions etc"

Areas of difficulty that had been addressed but persisted involved: (i) inability always to meet student wishes regarding placement area choices, especially due to capacity issues in practice areas where redesign and closures impacting (ii) some problems with student and mentors not being able to work together, and (iii) manpower issues for HEI staff in order to identify placements and make allocations.

In addition to these aspects, two staff had a range of more in-depth concerns about the nature of the new model and its implementation.

"I have questions/concerns about the equality of experience and quality of 'spokes' – we do not have a clear list of where students have been on their spokes This does then lend itself for students to have quite different profile of learning and I am not sure we are clear that the quality of experience and learning opportunity is of an acceptable standard for every student"

"It is not clear how the mentor is informed regarding student attendance and behaviour while on a spoke. There do not seem to be any rules about how many spokes would be expected during a placement or whether all students should access all spokes and who decides what takes place. There is no record of the learning provided by each spoke and processes for organising spokes are not clear"

These concerns relate not only to HEI consistency and control but also to NHS sustainability.

"This model needs to be kept under control, so all students get equity of opportunity. More rigorous recording is required"

"It has to be sustainable and utilise existing structures – the reliance on clinical staff to manage this model may not be sustained"

The contrast of emphasis in other staff summative evaluations was marked.

"This has been a worthwhile exercise as it has given students and mentors ownership of learning & development (within their own area of responsibility) which can only be good for developing the skills required of a mental health nurse"

4.3 Key developmental and preparatory processes involved for implementing the model

This sub-section of the findings relates specifically to question 1 of the study i.e.: what are the key developmental and preparatory processes involved for the HEI and its NHS partners when introducing this hub and spoke placement model? Most of the pertinent data relating to this question has been reported in the foregoing sub-sections which presented perceptions from the stakeholder groups. Generally agreement was found across the groups on the key processes, but views varied about how successfully they had been carried out to date.

Accordingly, key developmental and preparatory processes are now summarised:

- Key actors from HEI and NHS spending time working up and working out the model: consensus around the aim of the development
- Early engagement with practice, especially with managers and mentors
- Explaining the model and its rationale to mentors, students and other staff: communication and feedback essential
- Use of roadshows and/or workshops to the above ends
- Practice based facilitator essential to identify hubs and spokes
- Developing and sharing clear operational processes and procedures

As other findings have shown, enactment of the latter point is somewhat contested in feedback from a range of participants, particularly around the experience of spokes. Indeed the issue of how much prior guidance and regulation should be undertaken before implementation is a fundamental one. On the one hand there was a desire from some key actors within both the HEI and NHS to free up the system and encourage flexibility/creativity.

"Promoting flexibility in service areas which will enhance learning for students (depth and breadth of experience) and enable them to meet NMC standards"

On the other hand, as reported, there was a felt need to regulate experiences.

4.4 Key factors that appear to influence the success of implementing the model

This sub-section of the findings relates specifically to question 3 of the study i.e.: what are the key factors that appear to influence the success of implementing the model? (e.g. in terms of local placement related factors, NHS strategic management related factors, and HEI related factors). Again some of the pertinent data relating to this question has been reported, either explicitly or implicitly within stakeholders' perceptions. While there was some agreement found across the groups on the influence of individual factors, there were more varied views about the extent to which each had manifest and generated positive impact.

Given that key preparatory factors have already been identified, key influencing factors pertaining to subsequent enactment are now listed:

- The beliefs and attitudes of individual mentors, clinical colleagues and students
- Commitment and support of key HEI leaders and managers
- Adaptation of roles and support of HEI academic and administrative staff
- Commitment and support of key NHS leaders and managers during significant service redesign and cutback
- Early awareness and sharing of information about any service re-configuration
- Availability of a wide range of placements with sufficient capacity (balance of hospital and community settings in relation to changing patterns of provision)
- Creativity in identifying other suitable placement settings
- Awareness and promotion of student engagement with service user and family journeys through care systems
- Having a practice based facilitator and practice team to drive forward the changes
- Structures such as CLETS (Clinical Learning Environment Teams) can be an essential conduit
- Similarly a mentor forum and training opportunities for mentors were seen as essential for the model to work

