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Engaging, enabling and embedding professionalism through scrutiny of practice in healthcare

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**UNIVERSITY OF
PLYMOUTH**

**ENGAGING, ENABLING AND EMBEDDING
PROFESSIONALISM THROUGH SCRUTINY OF
PRACTICE IN HEALTHCARE**

by

MARGARET LOUISE FISHER

**Research portfolio submitted to the University of Plymouth in
partial fulfilment for the degree of**

**DOCTOR OF PHILOSOPHY
ON THE BASIS OF PRIOR PUBLISHED WORKS IN
NURSING AND MIDWIFERY**

School of Nursing and Midwifery

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I have so many people to thank for their contributions to the research portfolio presented as partial submission for my PhD on the Basis of Prior Published Works.

Firstly, I am indebted to the research and writing teams who have worked with me over the past 15 years. Their collaboration, commitment, constructive criticism and creativity have supported and inspired me. The various studies and publications would not have been the same without each individual's contribution and expertise. The Midwifery Practice Assessment Collaboration steering group has enabled wider dissemination and application of our research outputs, and it has been a privilege to be part of the team developing the new national midwifery practice assessment documents.

I am also very grateful to all the students, clinicians and academic participants in the studies, both locally and nationally, who have given their time to share their perspectives and experiences. This diverse range of individuals has challenged, corroborated and clarified findings, leading to the conceptual framework and model proposed in this programme of research. The LME-UK Executive, as both participants and gatekeepers, deserve particular mention; it has been an absolute pleasure to work with and represent them over the years.

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DECLARATION

At no time during the registration for the degree of Doctor of Philosophy has the author been registered for any other University award without prior agreement of the Doctoral College Quality Sub-Committee.

Works submitted for this research degree at the University of Plymouth have not formed part of any other degree either at the University of Plymouth or at another establishment. All projects and publications included in this body of work were undertaken subsequent to my achievement of MSc in Health Care and Educational Practice at the University of Plymouth in 2004. I am a dual-registered nurse and midwife and registered midwife teacher with the Nursing and Midwifery Council.

This submission comprises a set of works resulting from several collaborative projects undertaken between 2005 and 2019 during my full-time employment as a midwifery lecturer with the University of Plymouth. The outputs presented from this programme of research were published between 2009 and 2019. I can confirm that I was the Principal Investigator and lead of the teams throughout – preparing research proposals, collecting and analysing data, synthesising findings and developing recommendations.

I was the lead and corresponding author on all but one publication (this being delegated to another member of the team to enable me to focus on refinement of a resource); writing the majority of each work and inviting contributions from others as appropriate. My proportionate contribution to each work is identified in Chapter 3 (section 3.1), with evidence from co-authors in section 3.2.

Word-count of Integrative Summary (Chapter 1): 14,301

Signed: 

Date: 05/10/2020

ABSTRACT

‘Engaging, enabling and embedding professionalism through scrutiny of practice in healthcare’

Margaret Louise Fisher

Introduction: This portfolio presents a critical synthesis of the nature and significance of a programme of research, spanning a decade of the candidate’s academic career as a dual-registered nurse and midwife. Collaborative studies exploring pre-registration assessment of practice and post-registration revalidation in healthcare and social work have made a distinct contribution to the body of knowledge, through national and international dissemination. Findings from the set of nine published works continue to influence academic and clinical contexts, while also contributing to the evidence-base informing professional policy.

Aim: A conceptual framework is proposed, which seeks to advance the purpose of practice assessment and revalidation in healthcare through engaging individuals, enabling robust assessment processes and embedding positive attitudes to professional scrutiny.

Objectives:

1. To present the evidence from a range of research projects which have extended the body of professional knowledge relating to pre-registration assessment of practice and maintenance of healthcare registration through revalidation.
2. To appraise synergies between these pre-registration and post-registration processes, synthesised from the published outputs.
3. To formulate a conceptual model which promotes a continuum of purposeful professional development.

Methods: A range of methodologies was used to explore pre-registration practice assessment and post-registration revalidation in healthcare and social work. Mixed methods included an emphasis on qualitative data, although quantitative elements were included to identify trends. Research designs comprised longitudinal case studies, surveys, descriptive evaluations and a mini-Delphi discussion. One of the main projects within the programme of research, which generated four papers, included a focus on the action research process. The nature and significance of this research portfolio is demonstrated through systematic synthesis of the outputs, demonstrating coherence across the studies. The strengths and limitations of the programme of research and the leadership role of the candidate are reflexively critiqued.

Results and recommendations: Interrogation of the themes identified in both practice assessment and revalidation has identified commonalities in both facilitative and obstructive influences. Findings from this programme of research have corroborated much of the existing evidence-base, while methodological approaches have produced new interpretations and creative innovations. The research portfolio highlights that professional attitudes to scrutiny of practice are core to understanding and fulfilling the purpose of both practice assessment and revalidation. All stakeholders need to be prepared to engage in these processes by accepting responsibility for their own and others' ongoing development. Robust methods with a clear purpose enable professional growth and embed positive attitudes, thereby promoting safe and accountable practice throughout the individual's professional career. The evidence from this programme of research is integrated in a conceptual model which demonstrates the continuum from pre-registration period to qualified practitioner and beyond.

STRUCTURE OF THE RESEARCH PORTFOLIO

This research portfolio comprises the key documentation required for submission of a Doctor of Philosophy on the Basis of Prior Published Works. It has been divided into three chapters:

Chapter 1: Integrative Summary

This main chapter comprises the following sections:

- 1.1 Introduction
- 1.2 Aim of the research portfolio
- 1.3 Background
- 1.4 Contextual literature review
- 1.5 Theoretical framework
- 1.6 Contribution of the body of work to the discipline
- 1.7 Critique of methodology and reflexivity
- 1.8 Future perspectives
- 1.9 Conclusion

Chapter 2: Published Works

This chapter comprises the body of published works on which the research portfolio submission is based. These are categorised into three main sections; explanation for this logic is in section 1.3:

- 2.1 Engaging individuals in the process and purpose of assessment
- 2.2 Enabling robust assessment processes
- 2.3 Embedding positive attitudes to professional scrutiny

Each section includes an introductory list of the relevant works and their full citations. Individual works are preceded by a page including the candidate's personal contribution to authorship.

Throughout the research portfolio, publications are referred to by their numbers, shown in Figure 1 (e.g.: Work 1).

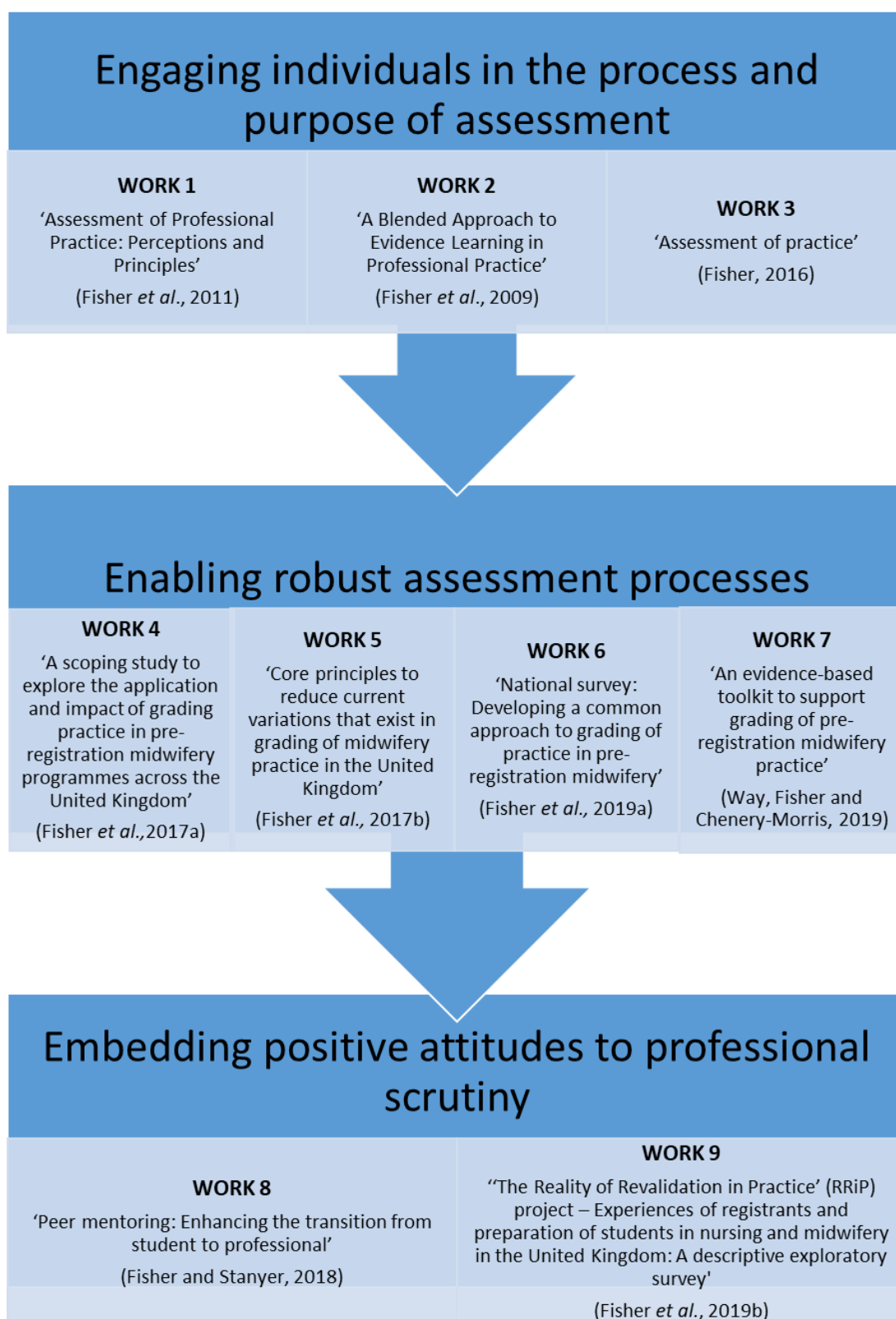


Figure 1: Body of works and categorisation

Chapter 3: Evidence of Contribution

This chapter comprises the required evidence of the candidate's contribution to the published works:

- 3.1 Role in collaborative works
- 3.2 Declarations from co-authors
- 3.3 Publications not included in research portfolio

Appendices

These comprise evidence to support section 1.6: Contribution of the body of work to the discipline. They include testimonials, communications and external feedback. These have been shared with permission or anonymised.

Terminology

Throughout the research portfolio, terminology for those supporting and assessing learning in practice is used inter-changeably. 'Mentor' is predominantly used as a generic term; it was relevant to the timeframe and regulatory body context during the majority of the programme of research and is widely used in the cited literature. Several published works refer to the term 'sign-off mentor', reflecting Nursing and Midwifery Council requirements for assessment of midwifery students throughout their programme and nursing students in their final placement (NMC, 2008), but this has only occasionally been included in the integrative summary. References to 'practice supervisor' and 'practice assessor' reflect more recent regulatory changes (NMC, 2018a; 2018b), and are mentioned in Works 6 and 7 as well as the integrative summary.

CHAPTER 1: INTEGRATIVE SUMMARY

1.1 Introduction

Regulatory bodies for healthcare and social work in the United Kingdom (UK) require students to gain experience in practice before registration (General Medical Council (GMC), 2016; Nursing and Midwifery Council (NMC), 2018a; Health and Care Professions Council (HCPC), 2019). These placement periods enable students to apply their knowledge in real-life settings, developing the skills and attributes integral to their chosen profession. The World Health Organisation (2009) stipulates that performance-based assessment of clinical learning in nursing and midwifery is undertaken by 'professional gatekeepers' (IFF Research, 2015); protecting public safety through assurance of competency. Professionals are subsequently required to maintain their registration through 'revalidation' (GMC, 2016; NMC, 2019a; HCPC, 2019).

This portfolio presents a coherent programme of research encompassing pre-registration practice assessment and post-registration revalidation in healthcare and social work professions, undertaken during the period 2005 to 2019.

Although midwifery was the main focus, multi-professional elements have strengthened findings and increased scope for wider application. A range of original projects has resulted in generation of innovative and complex ideas which extend the forefront of knowledge in the field. The works were externally refereed in a range of peer-reviewed publications, and presented at numerous national and international conferences.

The research portfolio is situated within the context of professional literature and policy relating to assessment of practice and revalidation. Synthesis of the body of work has identified synergies between these pre-registration and post-registration processes. A conceptual framework and model are presented, integrating the key themes and findings and promoting a continuum of purposeful professional development. Methodological approaches, philosophical assumptions and paradigms are appraised through reflexive critique. The contribution of the body of work to midwifery education, practice and research is presented and future perspectives are identified.

1.2 Aim of the research portfolio

Aim

A conceptual framework is proposed, which seeks to advance the purpose of practice assessment and revalidation in healthcare through engaging individuals, enabling robust assessment processes and embedding positive attitudes to professional scrutiny.

Objectives

1. To present the evidence from a range of research projects which have extended the body of professional knowledge relating to pre-registration assessment of practice and maintenance of healthcare registration through revalidation.
2. To appraise synergies between these pre-registration and post-registration processes, synthesised from the published outputs.
3. To formulate a conceptual model which promotes a continuum of purposeful professional development.

1.3 Background

The concept of practice assessment has long been of personal interest. This programme of research developed in an iterative process, involving a series of projects and publications led by the candidate, primarily focusing on pre-registration healthcare and social work practice assessment. Smaller pedagogic studies and development of educational resources were informed by, and contributed to, her academic practice. Appointment to the role of institutional revalidation lead enabled research to be extended to the post-registration period. The candidate was Principal Investigator for all three of the main projects:

- **Assessment in practice (Work 1):** A multi-professional project at the University of Plymouth (UoP) explored pre- and post-registration practice assessment in healthcare and social work through longitudinal multiple case study interviews. This was one of the development activities in the Centre for Excellence in Professional Placement Learning (Ce ppl), a Higher Education Funding Council for England Centre for Excellence in Teaching and Learning award. The research team comprised academics, clinicians, students and service-users from midwifery, social work and emergency care (nursing and paramedicine).
- **Grading of practice in pre-registration midwifery (Works 4, 5, 6, 7):** A five-year non-funded national project initiated by, and in collaboration with, the Lead Midwife for Education United Kingdom (LME-UK) Executive. A participatory action research approach enabled engagement with this group of 55 senior midwifery academics, representing each of the Higher Education Institutions (HEIs) delivering programmes leading to NMC registration as a midwife. The candidate led

a team of six colleagues from a range of universities. The first phase scoped practice assessment in midwifery across the UK, with a focus on grading. Drawing on these findings, the second phase sought consensus on a set of core principles, including a mini-Delphi discussion. The third and final phase comprised a national on-line survey of midwifery and nursing students, academics and clinicians; exploring experiences of practice assessment and testing grading tools devised by the project team. An evidence-based '*Practice Assessment Toolkit*' (PAT - Fisher *et al.*, 2019c) was developed from the project findings.

- **Reality of Revalidation in Practice (RRiP) (Work 9):** An on-line survey explored registrant experiences of undertaking, or supporting colleagues through, NMC revalidation. Preparation of students was also investigated. Participants included nursing and midwifery academics and final year students at the UoP, and clinicians from the local footprint. The research team comprised nursing, midwifery and medical academics and a nursing student.

The other works presented comprise:

- **Conference proceedings - Pilot practice portfolio (Work 2):** A report on development and evaluation of a pilot blended (electronic and paper) midwifery practice portfolio. The candidate led a research team comprising midwifery and nursing academics and a midwifery student.
- **Book chapter - 'Assessment of practice' (Work 3):** The candidate explained the process and purpose of practice assessment in this chapter of a co-edited book on midwifery placements.

- **Journal article for a special issue on mentorship models (Work 8):** A model for peer mentoring was presented in a professional paper. This drew on student evaluations of a pre-registration mentorship module led by the candidate and supported by a colleague.

Evidence of the candidate's contribution to each work is outlined in Chapter 3.

The three tables below provide a summary of the aims, objectives and key findings of each work. Categorisation reflects the theoretical framework proposed in section 1.5, aligning with the aim of the programme of research. The works are grouped according to their main application to the theoretical framework; other relevant categories are identified where synthesis of findings overlaps:

Table 1: Engaging individuals in the process and purpose of assessment

Table 2: Enabling robust assessment processes

Table 3: Embedding positive attitudes to professional scrutiny

Table 1: Engaging individuals in the process and purpose of assessment

Work Location Timeframe	Links to other categories	Aims and objectives	Key findings
Work 1 – 2.1.1 ‘Assessment of Professional Practice: Perceptions and Principles’ (Fisher <i>et al.</i> , 2011) University of Plymouth Nov 2005 to Nov 2010	Enabling robust assessment processes Embedding positive attitudes to professional scrutiny	To explore health and social care students’ experiences of practice assessment. To explore participants’ perceptions of the validity and reliability of methods used in their programmes. To explore the impact of the process of practice assessment on their learning.	<ul style="list-style-type: none"> • Major themes of process, preparation and purpose were identified throughout the study. • Additional themes became increasingly important: people, placements, and professional persona. • Perceptions of reliability and validity of the various methods of assessment used across the programmes concurred with the wider literature. • Concerns were raised about the potential to fabricate some of the methods; findings demonstrated inter-professional differences. • The impact of the context on the experience and reliability of the process – including environment and individuals – was highlighted. • Perceptions changed during participants’ journeys through their programmes, with the importance of professionalism and the links of this with practice assessment becoming increasingly evident in responses. • Understanding of the purpose and process of assessment by all stakeholders was emphasised as crucial to reliability, validity and effectiveness of methods.
Work 2 – 2.1.2 ‘A Blended Approach to Evidence Learning in Professional Practice’ (Fisher <i>et al.</i> , 2009) University of Plymouth April 2008 to July 2009	Enabling robust assessment processes	To present the development and pilot of an innovative blended midwifery practice portfolio. To promote the purpose of a portfolio as a learning method in individual students’ professional journeys.	<ul style="list-style-type: none"> • Overall positive feedback was received from students and academics about the new format. • A range of learning styles and self-assessed IT skills was represented, with no evident difference between participants’ abilities to adapt to the electronic format. • Written guidance was evaluated positively by participants, but verbal support would also have been useful. • The opportunity for students to demonstrate evidence of their learning and obtain formative feedback from personal tutors was well received. • Access issues were identified which helped inform the resultant bespoke e-portfolio.

<p>Work 3 – 2.1.3</p> <p>'Assessment of practice' (Fisher, 2016)</p> <p>Universities of Plymouth and Bournemouth</p> <p>Feb 2013 to Dec 2015</p>	<p>Embedding positive attitudes to professional scrutiny</p>	<p>To prepare midwifery students for practice assessment and promote professional attitudes towards this as part of lifelong development.</p>	<ul style="list-style-type: none"> • Findings from other studies (Works 1 and 4) were incorporated, together with key professional documents. • Links to fitness to practise were demonstrated. • Analogies and vignettes illustrated application of concepts. • 'Top tips' provided structured guidance for students.
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Table 1 (continued)

Table 2: Enabling robust assessment processes

+LME-UK Executive = Lead Midwife for Education United Kingdom Executive: A professional group of midwifery academics appointed by HEIs to be accountable to the NMC for midwifery education. Fifty-five HEIs were represented at the time of the project, across the UK (England, Northern Ireland, Scotland, Wales). The candidate was Principal Investigator throughout, and the UoP is the host for the project website.

Work Location Timeframe	Links to other categories	Aims and objectives	Key findings
<p>Work 4 – 2.2.1</p> <p>‘A scoping study to explore the application and impact of grading practice in pre-registration midwifery programmes across the United Kingdom’ (Fisher <i>et al.</i>, 2017a)</p> <p>United Kingdom, via the LME-UK Executive+</p> <p>March 2013 to Jan 2016</p>	Engaging individuals in the process and purpose of practice assessment	<p>To scope the range of approaches in applying the NMC (2009) standards for pre-registration midwifery education to grading of practice across the UK.</p> <p>To collate the various practice assessment processes used.</p> <p>To ascertain academic views on the impact of grading of practice on mark profiles.</p> <p>To determine clinicians’ views on grading of practice, via educationalists.</p>	<ul style="list-style-type: none"> • A wide range of approaches and processes was demonstrated across the UK, indicating a lack of parity in grading practice across midwifery programmes. • Variations included the credit weighting given to practice, application of grades or symbols and who was responsible for determining these. • Grade inflation was evident, but views on the importance of this varied. • A range of alternative assessments to moderate the impact of grade inflation was used across a number of institutions. • Clinicians appeared more confident in awarding the full range of grades as the process became embedded, enhancing decision-making for referral or reward of excellence; overall responses indicated a preference for grading as opposed to a binary pass/fail option. • Clinicians valued their role as gatekeepers to the profession. • Partnership-working between academics and clinicians was seen as very important to the effectiveness of the process of practice assessment. • Challenges in the process reinforced the wider literature.
<p>Work 5 – 2.2.2</p> <p>‘Core principles to reduce current variations that exist in grading of midwifery practice in the United Kingdom’ (Fisher <i>et al.</i>, 2017b)</p> <p>United Kingdom, via the LME-UK Executive+</p> <p>March 2015 to Feb 2017</p>	Engaging individuals in the process and purpose of practice assessment	<p>To enhance reliability of practice assessment by reducing variations in grading of practice identified in the first phase.</p> <p>To achieve consensus on a set of core principles.</p>	<ul style="list-style-type: none"> • Standardisation was welcomed by the LME-UK group, to enhance quality assurance and respond to concerns about grade inflation. • Continuation of grading practice in midwifery was supported, despite its challenges. • A set of 11 core principles achieved consensus following a process of refinement through a collaborative mini-Delphi discussion. • Principles were agreed relating to involvement and guidance of clinicians, assessing performance against clear criteria, ensuring correlation between grades and qualitative comments and encouraging use of the full range of grades.

