Designing for quality experiences and outcomes

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Introduction

To know whether something as complex as a programme of nurse education is successful we have to determine what 'success' looks like and then seek evidence to judge its worth. Whilst this may sound straightforward, those with an interest in the quality of nurse education - students, healthcare providers, commissioners, professional bodies, academics, patients, the university and the wider public - will each have their own, quite legitimate, perspective on success. Success to a student may mean good academic support and achievement, to a patient it may mean developing the competence and compassion for care, to healthcare providers it could mean readiness for employment within an evolving service, and to professional bodies it will mean the students' proficiency and fitness to practise for professional registration.

Whilst these perspectives on success are not mutually exclusive they do require education providers to design programmes that can evolve over the duration of their validation, accreditation or licensing period in order to maintain contemporaneousness, to draw on a range of data sources to evaluate learning quality within University and practice placements, and to demonstrate performance metrics that communicate the programme's worth. The worth of a programme is increasingly judged on the basis of value for money. Across the world, most higher education students take out government-funded loans or rely on family support and incur significant financial debt in order to complete their programmes, and hence there is expectation that programmes will lead directly to better pay graduate employment. There is also a highly competitive higher education market internationally and within most developed nations, and therefore the issue of designing for quality experience and outcomes takes on greater significance in order to ensure that degree programmes stand out from the crowd and are an applicant's first choice.

This chapter takes the reader on a journey exploring the different dimensions of quality and the measures that can be used to evaluate the student's learning experience, progress, achievement and outcomes. It will consider the most effective governance arrangements, exploring international perspectives that ensure internal programme coherence as well as the confidence of external stakeholders, which include the public as well as employers. By drawing on contemporary international evidence and experience of those leading in the field of nurse education, this chapter will help the reader understand the importance of quality whilst also recognising its value in achieving a competitive edge.

What is quality assurance in nurse education?

Quality assurance (QA) is a dynamic process that evaluates and judges the performance or value of something and then uses the judgements made to make improvements. In the context of higher education a nice simple definition suggests it is:

> *"The means by which an institution can guarantee with confidence and certainty, that the standards and quality of its educational provision are being maintained and enhanced." (ESIB 2002, p7)*

Similarly when applied to healthcare services, Kozier et al's (2011) definition succinctly captures some key characteristics:

> *"Quality Assurance is an on-going, systematic comprehensive evaluation of health care services and the impact of those services on health care services."*

Thus the dynamic emphasis of QA is on it being continuous (on-going), being based on good evidence (systematic) and all encompassing (comprehensive).

In the realm of nurse education the judgement of worth or value will be made against standards set by the professional bodies that accredit the programme and the higher education institution within which the programme is delivered. The QA process typically follows a cycle - see figure 1.

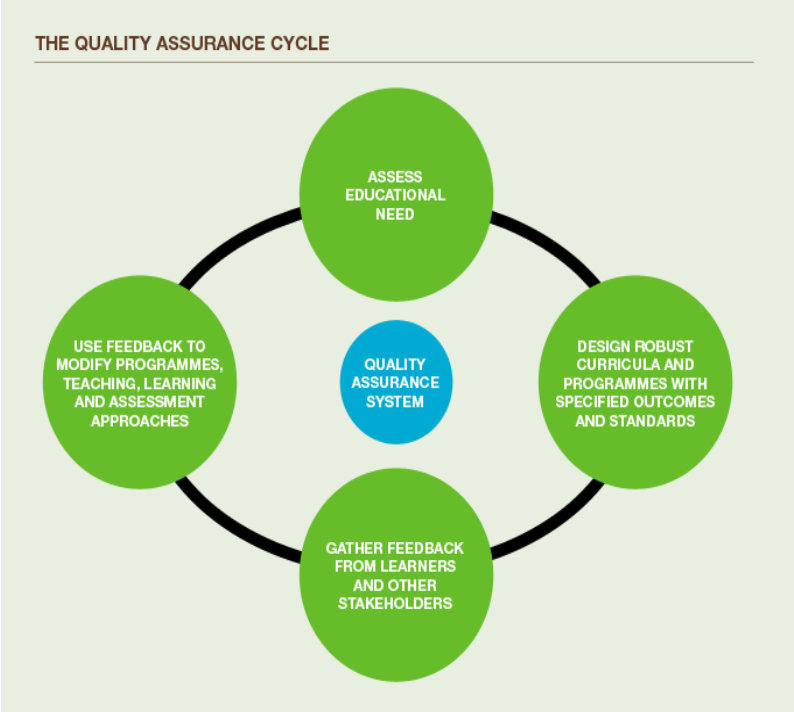


Figure 1 – The quality Assurance Cycle
From The London Deanery NHS London, 2012
http://www.faculty.londondeanery.ac.uk/pages/legal

Figure 1 illustrates the Quality Assurance Cycle as having four stages. Starting with the educational need, which is to prepare nurses for practice and registration, the second phase involves designing the curriculum against professional standards and outcomes required by stakeholders, the third involves gathering feedback from learners and other stakeholders and the fourth focuses the use of feedback to make modifications. We shall explore each of these phases in more detail throughout this chapter.

What are professional standards?

In considering the 'educational need', where an education provider is seeking professional accreditation for their programme they must first examine the standards that must be met to achieve accreditation. In the UK the professional standards are determined by the Nursing and Midwifery Council (NMC 2010). Similarly in Australia it is the Nursing and Midwifery Board of Australia who set the professional requirements, in New Zealand it is the Nursing Council of New Zealand, while in South Africa it is the South African Nursing Council. This pattern is replicated throughout the world.

The professional standards involve the development of criteria based on what are considered by the profession to be standards of care and norms of professional behaviour. These norms have typically been established over time, by members of the profession considered expert in the care of specific patient populations, including adults, older people, children, neonates, people with mental health problems or learning disability and so on.

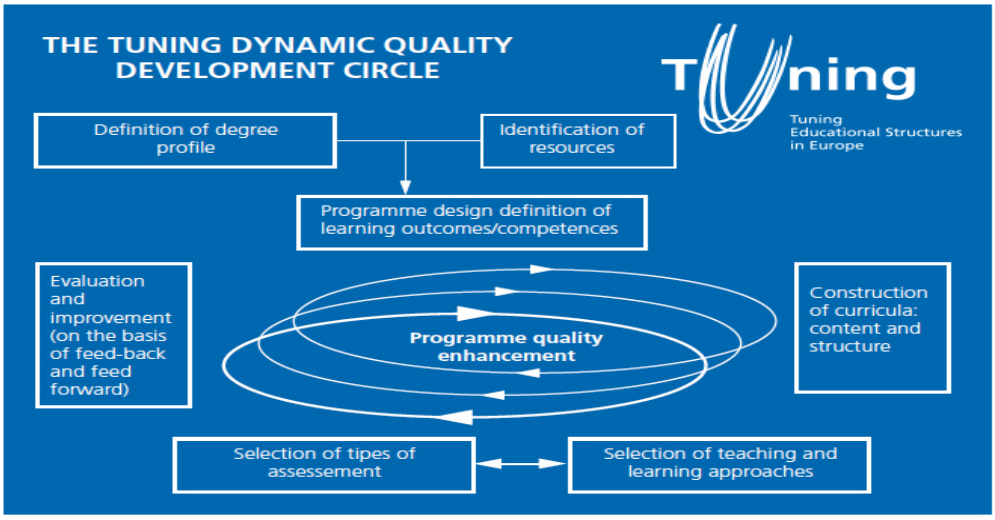
In addition to country-based professional standards there are also regional and international standards. The World Health Organisation in 2009 published its 'Global standards for the initial education of professional nurses and midwives' which had the sign up and endorsement of all 193 member states to attempt to improve education attainment and assure the quality of nurse education programmes throughout the world.