- Sufficient incentive and flexibility for students and mentors to plan and deliver productive learning experiences
- Sufficient clarity for students about structures and processes for placements (e.g. prior guidance for first placement students around spokes; recording of spoke experiences)
- Sufficient clarity for mentors about structures and processes for placements (e.g. requirements regarding communication and feedback between hubs and spokes)
- Willingness to identify and manage the degree of risk that comes with affording somewhat more control of learning to student and NHS staff than may have previously been the case

Reflecting on the above list, the first point emerges as fundamental across the findings. Without committed staff and students no placement model can prosper. Reflecting on the other points, it is reasonable to say that some remain more aspirational in nature than others. Nevertheless, these are the factors that would appear from participants' perceptions to dispose towards successfully influencing implementation of this particular hub and spoke model. In the next section of the report the study findings and their meaning are considered in the wider context of relevant literature and developments elsewhere.

SECTION 5: DISCUSSION

5.1 Limitations of the project

Before discussing the findings it is important to note the limitations of this study. Clearly the evaluation is limited to one HEI and three Health Boards and pertains only to the early stages of the model's implementation. Moreover, as Section 4.1 makes clear, there were relatively low levels of participation from some of the key stakeholder groups. While some of this can be attributed to the frequent need to rely on third party distribution of questionnaires, "evaluation fatigue" may also be a relevant factor as it is known that several other such studies were running during this period. This was also the case for the student population. As such, our interpretation of findings proceeds from an acknowledgement that caution is needed in considering the evaluation study's representativeness and the scope for related generalisations.

Contextual limitations also influenced the development and implementation of the project. NHS staff and their managers were naturally pre-occupied with maintaining delivery of clinical services at a time of particular service constraints and redesign. There were some difficulties in sustaining NHS infrastructure to support implementation of the model in the context of severe budgetary restraints and there was related delay in the appointment of the project secondees. The absence due to illness of several key project staff also was an inhibitory factor to progress.

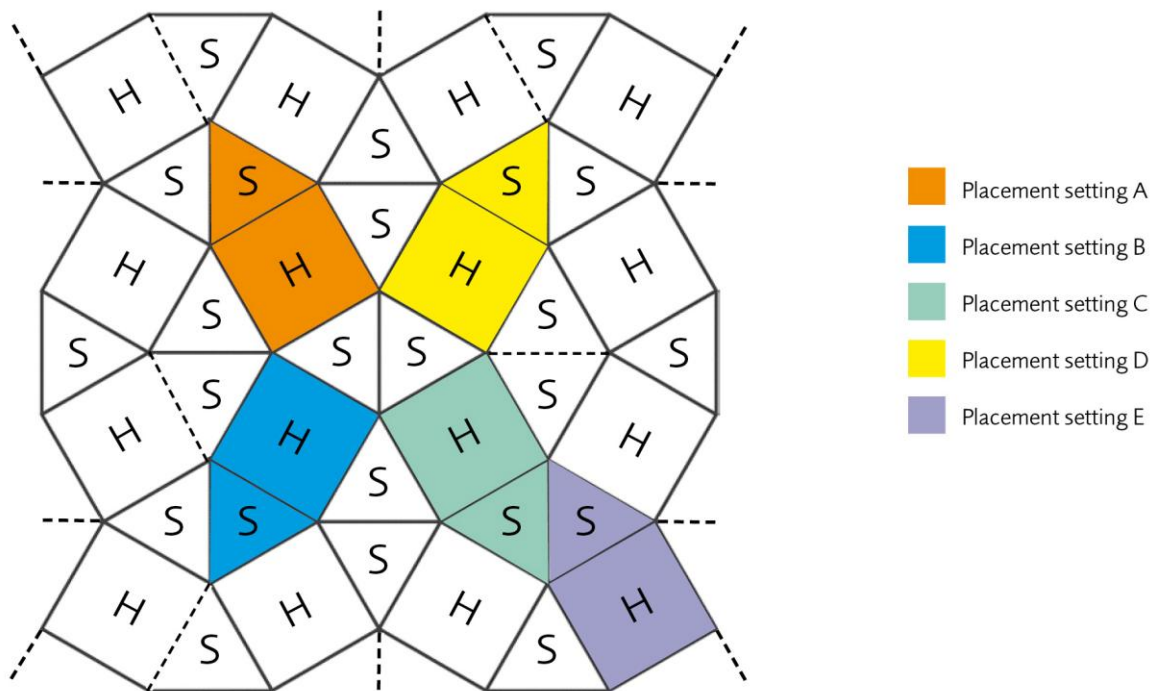
Nevertheless, it has been seen that the model has been implemented on a whole course basis across all cohorts undertaking mental health nursing and in all approved mental health practice learning environments, involving 80 students and 36 learning environments in total. Accordingly, it merits further analysis.