<p>Work 6 – 2.2.3</p> <p>‘National survey: Developing a common approach to grading of practice in pre-registration midwifery’ (Fisher <i>et al.</i>, 2019a)</p> <p>United Kingdom, via the LME-UK Executive+</p> <p>Nov 2016 to Nov 2018</p>	<p>Engaging individuals in the process and purpose of practice assessment</p>	<p>To enhance standardisation of grading of practice in pre-registration midwifery through creation of a generic framework for awarding grades or identifying levels of attainment.</p> <p>To test reliability and validity of proposed grading tools, developed from a common matrix of terminology, in a national survey involving midwifery and nursing academics, clinicians and students.</p>	<ul style="list-style-type: none"> • A fairly low level of confidence in the reliability and validity of existing assessment tools and processes was identified. • Mixed views on the concept of grading practice were identified, with midwifery participants being most critical. • Grade inflation was identified, and some students perceived the process as unfair. • The importance of preparing and supporting those assessing students was highlighted. • Participants were positive about the involvement of others in the process, with several highlighting the impact of the mentor-student relationship on reliability of assessment. • There was a clear appetite for standardisation in processes and introduction of a national practice assessment tool in both midwifery and nursing. • The ‘Purpose of assessment’ was seen as central; focusing on objectively assessing the student to enable determination of safety to practise as well as the level of performance, while also contributing to the student’s learning. • Other major themes were ‘Structure of the tool’, ‘Standardisation’, ‘Art of mentoring’ and ‘Ongoing guidance and support of the assessor’, while ‘Human factors’ and ‘Other factors’ highlighted other influences. A conceptual model was presented. • The proposed tools comprising ‘Lexicon Frameworks’ and ‘Rubrics’ were evaluated; both were seen as potentially valuable in promoting standardisation and increasing inter-assessor reliability as well as being transferable across professions.
<p>Work 7 – 2.2.4</p> <p>‘An evidence-based toolkit to support grading of pre-registration midwifery practice’ (Way, Fisher and Chenery-Morris, 2019)</p> <p>United Kingdom, via the LME-UK Executive+</p> <p>Aug 2018 to April 2019</p>	<p>Engaging individuals in the process and purpose of practice assessment</p> <p>Embedding positive attitudes to professional scrutiny</p>	<p>To raise awareness of the key findings from the ‘Grading of practice in pre-registration midwifery’ project.</p> <p>To disseminate the ‘<i>Practice Assessment Toolkit</i>’ developed following refinement of the tools proposed in the third phase.</p>	<ul style="list-style-type: none"> • Key findings from the three phases of the project were summarised. • The importance of using practice assessment as a form of learning was emphasised. • The importance of providing feedback on areas of strength and weakness rather than focusing on the grade was highlighted. • Examples from the modified ‘<i>Practice Assessment Toolkit</i>’ were presented, and the location of the full toolkit on the project website was disseminated.

Table 2 (continued)

Table 3: Embedding positive attitudes to professional scrutiny

Work Location Timeframe	Links to other categories	Aims and objectives	Key findings
<p>Work 8 – 2.3.1</p> <p>‘Peer mentoring: Enhancing the transition from student to professional’ (Fisher and Stanyer, 2018)</p> <p>University of Plymouth</p> <p>2015 to 2018</p>	<p>Engaging individuals in the process and purpose of practice assessment</p>	<p>To share an approach to preparing pre-registration midwifery students for their future role in supporting and assessing learners.</p> <p>To demonstrate the advantages of developing required skills prior to qualification.</p> <p>To disseminate a peer mentoring model.</p>	<ul style="list-style-type: none"> • The structure and purpose of the pre-registration module was explained. • The range of ‘fieldwork’ activities in which students were able to engage were presented. • Mutual benefits to the students and their recipients were demonstrated; including learning and an enhanced passion for their chosen profession. • Students undertaking the module gained confidence in their theoretical knowledge and clinical skills. • Students developed skills in providing constructive feedback and facilitating learning, including through role-modelling. • Evidence of the positive impact on development of a professional persona was provided. This included changing perceptions of the role and responsibility of the mentor, emotional intelligence and preparedness for transition to a qualified midwife. • A conceptual model was presented.
<p>Work 9 – 2.3.2</p> <p>‘The Reality of Revalidation in Practice’ (RRiP) project – Experiences of registrants and preparation of students in nursing and midwifery in the United Kingdom: A descriptive exploratory survey’ (Fisher <i>et al.</i>, 2019b)</p> <p>University of Plymouth and associated clinical settings</p> <p>Nov 2016 to July 2019</p>	<p>Engaging individuals in the process and purpose of practice assessment</p> <p>Enabling robust assessment processes</p>	<p>To explore the experience of registrants undertaking revalidation or supporting others through this process.</p> <p>To explore preparation of students for future revalidation.</p>	<ul style="list-style-type: none"> • The experience of undertaking revalidation was overall positive, particularly the reflective elements. • University participants appeared generally more satisfied than clinicians. • Reflective discussion partners and confirmers were important – they needed to understand the process, be supportive and not have conflicts of interest. • Some registrants were able to choose their revalidation partners while others were not; some deliberately decided to use a colleague external to their normal place of work, facilitating objectivity. • Registrants valued the opportunity for peer feedback and collegiate discussions. • Most registrants took the process seriously, although some saw it as a ‘tick-box exercise’. • Changes for registrants’ future revalidation focused on improved forward-planning and organisation.

			<ul style="list-style-type: none"> • Governance and scrutiny were welcomed by the majority – including transparency from the NMC. • Registrants supporting colleagues felt empowered by this role while benefitting from mutual learning and a greater understanding of others' roles. • Challenges included organisation of meetings, lacking choice in revalidation partners, time to collate evidence and potential conflicts of interest which could compromise reflective learning or transparency of the process. • Not all registrants were reassured that the purpose of revalidation had been achieved, particularly doubting its impact on public confidence. • Midwifery students felt better prepared than nursing. • Several pre-registration activities helped prepare students, including those involving reflection, maintenance of a portfolio and self or external assessment of practice. • A conceptual model was presented.
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Table 3 (continued)

1.4 Contextual literature review

Although the existing body of knowledge relating to professional practice assessment is extensive, synergies between professions and countries have not been well documented. There is a paucity of research into revalidation, and links between this and practice assessment have not previously been identified. This section provides a contextual review of some of the key issues raised in this programme of research, and its contribution to the published evidence base.

1.4.1 Professionalism and regulatory requirements

The purpose of healthcare and social work programmes is to ensure competence for professional registration, thus protecting public safety (Royal College of Nursing (RCN), 2016). Cruess, Johnston and Cruess (2004) developed a working definition of 'professionalism', incorporating concepts such as knowledge and skills, vocational science and art, ethics and governance, high morals and values, accountability, autonomy and self-regulation. The Royal College of Physicians (2005) suggested that excellence rather than competence should be the goal, with professionals committed to personal and peer scrutiny of their work. Corporate responsibility was identified, and the role of educators in promoting professionalism clarified (HCPC, 2015; NMC, 2018a).

A number of widely reported cases of poor practice have, however, reduced public confidence. These include reports by Keogh (NHS England, 2013), Francis (Department of Health (DoH), 2013) and Kirkup (2015), while a major inquiry into the safety of maternity services has recently been launched (Ford, 2020). Nieva and Sorra (2003) identified the need for a cultural change – seeing

mistakes as an opportunity for learning, rather than blaming individuals and discouraging challenge of systemic failures. Francis (DoH, 2013) recommended fundamental changes to professional regulation, education, leadership and quality assurance in his seminal report into substandard care in the Mid Staffordshire Trust. In response, the NMC commissioned a national evaluation of their existing standards by IFF Research (2015); subsequent changes are shown in Figure 2. Midwifery regulation was also amended in response to the Kirkup (2015) report (NMC, 2017a; NHS England, 2017). Changes were made to medical revalidation (GMC, 2016), and the HCPC (2019) reviewed allied health professions and social work processes. This historical summary puts into context the period of the programme of research to which the candidate and her teams were responsive; the outputs contributing to the nursing and midwifery evidence-base.

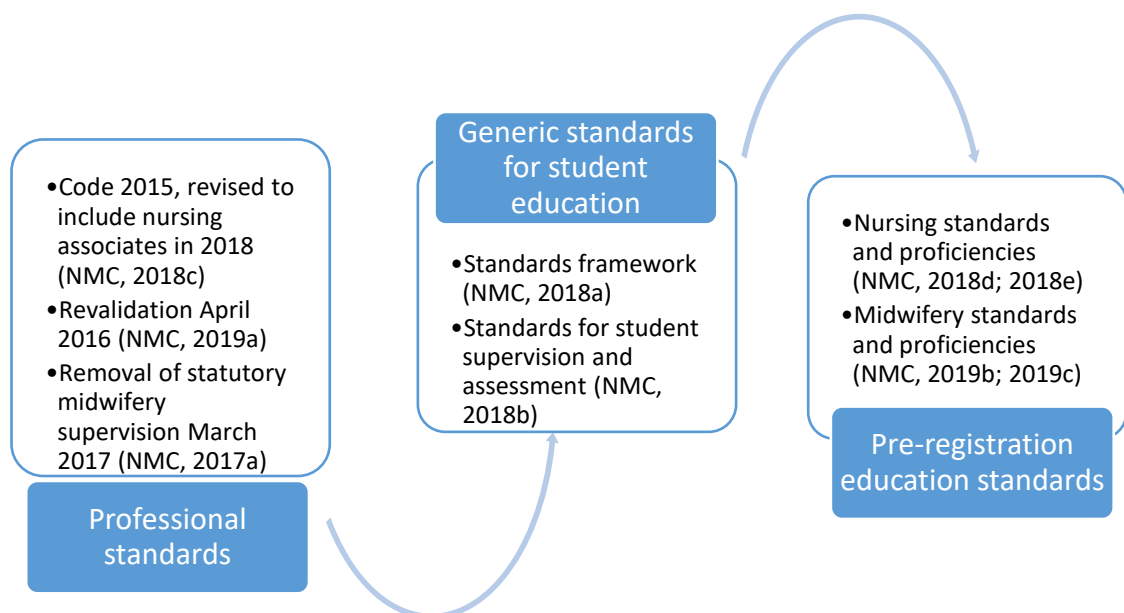


Figure 2: NMC changes in response to the Francis report (DoH, 2013), IFF Research review (2015) and Kirkup report (2015)

1.4.2 Professional relationships and reliability

Across the programme of research, positive experiences of practice assessment and revalidation required engagement of the assessor or fellow-registrant, demonstration of professionalism and accountability, experience of the specialism and understanding of their role. Relationships were paramount, endorsed by Rance and Sweet (2016), with essential attributes including effective listening skills, a supportive approach and acknowledgement of conflicting pressures. Bradshaw, Pettigrew and Fitzpatrick (2019) emphasised the importance of students feeling valued as members of the team. This brought a sense of belonging – described by Levett-Jones *et al.* (2009) as a fundamental human need, optimising learning and progress; a view upheld by McKenna *et al.* (2013) and Hallam and Choucrist (2019). Insufficient numbers of mentors, conflicts between service requirements and student needs, power struggles and a failure of staff to appreciate students' stress in meeting academic, practice and personal demands were problematic in Work 1, while over-controlling mentors, inconsistencies in approach, teaching style or expectations also created challenges (Works 1, 4, 6, 9). The latter highlighted concerns about potential conflicts of interest if the confirmer was a line manager with their own agenda, such as an employer with limited staff – a view upheld in Ipsos MORI (2018), who suggested that this relationship could change the dynamics of the reflective discussion. Work 9 emphasised the value of choice, enabling open discussion with a trusted colleague, whereas Hughes and Fraser (2011) noted an element of 'luck' in allocation of mentors for pre-registration students.

Although participants in Works 1 and 6 suggested that consistency in mentorship enabled students to establish their abilities and build up trust, Chenery-Morris (2015) underlined the importance of maintaining clear boundaries. Subjectivity is widely recognised as a major cause of unreliability in practice assessment (Bennett and McGowan, 2014; Helminen *et al.*, 2016). The theme of ‘human factors’ identified in Work 6 emphasised the role that the relationship between mentors and students played. One participant noted a tendency for grades to be higher if the student was previously known to the mentor, corroborating findings reported by Cassidy (2009). Chenery-Morris (2015) advocated gaining feedback from a range of individuals, corroborated in Works 1, 3 and 6, and subsequently required by the NMC (2018b).

Fotheringham (2010) argued that triangulation by different observers could, however, exacerbate unreliability by perpetuating the ‘halo’ or ‘horns’ effect if they were members of the same team. Registrants who selected, or acted as, an external revalidation partner considered that this facilitated objectivity (Work 9; Ipsos MORI, 2017).

The attitude and experience of the practice assessor or revalidation partner was pivotal to the quality of the interaction and reliability of each process. The majority of registrants took their role seriously and valued the part they played in determining who was fit to enter or be maintained on the register (Works 1, 3, 4, 9); corroborating Lafrance, Gray and Herbert (2004) and Moran and Banks (2016). Students in Work 8 were cognisant of their future role as gatekeepers to the profession. However, registrants who were disinterested or lacked the skills for this role compromised the quality and reliability of assessment (Work 1; Duffy, McCallum and McGuinness, 2016; Burden, Topping and O’Halloran,

2017) and the experience of revalidation (Work 9; Ipsos MORI, 2017; Archer *et al.*, 2018). This could not only de-motivate students, but also contribute to the phenomenon of failure to fail, widely reported in the literature (Duffy, 2003; Bachmann *et al.*, 2019). Hunt *et al.* (2012) determined that theoretical failure exceeded practice referral by a ratio of 5:1 in nursing programmes across England. Assessors who feared conflict (Brown *et al.*, 2012), thought their decision might be perceived as unfair (Cleland *et al.*, 2008), felt guilty for spending insufficient time with students (Elliott, 2017) or were worried about the repercussions (Luhanga, Myrick and Yonge, 2010; Jervis and Tilki, 2011) were prone to 'failing to fail' underperforming students, across a range of professions.

1.4.3 Reliability and validity of processes

Participants in Work 1 demonstrated diverse views when asked whether potentially unsafe students could achieve professional registration. This was considered unlikely in midwifery due to the consistency of mentorship, continuous observation of practice, involvement of other staff and use of tripartite assessments. Emergency care nurses and paramedics reported that objective structured clinical examinations (OSCEs) and the student-led verification tool (SLVT) provided protection, but were critical of ambiguity of assessment documents. Social work students did not perceive that assessment processes in their programme were sufficiently robust to identify negligence.

Fotheringham (2010) concluded in her literature review that reliability was enhanced through triangulation using different methods of assessment, with which Chenery-Morris and Passmore (2012) concurred. Work 4 similarly identified the value of 'moderating influences', including a range of approaches

additional to direct assessment of clinical practice. Methods explored in Works 1, 2, 4 and 6 included portfolios, reflections, OSCEs, graded and non-graded competence-based tools such as the SLVT, episodic observations of practice, tripartite assessments and involvement of service-users in professional conversations. The scope was therefore extensive, providing useful comparisons and extending the existing body of knowledge. Methods reflecting real-life situations received most positive evaluations. All entailed some form of direct observation, demonstrating a willingness by most students to have their safety to practise tested. They valued opportunities to evidence their competence in settings where there was a 'safety net' of non-clinical engagement (midwifery and emergency care OSCEs) or they could prepare for service-user encounters (social work observations and conversations). However, these 'snapshot' assessments could result in the Hawthorne effect, stress, atypical practice and dilemmas between meeting student and service-user needs. Similar findings have been noted in the literature across a range of professions: stress in OSCEs (Brosnan *et al.*, 2006; Byrne and Smyth, 2008), artificial or 'stage-managed' environments (Jay, 2007; Clouder and Toms, 2008) and conflicts of interest (Speers, 2008; Moran and Banks, 2016). Continuous assessment was believed to offer greatest authenticity, despite proving wearing at times (Work 1). This provided opportunities to reflect with the mentor, enabling contemporaneous feedback and constructive guidance to be received from someone who had seen students 'in practice'; a view supported by Clynes and Raftery (2008) and Duffy (2013).

Familiarity with portfolio development was identified as important preparation for revalidation in Work 9. Participants in Works 1 and 2 were generally positive

about the ability of portfolios to focus learning, promote critical thinking and provide records of progress, corroborating findings from Nairn *et al.* (2006) and McMullan (2008). These authors suggested that learning could, however, be compromised if they were summatively assessed rather than fulfilling a developmental purpose. Mirroring findings by Corcoran and Nicholson (2004) and McMullan (2008), some students in Works 1, 2 and 6 found portfolios cumbersome and workload-intensive. In contrast, the part-electronic portfolio piloted in Work 2 was overall positively evaluated, enabling formative review as advocated by Haigh, Dearnley and Meddings (2007). The PAT (Fisher *et al.*, 2019c; Works 6 and 7) aligned well with this integrated online approach, facilitating consistent feedback and accessibility.

Although the literature acknowledges the value of self-assessment (Elton, 2004; Haigh, Dearnley and Meddings, 2007), only a few HEIs included this in midwifery programmes (Work 4), and emergency care students in Work 1 were unsure of their ability to self-evaluate accurately. They also questioned the validity of self-selection of evidence for their portfolios; several raised concerns about the potential to “*cheat the system*” or “*blur the edges*” when compiling these (p9). Work 9 raised similar concerns about selecting peer or practice-related evidence for revalidation, corroborated in Ipsos MORI (2017) and Archer *et al.* (2018). Although reflections were considered to promote learning in Work 1 (supported by Bradshaw, Pettigrew and Fitzpatrick, 2019) and received extensive support in Work 9 (corroborated by Beach and Oates, 2015; Ipsos MORI, 2018), their use in summative assessment was more controversial. McMullan (2006) observed that reflective writing was not always honest, and apportioning marks could reduce its effectiveness as a learning tool. Work 1

mirrored these concerns, with participants stating that some students failed to focus on areas for improvement, or wrote what they thought the examiner wanted to read. Emergency care participants negatively evaluated their clinical incident logs as these had the potential for fabrication. Conversely, students noted that OSCEs could not be manipulated, making them a more reliable form of assessment.

Across the programme of research, a partnership approach to development of assessment tools and processes was valued, supported by Bourbonnais, Langford and Giannantonio (2008) and Ulfvarson and Oxelmark (2012). The importance of academic support for those assessing practice has been highlighted (Works 1, 4, 6; Jervis and Tilki, 2011; Black, Curzio and Terry, 2014). Nursing students in Price *et al.* (2011) noted that clinical visits by academics promoted valuable formative discussions about their progress. Fraser *et al.* (2011, p39) observed that these conversations facilitated mentor confidence in “*letting go*” of students; essential in aiding the transition to qualified midwife status (Avis, Mallik and Fraser, 2013). Tripartite meetings for managing student concerns have been recommended in a range of healthcare and social work professions (Duffy, 2003; Haigh, Dearnley and Meddings, 2007). Students and mentors appreciated the presence of the academic and the opportunity to reflect on practice, while Passmore and Chenery-Morris (2014) acknowledged the value all three individuals brought to the interaction. Students could be passive recipients, however, especially if they did not have a good relationship with their assessor (Haigh, Dearnley and Meddings, 2007; Chenery-Morris, 2014); participants in Work 1 compared them to a “*parents evening*” (p12). This approach has, however, been found to enhance intra- and

inter-assessor reliability in midwifery programmes by promoting congruency between mentor comments and grades awarded (Works 1, 4, 6; Fraser *et al*, 2011; Helminen *et al*, 2016).

1.4.4 Grading

Attitudes to grading of practice were mixed. Benefits cited in Works 1, 3, 4 and 6 included motivating students, rewarding achievement and valuing practice; supporting findings in Donaldson and Gray's systematic review (2012). Mentors' increased confidence in undertaking the grading process enhanced their decision-making, enabling them to be more constructive in their referral of students as well as rewarding high achievers (Work 4); Burden, Topping and O'Halloran (2017) reported similar findings. Clinicians were not enamoured with a binary pass/ fail categorisation and considered grading essential to reflect students' capabilities (Work 4), reflecting views of Heaslip and Scammell (2012) and Hallam and Choucri (2019). Fraser (2000) reported variability in quality of methods such as portfolios, if marks were not awarded. Criticisms of grading in Works 4 and 6 reflected evidence in the literature: inappropriate use of tools (Gray and Donaldson, 2009; Heaslip and Scammell, 2012), lack of parity within and across programmes (NHS Education for Scotland, 2008; Willis, 2015); inconsistencies between mentors (Heaslip and Scammell, 2012; Chenery-Morris, 2014); reluctance to use the full range of grades available (Donaldson and Gray, 2012) and perception of some students that the mark awarded failed to reflect their achievements in practice (Chenery-Morris, 2014; Hallam and Choucri, 2019).

Although grading in UK midwifery practice has demonstrated a more normal distribution curve in recent years (Work 4), it remains skewed to the higher marks, reflecting experiences in medicine and nursing (Cacamese, Elnicki and Speer, 2007; Heaslip and Scammell, 2012). Gray and Donaldson (2009) noted a prevalence of grade inflation in practice assessment across 14 professional groups. In an American study, Paskausky and Simonelle (2014) identified a discrepancy of five or more marks between clinical and academic profiles for 90% of nursing students, while 18% differed by 20 or more marks. This phenomenon is not exclusive to healthcare, however. Bachan (2017) noted an increase in the proportion of first and second class honours degrees across UK university programmes since the millennium. He mooted the influence of various pedagogic and social-cultural factors, including student-funded tuition, while Work 4 acknowledged increased academic entry requirements. Perry (2015) found that midwifery students typically performed better in practice, and Lok, McNaught and Young (2016) argued that such a pattern was acceptable if it reflected the quality of enrolled students. Work 6 cautioned that although grade inflation advantaged students' academic profiles, it may reflect inconsistencies in methods and assessors. Passmore and Chenery-Morris (2014) concluded that factors leading to this phenomenon included pressure from the student, a desire to avoid conflict and to give them the benefit of the doubt. Isaacson and Stacy (2009) and Donaldson and Gray (2012) recommended the use of rubrics to enhance reliability and reduce grade inflation; an approach which was adopted in Works 6 and 7.