In relation to evaluating quality the stated aim is:

> *"establishing benchmarks for continuous quality improvement and the progression of education in nursing and midwifery" (WHO 2009)*

At a regional level, such as in Europe, there are European Union standards for nursing and midwifery. In 2009 guidance was produced to support the implementation of the Munich Declaration, which seeks to encourage all relevant nursing and midwifery bodies to strengthen their focus on nursing and midwifery education in order to improve standards and access into higher education. It also called for the necessary legislative and regulatory framework within each member state. In Europe broader education quality is underpinned by the 'Tuning' process. This started in 2000 and involves an approach to (re-)designing, evaluating and enhancing quality in first, second and third cycle degree programmes. It is not about uniformity but about seeking points of convergence and developing a common understanding. The model below (figure 2) illustrates the Tuning Quality Development Cycle (González et al 2008).

Figure 2: The Tuning Quality Development Cycle



Higher Education Standards

Alongside professional and regional standards and frameworks described above there are also country specific higher education institutional standards which in the UK are set are set by the Quality Assurance Agency (QAA 2014). In Australia it is The Tertiary Education Quality Standards Agency (**TEQSA 2018**) whilst in Hong Kong it is the Council for Accreditation of Academic and Vocational Qualifications (HKCAAVQ 2007) with similar agenices existing in US, New Zealand and Singapore. The UK QAA quality code sets out the expectations on those delivering degree level nursing programmes. There are three sections. The first refers to expectations on the institution. Specifically this means the University must have transparent frameworks and regulations to oversee the awarding of the qualifications so that the QAA is confident that academic standards are maintained irrespective of the subjective of that degree. The second section is concerned with assuring and enhancing

academic quality and the third sets out expectations for higher education providers to produce clear and concise information for their intended audiences such as students, parents and employers and government, about the learning opportunities offered and providing assurances it is fit for purpose, in terms of accreditation, accessible and trustworthy. Similar approaches are used or are in development around the world. In Africa, the Pan-African Quality Assurance and Accreditation Framework (PAQAF) has recently been designed to harmonize higher education quality in Africa, and there is recognition of a need to develop minimum standards within other countries and regions such as the Arab States, Asia-Pacific and Europe (Garwe and Gwati, 2018).

Therefore the design of a programme of education for nurses should take account of the international, regional, national context in order meet the standards set within professional, educational and institutional frameworks (see figure 3).

Figure 3 – The realms of standards that inform nursing curriculum

Developing local engagement

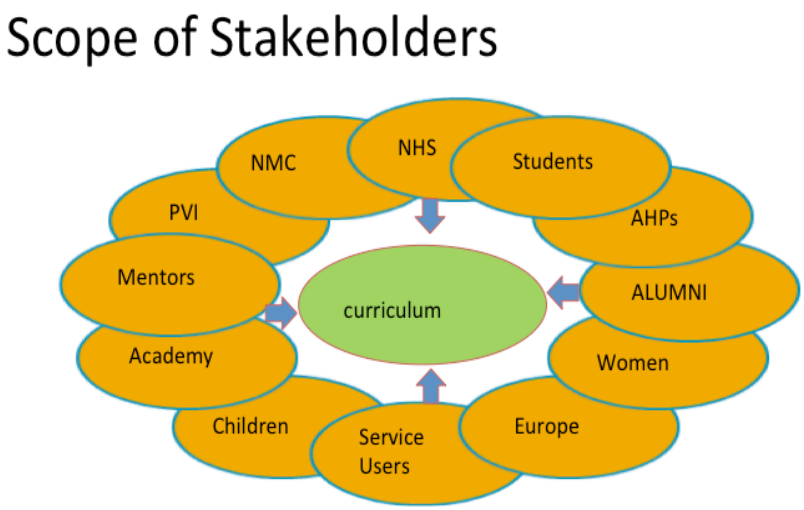
Alongside the statutory academic and professional requirements is the need to engage local stakeholders. Stakeholder involvement therefore becomes a key focus in programme design and on going quality assurance to achieve buy-in and engagement. For nursing the scope of stakeholders can be extensive and may include current and former students, employers and representatives from a wide range of interest groups.

Case example: The figure below provides an example of the multiple stakeholders involved in the design of one nursing programme in the UK. The aim of this level of involvement is to ensure that the programme meets local workforce requirements and in doing so achieves legitimacy and local 'ownership'. This is important for a vocational focused programme such as nursing as many of the stakeholders will provide students with placements.

In this example two of the key stakeholder requirements were to have significant inter-professional education and exposure to a range of non-statutory health environments. To ensure this was achieved and visible a number of allied health professionals (AHPs) and representatives from the private, voluntary and independent sector (PVI) were engaged in the design process.

Importantly these stakeholders were not only involved in the initial design but were also fully engaged in delivery and on-going evaluation of the curriculum.

Figure 4: The Scope of Stakeholder involvement in a UK nursing programme



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The example above illustrates UK expectations but the approach to consultation and stakeholder involvement outside the UK will vary significantly depending on the standards and expectations in each country. Ralph et al (2015) provide a useful analysis of the curriculum design process in Australia and similar guidance can be found in most countries around the world.

Measuring quality and outcome through evaluation

Having secured wide involvement in the design, accreditation and implementation of a programme, attention should then turn to measuring the quality and outcomes of the programme in order to determine whether it is meeting professional standards and stakeholder expectations.

Figure 1 suggested that determining quality involves gathering data and feedback from the various stakeholders. There is typically a huge array of data available such as progression and completion statistics, employments rates, destination data, student experience feedback etc. However as Einstein warns us (below), one needs to be selective and take a critical view of the available data in order to avoid erroneous or skewed judgements.

> *"Not everything that can be counted counts, and not everything that counts can be counted."*
> Albert Einstein

Evaluation involves judging the worth or value of something and is a process we undertake every day when we are making judgments about anything from perusing goods in a shop to purchasing a new house or car. It involves appraising the qualities, characteristics, functions, impact or future worth of something and will inform decisions we may go on to take.

If we are buying a car consideration may given to fuel economy, speed, capacity, make and style. Therefore its worth to a person interested in speed may be different to someone concerned with economy. Similarly when applied to something as complex and dynamic as a nurse education programme it becomes clear that it is not possible to make a single judgment about its worth but is a continuous process of appraising feedback from the various stakeholders.

The table below lists the key stakeholders, the broad focus in terms of judging value, the process by which their feedback is obtained and the sources of data that can be used to make judgments about quality that lead to changes and adjustments. A similar matrix of stakeholders would be expected in most countries providing nurse education.