5.2 What does this study add to the wider literature?

In considering the above question, it is firstly useful to revisit the nature and scope of this particular hub and spoke model. One striking feature of the RGU model is the number of clinical settings that are acting concurrently as hubs and spokes. A second feature is the relative success in opening up more community and more specialism based placements, with largely positive feedback so far from staff and students. Within this context the portrayal of hub and spoke

placements as envisaged in Section 1 seems rather too simplistic. Rather the enacted model might better be depicted as a more complex network of linked foci (placement settings) where many of these can be both hubs and spokes simultaneously, and where connections between some are stronger and more defined than others. Figure 10 below attempts to reflect this.

Figure 10: Matrix depiction of hub and spoke model



Thus a student might have setting A above as their acute hub and setting E as their ongoing care hub. Setting A would offer a range of established spoke opportunities (denoted by connecting continuous lines) and at least one spoke pathway that could be seen as more tentative and developmental (denoted by connecting broken lines). Placement setting E may require the student and mentor to be more proactive in finding pathways to spokes and perhaps establishing links outwith the established matrix.

As such, Figure 10 attempts to portray an open and evolving system that incorporates another striking feature to emerge from the study, namely the range of strategies that students used to manage their learning within and between these placement settings. Amongst the 09 student cohort in particular there was a strong sense of student agency, with evidence that they actively

planned and constructed their learning pathways within this formative new model. To hear students verbalise the noun by talking naturally about “*spoking*” (as in Section 4.2.2.5) is to gain some evidence of the model impacting into culture.

All the above points add to the rather limited evidence on hub and spoke models summarised by Campbell (2008). Our findings to date seem to confirm some of the envisaged benefits of hub and spoke models that Campbell identifies for mental health applications such as:

- (i) Being stimulating and motivating for students, and developing familiarity, belongingness and continuity
- (ii) Helping hub mentors to draw on knowledge and expertise to support students in specific learning objectives
- (iii) Making it easier to form connections between education and practice

Moreover our findings yield good evidence from a number of stakeholders that students are able to follow service user and family journeys through care services.

However the “jury remains out” as to the extent to which it necessarily expands learning opportunities and enhances learning experiences as promulgated within Campbell’s review. The “banking experience” sub theme shows the value that students place on breadth of learning, although other factors also contribute to students working as bank nursing assistants, and this trend predates the introduction of the hub and spoke model.

It also remains to be seen how well the model can address some of the challenges identified by Campbell. In this regard some concerns were raised about communication procedures between hubs and spokes, consistency and quality of student experiences, and related documentary recording processes.

Much of the difference between the student cohorts reactions to the new model can be understood in relation to timing. For the 08 cohort it arose quickly, was felt to be somewhat disruptive, and exacerbated concerns about breadth of experience and future employment. In contrast the 09 cohort knew no other model. Both cohorts, and a number of NHS staff, confirmed that the co-ordination of the model improved over the first year of implementation. Looking

across the data there is a sense of emerging benefits with the new model for students, mentors, colleagues and, ultimately, service users. However more work is needed to address the service/setting issues that have emerged.

5.3 Key issues and implications for wider application

Taking this analysis further, it is possible to identify a number of key issues that relate to the future development and implementation of the RGU model, but also may have wider currency. In effect this addresses question 4 of our study: In light of the strengths and weaknesses identified, what are the implications for possible wider application of this model? These issues are now framed as four questions with indicative initial answers.

1) Can more development of spokes provide enough variety and depth of relevant experience to counteract perceived restrictions/limitations of hubs?

Locally it is planned to extend the period of employment of a practice based implementation facilitator, so as to identify new placements and enhance the quality of existing ones (e.g. by developing more guidance on procedures and processes). Regarding the latter, there are some relevant examples available on the world wide web such as those of the University of Nottingham:

<http://www.nottingham.ac.uk/nursing/students/gnc/models/index.php>

These guidelines make a distinction between spoke visits (lasting 2 weeks or more with a named mentor) and insight visits (typically lasting one or two days). Within the RGU model, such a distinction may be helpful towards achieving more clarity for students and staff.