1.4.5 Peer teaching and assessment

The literature has suggested that role modelling of practice, skills and values is a significant contributor to professional development. Students have valued peer support, as their feelings are understood (Aston and Molassiotis, 2003; Akinla, Hagan and Atiomo, 2018), helping them to have a sense of belonging (Black and MacKenzie, 2008) while reducing anxiety (Christiansen and Bell, 2010). McKenna and Williams (2017) focused on the 'hidden curriculum', including the influence of senior students on socialisation and development of professional identity, reflecting Bandura's social learning theory in which identification with a role model reinforced behaviour (McLeod, 2016). Felstead and Springett (2016) suggested that students could differentiate between positive and negative exemplars. Third year students in Work 8 demonstrated an increased awareness of the importance of being effective role models, while their juniors valued these interactions. The final year students clearly gained confidence as they realised how far they had progressed.

Although various publications refer to the concept of peer teaching, or peer assisted learning, in healthcare professions, formal preparation is limited. Andre, Deerin and Leykum (2017) and Akinla, Hagan and Atiomo (2018) explored informal academic peer mentoring in medical schools. Neither clinical teaching sessions in Oslo, USA and Iran (Christiansen *et al.*, 2011; Brannagan *et al.*, 2013; Ravanipour, Bahreini and Ravanipour, 2015), nor cross-professional workshops between second year physiotherapy and first year nursing students in the UK (McLeod, Jamison and Treasure, 2018) included evidence of theoretical preparation. Rosenau *et al.* (2015), however, developed

an optional course for senior nursing students in Canada, involving co-teaching theory and clinical skills to junior peers.

The approach taken in the mandatory module (Work 8), equipping pre-registration midwifery students with mentorship skills, preceded the new NMC standards (2018d; 2019b) and proficiencies (2018e; 2019c) for nursing and midwifery programmes. Students are now required to gain theoretical instruction on the principles and methods of teaching, preparing them for their future role as practice supervisors (NMC, 2018b). A recent search of CINAHL Plus and MEDLINE, using the Boolean terms of 'midwif' *and* 'peer' *and* 'student', restricting this to research in English publications, identified only five additional publications on peer teaching in midwifery, none of which took as comprehensive an approach as in Work 8. A brief introductory session for final year students was followed by occasional interactions with first years (Hogan, Fox and Barratt-See, 2017; McKellar and Kempster, 2017), while two other Australian programmes provided theoretical preparation for discrete clinical skills sessions involving paramedic or first year midwifery students (McLelland, McKenna and French, 2013; Rance and Sweet, 2016). A clinical learning dyad model comprised orientation by a senior midwifery student in the first few days of placement in Utah (Cohen, Thomas and Gerard, 2015), with no academic input, and all students were already registered (licensed) nurses.

In recent years, there has been a move towards senior students working alongside juniors in clinical settings. Aston and Molassiotis (2003) took an informal approach to this, receiving criticism for not preparing the senior students. The more structured Collaborative Learning in Practice (CLIP) model

is becoming increasingly popular internationally (Harvey and Uren, 2019). A pilot at the University of East Anglia (Lobo, Arthur and Lattimer, 2014) received acclaim in the Willis Report (2015) as an example of good practice. A systematic review by Williamson *et al.* (2020a) identified that the evidence-base for this model in nursing placements was limited, and a subsequent qualitative study has extended this knowledge. Williamson *et al.* (2020b) found that this approach promoted individual professional development through increased clinical responsibility and peer interaction. In Work 8, some third year midwifery students organised teaching sessions in practice for their junior peers. This formalised buddy system aligned with recommendations by McIntosh, Gidman and McLaughlin (2013).

A focus on assessment skills in Work 8 was valuable in developing the art of constructive feedback. The students appreciated their accountability for decision-making and the importance of developing skills in scrutinising others. They identified the opportunity to co-examine mock OSCEs as particularly beneficial. Hellström-Hyson, Mårtensson, and Kristofferzon (2012) found that peer teaching promoted skills in critical judgement, while Christiansen *et al.* (2011) noted that senior students subsequently became more actively involved in seeking feedback from tutors on their own performance. Finnerty and Collington (2013) highlighted the importance of preparing mentors to use strategies such as scaffolding and fading. This module provided an opportunity to develop these skills, whilst the students themselves became increasingly conscious of personal benefits when their mentors engaged in such strategies.

1.5 Theoretical framework

This programme of research has explored wide-ranging approaches to practice assessment and revalidation. Understanding of the purpose and embracing positive attitudes to these processes became increasingly evident as key to achieving and maintaining professional outcomes. A theoretical framework is proposed, drawing on the emergent themes and setting these in the context of relevant literature. A conceptual model is presented, informed by earlier iterations, demonstrating the importance of engaging, enabling and embedding these principles in a continuum from the pre-registration period onwards.

1.5.1 Engaging individuals in the process and purpose of assessment

Process-driven practice assessment was described as *“jumping through hoops”* (p15) and a *“box to tick”* (p118) in Work 1. Some revalidating registrants in Work 9 similarly used this term, stating they were just *“going through the motions”* (RNU30, p24), reflecting findings in nursing and midwifery (Ipsos MORI, 2017; Attenborough and Abbott, 2018a) and medicine (Archer *et al.*, 2018). Self-assessment was promoted in Work 2 through creation of an electronic portfolio. Some participants embraced the concept of mapping evidence of their progress to learning outcomes; one student finding it beneficial to use hyperlinks as this *“shows evidence of learning”* (p117). Works 2 and 3 emphasised the role of portfolios and other forms of assessment as learning tools, promoting lifelong learning; links between pre-registration experience and preparation for revalidation were made explicit in Work 9. Those stakeholders who took the revalidation process seriously clearly understood its developmental purpose.

As the longitudinal interviews progressed in Work 1, participants were able to move from 'doing the job' (gaining knowledge and learning skills) to 'being a professional' (developing and applying personal attributes). They acknowledged that practice learning and its assessment prepared them for qualification, recognising that the purpose was to judge suitability for their future role. They described a heightened appreciation of reflection and reflexivity, enabling them to more readily create links between theory and practice and self-determine progress in skills development, knowledge and professional competence. One suggested that learning how to undertake assessments was an important part of the whole experience of discovery (p19), reflecting Hafferty's (2017) description of the journey of professionalism.

The 'journeys' experienced by participants in Work 1 focused on their personal progression through their programme to point of registration. In contrast, the students in Work 8 recognised that their accountability as a safe practitioner extended to development of the future workforce. They described a deeper understanding of the importance of self-awareness, responsibility to others – including failing students when necessary – and a sense of having *“something to offer that is valued”*. Students stated that the module had helped them *“to think more like a qualified midwife”* and their *“professional persona [was] beginning to develop”* (Figure 3, p58). One noted that *“transition from student to midwife has begun”* (p59). Appreciation of the importance of maintaining own and others' professional registration through nursing and midwifery revalidation was similarly highlighted in Work 9. Although the association between learning and assessment has increasingly been acknowledged in the literature (Nicol,

2007; Redmond *et al.*, 2018), this extended trajectory of professional development in supporting others has not previously been explicitly evidenced.

Positive perceptions of practice assessment methods involving reliable approaches to internal or external scrutiny were demonstrated throughout this programme of research. Students were appreciative of the importance of giving and receiving feedback. A desire for authenticity and growth was identified amongst most respondents in Work 9, reflected in a willingness to challenge and be challenged by trusted colleagues, and an appetite for external governance. In contrast, a number of participants in Work 1 identified the potential for certain assessment processes to be manipulated, demonstrating a lack of appreciation of the purpose of assessment beyond personal achievement. The dangers of students focusing on their own goals rather than needs of patients were highlighted by Hunt *et al.* (2016). They found that coercive behaviours by some pre-registration nursing students compromised integrity of assessment, suggesting that narcissistic personality traits resulted in a culture of expectation. Tuffour (2018) questioned whether competitiveness between HEIs and self-funding of healthcare education, turning students into consumers, risked indulging their needs and exacerbating egotistical attitudes. This could further compromise reliability of practice assessment. Worryingly, some of the comments in Work 1 were made by qualified nurses and paramedics, raising doubts about professional integrity. Gainsbury (2010) similarly reported mentors falsifying paperwork to enable students to pass, despite not having witnessed their practice. Manipulation was likewise evident (albeit limited) in the revalidation process (Work 9) – a concern also raised by Attenborough and Abbott (2018a). The most powerful voice came from service-

users themselves, who perceived an underlying culture of professionals failing them and destroying public trust by allowing incompetent students to enter the register and systemic deficiencies to persist (Malihi-Shoja *et al.*, 2013).

Cassidy, Coffey and Murphy (2017) claimed that emotional intimacy with students could compromise accountability of judgement in borderline assessment decisions. Black, Curzio and Terry (2014) conducted a hermeneutic study with participants who had been involved in failing final year nursing students. A “*moral virtue of courage*” (p229) was needed to make these judgements – sometimes in the face of opposition from the student, colleagues or university. Mentors experienced ‘moral stress’ including physical and psychological manifestations of guilt and anger, while questioning their own competence. They expressed disappointment with colleagues who had not upheld accountability towards the public, lacking ‘moral integrity’ through self-concern and lack of courage. ‘Moral residue’ resulted from mentors’ conscious choice to make the right decision in an objective assessment, mindful of their role as gatekeepers, despite the challenges and consequences of their actions. Begley and Piggott (2012) explained that these individuals could recover from moral stress as they had resolved a problem by acting according to their values and principles. They felt vindicated when they realised that students had been responsible for their own failure (Hunt *et al.*, 2016). In contrast, Begley and Piggott (2012) stated that ‘moral distress’ was caused by an individual knowing and wanting to comply with their moral duty, but lacking the moral courage to do so, or being constrained by external obstacles. This could result in lasting negative effects. Accountability for scrutiny of others’ practice clearly has a significant impact on the individual concerned, particularly when concerns arise.

Works 4 and 6 and the wider literature emphasise the importance of collegiate support to make these difficult decisions. Both students and registrants need to be engaged in the purpose of practice assessment and revalidation, recognising their personal responsibility and accountability in these professional processes.

1.5.2 Enabling robust assessment processes

This programme of research explored factors enhancing validity and reliability of practice assessment methods. Commonalities emerged, but differences were also noted between the various approaches and professions. As the studies progressed, it became evident that some obstructive aspects of practice assessment would inevitably persist due to the nature of healthcare and human factors. Key principles and proposed interventions began to show potential to alleviate certain challenges and raise awareness of others, thereby reducing their impact.

Having identified multiple inconsistencies in applying the NMC (2009) midwifery standards across the UK during the initial scoping phase of Work 4, consensus was achieved on a set of core principles for grading practice (Work 5). In collaboration with the LME-UK Executive, it was unanimously agreed to take forward one of these principles: to develop a generic tool measuring levels of performance, with the aim of reducing subjectivity and improving consistency in practice assessment. This goal was supported by Chenery-Morris and Passmore (2012) in their concept analysis of grading midwifery practice. Van der Vleuten and Schuwirth (2005) suggested that reliability was enhanced when a holistic approach was taken, comprising quantitative measurement in conjunction with a qualitative narrative. Lok, McNaught and Young (2016)

supported this stance, recommending a hybrid technique. In this model, a set of criteria (criterion referencing) is developed about the expected performance of a group (norm referencing). The rubrics are then applied to grades, and the student's performance is monitored against these criteria, creating a feedback loop. Acknowledging the diversity of midwifery registrants and students, and mindful of the NMC outcomes-based approach (2018e; 2019c), the PAT was created (Work 7; Fisher *et al*, 2019c). This enabled individuals to select from Wordles, Lexicon Frameworks and Rubrics, drawn from the common origin of a matrix of terms used in multiple programmes nationally (Work 4, 6).

The importance of professional performance was stressed in Work 6 and the PAT, rather than focusing on a numerical goal. Chamberlin, Yasué and Chiang (2018) found that grading motivates some students, whereas others find this increases anxiety. Practitioners were therefore encouraged to ensure consistency and specificity of narrative feedback to guide decisions about progress and achievement, irrespective of whether or not an actual mark was awarded. This approach was upheld by Shepard, Penuel and Pellegrino (2018). Findings in Works 4 and 6 suggested that mandatory grading of practice in pre-registration midwifery (NMC, 2009) had resulted in increased sign-off mentor confidence and enhanced discernment in judgements. It is important not to risk jeopardising this progress. Recent removal of this requirement (NMC, 2019b) and changes to the model of student supervision and assessment (NMC, 2018b) provide flexibility to HEIs about whether or not to continue to grade midwifery practice. Negativity towards grading seen in much of the literature, and reinforced in some of the midwifery responses in Work 6, may lead to programme teams resorting to the binary option of pass/fail. Grade inflation has

also been a major cause of dissatisfaction, and caution needs to be taken that practice assessors do not over-compensate for this phenomenon by erring towards average judgements (Brennan et al, 2017) – with or without numerical scores – as this has the potential for the converse outcome of failure to fail. Whether or not programme teams decide to continue with grading, close attention to descriptors remains essential to discriminate between those students who are achieving or not. Guidance on levels of performance will also provide constructive feedback and feed-forward for their development.

Many challenges and strengths of practice assessment were mirrored in the revalidation process. Work 9 and the national evaluation by Ipsos MORI (2017; 2018; 2019) highlighted the benefits of reflective and continuing professional development (CPD) activities. Similar weaknesses were found, such as taking a minimalistic approach, and a tendency towards seeing the process as a ‘tick-box exercise’ if it was not valued by stakeholders. A lack of openness in discussions if ‘choice’ of partner was not permitted, or dilution of the professional focus if revalidation was aligned with appraisals reflected findings in the GMC evaluation (Archer *et al.*, 2018).

Some subjectivity during inter-personal evaluation is inevitable. It is therefore essential that all stakeholders are mindful of the inherent complexities of practice assessment and revalidation, seeking to accommodate the human and other factors influencing judgements and outcomes. This not only includes an understanding of the purpose and a realistic but constructive approach to the strengths and limitations of the processes, but also embedding of professional attitudes.

1.5.3 Embedding positive attitudes to professional scrutiny

Predictive validity (Calnan, 2007) is arguably the most important measure of practice assessment, and central to the reflective component of revalidation (NMC, 2019a). Although the core principles in Work 5, unanimously upheld in Work 6, highlighted assessment of performance rather than a personal judgement, the individual's ability to interpret and rationalise decisions and actions are fundamental elements of professionalism, dictating future performance. The NMC publication 'Enabling professionalism in nursing and midwifery practice' (2017b, p3) states that "*Professional nurses and midwives demonstrate and embrace accountability for their actions*". This programme of research has shown that engagement of individuals and enabling of robust assessment processes contribute to professionalism. Preparedness to accept responsibility for personal ongoing development and self-regulation, and promotion of openness to professional scrutiny must, however, be sustained.

Students in Work 8 commented on the contribution the module made to their self-empowerment and development of a professional persona. Akinla, Hagan and Atiomo (2018) identified similar concepts in a systematic review of peer mentoring, noting that this promoted problem-solving, communication and leadership skills as well as enhanced self-awareness, resilience, empathy and accountability; characteristics of emotional intelligence. Eby *et al.* (2008) and Miao, Humphrey and Qian (2017) referred to 'organisational citizenship', recognising the value of mentoring in developing workplace proficiencies. Findings from Work 8 that this preparation was beneficial to prospective employment was supported in Andre, Deerin and Leykum (2017) and McLeod, Jamison and Treasure (2018). It was evident in Work 9 that similar skills were

needed by those fulfilling the roles of reflective discussion partners and confirmers, demonstrating the potential for wider application of peer mentoring experiences.

Registrants involved in assessing others need to be empowered to exhibit the 'moral courage' promoted by Black, Curzio and Terry (2014). Hunt (2019, p1479) described the necessity for a "*core of steel*", to ensure that only those students who should, enter the register. It seems to the candidate that the phenomena of grade inflation and 'failure to fail' are alternate sides of the same coin, with courage also being required to award realistic, evidence-based grades. This can be particularly challenging when faced with a student with a sense of entitlement – either to pass, in the case of an underperforming student, or to receive exceptionally high grades. Waljee, Chopra and Saint (2020) associated this attitude with the millennial generation, currently comprising around 40% of the workforce, noting tendencies towards over-socialisation, impatience, narcissism and a focus on results. Positive characteristics, however, included collaboration, diversity, decisiveness, innovation and a sense of purpose. It is likely that the current generation of students and recently qualified professionals will be more focused on purpose and outcomes, demonstrate greater adaptability to change and creativity in thinking. Such attributes complement the roles of practice assessor and revalidation partner, boding well for both professional processes.

The need for moral courage and integrity is not limited to qualified practitioners, however. Duffy *et al.* (2012) considered whether the expectation that students should act as whistleblowers if witnessing poor practice was realistic.

Relationships and concerns about the impact on their assessment were found by Bellefontaine (2009) to be barriers to challenging staff. Bickhoff *et al.* (2017) explored this in a qualitative study, highlighting the importance of “*patient advocate identity*” (p37), stemming from the individual’s moral code. They found that students gained confidence in questioning practice as they progressed through their programme, recognising the consequences to the patient if they failed to speak up. Numminen, Repo and Leino-Kilpi (2017) conducted a concept analysis of moral courage in nursing, highlighting the importance of responsibility and accountability. This extended from a willingness to acknowledge personal vulnerability and learn from own errors, to demonstration of ethical behaviours, even if non-conformity resulted in personal risk. Hunt *et al.* (2016) found that students who acknowledged that the needs of service-users superseded their own, tended to demonstrate positivity towards open and honest feedback and accepted responsibility for their own practice. This resonates with the programme theory proposed by Brennan *et al.* (2017), who stated that if the dissonance mechanism is triggered through receipt of feedback, the intermediate outcome is reflection which then leads to insight and behaviour change. Ferguson (2015) argued that this is dependent on the attitude of the appraiser and a supportive working environment. If these are not in place, Brennan *et al.* (2017) postulated that game-playing behaviour may result. It is therefore critical that all parties fully appreciate their individual professional responsibility and accountability. Black, Curzio and Terry (2014, p232) said of those mentors with moral integrity, who acted as positive role models despite challenges of the system or opposition from others: “*This reflects how embedded good nurses are within their profession. They are their profession, and their profession is them.*”

The pre-registration period is therefore a fertile time to harness these attributes. Instead of students being passive recipients of the assessment process, they need to be encouraged to share their own perspectives and skills and develop positive attitudes towards professional scrutiny of self and others. Mutual learning was very evident throughout the programme of research, and this needs to be promoted more explicitly as an outcome of both practice assessment and revalidation, bringing benefits to the individuals concerned, their organisations and the ultimate recipient – the service-user.

1.5.4 Development of the conceptual model

Synergies between themes in pre-registration practice assessment and post-registration revalidation became increasingly apparent as the programme of research progressed. A coherent conceptual framework emerged, based on commonalities of factors which engaged, enabled and embedded purposeful processes and enriching experiences. Throughout the body of work, professional approaches and positive attitudes to self and external scrutiny were fundamental.

Basit (2003) espoused construction of a conceptual scheme reflecting inductive reasoning during qualitative analysis, facilitating understanding and application. Integration of concepts into a framework provides direction and a broader explanation and interpretation of findings, which Imenda (2014) suggested is enhanced through use of a model. The candidate's preference towards philosophical assumptions which primarily reflect paradigms incorporating pragmatism, social constructionism and transformation (Spencer, Pryce and Walsh 2014; Creswell and Poth, 2018) influenced the

conceptual framework derived from this programme of research, ultimately resulting in the model: “*Developing and embedding professionalism through scrutiny of practice*” (Figure 7, section 1.5.4b).

1.5.4a Precursors of the conceptual model

The first influential model (Figure 3) originated from exploration of assessment of practice in Work 1. Perceptions of the validity and reliability of practice assessment methods and their impact on the student’s learning experience were the focus of the research questions; key findings are summarised in Table 1 (section 1.3). Although this version of the model was not included in the publication, iterations were presented extensively at national and international conferences. The longitudinal methodology of the project demonstrated evidence of progression from ‘doing the job’ to ‘being a professional’ (Work 1, p20). It was apparent that nurses and paramedics enrolled on the post-registration emergency care course already understood this concept. However, as discussed in section 1.5.1, this did not necessarily translate into professional responses to scrutiny of practice. It was evident that engagement of individuals in both the purpose and the process of practice assessment was needed. This required clear, consistent and timely preparation of all stakeholders, and was influenced by a number of external factors, which could be either facilitative or obstructive.

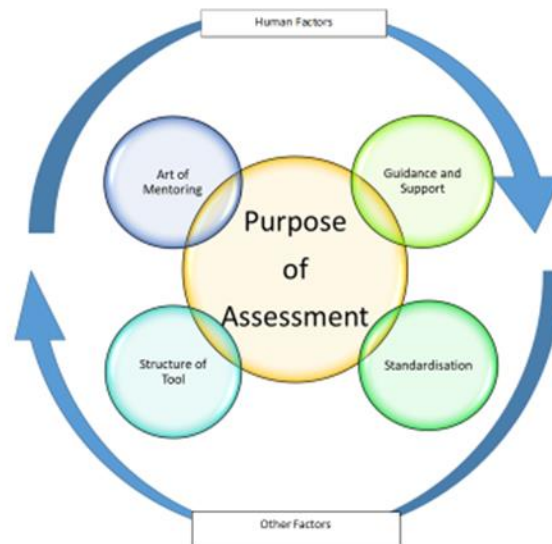


Figure 4: *'Evidence Based Model for Professional Practice Assessment' (Work 6)*

Inductive analysis of the qualitative findings from the revalidation survey (Work 9; Table 3) resulted in classification of themes including 'process', 'purpose' and 'preparation', resonating with the concepts previously identified in Work 1. 'Professional values' were identified as core to a meaningful process of revalidation, in which all stakeholders needed to engage. Positive influences were illustrated in green in the '*Model of Revalidation*' (Figure 5), and potential hazards situated on the periphery, coloured red. These echoed the facilitative and obstructive factors identified in pre-registration practice assessment (Work 1, Figure 3), and the 'human factors' and 'other factors' represented in Figure 4 (Work 6).