Table 1: Stakeholder focus and sources of evaluation data

Stakeholder	**Focus**	**Process**	**Source of evaluation feedback**
Professional Body	Concerned with ensuring that approved programmes achieve national standards. They would need to determine that there is come consistency across all approved programmes and that students are able to achieve the required level of capability for entry onto the professional register.	Programme validation, accreditation or licensing Annual Monitoring	Curriculum validation report Annual Monitoring report
Patients/service users/Lay representatives	There is a growing expectation that patients and service users are involved and visible in the design, delivery and evaluation of nurse education. They would be concerned that nurses have the core knowledge, skills, understanding and attributes to be an effective nurse to deliver person-centered care.	Validation or accreditation panels Recruitment and selection Assessment of students Education delivery	Feedback on their involvement in various activities Feedback on student performance
Clinical service providers eg hospital and community services	This group will be concerned with the competencies of practitioners that qualify from the programme. They would want assurance that students have sufficient practice experience in a range of settings and the underpinning evidence for practice that will allow them to deliver high quality evidence-based care to patients and service users with complex needs across a range of clinical settings. Clinical service providers will often be the chief employers and the providers of placements for students and so have a vested interest in ensuring the quality of the provision.	Meetings with employers Recruitment processes Fitness to practice Care quality processes	Mentor/supervisor reports Fitness to practice outcomes Employment rates Care quality reports
Peers and other academics from within and outside the discipline	They would be concerned with programme quality and parity with other similar programmes in higher education	Committees Working groups Academic	Peer review reports Committee minutes

		Boards Senate	Internal audit reports
Commissioners	Commissioners may not be a phenomena known in all countries but from a UK perspective, the commissioner is Health Education England, which has a statutory responsibility for workforce planning and contribute funding to support student learning. They will typically gather data on recruitment, progression, attrition and employment in order to judge the quality in relation to value for money and seeing a return on the investment from the public purse.	Quarterly and annual contract meetings	Recruitment, attrition and destination data
Government	Governments are concerned with workforce planning and supply as well as performance of the higher education sector more generally. They will analyse a raft of data to judge effectiveness and may introduce policies to increase competition through encouraging new providers into the market or new pathways into a profession with the aim of increasing quality, supply and/or efficiency of the sector. Recent examples of this in the UK are the degree apprenticeships in nursing which aim to widen participation into health careers.	Routine collection of data from each institution	Destination data Employment rates Workforce levels
Students - and their families.	Student perspectives on the value and worth of a nurse education will typically be focused on whether a programme leads to employment at the end of the course. However it is of course much broader than that, encapsulating the whole student journey from the process of recruitment and admission through their experiences whilst on the programme right up to graduation. National League Tables are one source of information that students and families will consult. In the UK, the Times, the Guardian and the Complete University Guide will make national comparisons between programmes each year. They bring together data from various sources such as NSS, destination, admissions, REF, to determine a ranking of each programme delivered in the UK. Although there is criticism about the rigour of the tools used and consequently the judgements made on the basis of the analysis, it remains the fact that potential students, their families and the wider public are using this data to make decisions and choices.	Web-based and UCAS information Open days Internal evaluation National surveys	National League tables Internal evaluation data Employment rates National survey results
University/ education provider	The institution providing the programme will be concerned that standards of higher education, in relation to teaching, learning, assessment and resources are maintained and comparable with other similar institutions across the sector both nationally and internationally. They will typically use a raft of data and measures to assess the quality of the programme much of which has been touched on already. This will start with recruitment numbers, which is an indicator of the attractiveness of the programme, levels of attrition (do students stay once on the programme?), progression (do students succeed?), pass rates (do students complete?), employability (are students attractive to employers?), experience (is the quality of teaching and learning acceptable?).	Programme management groups Annual Audit/Review Quinquennial review	Recruitment data Progression data Attrition rates Employment rates Satisfaction surveys External agency reports
External	The external examiner (EE) is an important mechanism used	Supplied with	Pass rates

Examiner	by institutions to ensure there is parity of education standards across and between institutions. The EE will produce reports on assessment strategies, samples of assessed work undertaken by students and the rigour of institutional procedures to determine and validate individual grades and awards. The EE's reports will be read by the Vice Chancellor or equivalent of the institution and will also be published on the institutions website so that it is publicly available and will also include the institutions response to any concerns that have been raised.	samples of student work Involvement in assessment design Attendance at exam boards	Progression data Completion rates Periodic and Annual reports
National Quality Assurance Agencies	In the UK The quality assurance agency (QAA) is a body that oversees national standards of quality across the higher education sector. It will make reports into institutional level governance and will publish these on their website for all to see. They will make institutional comparisons and at subject level will consider whether programmes meet subject level benchmarks.	Institutional and subject review processes	Institutional reports Subject level reports

The need for Governance

Whilst receiving all this feedback has the potential to be extremely helpful, little will be achieved in the absence of an effective governance system that operates with clarity and ensures decisions are appropriately communicated and changes are fully operationalised. Sometimes unfairly viewed as unnecessarily bureaucratic, governance is vital to assure quality and will typically involve an array of module/unit teams, programme teams, quality committees, student experience groups, recruitment and marketing teams, placement evaluation groups and fitness to practice panels amongst others. Each will have members drawn from a range of stakeholders and operate processes that generate programme evaluation data. It is challenging to fully articulate such a complex network of inter-relationships across a large range of entities all with a concern for quality, but the diagram (figure 5) below gives some indication of the key components of such a system and how these might be configured in a single faculty or school within a University.

All decision-making committees will typically feed into the overarching University Senate and will also have links with the Executive of the School/Faculty. The eight committees listed are for illustrative purposes only as there are many variations on this model, but a brief explanation of each:

- **Education Committee** - Concerned with strategic education issues including potential business opportunities and threats.
- **Academic standards and quality** – Concerned with ensuring the academic and professional standards of the institution
- **Student Experience** – Focused on enhancing and improving the student experience
- **Fitness to practice** – a UK professional requirement for nursing programmes - scrutinizes issues of unprofessional conduct
- **Examinations Board –** Concerned with the conferment of grades and awards
- **Programme Management** – oversees programme delivery, ensuring curriculum validation expectations are met

- **Course Approvals** – Considers modifications to existing or new programmes
- **Clinical Liaison –** Ensures regular engagement with health and social employers who provide placements for students

Figure 5: Typical Governance procedures operating in a nursing school/faculty

Using Student and stakeholder feedback

In order to understand the importance of student and stakeholder feedback to the design of quality experiences and outcomes, imagine what programmes might look like if *no* feedback were sought. Would students engage with education if their learning experiences were not valued through seeking feedback from them? Would professions and employers have confidence that graduate knowledge and skills would meet their needs if education outcomes were not mutually agreed and evaluated using *their* thoughts and feedback?

Feedback provides a view from another's perspective within an activity of shared relevance. The following discussion focuses on student feedback for programme design as opposed to transformative feedback provided to students on their development and progress. Student feedback is useful for programme design when it has relevance, is valued and is acted upon (Harvey 2011). For programme providers, feedback from students and other stakeholders enables identification of factors that relate to the effectiveness of education, the outputs and quality of the programme.