One of the lessons for possible wider application of the RGU model is that substantial time and effort is needed to prime practice areas and to develop capacity and diversity of relevant spokes. However one of the key strengths of the RGU model is that this time and effort is contributing to an integrated, whole systems change rather than occurring in isolation. In effect stakeholders are engaged together in making the transition to a new way of working and learning and are experiencing the challenges as well as benefits as the model becomes more embedded. From the very limited feedback that the evaluation obtained from service user representatives, it is evident that more work is needed to promote the involvement of this group of stakeholders in these developments.

2) *Can more structured operational policies be developed to guide staff and enhance consistency without stifling creativity and innovation?*

This relates to the issue of regulation versus innovation. One of the striking features of the RGU implementation has been the relative dearth to date of written policies and procedures for the hub and spoke model. Although the evaluation found evidence of a desire for more guidance from some students and staff, there was also evidence that students and staff felt that the model freed up opportunities for innovation and autonomy. It could be argued that the pre-existing good will and productive working between the three Health Boards and the HEI around mental health nursing education enabled an element of risk to be managed, with productive consequences. This may be useful for possible wider applications of such models. In effect more useful guidance may grow from evaluation of initial experiences rather than prescription and proscription. As such it would be useful now to produce more documentary guidance locally. The policy for hub and spoke placements produced by the Universities of Salford, Manchester and Manchester Metropolitan provides a very detailed example from which some learning points could be taken: <http://intranet.nursing.salford.ac.uk>

3) *What impact might the model have on student attrition and retention?*

Although the evaluation did not set out to directly address this question it is very much a relevant concern, given the ongoing body of Scottish Government work on recruitment, selection and retention (Scottish Government Health Directorate and NES 2010). The local figures show that to date three mental health students have discontinued from the 36 starting in September 2009, as have four from the 20 starting in September 2008. A formal evaluation of reasons for leaving and other associated factors would have to be undertaken before attempting to make any attribution of attrition to the hub and spoke model. However it is certainly worthy of consideration. Interestingly a number of stakeholders mentioned that the model actually helps towards earlier detection of student problems due to the continuing involvement with a named mentor.

Thus it will be useful to formally track instances of cause for concern within each mental health student cohort. This could run alongside study of student retention/attrition rates for the cohorts involved in the new model, with

comparison to rates in previous mental health nurse cohorts in RGU and concurrent adult and branch specialisms.

In order to interpret the significance of these rates and any relationship to the new model we would require to: (i) draw on routinely collected departmental data such as reasons for leaving identified at exit interview (ii) incorporate specific questions into existing stakeholder questionnaires and interview schedules in order to explore any perceived impact of the new model on reasons why students stay or leave, and (iii) conduct brief interviews with a group of four RGU Personal Tutors to explore the latter questions.

This work would have direct relevance to the priorities of the Scottish Government Recruitment and Retention Delivery Group.

4) *Is the model sustainable in practice and could it be extended to other programmes such as adult nursing?*

Our study has shown that the model can be introduced and yield some promising initial results even at a time of great constraint on both the NHS and HEI sectors. Crucially, however, this has been done from a basis of productive prior working between these local sectors, particularly in terms of commitment to initiatives ensuing from the Review of Mental Health Nursing in 2006.

While good prior relationships and planning seem necessary for implementing a hub and spoke model, they are not likely to be sufficient in themselves to sustain successful progress. Our study has shown that commitment to infrastructure within both sectors is very important, along with continuing extensive communication at strategic and operation levels. Within this ambit it is also likely that good leadership is a strong contributory factor. Moreover the foregoing presupposes sufficient congruence between HEI and NHS in terms of vision and values. As such, a number of factors have to continue to be fruitfully developed if this type of placement model is to be sustainable within mental health practice placement settings.

The wider question of whether this model might productively transfer to adult practice placements is a moot point. From the perspective of the evaluation team it has been inspiring to listen to students who are proactive in planning their learning, managing difficulties and engaging with service user perspectives.

Looking at the profile of both the cohorts studied they are more mature in years than their general (adult) student colleagues (and they also have a higher proportion of males). This may be a factor in their inclination towards a model which enhances student choice.