Figure 5: *Model of Revalidation with Professional Values at the Core* (Work 9)

The candidate analysed Work 9 findings in January 2018, in collaboration with an academic colleague and nursing student, avoiding mentioning results from earlier works until her co-researchers had classified the themes. This was a pivotal moment in the programme of research, when conceptual links between pre-registration practice assessment and post-registration revalidation were first identified. A similar approach was subsequently adopted, to avoid bias, when synthesising the qualitative coding from Work 6 in May 2018. Findings were again corroborated, reinforcing commonalities between pre- and post-registration status first identified in Work 1. The alternative paradigms and epistemological standpoints represented by co-researchers in each team strengthened credibility and confirmability of analytical decisions, informing creation of models and elucidating the emerging conceptual framework (Broom and Willis, 2007).

As the programme of research advanced, the importance of individual accountability and valuing of the processes and purpose of both practice assessment and revalidation became increasingly significant. Professional attitudes to scrutiny needed to be embedded from the pre-registration period and maintained after registration. This progressive trajectory was evident in both Work 1 (Figure 3) and Work 8 (Table 3, section 1.3). Midwifery students embraced the transition from pre-registrants to qualified professionals, recognising their accountability for personal and peer development. The '*Peer Mentoring Model*' (Figure 6) illustrated this journey, together with the range of activities in which students could be involved to aid their passage.

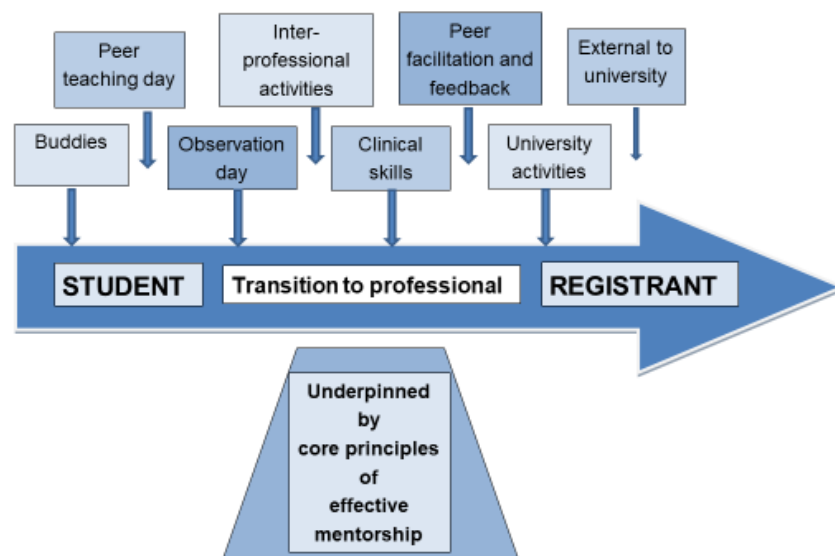


Figure 6: '*Peer Mentoring Model: facilitating transition from student to professional registrant*' (Work 8)

1.5.4b Conceptual model of the thesis

The conceptual model (Figure 7) emerged from the programme of research through an iterative process. Synergies identified in earlier models were captured, informing the key components of the conceptual framework: engaging, enabling and embedding professionalism through scrutiny of practice.

Throughout the continuum from pre-registrant student to registered practitioner and beyond, internal professional values – and a preparedness to be subject to scrutiny – are core. The individual is, however, dependent on various factors to engage, enable and embed purposeful, positive attitudes to this professional self or external examination. These not only include personal attributes, but also the ‘people’ accompanying them on their journey, the ‘processes’ and ‘paperwork’ through which professional knowledge, skills and attitudes are assessed, and the ‘placement’ or context of practice. Awareness is needed of potential hazards which may compromise the purpose and experience of practice assessment and revalidation, resulting in ‘tick-box’ exercises or lack of authenticity. Positive influences should be encouraged and used to their full potential. Registrants will not only be accountable for their own future practice but also contribute to development and monitoring of the wider workforce. It is therefore essential to engage individuals in the process and purpose of assessment, enable robust processes and embed positive attitudes to professional scrutiny from the outset of the journey. This will facilitate transition to registration and strengthen links with ongoing professional self-regulation, promoting safe and accountable practice throughout the individual’s career.

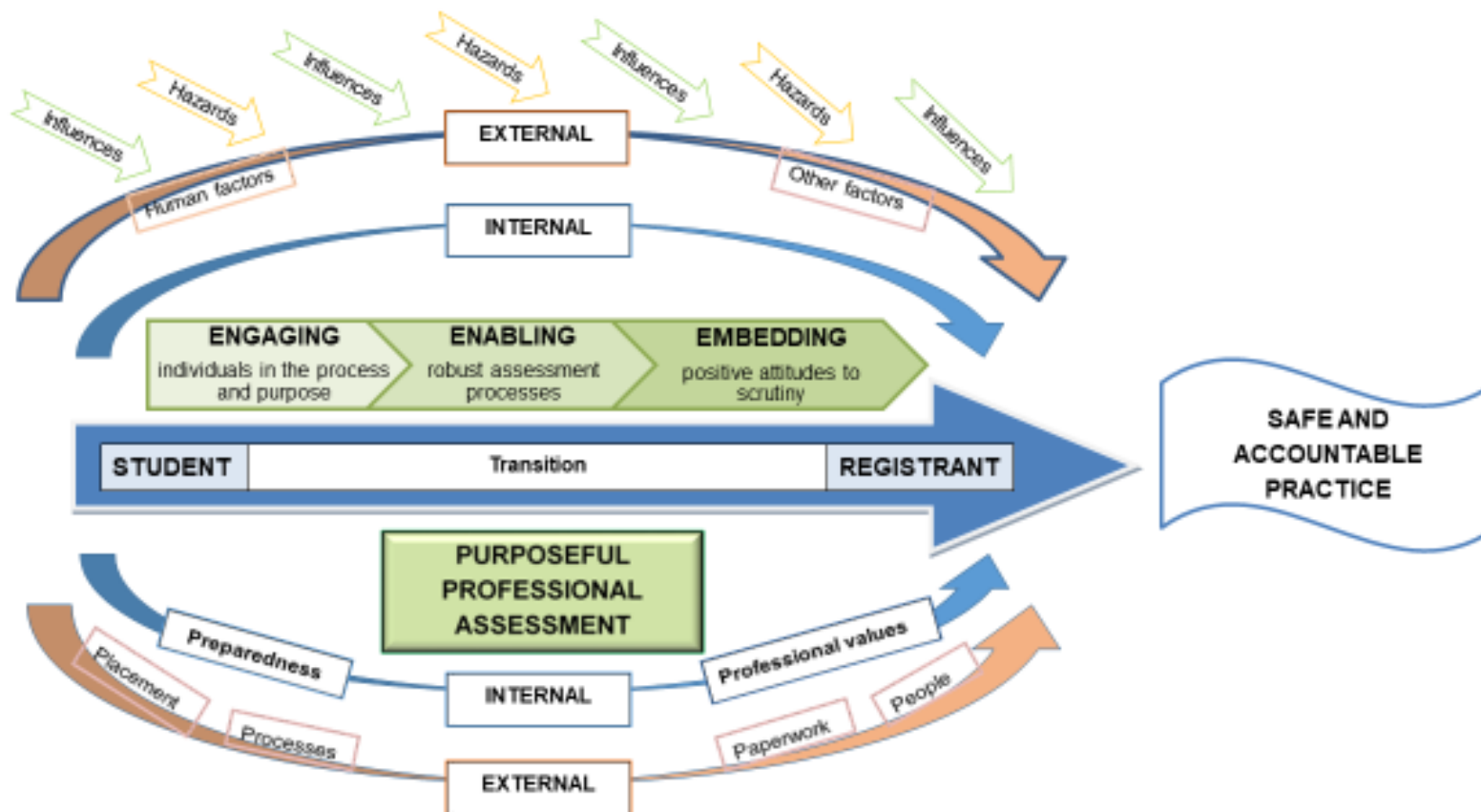


Figure 7: *‘Developing and embedding professionalism through scrutiny of practice’: A conceptual model*

1.6 Contribution of the body of work to the discipline

There is an ethical responsibility for researchers to make public their contributions to the body of knowledge, honouring the efforts and insights provided by participants and promoting evidence-based practice. External validation through peer review of newly generated knowledge (Wallace and Wray, 2016) has been achieved by widely disseminating the outputs from this programme of research through publications, national and international conferences and communications with key stakeholders. Findings have extended the evidence-base and identified inter-professional and regulatory commonalities. Recommendations and innovative solutions have sought to ameliorate some recurrent problems in practice assessment and revalidation, providing a significant contribution to the body of knowledge. Silverman (2013) purports that good research should inform practice and policy; this section explains the impact of these works on education, practice and research.

1.6.1 Education

Even during the longitudinal study in Work 1, comprehensive exploration of a range of practice assessment methods influenced current midwifery, emergency care and social work programmes. Several students commented on the benefits their participation had brought them and their peers, enabling changes to be initiated (p30). Emergency care nurses and paramedics noted that concerns raised about reliability of their SLVT had been addressed through improved explanations and a clearer framework (p13). The midwifery competence-based document was modified in response to findings from the longitudinal interviews, and participants were positive about the increased specificity, feedback and introduction of grading in its replacement (p11). Findings from this research

directly influenced changes to the format and purpose of the subsequent midwifery practice portfolio, described in Work 2. A range of national and international conferences and websites further extended its reach (Ceppl, 2010). On-line resources remain publicly accessible, including generic ‘*Top Tips*’ for staff and students (The Ceppl Assessment of Practice Team, 2011), catering for a multi-professional audience.

Work 3 drew on this evidence, while also capturing key findings from Work 4. The book (Cescutti-Butler and Fisher, 2016) has influenced midwifery students at an early stage of their professional journey, and is regularly cited in first year essays on personal and professional development. It was praised by external reviewers pre-publication, comprising midwifery students, clinicians and academics. Reviews on the Amazon website (Amazon, 2020 – Appendix 1) and in the Nursing Standard (Lavalley, 2016) were similarly positive; Work 3 was specifically mentioned in the latter:

“The author’s explanation of the assessment process that midwifery students must undergo is particularly useful.” (p28).

Findings from these earlier works have influenced, and been corroborated by, the subsequent major project exploring grading of midwifery practice (Works 4-7). This has had a significant impact on midwifery education at local and national level, evidenced by an LME testimonial (Appendix 2). Involvement of the LME-UK Executive throughout the project has enabled its findings to inform programme development across the country. The most notable impact has been its contribution to the new national midwifery practice assessment document for England and Northern Ireland, supported by the NMC and Health Education England. Strong support for a standardised midwifery practice

assessment tool in Work 6, the core principles (Work 5) and PAT (Works 6 and 7; Fisher *et al.*, 2019c) have directly informed development of the Midwifery Ongoing Record of Achievement (MORA), recently approved by the NMC for implementation across all new programmes from September 2020. The candidate has made a significant personal contribution as regional representative in the Midwifery Practice Assessment Collaboration (MPAC) steering group, demonstrated in a testimonial from the project lead (Appendix 3):

“In particular, your contribution to the design of the practice assessment rubrics in the Midwifery Ongoing Record of Achievement (MORA) has been invaluable.”

This included ensuring that the category ‘outstanding’ was included in the MORA rubrics, attempting to reduce grade inflation by preserving the highest grades and descriptors to reward excellence - reflecting findings in the programme of research and wider literature. The importance of ensuring that any grade or symbol awarded was congruent with narrative in student feedback was acknowledged in the MORA, drawing on the core principles from Work 5 and recommendations in Work 6.

These works have also contributed to the evidence-base influencing changes to the NMC educational standards. The candidate kept the regulatory body apprised of findings and publications throughout the project, and was invited to attend a ‘listening event’ during the consultation period on new standards for nursing and midwifery education, specifically relating to practice assessment (NMC, 2018a; 2018b). A letter of congratulation was received from the Director of Education and Standards on receipt of the full set of publications from the project (Appendix 4):

"We welcome collaborative approaches to midwifery programmes that are evidence-based and promote quality and robustness. ...Please pass on our congratulations to all who have contributed to this work."

The University of Plymouth was subsequently described as "pioneering" in a consultation webinar on the new 'Future Midwife' pre-registration midwifery education standards (NMC, 2019b). Not only has this programme of research raised the profile of the university, but also the role of the Lead Midwife for Education. An email was circulated to the group by the LME from Cardiff in April 2019 (Appendix 5), encouraging colleagues to utilise the evidence from the project in their responses to the consultation. The purpose was to seek to strengthen the role of the LME, which was diluted in the draft standards. The email suggested that a communication previously sent to the Council of Deans for Health (CoDH) by the LME from the University of Manchester comprised *"really useful information on LME role that is important for responding to NMC Future Midwife consultation"*. This highlighted that:

"I think the section on consistency can be strengthened using Fisher et al's work on grading in practice...Fisher et al's research provides a comprehensive and national review of the processes used in grading in practice in midwifery programmes across the UK. This study provides an excellent example of the unique role of the LME network, and how this role can be used to provide parity, and reliability, in the implementation of professional standards. This example illustrates the potential of the LME role in critically reviewing midwifery education, and enhancing consistency in the future development of the midwifery profession."

The consequent 'Future midwife: Consultation response document' (NMC, 2019d, p25-26) stated:

"There were numerous written responses to the consultation from individuals about our reference to the lead midwife for education, with many arguing that the role needs strengthening and articulating more clearly within the new standards... As a result the final version of the standards now more clearly provide for the LME role."

Locally, the programme of research continues to inform pedagogy and assessment in the midwifery curricula, responding to both professional strategic directions and technological advances. The candidate has led development of a fully electronic midwifery practice portfolio for the current curriculum, which is in turn informing adaptation of the MORA to a digital platform for the proposed new curricula (Appendix 2). This will continue to have national influence as it will be transferable to other institutions using the same software; the technology being piloted locally.

The works relating to practice assessment continue to be influential in delivery of the pre-registration module discussed in Work 8, heightening students' appreciation of their professional accountability. They have remarked on the significant proportion of evidence-based midwifery literature stemming from the candidate's work, frequently citing these publications in assignments. Nurses and other professions undertaking post-registration practice teaching modules have similarly extensively used Works 1 and 4. The innovative approach to the module is unique, combining comprehensive theoretical preparation and a wide scope of practical activities in both academic and clinical environments. It has therefore made a significant contribution to the body of knowledge relating to peer teaching and learning. The impact is both transformative and transferable, with comments from students including:

"This module has changed the way I think about the role of a mentor and enlightened my perception on mentorship, feedback and grading." (Peer teaching day, p57);

"This module has really helped me to think more like a qualified midwife who may have students in the future and how I would like to practice as a mentor." (Figure 3, p58);

"I have noticed my increased confidence and sense of responsibility towards others since taking on the role of mentor, there is a sense of

having something to offer that is valued...I now feel empowered to take more responsibility for [my learning and the culture of the workplace] myself.” (Figure 3, p58).

Peer teaching and mentoring activities discussed in Work 8 have also benefitted students from other professions. Midwifery students engage in inter-professional activities, including facilitating a workshop for nurses introducing them to key concepts of maternity care to enable them to meet their NMC and programme requirements, and teaching paramedic students. Students’ external interactions with prospective applicants at career and open days contribute to midwifery recruitment. The *‘Peer Mentoring Model’* (Figure 6) aligns with the new NMC requirement for pre-registration preparation for the role of practice supervisor (2018d; 2018e; 2019b; 2019c), providing a framework which may be useful to other programme teams. The module also provides an opportunity to apply the recommendations from Work 9 to *“role-model positive attitudes and encourage discussion about revalidation”*, providing a *“focused preparation in the final year of pre-registration programmes”* (p27), highlighting the links between practice assessment and maintenance of registration.

1.6.2 Practice

The PAT (Fisher *et al.*, 2019c), available on an externally-facing website hosted by the University of Plymouth, was disseminated wider in the midwifery community in Work 7 and through an unsolicited entry in the Royal College of Midwives members’ journal (Appendix 6). The strength of this toolkit is its national origin, encompassing terms used across 37 of the 55 HEIs delivering pre-registration midwifery programmes. Generation of the PAT is therefore unique in the literature, as is the conceptual development of two of the three original tools.

Not only were rubrics developed to enhance reliability, responding to recommendations in the literature (Isaacson and Stacy, 2009; Donaldson and Gray, 2012), but a set of tools catering for different preferences and learning styles was created. The Lexicon Framework and Wordles presented alternatives and proved transformational in local workshops preparing midwives for their new roles of 'practice supervisors' and 'practice assessors' (NMC, 2018b). An appreciation of the importance of consistency in documenting feedback was facilitated through application of the toolkit (Appendix 7):

"The tools for assessment were really useful and illuminating and have built my confidence in assessing students."

"Will find the 'cheat sheets' of words to use very helpful when writing statements about students."

"Really helpful to have links to the toolkit. Lexicon/ Wordles – amazing – really reassuring."

"The framework of assessment will reduce individual bias and improve inter-assessor/ intra- assessor reliability."

"I must ensure that I use the correct language so that there is a common understanding of the student's abilities between assessor and supervisor."

Students in the most recent delivery of the module discussed in Work 8 were able to support midwives supervising and assessing their practice to adapt to the new NMC (2018b) standards and apply the PAT, drawing on their own learning. This further demonstrated reciprocity of the relationship and the influence of the module in promoting lifelong learning.

The toolkit has been embraced in its entirety by midwifery clinicians, academics and students locally, enhancing consistency and reliability in narrative supporting practice assessment, evidenced in a testimonial from a clinically

active academic colleague (Appendix 8). On moderation of the portfolios recently submitted, terminology from the PAT was apparent and practice assessors demonstrated objective congruence between comments and grades awarded. During the COVID-19 pandemic, the PAT facilitated national response to the NMC (2020) emergency standards, which required immediate implementation of the new model of student supervision and assessment (Appendix 2):

“During the COVID emergency period, the practice assessment toolkit she [Margaret Fisher] developed has been particularly beneficial and used by other HEI’s nationally, since NMC emergency standards required implementation of SSSA in all areas; in some cases with very little “lead-in” time.”

Development of peer mentoring skills in the pre-registration module (Work 8) facilitated the dual purpose of preparing students not only for the roles of practice supervisor and assessor, but also future revalidation partners. New knowledge has been generated through exploration of these connections in this programme of research, further justifying recommendations in Work 9 to be more explicit about the links between pre-registration activities and revalidation.

1.6.3 Research

A distinct contribution to the evidence base on practice assessment has been made. Many findings have supported those in the literature, while others have produced new knowledge or introduced fresh perspectives. The longitudinal case studies undertaken in Work 1 comprised the only published research exploring a multi-professional perspective of practice assessment over students’ entire programmes. This enabled evolving understanding, changing attitudes and increasing professionalism to be captured and compared. More recent research outputs are having a major impact on applying and embedding the

new NMC standards in academic and clinical contexts. Not only has the research extended the forefront of knowledge in the field of practice assessment in the discipline of midwifery, but evidence of its potential to transfer to nursing and other professions has been demonstrated in participant responses in Work 6 and communication from a local Trust (Appendix 9):

“I attended a Trust NMC Standards group meeting today to discuss the changes in relation to assessing and grading of students in line with the new standards. During the meeting I discussed your Practice Assessment Toolkit and the Trust were very keen to implement this, they particularly liked the idea of using standardised terminology and language.”

Although grading practice is no longer identified as a mandatory requirement in the new NMC (2019b) midwifery standards and has not been introduced into nursing (2018d), this programme of research has contributed to the evidence of its complexities and challenges. The PAT (Work 7; Fisher *et al.*, 2019c) has the potential to empower practice supervisors and assessors to determine and address under-performance and – if awarding marks - reduce grade inflation, using this consistent and systematic framework. Although the Pan London and Yorkshire and Humber regions introduced common assessment tools in midwifery, neither of these have been published. Works 6 and 7 therefore comprise the first piloted and published national principles and grading tool. Their direct contribution to the MORA has enabled achievement of the long-standing goal of a national practice assessment document (Donaldson and Gray, 2012; Willis, 2015). This research attracted interest at numerous conferences, and publications have received multiple reads and several citations, as well as being acknowledged to have international value:

“You have conducted an important study that has international relevance.” (External reviewer);

“It’s really high quality and important work - we are pleased you chose our journal to publish in. Congratulations on the series.” (Editor, Nurse Education in Practice).

The contribution of Work 9 to evidence on revalidation is unique. It comprises the only published evaluation of NMC revalidation since its implementation in 2016, other than the commissioned Ipsos MORI reports. The body of knowledge is otherwise limited to the NMC annual data reports (2017c; 2018f; 2019e), a paper explaining preparation of academics for revalidation (Attenborough, 2017), two small studies of ten academics and five students respectively in which professional identity was explored (Attenborough and Abbot, 2018a; 2018b) and a paper discussing employer responsibility for CPD (Lanlehin, 2018). Work 9 is the only study to have included an equal balance of university and clinical staff, thus highlighting differences in experiences which are lacking in other literature, contributing to the recommendation that the confirmer should be an NMC registrant. It is also the only publication in any healthcare profession nationally or internationally to have specifically considered preparation of students for maintenance of registration, thus addressing a significant gap in the literature. Explicit links between pre-registration curriculum activities and revalidation were also reported for the first time. The NMC was alerted to the publication, enabling its evidence-based findings and recommendations to contribute to potential changes in policy following completion of the first triennium of revalidation.

1.7 Critique of methodology and reflexivity

Throughout this programme of research, the intention was to explore and enhance the quality of processes contributing to professional development, present valid and reliable evidence of achievement and ensure that credibility and integrity led to public protection. Research-informed teaching and teaching-informed research were entwined in this professional pedagogical journey. The organic nature of this body of work meant that reflection informed methodology, reflexivity was considered and the next cycle began. As such, this section provides a critique covering the strengths and limitations of both aspects.