Student and stakeholder feedback is an essential measure of internal and external quality assurance within nurse education (NMC 20, QAA 2014). It enables evaluation of the success of education programmes from the perspectives of those most closely associated with the experiences and outcomes of that education, and thereby enables targets to be identified for quality enhancement activity. In the UK, programme providers informally and formally

gather feedback from students, service users and carers, faculty staff, practice partners and employers in order to determine the quality and success of their programme. This feedback is important for quality enhancement because it identifies where on-going development of the programme is required to ensure it remains contemporary, effective, and where improvement is required as well as evaluating previous improvement activities. Student feedback on the quality of their learning experiences also features as a significant component in the ranking of nursing programmes in many countries; such as the Course Experience and University Experience surveys that feed into the Australian University Reviews and the National Student Satisfaction survey that features within the metrics of several university ranking tables in the UK.

Feedback data also enables external monitoring of education quality by the relevant Professional Statuary Regulatory Body (PSRB); such as in the UK the Nursing and Midwifery Council (NMC), in the USA the National Council of State Boards of Nursing (NCSBN), and in Australia the Nursing and Midwifery Board of Australia (NMBA). Data relating to the quality of programmes is important for government departments overseeing education provision and for those who financially support or commission education; in England this includes Health Education England and the Higher Education Funding Council for England (HEFCE).

Feedback can also enable a co-design approach to on-going programme development, a movement from a user-centered approach to sharing ideas (Sanders and Stappers 2008). In education, this shared approach using feedback and input from students and stakeholders can be translated as co-creation of learning.

Co-Creation of Learning Quality

Co-creation in learning is a globally recognised concept (Díaz-Méndez and Gummesson 2012) that has enabled greater understanding of the centrality of partnerships between all stakeholders in the facilitation of student learning, learning evaluation, learning development and learning quality. For nurse education, this includes recognition of the value of feedback and design input from students, health service users, faculty based educators and educators from clinical practice. Gathering and analysing feedback can require extensive effort and resources, so it is important to ensure the findings are acted upon and that the activity is therefore meaningful. For example, if student feedback on the clinical learning opportunities available to them in a named work placement is sought and identifies a culture where student learning is not valued or where service provision has changed such that the clinical activity does not fit with their learning requirements, then this should trigger activity to rectify the situation. However, gathering and analysing this data uses the staff resource and requires the collaboration of different staff so the student feedback is valued, explored and acted upon. It is also important to recognise that if action is not seen to arise from student feedback, then the impetus to provide feedback diminishes. You may hear students and stakeholders ask ‘what’s the point of seeking our feedback if nothing is done about it?’ Co-creation therefore relies on all parties kept in the on-going ‘development loop’ of seeking feedback, acting on feedback, reporting back on action taken, and seeking on-going feedback.

An example of co-creation for improved learning in a local setting can be seen in a Canadian study where the introduction of ‘student scholars’ identified challenges and transformative learning among the faculty and students when partnering in curriculum development (Marquis et al 2016). Another broader engagement example of good practice can be seen the Student Partnerships in Quality Scotland (SPARQS) initiative. SPARQS is an agency that is publicly funded and aims to support student engagement in the quality of learning experiences within Scottish universities and colleges (see: https://www.sparqs.ac.uk).

Feedback from the users of healthcare services and therefore recipients of student's practice learning also provides important data that can enhance student learning and programme design. Despite almost two decades of collaborations and partnerships that aim to enable genuine input from service users, meaningful involvement in education activity remains a challenge (Tee 2012). For example, some nursing programmes seek direct feedback from clients and patients on an individual student's performance in practice or within a simulated practice activity, and the opportunities or reporting mechanisms can be simplistic or tokenistic. Seeking meaningful feedback data requires careful management so that it is constructive and service users input is seen to be valued. Some organisations have overcome these challenges through careful support and preparation of service users, such as through providing tailored guidance (Webster et al. 2012).

Measures of Education Success through Metrics based on Feedback

Ensuring quality experiences and outcomes within nurse education through feedback from students and other stakeholders, as well as co-creation of quality, requires providers of higher education from governments to university programme leaders to monitor and demonstrate measures of success. There are no universal tools for measuring or evaluating nurse education as the relationship between educational input and outcomes is highly complex and contextual, with numerous confounding variables existing within the practice environment that challenge rigorous evaluation of learning as it is applied to practice (Attree 2006). However, it is possible to gather some useful evaluative data through seeking student and stakeholder feedback.

One way to conceptualise how feedback data is used to measure learning success is by viewing the diverse evaluation metrics through micro, meso, macro and meta lens (Hanne Foss Hansen 2009). Micro-evaluation tends to be that undertaken within the education environment through dialogue between students and their educators. Meso-evaluation focuses more at an institutional level and may be enacted externally to the institution. Macro-evaluation is that which enables comparisons between institutions and meta-evaluation is the 'second order' evaluation, a systematic synthesis of the macro-data (table 2).

Table 2: The micro, meso, macro and meta evaluation metrics in nursing programmes

Micro-metrics focus	**Meso-metrics focus**	**Macro and meta-metrics focus**
Focus on individual student or cohort level perceptions of successful learning experiences over the course of their programmes	Focus on more general local measures of quality for a programme at institutional level from feedback by a cohort of students or from other stakeholders	Focus on the quality of nurse education experiences and outcomes nationally and globally, enabling comparisons over time, and providing opportunities to evaluate a trajectory in quality and outputs
Micro-metric examples	**Meso-metric examples**	**Macro and meta-metric examples**
Most programmes of nurse education seek feedback on learning from students on individual taught sessions, units of learning or modules, and on their practice based placements. Feedback is also sought	These metrics include student progression and completion data as well as metrics that reflect the student feedback on a completed programme or their practice-based learning. Evaluations such	Feedback from employers and graduates that demonstrate student employability is a measure that is used to illustrate the output success from higher education, including nursing programmes. Although employability is an important

from service users and/or practice based teachers and assessors on an individual student's or whole cohort's performance. These data have limitations in terms of their evaluative merit if used in isolation. For example, surveying individuals' feedback on completion of learning activities has been referred to as collecting 'happy sheets' due to the tendency of students to rate experiences according to their perception of the event rather than the learning achieved (Lambert 2012).	as these through feedback from students are a commonly used measure for on-going development of elements that make up a programme, such as a single unit of learning or module, or the whole programme and the metrics used are usually designed by individual higher education institutions and used across their provision. However, it is evident that these metrics are used for more than assessment of student learning; they are now important in ranking the quality of a university, creating league tables such as in the Australian Good Universities Guide.	general metric, it must be considered with caution as a measure of quality for a professional discipline in areas or countries where there are abundant employment opportunities for that profession due to staff shortages. The level of degree attainment within higher education, a first class honours or a third class degree, is also a measure of quality. The percentage of higher degree classifications within a graduating cohort provides further meta-data that enable comparisons between programmes within a university's education provision and between universities for specific programmes such as nursing and globally such as in the annual World University Rankings.
Micro-metric value	**Meso-metric value**	**Macro and meta-metric value**
Micro-metric data can be a valuable component of the overall data set data that provides the bigger picture of learning quality and learning opportunities. These micro-metrics within elements of education and within learning environments can contribute to an overall evaluation of an individual student's learning progress over time or the quality of a placement provider's support for student learning. Such metrics can expose areas for curriculum and placement development, as shown within the Mabuda et al. (2008) study in Limpopo, South Africa. Internal analysis of micro-metrics therefore enable valuable on-going development of single taught sessions, single units of learning or	Student feedback on and satisfaction with their teaching is increasingly being used by higher education institutions around the world in measures of staff performance, partly driven by the funding implications of university league tables and teaching quality (Shah and Nair 2012). In the UK, the introduction of a Teaching Excellence Framework (TEF) in 2016 was intended to be aligned directly to setting education fee levels (BIS 2016). Substantial weighting within TEF measures is the measure of student satisfaction and this raises the question of whether student 'happiness' feedback sufficiently reflects and strengthens 'academic rigour and student	The importance of enabling between universities comparison cannot be underestimated as higher education exists in an increasingly competitive market place for national and international students in nursing. In the UK, further macro-data through student feedback is independently and formally collected within an annual survey of all final year undergraduates within Higher Education, the National Student Survey (NSS). NSS data has been collected since 2005 (HEFCE 2016), with statistical analysis of the data from each higher education institution published for public viewing. It is used for a number of purposes such as a metric within UK university league tables and identifying development areas to improve the student experience. Despite some criticisms of the NSS as a blunt instrument, it has forced higher education institutions to