Undoubtedly the questions of placement capacity and consistency would loom larger if the RGU model was applied to larger cohorts. In the view of the authors it would be feasible, with forward planning, to implement whole course hubs for larger groups within other fields of practice. However it would be beneficial to take a more structured approach to the identification and implementation of relevant spoke experiences in the first instance, with a view towards subsequent enablement of more fluid “spoking” in response to patient journeys. Investment in identifying individuals to support the identification and development of spokes within services would also be recommended.

Interestingly, examples are beginning to emerge of innovative curricula which shift away from dependence on traditional placement settings. Arnott (2010) outlines a new pilot pre-registration adult nursing programme preparing a small cohort of students to work in the community and general practice setting at point of registration. A hub and spoke placement model has been developed. The aim is to “shift away from a “one size fits all” approach”. In Arnott’s words, “this calls for some innovative and creative thinking and a level of risk taking by educationalists and workforce organisations to prepare nurses to be fit for the future”.

Within this context, the information about number, range and scope of spoke experiences provided within our students’ Practice Learning and Assessment Documents (see Appendix 2 for examples) demonstrates the breadth of *patient-centred* practice learning experiences that a hub and spoke model can facilitate. These examples highlight the opportunities that students can have to experience the care of the patients/ clients they are working with across different nursing environments and services. Substantive interagency and inter-professional learning and working are also to the fore. Moreover, the model appears to have been relatively successful so far in facilitating students’ experience of more specialist environments such as CAMHS.

Taken together, the above factors suggest the potential of this model to proactively address specific future workforce requirements in a creative way. To this end pathways of hub and spoke placements could be designed to prepare adult nurses to care better for patients with dementia who are in general hospital in-patient settings. With the inception of the new standards for pre-registration nursing education (NMC 2010) it may even be possible to develop the hub and spoke practice placement model to support a dual qualification programme, for instance in mental health nursing and social work.

Indeed a possible benefit of a whole course hub approach where the student has the same mentor year upon year relates to the inclusion within the new NMC standards of a second progression point. Progression point 2 normally occurs when students are moving from year 2 to year 3, and includes the criterion "work more independently, with less supervision, in a safe and increasingly confident manner." Our findings provide some evidence that mentors feel in a better position to effectively assess students' achievement of this criterion when they have provided support, supervision and mentoring at earlier stages of the student's course.

In the short term it may be that a modified version of the RGU hub and spoke model could be usefully incorporated into new adult nursing curriculum developments. In order for any such developments to be optimally informed it would clearly be very valuable to further evaluate the progress of the hub and spoke model within the mental health field. In particular our findings suggest that further insights could be gained by following the progress of the 2009 student cohort up to registration and possibly beyond. Inclusion of the recent 2010 cohort would also be germane.

5.4 Conclusion

From the evaluation findings and the discussion above it can be seen that this study has achieved its objective of addressing all four of the substantive questions identified in Section 3.1. Overall it is evident that this demonstration project has made a promising start. Accordingly RGU and its NHS partner boards intend to continue to develop and implement the hub and spoke model. The project as a whole has also made an initial distinctive contribution to the evidence base on hub and spoke practice placement models within mental health nursing education. The development, implementation and evaluation of such a model across a whole programme is, to our knowledge, unique in Scotland. This complements the different approaches that have been concurrently evaluated in the Universities of Stirling and Edinburgh Napier respectively, affording cumulative possibilities for learning. To this end our strategy for further dissemination is presented below before a final section detailing specific recommendations

5.5. Dissemination strategy

- Local dissemination of findings to NHS and HEI staff through the CLET, mentors fora, Steering Group meetings, and seminar presentations
- Final report and executive summary to be available for full download through the NES and PIRAMHIDS websites
- Joint presentation with the other Scottish demonstration projects at the forthcoming Nurse Education Today conference, University of Cambridge, September 2011
- Seek to present at future Scottish mental health nursing conferences
- Prepare an academic paper based on this report for publication in a suitable academic journal such as Nurse Education Today or Journal of Psychiatric and Mental Health Nursing