1.7.1 Positioning

Creswell and Poth (2018, p228) highlight the importance of explicitly "*positioning*" self in writing up research, but van Manen (2014) notes that this is often omitted. It is acknowledged that the majority of the original works presented in this portfolio have not adequately considered reflexivity; word-counts set by journals contributed to this, and the team approach included multiple perspectives. The candidate's own professional development has therefore benefitted from the opportunity to critique personal philosophies and assumptions underpinning the programme of research. These primarily reflect a system of values and beliefs incorporated in interpretive frameworks of pragmatism, social constructionism and transformation (Spencer, Pryce and Walsh, 2014; Creswell and Poth, 2018), influencing the objectives and design of the component studies and publications. Wallace and Wray (2016) explain that this position incorporates an axiology in which research is based on value assumptions, focusing on generating knowledge which seeks to make improvements. Combining an epistemological standpoint that knowledge is

socially constructed with an ontological stance that there are multiple subjective realities, the candidate's pragmatic paradigm has provided flexibility to purposively investigate a wide range of stakeholder views through diverse methodologies. Wallace and Wray (2016) further note that this approach may result in intellectual projects which inform policy; the candidate has demonstrated how these have contributed to the body of knowledge.

The nature of the candidate's research interest meant that personal values were intrinsic to its aims, objectives and design. A Myers-Briggs Type Indicator report in 2016 (Myers and Myers, 2013) identified her as 'ENFJ' type (having a preference for extraversion, intuition, feeling and judging). This interpersonal focus includes *"enjoyment of working with others on a variety of tasks that encourage the development of people"* (p10), being decisive and action-oriented, supporting and inspiring others with shared values to accomplish results in a team approach, role-modelling follow-through, seeing potential in others and effectively delegating. Negative aspects of the candidate's ENFJ type, however, include a tendency to be overzealous, which may result in giving data insufficient consideration or too readily seeing these as positive. It was therefore important to reduce bias as far as possible. Aligning with the candidate's collaborative and transformative paradigms, teams were therefore invited to contribute to the majority of the works presented. Students, service-users and colleagues were given opportunities to actively participate in research, write for publication and present at conferences.

1.7.2 Research team collaboration

Engagement of professionals, students and service-users who shared a common desire to initiate and implement change enabled multiple epistemological, ontological and philosophical standpoints and skill-sets to contribute to selection of methodology, construction of questions, analysis and synthesis of findings within the culture of inquiry (Creswell and Poth, 2018). These alternative paradigms represented a broader range of perspectives than could ever be achieved by a single researcher, enhancing the outcome of knowledge production (Broom and Willis, 2007), and resulting in outputs with the potential to resonate with a wider audience. Working alongside colleagues with wider experiences, such as ethics committee membership, enabled mutual sharing of expertise. A greater breadth of literature was incorporated due to the range of academic and research interests represented. The teams formed a critical mass, with triangulation of data analysis reducing individual bias; Eisner (2002) terming this consensual validation. An inherent risk of this approach, however, is that the community may well share common beliefs. Eisner suggests that structural corroboration is therefore needed to achieve consistency and coherence in research claims. This was achieved as multiple studies conducted by different teams identified common themes. Referential adequacy is also required, in that the claims must have usefulness and purpose; the impact of this programme of research and its outputs were demonstrated in section 1.6.

1.7.3 Stakeholder collaboration

Interactive collaboration with participants and key stakeholders to inform research design is recognised as a validation strategy by Creswell and Poth

(2018). Consultation with wider groups external to the research teams formed a strong thread throughout the programme of research, including creation of questions, decisions about data collection methods and analysis of results. A multi-professional workshop, preceding the longitudinal study in Work 1, was essential to share understanding of other programmes and terminology, enabling the research itself to be positioned in these various perspectives and increasing potential for transferability of the findings (Gray, 2009). Not only were students, clinicians and academics involved, but there was also strong service-user representation. In contrast with the concerns raised in Malihi-Shoja *et al.* (2013) in section 1.5.1, they experienced being part of a project exploring professionalism and reliability of assessment, to mutual benefit. A set of focus groups held with final year emergency care, midwifery and social work students prior to commencement of the longitudinal study informed the research questions in its first year. In Work 2, development of the pilot blended portfolio was informed by discussions with students, clinicians and academics, who reviewed the previous practice portfolio against evidence from the literature and early findings from Work 1.

The multi-professional research team for Work 1, comprising representation from the full stakeholder group, reviewed findings and collaborated on interview schedules for each phase. The interviews themselves were conducted by clinicians, students and academics – ensuring that internal validity was upheld by creating dyads from different professions (Creswell, 2013). Participants were invited to member-check interview transcripts (Shopes, 2011) and were sent the schedules for the final interviews in advance to enable them to prepare; an approach which provided rich data and was positively evaluated. Work 3

included contributions from several students, incorporating student vignettes and top tips, visual images and text. This representation of multiple genres achieved a form of triangulation described by Ellingson (2011) as crystallisation, enhancing appeal to the readers. Earlier phases of the grading of practice project (Works 4, 5), roundtable discussions with academics, clinicians and students at a revalidation event and anecdotal feedback from colleagues contributed to formulation of questions for the surveys in Works 6 and 9.

Participatory action research (Denscombe, 2010) engaged the LME-UK Executive throughout the national grading of practice project. Williamson, Bellman and Webster (2012) emphasise that collaboration between researchers and stakeholders is an inherent characteristic of this methodology, while Wallace and Wray (2016) note that investigating and challenging habitual activity is key. Different perspectives are deliberately sought and integrated with other types of evidence, enabling conclusions to be drawn about how and why to change practice. Waterman (2007) explains that this approach carries an emphasis on critical reflection, including examination of professional values and assumptions. Williamson, Bellman and Webster (2012) propose that it is more likely that these changes will occur if key stakeholders gather their own information about the issues at hand and identify future direction, generating new knowledge. The group was therefore regularly consulted about findings and next stages, and the spiral design and iterative process of this methodology enabled each phase of the project to inform the next. Consensus was reached on core principles in Work 5, having drawn on the scoping study in Work 4. The LMEs subsequently acted as gatekeepers in Work 6 to facilitate national dissemination of the survey to academics, clinicians and students in both

midwifery and nursing. Waterman (2007) notes that participatory action research broadens the developing theory, enabling wider communication and application. Because the LME-UK Executive instigated the project and were closely involved throughout its phases, there was extensive interest in the relevance of the findings. The resultant impact on the national MORA was testament to the value of participatory action research in initiating and embedding change through stakeholder ownership.

1.7.4 Methods critique

Each stage of the organic programme of research informed design and methodology of subsequent studies, with the interrelationship between patterns and categories becoming increasingly clear. Knowledge generated in Works 1 and 2 was verified in Works 5, 6 and 8 and resonated with Work 9. Cumulative consistency in findings enhanced dependability and transferability, ameliorating limitations in methodology of individual studies (Wallace and Wray, 2016). Importantly, membership of each team was different, bringing external perspectives and new epistemological and ontological stances. This collaborative approach reduced candidate bias and enhanced authenticity (Saldaña, 2014), while mutual understanding and consensus promoted validity and credibility (Kihlgren, 2016).

A mixture of purposive and convenience sampling was employed (Davis and Scott, 2007). In Works 1 and 2, members of the research team or academic colleagues invited volunteers from programme cohorts to participate. University databases enabled LME and administrative gatekeepers in Works 6 and 9, respectively, to invite specific members of the target population who met the

inclusion criteria, selecting those who would best be able to inform the research question (Creswell and Poth, 2018). Post-registration students enrolled on education programmes were approached to represent clinicians in Works 6 and 9, as it was assumed that they might find the surveys relevant and of interest, and third year students were invited to participate in Work 9 as they were approaching qualification. As Work 4 included third party views of clinician perspectives, it was important to gain direct responses from this group through purposive sampling in Work 6. In contrast, participatory action research enabled the full population of the LME-UK Executive to contribute to the grading of practice project (Works 4-6). This was particularly evident during Work 5 when consensus was sought through a mini-Delphi approach (Green, Armstrong and Graefe, 2007), involving face-to-face discussion and follow-up email correspondence.

A mixed methods approach was adopted in Works 6 and 9 on-line surveys, incorporating both quantitative and qualitative elements. This enabled multiple perceptions and standpoints to be considered (Creswell, 2011), while identifying trends. Participants included students, academics and clinicians in both midwifery and nursing professions. It was therefore of interest to draw some descriptive analytical comparisons within and between participant categories, citing numbers and percentages (Argyrous, 2007). The research teams did not seek to undertake correlational tests or determine statistical significance from the quantitative data, however, as qualitative responses were deemed more relevant. Had this been an intended aim, it would have been necessary to address methodological weaknesses in the quantitative elements: totals of the target population were not known due to third party circulation of invitations,

systematic bias was evident in under-representation of some groups (Faber and Fonesca, 2014), there was uncertainty regarding the status of the currency of databases and no power-testing was performed (Davis and Scott, 2007). Caution was therefore taken in making claims and drawing inferences from quantitative results (Wallace and Wray, 2016). Certain findings were tested in subsequent studies, however, with Angen (2000) explaining that understanding derived from previous research gives credence to the inquiry. Work 6 explored wider views on reliability of assessment methods by including factors previously identified in Work 1, and core principles from Work 5, as optional responses. Verification of these findings justified their inclusion as key principles for assessing practice in Work 7. Full reports of both surveys were uploaded to the open access project websites in advance of publication of Works 6 and 9, ensuring that participants were able to engage with findings in a timely manner and the detailed underpinning data were externally available (Fisher *et al.* 2018a; 2018b).

Methodological errors are recognised by Wallace and Wray (2016) as part of ongoing learning which pushes the boundaries of the researcher's existing knowledge and skills. Experience was gained in the use of SurveyMonkey® (2020), previously identified as a useful data collection tool in healthcare research by Gill *et al.* (2013). As no members of the revalidation team were familiar with this software, the candidate sought support from an experienced colleague and applied these new-found skills to the survey in Work 9. Mistakes were made and learned from, such as inclusion of too many options in some quantitative questions, necessitating exclusion of these data. Inadequate specificity of other questions meant that manual cleansing was required to

ensure accuracy of participant categorisation and re-filtering of data. Although time-consuming, data cleaning was essential for credibility (Gray, 2009).

Questions were made more specific in the subsequent survey (Work 6), with greater use of binary options. This improved accuracy of data and facilitated software analysis. Pilots were undertaken prior to both surveys, and refinements made, ensuring content and face validity (Calnan, 2007).

Qualitative analysis was primarily through inductive reasoning; determining patterns and themes (Broom and Willis, 2007). Creswell and Poth (2018) suggest that data analysis may be represented by a spiral image rather than a fixed linear approach. They recommend 'lean coding' (p190), using a short-list which can be expanded when necessary. Combination of these codes into five or six themes enables layering of increasing levels of abstraction, through identification of inter-relationships, when writing the narrative. Single and cross-case analysis and synthesis in Work 1, using the framework technique proposed by Yin (2003) and espoused by Ritchie *et al.* (2014), confirmed themes and strengthened findings. The longitudinal approach facilitated exploration of the totality of the student journey, allowing changing views to be reflected. Development of a relationship within the interview dyad facilitated engagement and generation of deep knowledge. Use of participant language added richness (Simons, 2014), with some quotations evoking powerful images, such as the desperation of a student struggling to meet portfolio requirements, likening this to "*parachuting bits of a jigsaw down a dark well*" (p9).

Mindful of the impact of reflexivity, it was crucial to address potential bias.

Simons (2014) notes that subjectivity of both the researcher and participants is

inevitable in much qualitative research, and can be essential in interpreting and understanding the data. As the candidate was already working towards her PhD from Works 5 onwards, it was essential to avoid bias in interpretation and presentation of the findings. Team members and the Principal Investigator therefore independently coded sections, and teams then met face-to-face to confirm inter-coder agreement (Richards and Morse, 2012; Kuckartz, 2014). Overarching themes were identified and conceptual and visual models developed to reflect the data (Basit, 2003). Very similar themes emerged in Works 4, 6 and 9 to those previously identified in Work 1, without co-researchers having background knowledge of earlier findings. To avoid contaminating the inductive process (Gray, 2009), the candidate therefore ensured that previous themes and models were not mentioned until the teams had undertaken analysis and synthesis.

As the university revalidation lead, the candidate had pertinent experience to contribute to Work 9, having herself undertaken the process and supported a number of colleagues through this new professional requirement. Other members of the team also wished to participate in the survey. It was therefore particularly important that thematic analysis remained neutral. The raw data were sent to the team as comments only, with no indication of participant codes or symbols. Four members of the team independently analysed sections of the data, which were then code-checked by others. This triangulation enhanced rigour and contributed to authenticity (Creswell and Poth, 2018). Several of the candidate's comments were highlighted as valuable; a balance was therefore deliberately sought when selecting quotations for publication of Work 9. Bias also needed to be considered as the study was based in the research team's

own organisation. Creswell and Poth (2018) suggest that this may cause challenges, but also bring benefits of reciprocity. Participants knew the candidate, which promoted trust and instilled confidence; it was, however, essential that anonymity was ensured from the outset of the survey to encourage open responses. Participants were reassured that their contribution would influence change and that it was likely that there would be personal gains.

1.7.5 Participative writing

Co-researcher involvement and external peer review have been vital to strengthen confidence in the findings and credibility of the research outputs (Creswell and Poth, 2018). The candidate took the lead in writing the majority of each work. Co-researchers were invited to contribute wider reading and verify accuracy of findings, including presentation of Work 8, as the candidate had personal investment in the module. Participative writing enhances transparency and trustworthiness (Saldaña, 2014), and is espoused for the quality it brings to publication (Waterman, 2007; Wallace and Wray, 2016). Leadership of writing Work 7 was, exceptionally, delegated to another team member to share workload and introduce a fresh approach for this 'launch' article while the candidate took responsibility for preparing the PAT (Fisher *et al.*, 2019c); a significant personal contribution was made, however. Although some papers met publisher requirements in their early stages, several needed to undergo major amendments. This process was painful but ultimately beneficial. Wallace and Wray (2016) emphasise the importance of anticipating the expectations of a critical audience, acknowledging the challenge of meeting stakeholders' diverse epistemological and philosophical stances. The process of building up a body of

work through multiple publications has developed the candidate's skills in strengthening the evidence to support arguments and increase relevance to an international and multi-professional audience, taking into account readers' varying agendas.

1.8 Future perspectives

The nature of this programme of research has been broad and organic. Future perspectives are therefore dynamic and regular revision will be needed in the context of education, practice and research developments. There are key areas, however, which are more clearly defined. The candidate proposes the following actions to further promote and embed this programme of research:

1.8.1 Education

- a) Findings from the programme of research continue to inform the local midwifery electronic practice portfolio, recently developed by the candidate in collaboration with technologists. Work will next involve transfer of the national midwifery MORA to an electronic platform, which will be shared with other HEIs.
- b) The pre-registration module preparing midwifery students for their future roles as practice supervisors and assessors will continue in its current format for the existing curriculum. Modifications will, however, be made for three new curricula commencing in September 2021, including post-graduate pathways. This approach will embrace the requirements of the extended NMC proficiencies (2019c) for pre-registration students to develop excellence as colleagues, scholars and leaders.
- c) The links between pre-registration activities and revalidation will be made increasingly explicit in the new midwifery curricula; approval documentation has already reflected these changes. The candidate will liaise with colleagues in nursing and other healthcare and social work programmes, offering student-centred reflective workshops in her role as

revalidation lead. This will align with the faculty strategy to promote integrated inter-professional learning.

1.8.2 Practice

- a) The candidate and co-editor are currently in communication with the publishers about reviewing and updating the book on midwifery placements (Cescutti-Butler and Fisher, 2016) to reflect contemporary practice and the new NMC standards (2018b; 2019b; 2019c). The opportunity to create clear links between pre-registration practice assessment and revalidation will also be captured.
- b) The candidate is currently collating experiences of stakeholders in the UoP footprint during the first year of implementation of the NMC standards (2018b), including use of the PAT. Findings from this evaluation will be used to inform practice locally. A paper, co-authored by a student and one of the LME research team, will disseminate early evidence of the impact of these regulatory changes and application of the PAT more widely.

1.8.3 Research

- a) The conceptual framework and model developed in this research portfolio will be disseminated in an appropriate peer-reviewed journal.
- b) The candidate is contributing to a doctoral student's realist review of medical appraisal which has been extended to include nursing appraisal. Knowledge generated during Work 9 is informing this paper, clarifying the professional context of nursing and midwifery appraisal and revalidation processes. This co-authored article will extend the

theoretical mechanism of dissonance (Brennan *et al*, 2017) to a nursing and midwifery readership.

- c) A collaborative paper is proposed with the project lead of the national MORA, disseminating its development. This will include the impact of Works 4-7 on its inception.
- d) The research team will formally evaluate the impact of the PAT and implementation of the NMC (2018b) standards in midwifery programmes at national level. The current local evaluation will help inform research design and methodology. A research grant application will be submitted to enable more in-depth qualitative data collection, such as focus groups.
- e) Narrative research exploring professional attitudes aligned with revalidation and scrutiny of practice is under consideration, in collaboration with a colleague who is an expert in this field. A phenomenological approach would strengthen the evidence base of not only nursing and midwifery revalidation, but potentially be extended to medical and allied health professions. External funding will be sought for this study.
- f) Research to explore the apparent differences between experiences of registrants in university and clinical settings is proposed, in collaboration with the lead from another HEI. It will be essential that this gap in the literature is addressed across multiple settings to avoid the localised bias in previous research. Differences between nursing and midwifery experiences would also be a useful area to investigate further.

1.9 Conclusion

This programme of research presents a coherent and systematic set of works which has contributed to the evidence in the field of practice assessment and professional revalidation. Publications have reinforced findings, generated new knowledge, introduced innovative methods and proposed recommendations. A conceptual framework and model have been presented, aspiring to enhance professional attitudes and practice. Parallels between the contextual influences on practice assessment and revalidation have highlighted congruence between the various points on the trajectory of professional development. The core theme in this body of work is the importance of all stakeholders' professional attitudes. Both the programme of research and wider literature espouse responsibility and accountability, a desire (or even a passion) to deliver a professional service, and ongoing motivation for learning and personal development. These attributes may already form part of the individual's personality and ethos, but some may need to be nurtured. The conceptual model focuses on embedding positive attitudes to critique of self and others from the outset of the professional journey, linking pre-registration experiences meaningfully to future careers and promoting public safety.

The interrelationships between practice assessment and revalidation are evident. Enabling the individual by engaging them throughout this continuum of purposeful professional development will not only have a personal impact, but also influence those they encounter on their journey. Key to this trajectory is a willingness to challenge and be challenged. To hold up a mirror and really look deeply at motivations, goals and *raison d'être*. To embrace scrutiny and cultivate integrity. To be professional.

CHAPTER 2: PUBLISHED WORKS

2.1 Engaging individuals in the process and purpose of assessment

- 2.1.1 **WORK 1:** Fisher, M., Proctor-Childs, T., Callaghan, L., Stone, A., Snell, K. and Craig, L. (2011) 'Assessment of Professional Practice: Perceptions and Principles', in Wergers, C.E. (ed.) *Nursing Students and their Concerns*. Hauppauge, New York: Nova Science Publishers, pp1-36. Available at:
http://www.novapublishers.org/catalog/product_info.php?products_id=2296582
- 2.1.2 **WORK 2:** Fisher, M., Thoburn, A., Arkinstall, T., Proctor-Childs, T. (2009) 'A Blended Approach to Evidence Learning in Professional Practice', in Salajan, F. (ed.) *Proceedings of the 4th International Conference on e-Learning*. University of Toronto, Canada, 16-17 July. Reading: Academic Publishing Limited, pp114-120.119
- 2.1.3 **WORK 3:** Fisher, M. (2016) 'Assessment of practice', in Cescutti-Butler, L. and Fisher, M. (eds.) *The Hands-on Guide to Midwifery Placements*. Chichester: John Wiley & Sons Ltd, pp50-76. Available at:
<https://pearl.plymouth.ac.uk/handle/10026.1/6547>130

2.1.1 WORK 1

Fisher, M., Proctor-Childs, T., Callaghan, L., Stone, A., Snell, K. and Craig, L. (2011) 'Assessment of Professional Practice: Perceptions and Principles', in Wergers, C.E. (ed.) *Nursing Students and their Concerns*. Hauppauge, New York: Nova Science Publishers, pp1-36. Available at:

http://www.novapublishers.org/catalog/product_info.php?products_id=22965

Candidate's contribution to authorship: 80%

ASSESSMENT OF PROFESSIONAL PRACTICE: PERCEPTIONS AND PRINCIPLES

Fisher, M., Proctor-Childs, T., Callaghan, L., Stone, A., Snell, K. and Craig, L. (2011) 'Assessment of Professional Practice: Perceptions and Principles', in Wergers, C.E. (ed.) *Nursing Students and their Concerns*. Hauppauge, New York: Nova Science Publishers, pp1-36. Available at: http://www.novapublishers.org/catalog/product_info.php?products_id=22965

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ABSTRACT

A multi-professional research team comprising practitioners, academics, service-users and students has undertaken a major research project on pre and post-registration students engaged in Social Work, Midwifery and Emergency Care (Nursing and Paramedicine) professional degrees. The aim of the study, under the auspices of the Centre for Excellence in Professional Placement Learning (Ce ppl) at the University of Plymouth in the United Kingdom, has been to explore students' perceptions of the tools and methods used to assess their practice and the impact these processes have had on their learning and professionalism during their journey through the programme. A four-year longitudinal study comprising annual interviews with 14 students has enabled their developing understanding and changing views to emerge, rather than just gaining a snapshot as in previous literature. Single-case and cross-case analysis and synthesis using the Framework Technique has enabled individual, professional and cross-professional issues to be explored through the multiple case-study approach.

The main themes identified were: Process, Preparation, Purpose, Placements, People and Professional Persona – the six 'P's of practice assessment. Issues around reliability, validity, consistency, honesty, relationships with assessors and timing of suitable placements have been highlighted.

This chapter explains the methodology of the study and expounds on the findings under the main themes. Comparisons are made between students' perceptions at the various stages of their programmes, and commonalities and differences between professional groups are explored. Principles of good practice are suggested which may be applied to a range of professional programmes incorporating placement learning and assessment.