modules, placement experiences and specific aspects of programmes of study.	attainment of learning outcomes' (Shah and Nair 2012). Alongside student feedback, other stakeholders provide feedback on nurse education at the meso-level. They do this through practice partner and service user engagement opportunities with programme providers. These engagement opportunities are often formalised through programme management meetings. Opportunities for stakeholder partnership engagements are normally built into programme management planning prior to programme validation and are an expectation of NMC standards for education providers in the UK (NMC 2010:66).	engage better with students, seek their feedback and respond (Williams and Mindano 2015). NSS data use within a range of national league tables also provides the public and future applicants to UK higher education with indicators of comparative quality for institutions alongside subject specific student satisfaction. Other quality metrics feeding into the league tables include entry qualifications, students to staff ratios and research quality. This same data is also translated into meta-metrics that are utilised in international league tables for Higher Education. In the UK, nursing programmes are also influenced through further macro data available from National Health Service (NHS) service user and NHS practice staff date collected within annual surveys and these data in part reflect the quality of education of nurses within an organisation (CQC 2016, NHS 2015).

Alongside these data contributions, feedback on student learning is also collected from the recipients of care provided by students via practice based assessment and service feedback mechanisms (such as inpatient evaluation of their experiences within a service or during a hospital stay). This feedback on the quality of clinical performance by students and newly qualified nurses is sought by educators to identify opportunities for programme content development, ensuring the student's curriculum remains contemporary and reflects changes in practices or professional/employer requirements within the clinical environment.

Faculty environment and culture

Imagine the experiences of a football team attempting to play on a water-logged field, without access to training or time to practise, and without opportunities for communication between them; would the quality of their football be diminished? Team experiences are dependent upon their working environments such as the physical space and resources available to them. Team experiences are also dependent on their working practices and culture. Undoubtedly there is a link between faculty experiences and the quality of the education programmes they provide; although no rigorous evidence is available to explain the mechanisms and impact of this within nurse education programmes.

Designing environments that support quality experiences and outcomes for student nurse learning is therefore an essential component of programme planning and provision within

both university and clinical practice settings. Around the world, health and care service providers are the main employers of nurses who supervise the learning of student on placement and each organisation will have its own culture and processes underpinning their environment. University environments host and employ nurse academics and teaching staff responsible for the delivery and quality assurance of nursing programmes. Both employers and all these groups of staff work collaboratively to support student nurse learning in practice, although the mechanisms by which this happens vary from one institution to another, within and between different nations. It has been recognised that nursing faculty experiences and cultures can create stress and have led to nurse academic shortages in the USA (Owens 2017) and the stresses of supporting student nurses within challenging practice contexts can ultimately impact upon both the academic's and the student nurse's experiences (Curtis 2013a).

Understanding collaborations between faculty inside and outside the clinical environment enables insight into stakeholder experiences and the culture that supports student nurse education. Faculty working within the university setting have different experiences and challenges from those working within the clinical practice setting. Both are important to understand in the context of enabling excellence within the learning environment for student nurses.

Faculty Experiences within University Environments

The quality of the physical space where a programme is provided has an impact upon working practices and is therefore important to consider prior to a discussion of faculty experiences or culture. Working in a well resourced and supported environment tends to demonstrate that staff are valued by their employer. Alongside physical space, student to staff ratios are also an important factor supporting the quality within nurse education, as well as a recognised education metric within UK University league tables as previously discussed. Where there are large cohorts of nursing students requiring access to limited resources such as teaching staff, classrooms, computing and simulation facilities, then the resource is either stretched or used in ways to maximise faster throughput. Crowded or rushed learning environments are unlikely to be as helpful to student learning as environments where resources are more plentiful. However, it needs to be recognised that most employers such as universities and clinical services do not have infinite financial resources or excess staff, and a balance is usually required between the ideal and the available. Limited resources may therefore reduce the quality of learning experiences. On the other hand, it is important to also acknowledge that limited resources can become a catalyst for innovative thinking and creative new ways of facilitating learning.

Creativity within nursing programme design is evident in the rising use of innovative technology enhanced learning (TEL) such as podcasts, virtual classrooms, and in the use of *flipped classrooms*. For example, a flipped classroom approach in the USA has been shown to encourage students to access and learn material before coming to the class and in the classroom they deepen that learning through teacher facilitated discussions, debates and other problem-solving learning activities (Bergmann and Sams 2012). This optimises the use of scare or expensive resources such as teachers and classroom space for interactive components of learning, by encouraging student engagement with preparatory learning instead of didactic teaching. The use of flipped classrooms has also improved student satisfaction (O'Flaherty and Phillips 2015).

Investment in electronic library resources, classroom technology and online learning activities has also enabled a significant evolution in nurse education and improved the breadth of opportunities for student engagement and learning during the last 10 years. For most modern programmes, gone are days of chalk and talk, textbook loans, and teacher-centred learning.

The rise in the use of *smart technology* has facilitated student led learning through remote and easy access to resources and learning apps on their mobile phones. These electronic strategies for maximising student engagement include blogs and electronic discussion boards, and literature searching without relying on outdated books or the need for library visits to access the most up to date evidence for practice. Students are increasingly literate in online professional database searching and learning within a 'virtual' reality where simulated practice with real-time feedback is available, and these approaches are now commonplace in most modern universities around the world.

This evolution of student-centred learning opportunities through the creation of a virtual world of exciting and interactive materials, has maximised opportunities for student engagement, self-testing, applying their learning to virtual realities, and thereby given students a richer learning environment and potential for deeper learning. The electronic resources also enable students to develop deeper learning, and this in turn has a positive impact on patient related outcomes, particularly within the field of TEL and simulation (Cook et al. 2011). In Button et al. (2014) review of literature on electronic learning and communication within nurse education, they identify that this evolution has required faculty from around the world to develop new skills for technology enhanced learning, and for some this has meant extra demands on their workload, created learning challenges and required change in their practices.