SECTION 6: RECOMMENDATIONS

6.1 Local, focal recommendations

- 1) Development and implementation of the model should continue locally with particular emphasis on mapping, expanding and enhancing spoke learning opportunities
- 2) Similar hub development should continue with emphasis on profiling particular learning opportunities relevant to different levels of learning and proficiency as the student returns and progresses
- 3) The above work streams should continue to be enabled through the secondment of an implementation facilitator and ongoing input from the Practice Education Facilitator and Practice Education Lecturers
- 4) Further development of specific guidance for staff and students on processes relevant to the hub and spoke model should focus on: communication processes between hubs and spokes; recording of experiences; and updating of the Practice Learning and Assessment Documentation
- 5) The term "insight visits" should be adopted to describe very short spoke visits
- 6) More sustained effort should be directed towards engaging service user groups in the further development of the model
- 7) The RGU team should seek funds to further evaluate the implementation until at least one cohort has completed a full programme of hub and spoke practice placements. This should build from the current study by incorporating particular emphasis on the sustainability of the model and any relation to student attrition/retention

6.2 Broader, national recommendations

- 1) HEIs and partner Health Boards developing new approaches to curriculum design in all areas of pre-registration nursing should:
 - (i) Consider the potential benefits of a whole systems hub and spoke practice placement model in terms of enhanced continuity for students, staff, patients and families
 - (ii) Consider the potential benefits that hub and spoke placement pathways may have for addressing specific contemporary practice and workforce challenges
 - (iii) Consider the learning points for development and implementation generated by this project
- 2) The matrix depiction of an open, evolving hub and spoke system should be further developed in order to promote more advanced understandings of the inter-relationship and flexibility of hub and spoke practice placement settings

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9 If you have any other comments about the introduction of the hub and spoke model, please write these below.

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.....

10. We are keen to learn about your experiences of the new model in more depth. If you would be willing to take part in a brief interview (by telephone or in-person), please complete the attached consent form and return it in the FREEPOST envelope with this questionnaire. We would get in touch beforehand to arrange a mutually convenient date and time.

Thank you very much for making the time to take part in this evaluation.

Dr Colin Macduff, School of Nursing and Midwifery, The Robert Gordon University, Garthdee Campus, FREEPOST
AB313, Aberdeen, AB10 7GG 01224 262935 c.macduff@rgu.ac.uk

Indicative schedule for interviews with mentors and workplace colleagues

1) Check understandings - Purpose and format of interview. Consent form returned. Confidentiality. Is interviewee happy with this?

2) Check circumstances - Current role and work setting. Hub or spoke?

3) What has been your own involvement so far in working with the hub and spoke model in practice?

4) What do you see as the key processes/issues involved in introducing it?

Probe on preparation for change to new model. Comparison with previous model.

Explore new hub and spoke processes – student and mentor inputs, assessments documentation

Probe re student, mentor, service user/carer involvement/experiences and RGU/NHS joint working

5) Can you give any examples of successes/benefits in relation to the model so far?

What factors have influenced this?

Probe re student, mentor, service user/carer involvement experiences and RGU/NHS joint working

How might these be replicated/shared/developed?

6) Can you give any examples of difficulties/drawbacks in relation to the model so far?

What factors have influenced this?

Probe re student, mentor, service user/carer involvement/experiences and RGU/NHS joint working

How might these be prevented/reduced/addressed?

7) What do you see as the main issues for the future development of the model?

8) Any other comments –

9) If you had to give us one message for the evaluation so far, what would it be?

10) Check understandings (key points as I understand them)

QUESTIONNAIRE FOR STUDENTS TIME 1



The development, implementation and evaluation of a new approach to providing practice placements in the pre-registration nursing programme

1. What intake are you in? (e.g. Sept 09 etc.)
2. Where was your hub placement? Hospital Community-based primary health care
Social Care Setting

3 Please specify the setting/focus (*e.g. forensic unit, old age psychiatry etc*)
.....

4. What Health Board was the placement in? ...NHS Grampian NHS Shetland NHS Orkney

5 Thinking of aspects such as your learning experience, and relationships with mentors, staff, service users and families, please comment on your experiences of **hub placement** so far:

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6 Again, thinking of aspects such as your learning experience, and relationships with mentors, staff, service users and families, please comment on your experiences of **spoke placements** so far:

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7 If you have any other comments about the introduction of the hub and spoke model, please write these below.

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Finally, we are keen to learn about your experiences of the new model in more depth. If you would be willing to take part in a brief focus group interview in RGU, please complete the attached consent form and return it in the FREEPOST envelope with this questionnaire. We would get in touch beforehand to arrange a mutually convenient date and time.