INTRODUCTION

The value of practice placements in any professional educational programme cannot be over-emphasised. This is particularly the case in health and social care professions. Through exposure to the real-life setting, students have the opportunity to develop the knowledge, skills and attributes essential to their role as practitioners of the future. As Cowburn, Nelson and Williams [2000] assert in their research in a Social Work context, the primary purpose of assessment is to safeguard people in receipt of such services. Therefore every effort should be made to ensure that assessment methods used are valid and reliable, enabling accurate judgement of the student's ability to practise safely and competently. A literature review undertaken by Chambers in 1998 identified problems in professional practice assessment which may lead to non-failure of students. This continues to be a matter of concern, as a major study exploring the reasons why mentors 'failed to fail' Nursing and Midwifery students in practice in the United Kingdom [Duffy 2004] and subsequent papers by Rutowski [2007] and Shapton [2007] show. Norcini [2005] concludes in his research with trainee general practitioners that it is not possible to make a fair assessment in a practice setting because the variables cannot be scientifically controlled. A constructive approach to assessment of practice is essential in order to produce healthcare professionals who are well prepared to step into the workplace [Clouder and Toms 2008]. Cowan, Norman and Coopamah [2005] conducted a literature review which concluded that a holistic approach is most conducive to assessing practice. The process should also contribute to the student's learning.

This chapter reports on the lived experiences of a group of students in their journey through practice learning and assessment towards qualification as practitioners in the fields of Social Work, Midwifery and Emergency Care (Nursing and Paramedicine). The study took place over a four-year period, and was one of the strands of activity associated with the Centre for Excellence in Professional Placement Learning (Ceppl) at the University of Plymouth in the United Kingdom. An inter-professional research team of academics, practitioners, service-users and students from Social Work, Midwifery and Emergency Care informed the various stages of the study throughout its course. The diversity of the team enabled the members to reflect the understandings and perceptions of the various stakeholders, building on previous such experience [Elliot et al 2005].

A longitudinal case study approach was used to explore the students' experiences of practice assessment, with the focus of the research questions being on their perceptions of the validity and reliability of the methods used and the impact of the assessment process on their learning experience. A total of 14 students took part in semi-structured interviews which were held at the end of each academic year throughout their two to three year programmes. The longitudinal approach allowed the students' journeys to be seen in total rather than as a snapshot of an experience. This approach was also employed to enable the research team and student participants to build up a relationship throughout the study period, thereby optimising freedom of expression and richness of data.

For the purposes of this study, the research team developed generic definitions of the following key terms, drawing from a multi-professional workshop which preceded the main study:

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- **Practice:** The application and development of the appropriate skills and knowledge to the professional role in the environment where that professional activity takes place.
- **Practice learning:** Distinguished by the framework of support, teaching and assessment for students on professional programmes, working alongside others to deliver a service to the public as part of their course.
- **Practice assessment:** May not necessarily take place in the clinical/ practice environment but must incorporate practice. Involves both formative and summative elements and includes all the evidence contributing to the judgement about whether the student can progress or not in practice.

In order to clarify the different interpretations and various roles and practice assessment methods used in the three professional programmes, a glossary of terminology is provided in Table 1.

Table 1: Glossary of terms relating to assessment of practice

Term used	Professional group	Explanation
Assessor	Social Work	A qualified professional, who holds or is registered on the Practice Teaching Award who supports student learning and makes a judgement about the quality of the student's performance against the assessment criteria, including during the observations. An Independent Practice Assessor marks the summative portfolio.
CRAG (Criterion Referenced Assessment Grid)	Midwifery	A set of criteria against which the student is assessed. These comprise sets of key personal/ professional as well as clinical skills. The level to be achieved is based on Benner's "novice to expert", and gradually increases during the student's programme.
Mentor	Midwifery	A registered midwife with a mentorship qualification who facilitates the student's learning, supervises their practice and assesses them in the practice setting – completing documentation at identified points in the programme in the student's portfolio, particularly the CRAG.
Observation	Social Work	A pre-planned encounter with a service user/ carer (or group). The student prepares for this, is observed by an Assessor and receives feedback on the accuracy of their reflective self-assessment of their objectives and performance.
OSCE (Objective Structured Clinical Examination)	Emergency Care, Midwifery	A set of passive and/or active stations which are timed and assessed. These provide the student with a variety of opportunities for them to demonstrate to two assessors (usually one academic and one clinical) specific interpersonal and clinical skills.
Personal tutor	Midwifery, Social Work, Emergency Care	University lecturer who provides academic and pastoral support and monitors the student's clinical progress. In Midwifery this includes undertaking tripartite discussions at formative and summative points to 'moderate' the process of assessment

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Portfolios	Social Work, Midwifery, Emergency Care	A compilation of evidence which comprises a range of materials depending on the programme being undertaken. These commonly include learning objectives/ outcomes, reflections, evidence of assessments (eg: observations in Social Work, clinical logs in Emergency Care, CRAG in Midwifery), progress reports or feedback from a variety of sources.
Practice Learning Manager	Social Work	A qualified professional, who holds or is registered on the Practice Teaching Award who is the link between the student, agency and programme. Identifies learning needs and co-ordinates practice learning experiences to meet them. Responsible for overall management of the student's practice learning, but is not directly involved in assessment.
Practice Supervisor	Social Work	The individual in the placement setting who allocates work to the student and provides on-site day-to-day supervision and evidence to inform the assessment. Involved in the student's practice learning, but not directly involved in assessment.
Reflection	Social Work, Midwifery	A process of using knowledge to critically analyse practice experience, promoting learning from the situation and enabling the student to identify how it will influence their future practice.
Reflective log	Emergency Care	Structured reflections on practice demonstrating achievement of specific competencies.
Service-user/ carer	Social Work	Someone who has received a Social Work service themselves or for someone they care for. They participate in all aspects of the student's programme, from planning to initial conversations (prior to starting practice), to involvement in providing feedback, teaching and participation in assessment boards.
SLVT (Student Led Verification Tool)	Emergency Care	A practice-based assessment project. The assessment document comprises three themes. The student uses cues to guide the different aspect of the themes which more often than not is devoted to one subject. They can undertake a variety of subjects but the important aspect is that they are doing this theoretical or actual project in practice. Each theme is then written up and submitted for assessment.
Tripartite	Midwifery	A formal three-way discussion held between the student, their mentor and personal tutor. The purpose is to discuss progress at formative and summative points, provide guidance for future development and ensure that the criteria have been achieved.
Verifier	Emergency Care	A qualified health professional who guides and provides feedback to the student, and 'countersigns' their achievement of a practice action/ s.

METHODOLOGY

The aim of our study was to explore students' perceptions of the methods and processes used in the assessment of their practice throughout their professional programmes. The research questions were:

1. What are perceptions of validity and reliability of the practice assessment methods?
2. What are perceptions of the impact of the practice assessment process on the student learning experience?

Recognising that these views might well change over the two to three-year period of their programmes, a longitudinal case study approach was selected. Our rationale for choice of this qualitative approach was that it enabled complex phenomena to be explored from a range of perspectives, as the design allows for individual as well as multiple case studies to be examined. The advantage of a multiple as opposed to a single case approach is that evidence is considered more compelling and the study more robust [Yin 2003]. Case study design is predominantly used in the social sciences to provide an in-depth method of enquiry focusing on real life events. It is a methodology that is used across disciplines as diverse as Social Work and Management Science [Darke et al 1998]. Yin [2003] considers that case studies are valuable when considering the 'how' and 'why' questions of phenomena where the researcher has little control over events in given situations. The flexibility within the methodology enables real life practice to be explored and issues inherent in everyday practice to be addressed. It is therefore deemed to be particularly appropriate for practice based disciplines which are complex, in a state of constant flux and intrinsically linked to the social milieu of the discipline [Payne et al 2007]. Case studies are popular in educational projects to explore the experiences of individuals in educational settings in order to generate theory and move towards generalisation [Yin 2003]. Luck et al [2006] emphasise that it is the identification of the case/s to be studied that is crucial and that this must be decided and guided by the research question. In our research a case comprised firstly the individual student and their experience over the duration of their programme and secondly the student as part of the whole group of students.

In the case study approach, there is no statistical basis for sampling. The number of cases (or units of analysis) selected depends on the certainty the researcher wants [Yin 2003]. As the cohort numbers ranged from 15 – 90 students in the three professional programmes being studied, the research team decided to select five volunteer students from each. This enabled a range of placement areas to be represented, whilst ensuring the scale of the study remained manageable, as this approach is highly resource-intensive. It also allowed for some degree of attrition over the study period (ie: through withdrawal from the study, interruption or withdrawal from the programme) – whilst still protecting the multiple case element. A convenience sampling approach was taken [Frankfort-Nachmias and Nachmias 1996] – the invitation being extended to all students in the relevant cohorts during the first year of their programme. This took the form of an initial introductory email which was sent to all the students and was followed by a presentation visit by one of the research leads. A random number table was used to select five students from each cohort where more than

the required number volunteered. There were no exclusion criteria. Ethical approval was obtained for the study.

The target groups were first year students on the following programmes at the University of Plymouth:

- Pre-registration Midwifery students undertaking the three-year BSc (Hons) Midwifery
- Pre-qualified Social Work students undertaking the three-year BSc (Hons) in Social Work
- Nurses and Paramedics undertaking the two-year post-registration BSc (Hons) in Emergency Care

Because of the nature of the Emergency Care programme (some students doing the full-time two-year degree whilst others undertook this in a part-time self-funded capacity extending over a period of up to five years) this was not a homogenous cohort. The participants were at varying stages of their programmes: two were coming towards the end of their part-time programme whilst the other two were in the first year of their full-time degree. Only four students were able to be recruited from this cohort. However, five students were recruited in their first year from both the Midwifery and Social Work programmes, resulting in a total of 14 participants.

The students were invited to take part in individual semi-structured interviews held at each annual summative assessment point, having first submitted their work. It was considered ethically important not to interfere with the assessment process itself, in order to avoid advantaging or disadvantaging the participants or other students. One of the students was referred in their final year, which meant that completion of the interviews was delayed until this student had also qualified. One student went on maternity leave in her third year which meant that we were unable to capture further data from this student, and another failed to attend for her final interview despite several appointments being made, with no explanation given. The interview data available from both of these students was, however, incorporated into the relevant year's findings. Table 2 shows the data relating to the number of interviews conducted with each participant. Of note, Emergency Care students were only recruited in the second year of the study due to their shorter programme, so only one or two interviews were conducted with this group.

The schedules for each set of semi-structured interviews were devised through consultation with the whole research team. In the first year these were based on the initial literature review and findings from a set of focus groups which had been held with final year students in the same three programmes prior to commencement of the longitudinal study. A report on this small exploratory study is in the process of being published [Fisher et al 2010]. In subsequent years the schedules were refined and developed, based on the emerging data from previous sets of interviews. The research team wanted to make best use of the longitudinal design, which enabled sequential interviews to be undertaken with the students and facilitated the identification of changed perceptions and development of the individual. Therefore in the final year some modification of the interview process was made. Not only were views on the current year wanted, but it was important to capture perceptions of the programme as a whole, in the context of practice assessment. Participants were sent the transcripts from their previous interviews as well as the final interview schedule in advance of the meeting. This enabled them to give deeper thought to the issues as well as helping

them to compare their earlier and current perceptions. Several attended the interview with notes they had prepared, and commented favourably on this approach.

The interview team comprised the two lead researchers who were academics, two practitioners and one recently qualified student. Training of all members of the team was provided to ensure interviewer reliability [Silverman 1993, cited in Cohen et al 2000]. In an effort to reduce bias students were interviewed by a researcher who did not share the same professional background and/or was not previously known to the participant. The same student-interviewer partnerships were maintained throughout the duration of the study, which enabled a relationship of trust to be built up over the period and enhanced the depth of qualitative data obtained – a philosophy supported by Yin [2003].

Interviews were tape-recorded with the participants' written consent, and these were transcribed verbatim either by the interviewers themselves or research assistants employed by the Ceppl. Codes were used to protect anonymity. The transcripts were then emailed to the participants by their interviewer (ensuring confidentiality) in order to obtain member validation, and students were asked to add further comments as appropriate. They were also invited to request further informal interviews or contribute additional information via email at any point during the year prior to their next interview, should they wish to do so. During the four years of the study only one student requested an additional interview but several emails were received from other participants.

Table 2: Interview data (Shaded areas indicate interview undertaken this year)

Student code	Year one (2006)	Year two (2007)	Year three (2008)	Year four (2009)
ML1				Interviews completed
ML2			Referred – did not attend interview	
ML3				Interviews completed
ML4				
ML5				
S1			Maternity leave X2 years	
S2			Did not attend final interview	
S3				
S4				
S5				
EC1	Not recruited in the first round			
EC2				
EC3			No further interviews as programme completed	
EC4				

A general analytic strategy based on theoretical propositions was used in line with the case study approach. This involved pattern matching, explanation building and cross-case synthesis [Yin 2003, Miles & Huberman 1994]. The Framework technique devised by Ritchie and Spencer [1994] formed the baseline for single-case and cross-case analysis and synthesis of data. Thematic Content Analysis [Smith 1992] was undertaken independently by the two lead researchers after each round of interviews, and coding was cross-checked. Terminology used for themes and sub-themes was agreed through discussion. Findings were shared with the rest of the research team, and used to inform the subsequent interview schedules.

FINDINGS

Three major themes emerged in the first round of interviews, and were strongly evident throughout the study. These comprised:

1. Process
2. Preparation
3. Purpose

Other themes were alluded to in the first year, and became more significant as the interviews progressed. There were some profession-specific differences in the timing and degree of importance of these issues to the participants. However by the final year they had become major themes to all professional groups. These were:

4. Placements
5. People
6. Professional persona

Discussion of the findings in the context of the stage of programme and professional groups is based on these six themes.

1. Process

The methods used for practice assessment were explored at each interview. Questions were asked in relation to the students' perceptions of the reliability and validity of the various tools used. They were also probed on wider issues relating to the process of practice assessment. Some of the methods and tools were used in all professional groups and some were programme-specific. For ease of interpretation each is discussed individually in the context of the professional groups using the tool and changes to students' perceptions during their sequential interviews.

Portfolios

Portfolios were used in some format in all the programmes. Strengths included that they provided evidence of the student's capability and encouraged them as they could see their

progress, giving them confidence. They also provided a focus and motivated their learning. One Midwifery student said how she

“loved the portfolio because it makes you think” (ML3).

Some students liked the self-directed components, although others were not sure that they were able to self-assess effectively. They were generally seen to be reliable and effective tools. Workload was a disadvantage – both the amount of time and forward-planning required to complete them and their physical bulk. One student suggested that electronic portfolios would be better. Emergency Care students were critical of the number of portfolios they were required to present.

Some Social Work students thought that their portfolios could be too prescriptive and weighting of marks was considered to be unbalanced. These negative aspects led to anxiety, and several students commented on elements which were viewed as *“ticking-box exercises”* which did not necessarily reflect their progress. The restricted expression through limited word-counts did not allow them to expand on and explore their learning. Several felt that they were unable to acknowledge some of their best work or the complexities entailed as there was nowhere to put this in their portfolio – just a *“list of work done”* (S3). This student went on to say that the need to *“jump through hoops”* and meet requirements meant that much of what was learned slipped away in the process of demonstrating the academic level required. One participant described it as

“parachuting bits of a jigsaw down a dark well” (S3)

and thought that it squandered the opportunity to recognise the student as a whole. There were also mixed views as to the appropriateness of having an unknown independent assessor marking their portfolios. Some saw this as consistent and objective, whereas others considered that these individuals lacked knowledge of the student and an appreciation of the context of their situation. Professional judgement of assessors was considered to vary. The portfolio caused a lot of anxiety to Social Work students and they wanted it to be more celebratory.

Some participants suggested that there was room for dishonesty in completion of their portfolios – there being the potential to *“cheat the system”* or *“blur the edges”*, thus making them unreliable – particularly highlighted in the Social Work and Emergency Care programmes. Potential for breaching confidentiality was also raised by both Midwifery and Social Work students. It was felt that the combination of first names of clients and some very unusual names for their babies could make them easily identifiable in the Midwifery portfolio.

However most students saw portfolios as a valid method of recording feedback from mentors and other staff with whom they worked. They appreciated comments being made which showed them where they could improve, and saw portfolios as a valuable method of demonstrating progress. They were generally viewed favourably and seen as a valuable reflective tool.

Reflections

Reflections were also used in all the programmes. These were generally deemed to be helpful, promoting growth and providing evidence of students' learning. All participants valued the process of reflection and felt that their skills in this area had developed, some having benefited from experimenting with a variety of structured models. One Social Work student commented that the increased opportunity to reflect in their second year portfolio had enabled them to demonstrate how their values had changed.

However reflections were generally seen as a very unreliable form of assessment. The sub-theme of 'twisting the truth' again emerged with frequency in both Social Work and Emergency Care programmes, and a Midwifery student stated that it was

"easy to write down what you think people want to hear" (ML3)

This view was demonstrated across all programmes and throughout the interviews. Concerns were also raised about issues of ethics and confidentiality. Some students said that reflections did not always evidence the reality of practice, and could be seen to be an exercise in "*ticking boxes*". Emergency Care students stressed the importance of individuals choosing competencies which needed improving as topics to reflect on, rather than those which provided the line of least resistance. It was apparent that the effectiveness of reflections rested largely with the individual student's attitude and integrity.

OSCEs (Objective Structured Clinical Examinations)

Objective Structured Clinical Examinations (OSCEs) were used in both the Midwifery and Emergency Care programmes. This is a type of simulated practical examination used widely in medicine and other healthcare professions. All the students had found them to be very stressful and daunting, to the extent that some peers had been too nervous to attend on the day. The vast majority had, however, ultimately enjoyed them and felt they had benefited from this method of assessment. Most students thought that it was necessary to see how people behaved in a stressful exam situation. One Emergency Care student stated that he was wary of the argument that some peers felt unable to practise under clinical exam conditions, as they would have to be able to work and function in that type of environment. Students appreciated being able to demonstrate their knowledge and skills in a setting in which patients and clients were not being put at risk, particularly in emergency situations.

OSCEs seemed to particularly appeal to students who could liken the active stations to real-life practice (eg: Emergency Care Practitioners). However, some students considered that their typical practice was more holistic and that they did not verbalise their actions to the same extent in real life. It depended where the student's normal place of work was as to whether everyday practice was represented. One Emergency Care student thought that it was a very false environment which was alien and not holistic – saying that bits were missed out, and their ability to plan care was not picked up. Another likened it to "*playing a game*" (EC4). A Midwifery student expressed disappointment that they had not been tested in everything, considering that all high risk scenarios and emergencies should have been examined to ensure competence. She also suggested that it would be better to defer them to the third year when students had had more practice and were more confident. Some

Emergency Care students were concerned if they were assessed by people they worked with, but Midwifery students liked the fact that their tutors could see them “*in practice*”. The OSCEs were rated highly for being consistent, fair, standardised, clear cut and professional and students liked their structured approach. Although some Emergency Care students had not been as enthusiastic in the first year of interviews, in the final round they clearly recognised the value of OSCEs as being able to inspire motivation and confidence and appreciated that this method tested safe practice. Participants considered that the tool engaged the students’ learning and prepared them for emergency situations. It was identified as the one assessment which students really could not fabricate, and was therefore considered to be very reliable. Although stressful, the consensus was that it was an excellent tool which reflected practice and also formed a safety net for identifying incompetence.

Competence-based tools

Throughout their programme Midwifery students were continuously assessed through the use of the CRAG document (Criterion Referenced Assessment Grid) – a set of criteria statements identifying core clinical and professional skills which progressed along the lines of Benner’s ‘novice to expert’ theory (1984). This tool was generally deemed to be reliable and provided guidance as to what needed to be assessed in practice. In the first year students found that the criteria were mostly achievable and focused their learning, however some were unrealistic and dependent on the placements the students were undertaking at the time. In subsequent years the weaknesses became more evident - particularly in relation to ambiguity and lack of clarity which could lead to variable interpretation of the “*woolly*” criteria, thus reducing their reliability. There was an element of subjectivity, and assessment depended on the honesty and professional judgement of the mentor. Some participants were aware of the changes which had already been made to the assessment tool in the new Midwifery curriculum – largely as a result of the concerns expressed during the longitudinal study – and were positive about the breakdown of the criteria into specifics, grading of practice and opportunity for comments guiding students on their progress.

In their first year the Midwifery students had also been required to complete a competence-based assessment tool which was commonly used throughout the Nursing programme in the institution. This comprised a set of performance criteria which had to be evidenced through at least two means. Students were very scathing of this in the initial round of interviews, criticising it for its unclear and unwieldy criteria and saying that they and their mentors had found it difficult, confusing, illogical and time-consuming to complete. However, interestingly, at the final interview a couple of the students said they would like more skills-specific assessments of this nature. Formal tests such as drug rounds would have also made the students feel more confident.

The Emergency Care programme used clinical logs as a competence-based assessment tool. These were on the whole viewed negatively, as they entailed a lot of paperwork and a large number of competencies. This was another form of assessment which seemed to be open to dishonesty as students said they could potentially make up these experiences because they were not always directly observed. One student described them as “*a bit dodgy*” (EC4). However, they did provide evidence of a range of skills.

Tripartites

Three-way meetings or tripartites were routinely undertaken in Midwifery and on occasions in both the Social Work and Emergency Care programmes. Although they could be difficult to arrange they were generally seen to be very helpful, providing a means of focusing learning and reflecting on progress. The meetings were perceived to be useful checkpoints and provided an opportunity for clarification of issues, constructive feedback and raising concerns. They were most reliable if the students had worked for a significant period of time with the mentor or communication had taken place with colleagues prior to the tripartite. Midwifery students found them to be generally transparent, supportive, relaxed and student-centred. However one participant likened the meetings to a “*parents evening*” or “*signing session*” (ML2). Some found it challenging to express conflicting opinions during the meeting, and it was suggested that the mentor and tutor should also have an opportunity for private discussion of the student’s progress. One student remarked that comments during the tripartite had been at odds with previous feedback received from her mentor. Another said that she would have liked more “*feed-forward*” as comments such as “*this is fine*” were not particularly helpful. A third suggested that the process just gave a “*snapshot*” of a particular placement and mentor – both good and bad experiences of other placements could be missed out in the discussion. Tripartites were generally deemed to be helpful, and students valued the opportunity to hear out loud the thoughts of their mentor and personal tutor. It was suggested that an initial meeting with the mentor was also useful as it had helped to clarify learning objectives and expectations.