Alongside the technological evolution in education, there remains a need for discussion and individual face to face student support for learning, particularly where students could benefit from facilitated reflection in order to make sense of challenging experiences (Mann et al. 2009). It is not uncommon for student nurses to have had an upsetting experience within the practice setting and despite good support from practice based staff, they may feel unable to explore the experience at the time and remain troubled by it. Examples may be ethical dilemmas such as sustained and unsuccessful resuscitation attempts, or perhaps confusion about a care practice or treatment they witnessed. Meeting this student learning need could be seen as an imperative of compassionate student nurse education. To facilitate it may require individual student or small group time with nursing faculty from the University setting. These university staff may have many competing priorities upon them that make it difficult to always meet this need; such as their timetabled teaching and meeting University research and publication demands. University based faculty also have the need to maintain their own clinical credibility and knowledge, so adding another layer of demand on them. The experience of competing priorities within a resource stretched environment can leave faculty staff feeling unable to fully support students who are suffering, and feeling that they are unable to fulfil their educator role to the best of their ability (Curtis, 2013a). The challenge of competing priorities can create a faculty culture that promotes efficiency over quality of learning and prioritises key performance indices over those that are not as easy to measure or as visible, such as managing student's emotional vulnerability (Curtis, 2013b). The experience of pressures and demands upon university based faculty are in many ways similar to those experiences by faculty within the clinical learning environment.

Faculty Experiences within Clinical Practice Environments

In many countries, such as the USA, Australia, South Africa, and New Zealand, clinically based support for nurse education is provided or supplemented by university employed faculty working alongside the students caring for patients or clients. Different models of learning support within clinical placements and environments have been examined for their efficacy and it is clear that no single model has been found to be better than another; what works within one country, culture or clinical context may vary from what works in another culture or context.

In the UK, Registered Nurse Mentors are the clinical faculty employed by service providers who manage much of the students learning and assessment within the practice environment. Mentors are a recognised role within UK nurse education (NMC 2006) and yet most of the evidence supporting the role has come from small studies. There is limited robust evidence available to fully evaluate the mentor role as it is currently enacted, probably due to the diversity of environments within which mentors work with students, and the complexity of how the role is managed alongside the other role expectations on these individuals. Despite the difficulties investigating the mentor role, some studies have shown that mentors can have a very positive impact upon learning quality while managing their own nursing workload and the challenge of inadequate support from their employer organisations (Chandan and Watts 2012).

Faculty involved in student learning within the practice setting require time and support to facilitate individual student's learning opportunities and assessment of a student's competence. There has been some concern about the environmental learning culture over recent years in the UK, with mentors not provided sufficient recognition and time for their role in some areas and qualified staff not being able to access opportunities for their own professional development (Coventry, Maslin-Prothero and Smith 2015).

An organisational culture that values support for students has a positive impact upon their learning and experience. Leadership of the clinical environment therefore has a significant impact upon a student's learning (Henderson et al. 2011) and has been shown to be a pivotal factor in the support of learning within UK practice settings (O'Driscoll, Allan and Smith 2010).

Alongside the challenges of supporting learning within the clinical environment, there is also global recognition of the scarcity of nursing faculty and availability of academic staff as a clinically based resource for student nurse learning (Feldman et al 2015). Where clinically based faculty resources are scarce, it is therefore imperative students are well prepared to make the most of the clinical environment in terms of how to identify learning opportunities and succeed in achieving learning outcomes. Prior knowledge of the factors within clinical learning environments that impact on their learning, such as organisational culture (Flott and Linden 2015) can assist students in self-management and in becoming competent registered nurses.

Alumni relations

One further area of importance within the design of programmes is the engagement with alumni. Alumni are those individuals who have graduated from a programme at that institution. Alumni can provide insight or support to programme content and delivery; they can encourage current students through donations such as student prizes and can inspire through sharing their reflections on their own student or career experiences. Keeping in contact with alumni provides these opportunities; particularly when former students have gone on to do wonderful things, such as improving global healthcare provision through their research, using their celebrity for charitable ends, or have excelled in their career. Celebrity alumni can also facilitate marketing to attract new students. In nursing, alumni can be a highly valued asset that demonstrates the potential for a long and rewarding career and the promotion opportunities possible.

Resources and their allocation

Healthcare programmes with their emphasis on the development of clinical competence require significant investment by the institution into clinical skills facilities, simulation labs

and related technology and teaching aids. With the developments in the use of digital health technology in clinical practice, this places ever-increasing demands on the institution to provide the most up to date kit. Of course some of this may be developed in partnership with service providers who may use similar resources for staff CPD but what ever the model, careful thought has to be given to balancing finite resources matched with the ability to deliver a contemporary programme that meets modern professional standards.

Any nursing programme needs to have a sound business case outlining the expected student numbers (income) against the total resources required to deliver (outgoings) with something left over to support central services and to invest in staff development. Often staff:student ratios (SSRs) are used by professional bodies, as a measure of programme quality and student experience but this is an extremely crude and notoriously unreliable measures of the actual resource dedicated to a programme.

Health programme providers will use a variety of means and mechanisms to support and enhance learning by investing in library and learning technologists, online learning, lecture capture, subject specialists who may not be discipline specific and interprofessional learning where groups are combined. These vital initiatives add significant value to a programme and enhance quality but may not be fully reflected in SSRs because they are not counted in the staff allocated to a particular programme.

Many institutions adopt staff workload models to seek to ensure that the staff resource matches, as near as possible, the delivery requirements of the programme. There will always be differences in the allotted contact time for students reflective of different disciplinary requirements and professional standards. In nursing in the UK there are Professional specifications from the NMC requiring all approved programmes to be of three-year duration delivering a minimum of 4600 Hours split into 50% theory (2300 hours) and 50% practice.

As a rule of thumb, most institutions operate a formula for each module within a programme to specify the amount of "student effort" which may then be further broken down into various activities. For a nursing module this might include taught face-to-face activity, student directed, self-study, clinical skills, practice placement, simulated learning, on-line learning and so on.

The calculation made is typically one academic credit equates to ten hours of student effort. In a full undergraduate award of 360 credits over three years, this will involve approximately 3600 hours for the full programme that is then broken down to the various course activities appropriate to the discipline. This model already reveals that a UK nursing programme is expected to provide 1000 more hours over the course of the programme than a standard academic degree.

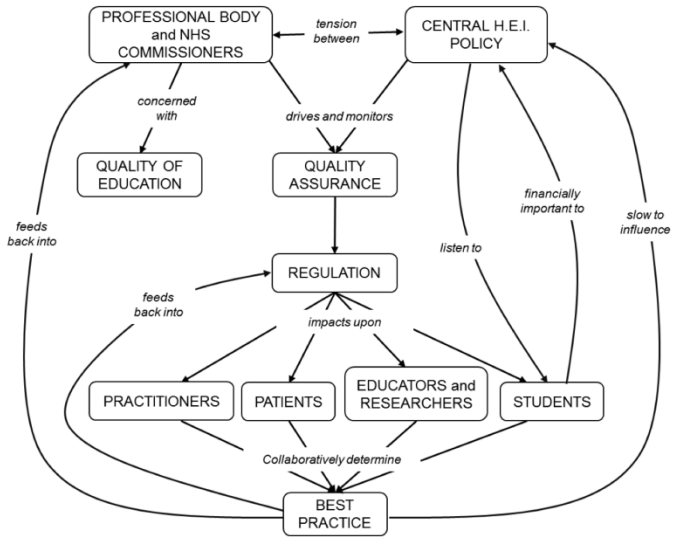
Whilst never an exact science, understanding these calculations does allow for some data driven resource planning decisions to be made. Thus a good workload model combined with effective governance will allow an institution to determine where quality enhancements are needed and to be able to quickly focus available capacity on an area of need. Where, for example, students identify the need for more support in the practice environment, institutions may choose to establish a dedicated team of people to support learning in practice rather than employ lecturing staff. Key to such decisions is to ensure parity of experience within the regulations of the programme. For example, in 2016 at Bournemouth University in the UK, the NMC commended an approach to maximize support for practice-based learning using a team of University Practice Learning Advisors. These staff work alongside the University based nursing faculty by providing education, guidance and support to the clinically-based faculty (nurse mentors). This support ensures practice-based learning meets all the required programme regulations and standards, and encourages excellence within the learning opportunities for student nurses during their placements.