Thank you very much for making the time to take part in this evaluation.

Indicative schedule for focus group interviews with students

1) Check understandings - Purpose and format of interview. Consent form returned. Confidentiality. Are interviewees happy with this?

2) Check circumstances - Current stage and work settings experienced on placements

3) To what extent have you had input into the choice of hub placements?

4) What has the experience of hubs been like so far?

Probe re student, mentor, service user/carer involvement/experiences, RGU/NHS joint working, assessment documentation

5) What has the experience of spokes been like so far?

Probe re student, mentor, service user/carer involvement/experiences, RGU/NHS joint working, assessment documentation

Input into choice? Planned spoke experiences? Opportunistic spoke experiences?

5) Can you give any examples of successes/benefits in relation to the model so far?

What factors have influenced this?

6) Can you give any examples of difficulties/drawbacks in relation to the model so far?

What factors have influenced this?

7) If you experienced the previous model, can you comment on any preparation for change to the new model?

Comparison with previous model? Greater depth?

8) Any other comments –

9) If you had to give us one message for the evaluation so far, what would it be?

10) Check understandings (key points as I understand them)

Indicative schedule for interviews with HEI staff and NHS managers

1) Check understandings - Purpose and format of interview. Consent form returned. Confidentiality. Is interviewee happy with this?

2) Check circumstances - Current role and work setting.

3) What has been your own involvement so far in developing the hub and spoke model and introducing it into practice?

4) What do you see as the key processes that have taken place so far (developmental and preparatory for its introduction)?

5) Can you give any examples of successes in relation to the model so far?

Probe re student, mentor, service user/carer experiences and RGU/NHS joint working

How might these be replicated/shared/developed?

6) Can you give any examples of difficulties in relation to the model so far?

Probe re student, mentor, service user/carer experiences and RGU/NHS joint working

How might these be prevented/reduced/addressed?

7) What do you see as the main issues for the future development of the model?

8) Any other comments –

9) If you had to give us one message for the evaluation so far, what would it be?

10) Check understandings (key points as I understand them)

APPENDIX 2: SAMPLES OF INDIVIDUAL STUDENT PATHWAYS

Collation of SPOKE Placements from HUBS: Student Record

Intake: SEPTEMBER 2009...

	HUB 1 – ADULT SERVICES Community Psychiatric Nurse	HUB 2 - Functional Acute Admission In-patient for over 65 year old service Users
	1st Rotation 4:01:10 – 22:03:10	1st Rotation 26:04:10 – 7:08:10
SPOKE EXPERIENCES ACCESSED	CPN Meeting - Presentation on Mentalisation and Group work in Sexually Abused Men- 1/2 Day	Adult Support and Protection – The Legislation and Local Policy- 1 Hour
	Art Therapy Group Afternoon Session	Physiotherapy in Mental Health – 1 hour
	Acute Admission In-patient Ward (Educational Meeting) 1 Hour	Fronto-Temporal Dementia – 1 hour
	Acute Admission In-patient Ward (CPN catchment ward) 3 Days	
	Art & Craft Group at voluntary sector advice and support drop in centre Morning Session	
	2nd Rotation 20:09:10 – 18:12:10	2nd Rotation 2:05:11 – 13:08:11
	Art Therapy Group Weekly Wednesday Afternoon Sessions	
	Work alongside Mental Health Officer – 1 Week	
	Work alongside Social Worker – 1 Week	
	Acute Admission In-patient Ward (CPN catchment ward) 4 weeks	
	Liaison Psychiatry - 2 Morning Sessions	
	Client Meeting with Hospital Chaplain - afternoon session	
	Child Protection Review – morning session	
	Sharing Best Practice Talk – Cognitive Stimulation by Caregivers for People with Dementia 1 hour	
	The Workers’ Educational Association Reach Out and Reach Forward – morning session	
	3rd Rotation 16:01:12 – 21:04:12	3rd Rotation 14:05:12 – 11:08:12