Although they were not a formal element of the Social Work programme, one student also commented on the value of “*three-way meetings*”, saying that these provided a good opportunity for feedback, created a balance between the student’s self-assessment and others’ interpretation, and that through these meetings they were able to turn incidents into learning experiences.

SLVT (Student-Led Verification Tool)

The Student-Led Verification Tool (SLVT) was a method specific to the Emergency Care programme. It comprised a structured practice-based project. All the participants initially found this tool daunting and difficult to understand, and would have valued being shown more examples and having a previous student reassure them that their anxiety was normal. However they learned a lot in the process and felt more prepared for its subsequent use. One student suggested that:

“Maybe that’s part of the educational process and maybe I needed to work out how to use it” (EC4).

This assessment method extended both academic and practice skills - but the degree of growth depended on the right subject being chosen which would be crucial to their practice. Students were pushed to research more widely and developed new strategies such as conducting a SWOT analysis or audit, whilst also

“expanding their ability to work and write at degree level more than anything” (EC2).

Earlier use of this tool was suggested in order to develop these skills from the outset. Overall students enjoyed using the SLVT, which was thought to be structured and safe. During the course of the study some modifications were made to the tool, contributed to by our findings, and participants thought it had subsequently improved as explanations and the framework seemed clearer.

Observations

In their second and third years Social Work students had to undertake a specified number of direct observations. These were assessed by someone who did not normally work with them. Opinions varied widely regarding these. Some considered that observations were valuable, and they benefitted from the opportunity to prepare for them – although acknowledged that the time this took was unrealistic in the context of real-life work. Some students had to be creative in achieving their outcomes and set up situations which were not necessarily the norm. Some thought the observations reflected everyday practice such as interaction with the service-user and family, whereas others felt that they lacked authenticity due to the selection of a specific service-user to meet their needs and the amount of pre-planning involved. The process of being observed could also change the dynamics of the student-service-user interaction. Some students struggled to organise appointments with their assessor or found it was not always a suitable time for the service-user. One student had experienced difficulties in prioritising whether to deal with a service-user need or complete their evaluation in their portfolio – a dilemma which had resulted in them putting the needs of the service-user first and reflecting in their portfolio why the evaluation was submitted late. On occasions service-users were in a situation where they were not “*voluntarily engaged*” (ie: prisoners) which could make conversation difficult. There was the suggestion that this was an area in which life or work experience could be beneficial in overcoming these issues. One student commented that their best work might not be observed as engagements with service-users could be too fragile, and considered that the fact that continuous assessment of practice didn’t feature in the programme was a “*serious and significant failure*” (S3). It was suggested that a whole day of being shadowed while undertaking their normal activities would have been more authentic. Observations were, however, deemed to be a more reliable form of assessment than portfolios and reflections as you couldn’t “*twist the truth*” with them. They also gave the assessor a good insight into the student’s practice and developed their learning. Students valued the feedback they received from a variety of sources, and the opportunity to reflect on the process with an experienced practitioner “*holding up a mirror to it*” (S3). Some students saw it as an advantage if they had more than one assessor for their observations as each could pick up on different issues and identify new learning needs, however others thought that this led to inconsistency. Inconsistency was also noted in guidance given and the level of experience of observation assessors. Placements, personalities of staff and their engagement with the role, as well as the student’s own proactive approach contributed to the reliability and quality of the assessment.

Conversations

‘Conversations’ were held between the Social Work students and service-users as a means of ensuring their safety to practice in their first year. These were generally felt to be useful, providing a

“thumbnail sketch of the student’s person-centredness and communication skills” (S3).

Feedback was helpful. However, some students found this a “*nerve-racking experience*” and one considered that word limits for recording conversations “*short-changed the service-user*” (S1). They were also challenging to organise.

Presentations

Although the research team had not anticipated presentations being identified by the students as practice assessment tools through the preliminary work undertaken prior to the longitudinal study, several participants seemed to view these as such. One of the Midwifery students acknowledged their close links with practice. Emergency Care students had found their case study presentation to be highly pressured but beneficial, boosting their confidence and pushing them to the next level. Involvement in journal club presentations resulted in useful verbal and written feedback, and it was suggested that this could have formed part of the final mark. Students recognised that presentation skills were now more a part of their clinical work, such as patient handovers, as well as in their future roles as mentors.

General comments on the process of assessment

Certain aspects of the assessment process were seen as ‘facilitative’, whilst others were ‘obstructive’. ‘Facilitative’ aspects included:

- Assessors who had a clear understanding of the process and documentation and regularly supervised students.
- Direct observation of students’ real-life practice, and not just a ‘snapshot’.
- A general preference for grading to be undertaken to provide a benchmark, with a ‘pass or fail’ approach being less positively received. Students were keen that all elements of their practice should contribute to this grade, and that assessments should be marked individually to improve this benchmarking process.
- The overwhelming importance of constructive feedback was highlighted by all the participants throughout their interviews. This kept students on target, enabled clarification of expectations, confirmed skills and highlighted needs. It was very important to acknowledge the student’s progress and help them to realise abilities they had not previously recognised. The timing of feedback was however vital, as if it was delayed the student could become demoralised or it would be too late to take into account suggestions made. Feedback comments also needed to match any mark given. Constructive feedback needed to be both verbal and written, and students wanted this to be detailed to enable them to develop. It was helpful if holistic reports came from a range of individuals including their mentor or assessor, personal tutor, other practice staff and the service-user. They acknowledged that some of the responsibility fell on themselves in being proactive and asking for specific feedback.

‘Obstructive’ elements to the process included inconsistent communication or mixed messages, lack of clarity about the correct way to use tools, unclear weighting of marks or expectation of milestones. Timing of portfolio submission could also be seen to be unfair or lacking in parity. Lack of time and workload were also factors which were ‘obstructive’ –

some of the guidance given earlier was forgotten due to the sheer volume of the workload. At times there was a lack of clarity of the role of the assessor or their understanding of the assessment processes. Poor or delayed feedback, poor guidance by inexperienced supervisors, overpowering supervisors and inappropriate placing of students in situations where they felt out of control were seen to be unhelpful. Midwifery students had found the process wearing and stressful – particularly the constant scrutiny and time constraints.

When asked whether they thought that their practice which was being assessed reflected their normal practice, responses fell under four sub-themes:

- 'real-life',
- 'ivory tower',
- 'dark forest',
- 'jumping through hoops'.

Midwifery students were generally confident that their assessments reflected 'real life' and that their assessments were reliable. This was attributed by all students to the daily assessment, feedback and guidance they received through working closely with their mentors. One Midwifery student suggested that their true practice could only be assessed if they were shadowed all the time. Some Midwifery students barely recognised they were being assessed whilst others commented on the Hawthorn effect. One participant felt unsure about self assessment and another stated that the OSCE's might not reflect normal practice by being too controlled, thus coming under the heading of 'ivory tower' – although it was acknowledged that this was a necessary part of teaching "*correct skills*".

In contrast, Social Work students were more ambivalent about their assessments reflecting normal practice. A few who drew from their past experiences considered that they were representative, some had their doubts ('dark forest') and others stated that there was too much of an emphasis on tasks and ticking boxes ('jumping through hoops'). The 'ivory tower' was a significant theme in this group. There were concerns about the normality and representative quality of the planned observations and some of the placements. The conversations with service-users in the first year of the Social Work programme were deemed to be artificial, and didn't reflect real practice. One student took the view that:

"You're not assessed on your practice; you can practice superbly and you could fail the module, because what you're actually assessed on is your perception to your practice, your recognition about how your practice has changed, and that is evidenced through the portfolio." (S3)

There was a real difficulty with being able to put complex situations into a restricted word-count. Some students said they tended to put on their best behaviour and exaggerated this to demonstrate that they were safe and respectful practitioners, however another said that they were able to overcome the Hawthorn effect. There was a general view that a longer period of observation would be preferable, with students being shadowed undertaking their daily work such as telephone conversations in order for real practice to be observed.

Emergency Care students thought that 99 percent of the time their 'real life' practice was being assessed, but that there was a risk that some students could make up procedures and cases for their clinical logs – there being a "*loophole for fudging*". Even though OSCEs were

not typical practice as they were simulated, these provided valid evidence of the student's ability and safety. The students considered that assessment both influenced and reflected typical practice, thereby developing it. This student group differed from the other participants in that they were undertaking post-registration activity in their usual workplace, so were well aware of what 'real life' entailed.

Although participants across the programmes thought most assessment methods demonstrated achievement of learning, some required students to 'jump through hoops' and 'tick boxes'. In earlier interviews students had worried about these and the workload involved, but later on students valued the direction and focus they provided. This became accepted as part of the process by the final year, but they did need to have a clear purpose.

In the final interviews, participants were asked whether they thought that potentially unsafe practitioners could qualify with the practice assessment methods used in their programmes. Midwifery students were overall of the opinion that this was unlikely. The fact that they had worked with different mentors with different styles was seen as a safety-net. However, consistency of mentorship was key – if this was not available then it was more difficult for mentors to judge progress. Generally mentors seemed to be very aware of the accountability of their role – they wanted the students to do well but were concerned for the safety of their clients and very aware that the students were practising under their registration, so they were thorough in their supervision and assessment. Some participants had heard of peers who had been picked up as incompetent, and action was quickly taken – there being good communication between the mentors and the university tutors. However two had also heard of mentors who seemed prepared to sign anything, and the ambiguity of CRAG was also seen to be a risk factor. They were pleased that grading of practice was coming in, as they felt this would be an additional safety feature, and that mentors would make more considered opinions before signing students off.

Two of the Social Work students said there was definitely potential for unsafe practitioners to qualify, whereas a third thought that those people would get weeded out over the years. Risk factors were that there was nothing in the process which would find out if people were wilfully negligent, and the benchmark for passing was set too low. It was considered that people who were dangerous would not get through the assessment process, but borderline students certainly could. More of an emphasis needed to be placed on practical skills. Students highlighted the importance of triangulation of assessment in order to achieve reliability. There was a strong view that if just the portfolio was used as demonstration of practice competence this would cause concern.

Although Emergency Care students were generally happy with the assessment methods, they all had concerns about the potential for cheating. It was a very small risk, but present. They were dismayed that there were apparently plans to remove OSCEs from the programme, as they considered this tool to be a safety-net which would identify incompetence. It was known that plagiarism had occurred with assignments, and that clinical logs had been embellished – however one student concluded that this may not in fact always be a negative process as the student would still need to analyse the situation and anxieties, and consider how it would influence their practice in the future. It was unlikely that students could cheat in the SLVT as this was so complex and the tutors knew the subject so well that they could pick up on any problems. As in Social Work, the Emergency Care participants considered that triangulation of assessment methods increased reliability.

When asked what impact the practice assessment process had had on their learning, students generally responded that it had made a significant contribution. Students identified personal, professional and educational growth which was apparent from the first year and became even clearer by the end of their programmes. Most students talked about increased motivation, commitment and personal development. They considered that the assessment process reinforced existing experience and refocused learning. This resulted in them having an excitement at how the education process was moving them forward. The Midwifery and Emergency Care students clearly noted their progression and achieved a definite end-point. Social Work students had a less apparent structure. It seemed that they had reached a point on their journey rather than completion. All participants very clearly recognised the importance of life-long learning.

All the Midwifery students thought that the assessment process had enhanced their practice, although it had been an intense experience. Students had recognised their core skills and competencies and built on these, focusing around the CRAG criteria and addressing any gaps through proactive planning. This had become more structured as the years progressed and as the students moved towards an increased autonomy, taking responsibility and planning care. OSCEs were thought to have had a *“huge impact on learning”* (ML4), increasing their knowledge base and learning in practice. One student commented on their increased understanding of the point of reflection and the linking of practice and theory. They were unanimous in their view that the success of assessment lay in the experience and continuity of their mentor.

Social Work students were generally positive about how the assessment process had contributed to their learning, but there were also some criticisms. One participant identified negative aspects which included anxiety, concern and discomfort. Students felt that they had undertaken a steep learning curve in their first year and could see how far they had come both personally and professionally. They had developed reflexivity, the ability to question conflicts arising in practice and to determine their own levels of skill together with enhancing competence, knowledge and values. Students were more aware of self and other influences including politics, and had been pushed to do more research. Their confidence had increased and the relation between theory and practice had become clearer. One student had found it

“empowering and liberating to bring in different knowledge to social work practice” (S3)

and he had been able to apply this to different areas of his work. One student felt they had learned more in their second than third year, and that their creativity had been stifled as the criteria had remained the same – seeing the third year as

“a series of boxes to tick and hoops to jump through” (S4).

The observations had helped practice and improved participants' learning, but also slowed down their work. One criticised them as being *“snapshots”* which devalued the process of learning. It was suggested that if students could enjoy the observation process more rather than feeling they were *“ticking a box”* they would benefit more. One participant said they had lost sight of what they needed to learn as they were so busy concentrating on word counts, meeting requirements, presenting their portfolio to best advantage and selecting appropriate

service-users for observations. They said it was not always possible to record in a portfolio what had been learned. Students were clear that the learning process is important – assessment should not be a “*tick-box*”. It was identified that if students were proactive they could develop their skills and take learning from most situations – but not all students in the group had been able to do this.

Emergency Care students had developed both practical and academic skills. OSCEs were a very clear favourite for developing their learning. The SLVT was likewise considered to have been very beneficial – new skills had been developed and the achievement of understanding had proved rewarding. Students felt motivated and enthused, and thought they could now contribute more to their work-place. There was a real sense of achievement. Assessment gave them direction and they realised the benefit of being motivated to improve their practice. They had valued formal feedback on their practice and found the development of their reflective skills very beneficial. They now self-assessed continually, questioning their practice and following up gaps in knowledge, enabling continuous professional development. They had found the experience of education liberating and were able to be more autonomous, confident and competent in their practice – “*It’s a joy*” (EC2). One stated that it was “*like having been in a little box and allowed out*” (EC4). They thoroughly enjoyed sharing their knowledge with colleagues and felt empowered, which had in turn led to them being better able to empower peers and patients and promote good care. One of the students stated that assessment in the workplace was crucial to their role. They had learned to “*come from the right direction – safety first*” (EC4).

2. Preparation

Preparation and guidance were fundamental to the students’ experiences across all professions and throughout the study. Their understanding of the ‘process’ and ‘purpose’ of practice assessment depended on sufficient preparation. All guidance needed to be seen to have a purpose and be relevant. Again, sub-themes of ‘facilitative’ and ‘obstructive’ guidance emerged.

‘Obstructive’ preparation and guidance was identified as inadequate clarity about expectations of the student or instructions regarding the various processes and methods used, incomplete information being provided in documentation, poor communication between the university and placement setting and inconsistency between verbal and documented guidance or information given by different people.

‘Facilitative’ guidance included provision of examples, detailed documentation, clear and consistent guidelines and face-to-face meetings such as pre-placement discussions with assessors and tripartite meetings during the placement.

In most cases materials were deemed to be clear and staff were supportive in clarifying issues. It was generally felt that information was given at the right time. Plenty of warning was given to students regarding the demands and stresses of the course. More written guidance was wanted on the expectations for reflections, portfolios, working agreements and clinical logs. However at times excessive guidance was provided which could be overwhelming and cause confusion and frustration. Some students stopped looking at the extensive information as despite being advised not to use it as a checklist they found this

was unavoidable. Not all definitions and language were readily understood: “*Articulacy is actually a hindrance*” (S3), and this could cause confusion when trying to clarify a situation. Some staff supporting learners in the practice environment appeared to need more guidance about what was required of them or further explanation of assessment documentation. All outcomes needed to be very clear and explicit to avoid variations in interpretation or individual expectations and agendas.

There was an increased emphasis on the value of feed-forward in the final interviews. This included being shown examples of completed tools, sharing others’ experiences and identifying areas for improvement. Some students suggested that earlier preparation pre-placement was needed, including its reality and complexities. One student commented that there had been poor communication between the university and the placement – the latter not expecting them and a supervisor not having been allocated. She suggested that a pack could have been sent to the area in advance. Where packs were used, such as in the Midwifery programme where one had been designed to assist them to make best use of non-maternity placements, this was identified as a positive experience, although not all the students had located or used this facility. Early in the programme, the students needed to be warned of the importance of keeping up with all assessments. They also thought it would be helpful to be able to speak to other students who had been through the process. Midwifery students would have appreciated regular guidance about the portfolio and detail of what was required, with specific criteria and milestones being highlighted each year. More information about what a tripartite comprised as well as expectations of the student-mentor relationship was wanted at the beginning of the programme. The value of pre-clinical and midpoint meetings with the mentor were highlighted, when interpretations of assessment criteria and expectations could be clarified. Workshops were provided on the observations, but some Social Work students found these lacked focus and were too late to be useful. It was also suggested that at least one observation should take place in the first year to “*demystify the process*”. Emergency Care students commented that they would have benefited from more preparation for their OSCEs, and had valued student-initiated peer practice sessions and an explanatory DVD. They needed early access to practice OSCEs, and plenty of opportunities to rehearse them. They would have liked a formal mock examination. Students from all professions commented on the value of ongoing guidance. Not only was clear guidance and preparation needed prior to the placement, but regular rehearsal of the assessment methods and formative feedback was wanted, and was appreciated when it was received.

By the final year of interviews it was interesting to note how some students seemed to acknowledge that they couldn’t actually have everything explained to them, and that they should not be spoon-fed. Some suggested that understanding how to undertake the assessments was perhaps a part of their learning - the very process of discovery seeming to contribute to the impact on their practice learning and personal development. One summed up the process of learning as:

“If you don’t go through the barrier, then you don’t get the benefit of knowing what the benefit is” (EC4).

3. Purpose

Students were asked in each year what they thought was being assessed in their practice. Three sub-themes were evident throughout: Knowledge, Skills and Attitudes. The overlap between these and the existence of both inherent and learned factors resulted in two further sub-themes being identified:

- a) Doing the job (knowledge and practical skills)
- b) Being a professional (personal attributes and application).

There were some clear profession-specific differences in response to this question. In the first year the majority of comments related to 'doing the job' – particularly amongst the Midwifery students. Explanations for this may have been that several of the Social Work students had already had experience of working in a social care environment so would have already developed many of the core skills, or that this indicated the practical nature of Midwifery. It also reflected the different professional roles of the groups. Midwifery students predominantly referred to 'clinical skills', 'basic skills', 'evidence of ability' and 'active fulfilment of criteria'. The Social Work students, however, focused more on interpersonal skills such as 'negotiation', 'information handling', 'understanding' (of clients), 'interest' (in clients), 'empathy', 'conflict resolution' and the ability to determine situations. Both Social Work and Midwifery students identified similar aspects of 'doing the job' which included knowledge, application of theory to practice, ability and competence, rapport with clients, response to situations and team-working. All students highlighted the importance of listening, observation and communication skills.

In the second year the participants were specifically asked what they considered to be the point of practice assessment. It was evident in this round of interviews that the students had a clearer recognition of the purpose of practice learning and its assessment. They had moved on from 'doing the job' to 'being a professional', suggesting that not only was their ability to do the job being assessed but also their suitability for the profession. There was a clearer understanding of the links between theory and practice, and students were able to apply their knowledge more effectively. 'Self-awareness' and 'reflective ability' were recognised as being important attributes as well as confidence to undertake the role.

Midwifery students were particularly conscious of needing to learn the skills which were required to become a safe, knowledgeable, professional and competent practitioner, with the necessary clinical abilities. They were building on existing skills and acquiring new ones as well as applying transferable skills to other settings. They were linking theory with practice and thinking holistically. They considered that practice assessment tested this knowledge and ability as well as providing guidance on how their practice should be developed. Students stated that they were being assessed on their midwifery practice and ability to cope with real life situations. They realised that this not only provided them with the opportunity to achieve the programme requirements but also enabled them to work towards a professional qualification. It appeared that the knowledge learned to 'do' the job, in both groups then fed into the ability to apply this knowledge to 'being' professional.

Social Work students were likewise very conscious of the importance of safety and competence as a practitioner, and considered that the assessment judged their ability to practice within a "safety net". There was an emphasis on self-awareness - critical analysis of

their own practice, recognising limitations and how to address these, the way they approached life and personal attributes. Assessment of interactions with service-users was important, as evidenced in the observations. Students recognised that they needed to gather their skills such as communication and increase their knowledge, integrating these into practice. They thought their practice learning developed their ability to use skills and language without consciously thinking about them. They were being assessed on their ability to monitor risks as well as their own values such as their approach towards issues of authority/ gender/ class/ race. They valued the objective feedback they received as a means of improving their practice. They considered that assessments tested ethical practice and their ability to put theory into practice, developing the 'art' of becoming a social worker.

Emergency Care students were only interviewed for the first time in the second year, but because they were already registered healthcare professionals, their responses were more similar to the later interviews with the Midwifery and Social Work students. They outlined a range of personal and professional skills which were developed during their programme. These included autonomy, clinical leadership, critical analysis of actions, assessing and planning skills, communication skills and the ability to relate to the client, reassure them and take histories, clinical governance, depth of understanding, approach, performance and ability to undertake clinical skills. Safety and competence were identified as well as self-awareness – "ability to know ability" and gaps in knowledge. One student commented that the complete health care professional was being assessed, with the bigger picture being viewed. The students commented favourably on their University programme compared to the "*number-crunching method of assessment in the ambulance service*" (EC2) which was an ongoing check on competence. Students considered that their Emergency Care programme brought a different perspective to the assessment of practice, with there being more of an emphasis on what was learned than what was taught.