Programme regulations to support high quality learning

Regulations govern higher education and thereby maximise the parity of experience and quality between and within programmes across institutions, and between and within student cohorts. In the UK, regulations for nursing programmes are set by individual education institutions and by the NMC, and thereby standardise expectations and support quality assurance; as discussed earlier.

The complexity of regulation within UK nurse education alongside competing demands from stakeholders inside and outside the university setting who are involved in assuring programme quality, can create a sense of 'pedagogic frailty' (Kinchin et al., 2016). Nursing faculty can experience a sense of juggling demands from these many loci of control, leaving staff feeling the challenge of keeping all the balls in the air. The complexity of the locus of control is illustrated below (Figure 6).

Figure 6: The Locus of Control in a UK Healthcare Programme (Kinchin et al, 2016)



To illustrate the inter-relationship between the higher education institution and NMC within UK nursing programmes, two examples are presented: values based recruitment for admission to programmes and expectations of student behaviour that meets fitness to practise. Similar regulations exist within most nurse education providers around the world and they serve similar purposes.

UK nursing programmes are required to demonstrate how their admissions policy and processes meet both university and NMC expectations in order to be validated. Most UK universities set their own admissions policy, indicting minimum academic qualifications for entry to a programme and other entry pre-requisites such as required level of written and spoken English language. These enable the university to have confidence that the student will manage the academic demands of higher education. The minimum academic entry qualifications can vary year on year, often depending upon the ease at which programme places can be filled and the drive for universities to demonstrate high tariff entry qualifications as a quality metric that feeds into league tables. However, high academic qualifications are not the only factor in giving confidence that students will cope with the pressures of a nursing programme or become suitable for Registered Nurse status. There is

also an expectation that students require the right values to be able to care for people who are vulnerable, to be able to communicate effectively, to be able to work within a team and in challenging environments with challenging emotional experiences.

Recruitment to nursing programmes over many decades has involved some means to assess that the candidate understands the expectations of becoming a nurse and is suitable, before commencing on a programme. In England, this expectation has recently been formalised within a framework of national core requirements for health professional recruitment as well as student recruitment (HEE 2016). The new framework arose following concerns about the quality of caring within nursing, following the Francis Report (DH 2013). Health Education England's Values Based Recruitment (VBR) framework sets out requirements that must be embedded in university entry processes for all NHS programmes, such as nursing. Most universities in England have met these conditions in full, with candidates interviewed to assess their values such as honesty, respect for diversity and intentions to care. It has yet to be seen if this new framework proves to be more effective than the measures that were already in place prior to the Francis Report.

Regulation to manage student behaviour is also an area of interest within nurse education. Universities have policies and processes for dealing with any student who breaks the law or who gives cause concern regarding their behaviour. Expectations for behaviour by all those involved in higher education programmes are usually set out at the start of the programme through Student Charters. Student charters are developed in collaboration between university staff and students with the aim that all students will have equal opportunity to thrive at university and in their learning.

Managing student behaviour concerns related to student health may require student well-being processes to be invoked, while concerns about a student's disruptive behaviour may invoke disciplinary panels. However, within nursing programmes these regulations exist in addition to regulations set out by the NMC. Student nurses are required to abide by The Code of practice for students and as they near registration, by the equivalent for registered nurses (NMC 2010, NMC 2015a). The Fitness to Practise of a student nurse can be questioned if their behaviour appears to breach these expectations and one such area that has been of serious concern in the last few years is communication within social media sites (NMC 2015b). A student who breaks confidentiality, uses racist language or is seen to bring the profession they want to join into disrepute through social media postings, risks having their suitability to continue on their programme decided by Fitness to Practise Panel made up of from university staff and registered nursing professionals. When the NMC and universities jointly undertake programme approval or monitoring, the adherence to these regulations are scrutinised to ensure processes are robustly used for managing student behaviour.

In addition to these within programme measures, student nurses in the UK are required to have a declaration of good character and good health in order to be allowed entry to the NMC Register (NMC 2015c).

Conclusion

This chapter has sought to illustrate how professional and academic systems operate to enable programme design for quality experiences and outcomes in nurse education. The specific structures will vary across national and local contexts but the fundamental principles are the same. Namely to create a dynamic and responsive environment that uses data and feedback to adjust, adapt and modify programmes and achieve continuous quality improvement, whilst adhering to national and international professional and academic standards.

Key to success is high quality stakeholder engagement that will ensure the programme is valued and sustained over time and meets their expectations. However it should be remembered that at the centre of this process is the student and the over-riding aim must be to avoid making the system overly bureaucratic and cumbersome so that the student voice can be heard loud and clear.

References

Attree M. 2006 Evaluating Healthcare Education: Issues and methods. *Nurse Education in Practice*, 6(6), 332-338.

Bergmann J. and Sams A. 2012. How the Flipped Classsroom was Born. Accessed online (29/07/16): http://www.thedailyriff.com/articles/how-the-flipped-classroom-is-radically-transforming-learning-536.php

Button D., Harrington A. and Belan I. (2014) E-learning and information communication technology (ICT) in nursing education: A review of the literature. *Nurse Education Today*, 34(10), 1311-1323.

Care Quality Commission 2015 *Surveys*. Accessed online (23/07/16) http://www.cqc.org.uk/content/surveys

Chandan M. and Watts C. 2012. Mentoring and pre-registration nurse education. Accessed online (23/07/16): http://www.williscommission.org.uk/__data/assets/pdf_file/0009/479934/Mentoring_and_pre-registration_nurse_education.pdf

Cook D., Hatala R., Brydges R. and Zendejas B., Szostek J., Wang A., Erwin P. and Hamstra S. 2011. Technology-enhanced simulation for health professions education: a systematic review and meta-analysis. *Jama* 306(9), 978-988.

Coventry T., Maslin-Prothero S. and Smith G. 2015. Organisational Impact of Nurse Supply and Workload on Nurses Continuing Professional Development Opportunities: an integrative review. *Journal of Advanced Nursing*, 71(12), 2715-2727.

Curtis K. (2013a) 21st Century challenges faced by nursing faculty in educating for compassionate practice: embodied interpretation of phenomenological data. Nurse Education Today, 33 (7), pp 746-750.

Curtis K. (2013b) Learning the emotional requirements of compassionate practice: Student nurse vulnerability and courage. Nursing Ethics, 21(2), pp210-223.