	HUB 1 –Assessment & Functional Illness Admission, Old Age Psychiatric Services	HUB 2 - CPN Adult Services
	1st Rotation 4:01:10 – 22:03:10	1st Rotation 26:04:10 – 7:08:10
SPOKE EXPERIENCES ACCESSED	Adult Acute Admission Ward (patient in HUB ward had been transferred from adult Acute admission Ward): 1 day	Community residential mental health unit; Weekly for social activities with service users
	Activities Nurse – 1 day	Acute Admission Inpatient Ward, (CPN Catchment ward) 5 days
	Occupational Therapist – 1 day	Night nursing experience in Brodie Ward – 2 nights
	Sharing Best Practice Talk – Cognitive Stimulation by Caregivers for People with Dementia: 1 Hour.	Out of Hours CPN service: 1 session
	Day Hospital OAP Services – 1 day	Out reach CPN to follow patient journey – walking group / art group etc. Weekly
		Visited local authority community centre with patient to find out what facilities, resources and classes were available
		Alternative Acute Admission Inpatient Ward, (CPN Catchment ward) 1 day
		Supported a service user with a learning disability to access Hearing Voices Network
	2nd Rotation 20:09:10 – 18:12:10	2nd Rotation 2:05:11 – 13:08:11
	Dementia Assessment Ward (managing distressed behaviours); involved in delivering therapeutic activities and personal nursing care: 2 weeks	
	OAP Ward for men exhibiting challenging behaviours associated with dementia, involved in delivering palliative care: 2 weeks	
	Activities Nurse – 1 day	
	Carers / Relatives meetings x 2	
	Medical Practice: practice nurses, leg ulcer dressings and aseptic technique	
3rd Rotation 16:01:12 – 21:04:12	3rd Rotation 14:05:12 – 11:08:12	

	HUB 1 Acute Admission In-patient Ward: Adult Services	HUB 2 CPN (Rural location)
	1st Rotation 4:01:10 – 22:03:10	1st Rotation 26:04:10 – 7:08:10
SPOKE EXPERIENCES ACCESSED	Podiatrist Clinic 2 days (patient journey)	Community mental health project – 1 day
	Treatment Clinic (Electro convulsive Therapy) 1 day	Independent residential addiction clinic – 1 day
	Burns and Plastic Surgery Clinic (patient journey)	Service user home visit with Social Worker
	Acute hospital Out patient assessment clinic (patient journey)	Employment support worker – 1 day
	Activities Nurse – 1 day	Rural mental health centre with client & support worker – 1 day
	Acute Assessment Ward - Old Age Psychiatry - 2 days	Supported accommodation in community for people with enduring mental health problems (city) – 1 day
	Dietician – in-patient services 1 day	Mental health officer, review of detained patients – 1 day
	CPN homeless service	Senior occupational therapist – home assessments – 2 days
	Gastro Intestinal Unit Acute hospital – 1 day (patient journey)	Substance misuse team (rural) , social worker - 1 day
	Mental health officer, Aberdeenshire – 1 day	Supported accommodation (rural) – 1 day
	Dental services – 1 day	Community Rehab Unit (city) - 1 day
	Psychiatrist clinic – rural – 1 day	Police interview of consultant & CPN following death of client – ½ day
	Eating disorder unit (talk)	Joint visit with Mental Health Officer to complete a single shared assessment and review health and well being of a client- ½ day

A & E department: treatment and care of people who overdose	GP/ community Mental Health Team meetings x 2
Home visit with service user & CPN	CPN support worker: craft group, shopping with clients – 2 days
Cardiac Department, Acute hospital – 1.2 day	Community support project – 1 day
	Horticultural training & therapy service (rural) – 1 day
2nd Rotation 20:09:10 – 18:12:10	2nd Rotation 2:05:11 – 13:08:11
Physiotherapist – 2 days	
Podiatry Clinic – 1/2 day	
Advocacy Service – 1 day	
Liaison Psychiatric Service – 1 day	
Ward - Learning Disabilities & mental Health problems – 1 day	
<i>Community Mental Health Team Remote location: 4 weeks</i>	
<i>Attached to all CPNs for a least one day</i>	
<i>Video conferencing meetings with multi-disciplinary team</i>	
<i>Video conferencing with service users in remote locations</i>	
<i>Community Support Project for alcohol abuse– 1 day</i>	
<i>Senior nurse night services</i>	
HM Prison – 1 day	
Hospital-based health and treatment clinic – depot clinic & clozapine clinic ½ day each	
3rd Rotation 16:01:12 – 21:04:12	3rd Rotation 14:05:12 – 11:08:11