Department for Business, Innovation and Skills (BIS) 2016 Higher Education: Success as a knowledge economy – White Paper. Accessed online (23/07/16): https://www.gov.uk/government/publications/higher-education-success-as-a-knowledge-economy-white-paper

Department of Health (DH) (2010) *Robert Francis Enquiry report into Mid-Staffordshire NHS Foundation Trust.* Accessed online (23/07/16): http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/report

Díaz-Méndez, M., Gummesson E. 2012. Value co-creation and university teaching quality: Consequences for the European Higher Education Area (EHEA). *Journal of Service Management*, 23(4), 571-592.
Feldman H., Greenberg M., Jaffe-Ruiz M., Kaufman S. and Cignarale S. 2015 Hitting the Nursing faculty Shortage Head On: Strategies to recruit, retain and develop nursing faculty. *Journal of Professional Nursing*, 31(3), 170-178.

ESIB 2002 European Student Handbook on Quality Assurance in Higher Education. The National Unions of Students of Europe. http://www.aic.lv/bolona/Bologna/contrib/ESIB/QAhandbook.pdf

Flott E. and Linden L. 2015 The clinical learning environment in nursing education: a concept analysis. *Journal of Advanced Nursing*, 72(3), 501-513.

Garwe E.C. and Gwait L. 2018 The Role of International and Regional Quality Assurance Bodies. *Higher Education Research*, 3(1), 15-22.

González J. Isaacs K. & Wagenaar R. 2008 Applying the Tuning Approach to third cycle studies. Tuning Educational Structures in Europe http://www.unideusto.org/tuningeu/tuning-3rd-cycle/applying.html

Hanne Foss Hansen (2009) Educational Evaluation in Scandinavian Countries: Converging or Diverging Practices? *Scandinavian Journal of Educational Research*, 53:1, 71-87.

Harvey L. 2011 The Nexus of Feedback and Improvement, in Nair C. (Ed.) *Student Feedback: The cornerstone to an effective quality assurance system in higher education.* Burlington: Elsevier Science.

Health Education England and the Higher Education Funding Council for England (HEFCE) *2016 National Student Survey*. Accessed online (21/07/16): http://www.hefce.ac.uk/lt/nss

Health Education England 2016 *Values Based Recruitment Framework*. Accessed online (30/07/16): https://www.hee.nhs.uk/our-work/attracting-recruiting/values-based-recruitment

Henderson A., Briggs J., Scghoonbeek S. and Paterson K. 2011. A framework to develop a clinical learning culture in health facilities: ideas from the literature. *International Nursing Review*, 58, 196-202.

HKCAAVQ (2007) Hong Kong it is the Council for Accreditation of Academic and Vocational Qualifications https://www.hkcaavq.edu.hk/

Kinchin I., Alpay E., Curtis K., Franklin J., Rivers C. and Winstone N. (2016) Charting the Elements of Pedagogic Frailty. *Educational Research*, 58(1), 1-23.

Kozier B, Harvey S, Morgan-Samuel H. 2011 Fundamentals of Nursing: Concepts, Process and Practice. Pearson Education, Essex, UK

Lambert N. 2012 Ban happy sheets! – Understanding and using evaluation. *Nurse Education Today*, 32(1), 1-4.

Mabuda B., Potgeiter E. and Alberts U. (2008) Student nurses' experiences during clinical practice in the Limpopo Province. *Curationis*, 31(1), 19-27.

Mann K., Gordon J. and MacLeod A. 2009 Reflection and reflective practice in health professions education: a systematic review. Advances in Health Sciences Education, 14 (4), 595

Marquis E., Puri V., wan S., Ahmad A., Goff L. and Knorr K. (2016) Navigating the threshold of student-staff partnerships: a case study from an Ontario teaching and learning institute. Internationalo Journal for Academic Devlopment, 21(1), 4-15.

National Health Service 2015 *NHS Staff Surveys*. Accessed online (23/07/16): http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2015-Results

NHS London 2012 The quality Assurance Cycle. From The London Deanery NHS London, 2012 http://www.faculty.londondeanery.ac.uk/pages/legal

Nursing and Midwifery Council 2006 *Standards to support learning and assessment in practice*. London: NMC

Nursing and Midwifery Council 2010 *Standards for pre-registration nurse education*. Accessed online (22/07/16): https://www.nmc.org.uk/standards/additional-standards/standards-for-pre-registration-nursing-education

NMC 2010 Guidance on professional conduct for nursing and midwifery students. London: NMC.

NMC 2015a The Code: Professional standards of practice and behaviour for nurses and midwives London: NMC.

NMC 2015b Guidance on using Social Media Responsibly. London: NMC.

NMC 2015c Quality Assurance Framework. Accessed online (231/07/16): https://www.nmc.org.uk/globalassets/sitedocuments/edandqa/nmc-quality-assurance-framework.pdf

O'Driscoll M., Allan H. and Smith P. 2010. Still looking for leadership – Who is responsible for student nurses' learning in practice? *Nurse Education Today*, 30(3), 212-217.

O'Flaherty J. and Phillips C. 2015 The use of flipped classrooms in higher education: a scoping review. *The Internet and Higher Education*, 25, 85-95.

Owens J. (2017) Secondary Stress in Nurse Educators. *Teaching and Learning in Nursing*,12(3), 214-215.

Quality Assurance Agency (QAA) 2014 *The UK Quality Code for Higher Education*. Accessed online (23/07/16): http://www.qaa.ac.uk/publications/information-and-guidance/publication?PubID=181#.V5NDwbgrKUk

Ralph N Birks M Chapman Y 2015 ''Settling for less'': Designing undergraduate nursing curricula in the context of national accreditation. http://dx.doi.org/10.1016/j.colegn.2015.09.008 1322-7696. Australian College of Nursing Ltd. Published by Elsevier Ltd

Sanders E.B. and Stappers P.J. 2008. Co-creation and the new landscapes of design. *International Journal of CoCreation in Design and the Arts*, 4(1), 5-18.

Shah M. and Nair C.S. 2012 The changing nature of teaching and unit evaluations in Australian universities", Quality Assurance in Education, 20(3), 274 – 288.

SPARQS (Student Partnerships in Quality Scotland) [accessed online 14/10/18] available at: https://www.sparqs.ac.uk

Tee S. 2012 Service User Involvement – Addressing the crisis in confidence in healthcare. *Nurse Education Today*, 32(2), 19-20.

TEQSA 2018 Tertiary Education Quality and Standards Agency https://www.teqsa.gov.au/

González J, Isaacs K and Wagenaar R 2008 Applying the Tuning Approach to the third cycle. Tuning Education Structures in Europe.
http://www.unideusto.org/tuningeu/tuning-3rd-cycle/applying.html

Webster B., Goodhand K., Haith M. and Unwin R. 2012. The development of service users in the provision of verbal feedback to student nurses in a clinical simulation environment. *Nurse Education Today*, 32(2), 133-138.

Williams J. and Mindano G. 2015 *The Role of Student Satisfaction Data in Quality Assurance and Enhancement: How providers use data to improve the student experience.* Gloucester: QAA Subscriber Research Series 2015-16

World Health Organisation 2009 'Global standards for the initial education of professional nurses and midwives'