In the final round of interviews all the students were very clear on what was being assessed, and were very aware of the professional end-point. Most stated competent clinical and professional performance which demonstrated that they were ready for qualification and registration. The ability to practise autonomously and safely, demonstrating the ability to make decisions, problem solve and cope with stress was mentioned by all professional groups. The application of knowledge and professional values to real practice was also highlighted. All students clearly wanted to be assessed in practice.

In the final year, when asked who they thought they needed to please in order to achieve in their practice assessment, nearly all students identified the assessor, self, the service-user and academic staff. Students rationalised and gave differing priority to these. Mentors and practice assessors needed to ensure the student was safe and met the criteria. Academics needed to ascertain that the student was following due process – two Social Work students said they needed to tick the university boxes. Across the range of professions, some participants identified that the service-user was the first person to make happy and this was more important than the student's practice assessment experience. In fact one Social Work student went so far as to say that they were not trying to please anyone, but were trying to find the right outcome for the service-user. Students wanted to please themselves by performing well and meeting their own expectations – it was important to prove that they were safe, competent practitioners.

The differences between the groups' identification of knowledge and skills may well support the argument that even though there may be generic principles of assessment, a profession-

specific component is likely to be needed in order to meet the requirements of each professional role.

4. Placements

Placements were seen as a major factor in Social Work and Midwifery student programmes. These could greatly affect practice learning and assessment experiences. Appropriateness of the placement setting and timing in relation to practice assessment was very important. Variations between placement experiences and levels of support in these could impact on the student's learning as well as their ability to achieve the required elements of the assessment. The nature of the service where the students practised also had an impact on their ability to conform to the assessment processes. In both professions inconsistency of placements meant students had differing experiences, which affected their learning. There were also concerns about availability of sufficient placements.

Not all placements contributed to the students' understanding of what Social Work really entailed. Some were useful but others lacked clear purpose, were inappropriate and disorganised and caused conflict. In one the milestones had changed during their placement which also had health and safety implications for the student. Some Social Work students had found it difficult to link the practice learning module outcomes with their placements and not all had met their learning or assessment needs. Although issues around placements (such as whether they were in the statutory or voluntary sector) could impact on experience and learning, one student said they had learned to deal with the challenges and complexities of their placement, using setbacks as a positive experience.

Timing of placements in relation to summative points and their location had a significant influence on the Midwifery students' experiences, there being a wide geographic spread of placements. The ability of assessments to reflect typical practice depended on a student's placement at the time. The CRAG statements were not always attainable in every placement, and students sometimes needed to access alternative clinical areas to achieve the criteria. When students worked on labour ward this gave a correct impression of how they were in practice because they worked with a midwife all the time, whereas on the postnatal or antenatal ward more autonomous working meant that they were not always observed in their work and interaction with women. Consistency of mentoring was found to be more difficult to achieve in the hospital than the community setting. Likewise, it was more difficult for students to be directly observed in hospital due to staff shortages. A placement in a gynaecology ward was deemed "*fantastic*" (ML5) as this had been "*wonderful in rounding out nursing skills*" as well as providing the opportunity to work in a different team environment. One Midwifery student thought that it was an advantage to work in a single clinical area as her capabilities were then better known and she was given more opportunities to undertake wider learning experiences.

Placement issues did not appear to be such a concern for Emergency Care students. This was probably because most were already employed in the relevant areas – although one did comment that she had to seek specific experiences elsewhere in order to meet the programme needs.

5. People

The person supporting the student in practice was seen as crucial in all three professions. They were the gatekeeper enabling the student to gain the experiences they needed and achieve the required elements. The student's relationship with this individual was crucial.

The attributes of the assessor in all programmes were also significant. These centred around their professionalism, accountability, personality and experience. One Midwifery student stated that a good mentor could not be fooled. Their values and beliefs, professional judgement and accountability were vital. Their knowledge and ability to undertake a reliable and fair assessment and give constructive feedback were essential to enable the student to develop and meet the required competencies. In one case a Social Work student commented on receiving poor feedback and commitment from their Practice Learning Manager which made them anticipate failure. Their attitude to the role was very important – a disinterested, inexperienced or over-controlling assessor could create a very negative experience for the student. Inconsistency between their approaches, styles or perceptions of requirements could also cause problems. Staff needed to take their role seriously and engage effectively with the student as well as liaise with practice and academic colleagues regarding their progress. They also needed to be aware of other conflicting demands on the student such as the interplay between practice and academic burdens. Students wanted them to be supportive and good listeners. Mentors and assessors needed to be well prepared for their roles.

Midwifery students thought that consistency of working with their mentors was vital. Continuity with the main assessor allowed them to note the student's progress, know their capabilities and build up trust, enabling them to “*back off*” so that their normal practice could come through. However if the mentor and student did not know each other well, this could result in the student being over-supervised in their third year when they wanted to demonstrate that they could “*fly*”. It was also important that the mentor knew the student well as they might otherwise assume that they were at the same level as other students in the year whereas in fact they may be struggling. One student commented that the advantage of having fewer mentors was that she did not have to keep starting again when working with someone new, and there were increased opportunities for their mentor to see them working in similar circumstances on more than one occasion. Emergency Care students also considered that there was real value in the continuity of the clinical assessor as they could more easily identify improvement. Social Work students verbalised that they would prefer more frequent, regular and extended contact and observation which reflected everyday practice rather than having artificially set up assessments. They expressed a desire for consistency in their Practice Learning Supervisor.

In contrast most students also identified the importance of others being involved in their assessments. They appeared to desire a triangulation of views as this could improve practice, increase reliability and provide a safety-net for detection of poor practice. A range of professionals in both practice and academic settings already contributed to the assessment of students. In addition, service-user feedback was part of the Social Work programme. All students welcomed contributions from others, stating that this created a balance - however one Social Work student commented that more than enough people were already involved in assessing their practice, but the way in which this occurred needed to change. Both Midwifery and Emergency Care students wanted contributions from a wider range of professionals such as consultants and staff from other health professions.

Emergency Care participants were particularly keen on a more structured model of mentorship for reflection and advice. It was noted by Midwifery students that if they had worked with more than one mentor it would be helpful to have them contribute formally or attend the tripartite to give a more realistic view of the student, as one student said that information about other experiences wasn't always being relayed. Some of the participants also expressed a wish for greater contact with other students. This could include sharing of experiences of assessment methods and tools, demonstration that they had "survived" the process, teaching junior students, group discussions and mutual feedback. Although most students were keen on the involvement of service-users or clients and perhaps peers in their practice assessment, this did also raise concerns regarding a potential conflict of interests. Students were generally positive about the support they received from their academic tutors. Academic input to practice was explicit in Midwifery and Emergency Care, but only seemed to take place if there was a problem in Social Work – however a positive relationship with the Practice Learning Manager could enhance these students' experiences. Effective communication between university and placement staff was seen as vital.

6. Professional Persona

This theme began to emerge in the first round of interviews but became much more significant as the students progressed through their programmes. In the first year Midwifery students were aware of political professional issues, some of which impacted on them personally whilst there was also recognition of the wider role of the midwife. Shortage of staff and budgetary cuts affected some students' practice experience, resulting in a feeling that they were being "used". There were also concerns about role changes resulting in skill loss for qualified midwives (eg: the Midwifery Support Worker taking away their holistic role).

In the second year all participants were developing a 'professional persona'. Midwifery students emphasised the importance of developing confidence and competence, enabling them to become safe and autonomous practitioners. They thought that the consolidation of practice prepared them for work in the real world, and expressed the hope that they would be given even more responsibility the following year. They were conscious of the level of accountability in what could be a very high risk environment. They were also mindful of the responsibility of and onus on being a mentor. Overall, the perceptions of Midwifery students with relation to practice assessment seemed to have changed - either through personal circumstances, professional development or their experience of the assessment process. This led to greater awareness of the importance of acquiring practice competence versus theory success. Midwifery students were keen to have weaknesses identified and not to be automatically passed in practice. They acknowledged that "*learning is phenomenal in two years*" (ML3) and that it was very hard work, but it had all "*clicked this year*" (ML3). The people they worked with seemed to have more faith in the students' abilities, and all experiences had added to their confidence.

Many Social Work students had become more skilled at reflecting on their practice. One said she wanted to

“develop into a particular type of practitioner with individualistic style who is able to go above and beyond the social work literature to create an appropriate form of practice which transcends the way social work is moving at the moment” (S4)

and another thought that their practice learning should develop an *“insightful practitioner”* (S5).

Although it was the first year that Emergency Care students were interviewed, their range of experience varied and some were already at the end of their programme. This, together with the fact that they were already qualified practitioners undertaking post-registration studies, seemed to result in them having a much clearer understanding of the need for a professional approach. They knew their limitations and saw this as a strength, valuing the opportunity to practise and develop in identified weak areas. One student said their learning had *“hugely enhanced [my] ability to go out and give people the right care pathway they need”* (EC3).

There was clear development of the professional persona in the final interviews. Students were much less focused on themselves and more aware of their peers and the wider context in which they were practising. They were clearly able to verbalise aspects which needed improvement. The individual's values and personality were recognised as impacting on the professional they would become. There was a marked difference between the students who had had previous experience in the professional roles and those who didn't. Both the Emergency Care students and the Social Work students who had previously had experience considered that the programme and assessment processes had enhanced their skills and values as well as teaching them new ones. The Midwifery students, however, seemed to demonstrate a much more structured and progressive development of their skills during the programme. All the students took responsibility for their own development and achievement. Poor experiences of placements or individuals were used positively and blame was not laid.

In the final interviews students were specifically asked in what ways the practice assessment had contributed to them becoming a professional, ready to qualify. Midwifery students were positive about the contribution the practice assessment process had made. They identified focus and consolidation of learning, huge personal development, gaining confidence, being made to think and being able to shine in one area if they did not have skills in another. The process gave them structure in their placement and the things they needed to learn. They said that it was crucial that they had as much practice as they did, and that this ran throughout the course. One had benefited from seeing a lot of integrated team practice, and they had got to know people and learned to function in a multidisciplinary team. They had been able to notice the difference in themselves – although it seemed a slow process they looked back and realised how far they had come. They had tried to become more specific in ensuring they met their landmarks, picking up on gaps. Progress statements in their portfolio were good to read through. They had found feedback from everyone – academics, mentors, other staff, women they cared for – very constructive, and said that this had mostly been tactfully given. One Midwifery student identified the importance of knowing her limitations and feeling ready before being signed up as competent.

Emergency Care students had found their knowledge and confidence hugely boosted. It had made them a more professional practitioner by enhancing existing practice, smoothing off the edges and making them more well-rounded and dynamic. Evidence-based practice techniques were demonstrated through their practice, and they were constantly updating

themselves – the assessment process had encouraged them to research and think for themselves. They wanted to improve continually, and were more autonomous practitioners.

Similarly, some of the experienced Social Work students thought that it had guided and refined their practice, defined their values, provided them with an academic base and enabled them to be agents of social change. It had become clear what they wanted to be, and did not want to be. Challenging experiences had taught students not to respond in a knee jerk fashion or take things personally. Students had become more reflective and self-critical.

Of interest, one student in each of the three professional groups had advanced further in that they were considering their future role as a mentor – either having already committed themselves to becoming one or putting themselves in their assessor's shoes and considering how they might supervise students in the future.

The loopholes for validity and potential to "*twist the truth*" continued to be concerning. Although it is recognised that students will inevitably choose the easy option at times, it is still worrying that these are potential (or existing) professionals and it raises questions about accountability. However the reassuring aspect was that the participants clearly disapproved of such practice, and felt there should be tighter measures to prevent this. They wanted the borderline students to be detected and addressed, and were pleased when this took place.

Other findings

In the final round of interviews, participants were asked whether they thought that it was appropriate or indeed possible to measure aspects such as confidence, motivation, attitudes and professional identity. This question gained mixed responses from all professional groups. Many students felt that these aspects were inherent in the student's personality and assessment of them as individuals. Some thought this was already sub-consciously undertaken through the overall assessment, and was enhanced by continuity of an assessor who could note improvements. Although some aspects were easier to identify such as motivation and a positive attitude it was more difficult to measure confidence. Not all students were equally confident but could be equally competent. Generally students didn't think that professional identity could be measured, although there was some potential for this in the reflective portfolios, and a Social Work student thought that this developed in the third year. Most students thought these aspects could not be summatively measured, but could be a part of formative assessment – however this should not be in a critical manner. It was generally thought that any measurement would be likely to be subjective, and could not be broken down into a set of statements or tick-boxes. One Emergency Care student thought a non-invasive measurement such as a scale of nought to five could be helpful – with it being contributed to by the assessors and themselves. It would, however, be a very changeable measurement and it would be difficult and probably not helpful to mark. Another suggested that motivation and attitude should be criteria for selection for the course. A Social Work student said that psychometric testing should be undertaken for all potential students. It was also suggested that tutorials, student presentations, group activities, demonstration of professional behaviour and competent practice in the work-place and reflective portfolios already assessed these aspects.

A number of issues contributed to conflict for the students in all programmes. There were concerns about availability of sufficient mentors and placements in more than one

programme. Some Social Work students had experienced dilemmas associated with the needs of the service-user versus their own. There had been a power struggle between one of the participants and her assessor. Some Midwifery students found the level of intense scrutiny they had experienced by being continuously assessed by their mentor wearing:

“It has been the most intensive, extended period of intrusive scrutiny of my entire life – it’s like being assessed everyday... and it’s so, they’re so testing your personality as well as your clinical practice that you just feel pulled apart the whole time... I do think mentors need to appreciate it’s a really tough course. It’s very, very full time and it’s exhausting” (ML1).

Several Social Work students commented on how hard the course had been, and how it had “*taken over your whole life*” (S2). Many of the participants had been challenged by the juggling of time between personal life and the course, and academic and practice demands. Both Midwifery and Emergency Care students had experienced difficulties with the attitude of clinical staff who were not always empathetic about the fact that the student was both doing clinical shifts and studying towards a degree. This was particularly the case in Emergency Care where the relatively new programme had been viewed with some suspicion by colleagues who had challenged the students, initially finding it difficult to understand why they were doing the course – though by the final interviews some had expressed an interest in undertaking it themselves! However students were generally positive about the level of support they had received, and were very pleased that they had achieved.

CONCLUSION

Having followed the chosen methodology of a longitudinal, multi-professional case-study approach, we were keen to ascertain how this had contributed to the body of evidence in the context of assessment of practice. A comprehensive review of the most recent literature published in the English language during the course of our study from 2006 until the start of 2009 was therefore undertaken in order to view the trends in the most current research, evaluation and debate within the area of practice assessment. Relevant databases were searched in order to ensure diverse coverage of international literature in terms of professional focus, research and evaluation methods and practice assessment definitions relating to health education, Social Work, Nursing, Midwifery and field education. Thirty-nine papers in this period specifically or broadly evaluated the assessment of practice and/ or practice assessment tools. The papers were reviewed in order to determine firstly the professional focus, secondly the extent to which tools used for assessing practice were evaluated by the literature and thirdly the methodology used. A summary of papers can be found in Table 3.

- **Professional focus** – In comparison with our study which had involved Midwifery, Social Work and post-registration Nursing and Paramedic students, all but three of the 39 papers reviewed were uni-professional in focus, with by far the greatest number of papers (20) solely targeting the assessment of Nursing practice.
- **Assessment tools evaluated** - Portfolios (reflective, electronic and paper-based) were the most widely evaluated tool, which reflected our study in which all three programmes had used this method. Four of the reviewed papers evaluated OSCEs and three other tools used to assess practice including Final Clinical Competence Assessments and Clinical Tutor Reports. Remaining papers focused on what can be

described as key areas or issues relevant to the assessment of practice, such as the involvement of others in student assessment, grading and the assessment of specific competencies.

- **Methodological approach used** – Only 11 of the 26 original research papers utilised purely qualitative methods in the form of interviews and focus groups, thematic analysis of learning outcomes documentation and open-response questionnaire items. Six studies used mixed methods such as questionnaires and focus groups, while the remainder used purely quantitative methods.

Table 3: Summary of current evidence

Category	No. of papers	References	Comments
PROFESSIONAL FOCUS			
Uni-professional	34	Brosnan et al. (2006)	Nursing (n=20)
		Byrne & Smyth (2008)	
		Cassidy (2008)	
		Dearnley & Meddings (2007)	
		Ghaye (2007)	
		Hobden (2007)	
		Kear & Bear (2007)	
		Kevin (2006)	
		Kneafsey (2007)	
		Kneafsey & Haigh (2007)	
		Lauder (2008)	
		McCarthy & Murphy (2008)	
		McCready (2007)	
		McMullan (2006)	
		McMullan (2008)	
		Nairn et al. (2006)	
		Pirie & Gray (2007)	
		Rushforth (2007)	
		Rushworth (2008)	
		Speers (2008)	
		Crisp et al. (2006)	Social Work (n=5)
		Clare (2007)	
		Hay & O'Donoghue (2008)	
		Humphrey (2007)	
		Swigonski et al. (2006)	
		Davis et al. (2009)	Medicine (n=3)
		Lewis et al. (2008)	
		Vnuk et al. (2006)	
		Clouder & Toms (2008)	Physiotherapy (n=3)
		Coote et al. (2007)	
		Hadfield et al. (2007)	
		Jay (2007)	Midwifery (n=1)
		Abbey (2008)	Osteopathy (n=1)
		Sharpless & Barber (2009)	Clinical Psychology (n=1)

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Category	No. of papers	References	Comments
Multi-professional	4	Atwal et al. (2008) Clemow (2007) Dunworth (2007) London (2008)	nursing; health care assistants; occupational therapists; physiotherapists post-registration nursing; paramedics; physiotherapists social work; post qualified nursing osteopathy & medicine
Generic	1	Johnson (2008)	
ASSESSMENT TOOLS EVALUATED			
Portfolios	11	Atwal et al. (2008) Davis et al. (2009) Ghaye (2007) Hadfield et al. (2007) Kear & Bear (2007) Lewis et al. (2008) McCReady (2007) McMullan (2006) McMullan (2008) Nairn et al. (2006) Swigonski et al. (2006)	
OSCEs	4 (+1)	Brosnan et al. (2006) Byrne & Smyth (2008) Jay (2007) Rushforth (2007) Lauder (2008)	 Did not evaluate efficacy of tool per se; employed the tool to measure competence
Other tools	3	Abbey (2008) Pirie & Gray (2007) Coote et al (2007)	Final Clinical Competence Assessments and Clinical Tutor Reports Competency assessment tool aimed at assessing the administration of blood components. Common assessment form for physiotherapy students.
METHODOLOGICAL APPROACH			
Qualitative	11	Byrne & Smyth (2008) Clare (2007) Clemow (2007) Clouder & Toms (2008) Dunworth (2007) Hay & O'Donoghue (2009) Humphrey (2007) Jay (2007) Kneafsey (2007) McMullan (2008) Speers (2008)	Focus groups, Interviews, Document analysis, Questionnaires (open-response)

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Category	No. of papers	References	Comments
Quantitative	9	Abbey (2008) Coote et al. (2007) Kear & Bear (2007) Kneafsey & Haigh (2007) Lauder et al. (2008) Lewis et al. (2008) McMullan et al. (2006) Nairn et al (2006) Vnuck et al. (2006)	Scales, Questionnaires, Analysis of student grades, Tool development
Mixed methods	6	Brosnan et al (2006) Pirie & Gray (2007) Davis et al. (2009); McCarthy & Murphy (2008) Dearnley & Meddings (2007) Atwal et al. (2008)	focus groups & questionnaires surveys & interviews questionnaires with open and closed questions included analysis of researcher memos structured observations
Literature review	4	Crisp et al. (2006) Hadfield et al (2007) McCready (2007) Rushforth (2007)	
Position/discussion paper/commentary/editorial	8	Cassidy (2008) Ghaye (2007) Hobden (2007) Johnson (2008) Kevin (2006) London (2008) Sharpless & Barber (2009) Swigonski et al. (2006)	
Reflections on study tour	1	Rushworth (2008)	

Our choice of qualitative methodology using a longitudinal case-study approach and involving a range of health and social work programmes was therefore unique, producing rich and varied data which has significantly contributed to the current body of evidence in the context of assessment of practice. It enabled an extended view to be taken of the student experience, which has provided a richness of data which a 'snapshot approach' would not have achieved. A level of trust was built up between the interviewers and participants which enabled the latter to demonstrate a surprising level of openness about some of the issues raised.

The longitudinal approach has enabled single-case as well as cross-case analysis to be undertaken. Diverse representation in the study group has provided valuable insights into the strengths and weaknesses of a range of assessment tools and methods across a variety of professions. It is hoped that some of the findings and recommendations of this research will be of benefit to a number of professional programmes.

Many of the students commented on the value of having been part of the study. This had not only benefitted them, but also their peers who had used the interviews as a conduit of communication with the programme teams. Several students had appreciated the opportunity to debrief and "off-load" at the end of each year with a trusted third party. They

had been appreciative of the programme changes which had already been made – some as a direct result of the feedback received during the interviews. They had been enthused by their involvement in the decisions which were made and had enjoyed being a part of the research.

The final round of interviews provided a wonderful opportunity not only to review the last year of the students' programmes, but to gain an overview of their individual journeys which had got them to the point of qualification and professional registration. A greater balance of opinions was apparent as the students had progressed beyond the initial stages to a new place of understanding and professionalism.

It was evident that much is good – and indeed excellent – in existing programmes, however practice assessment tools and processes are certainly not perfect. Each year participants were asked what suggestions they could make to further improve the validity and reliability of these. Although some very specific assessment tools were used in the programmes studied, key principles emerged which could be translated to a range of methods and professional groups. A set of generic recommendations for practice assessment has therefore been identified which can be seen in Table 4.

Although this study had its limitations – for example incomplete data sets and variable interviewing experience within the team – the longitudinal design seemed to overcome these to an extent. A particular strength was that findings did not rely on a 'snapshot' of experience, and changed perceptions were able to emerge in subsequent interviews. Some students indicated that they had consulted peers on their views and incorporated these into the discussion. This increased generalisability of the findings. Although it is acknowledged that these only reflect student views which may on occasions differ from staff opinions, the purpose of practice learning and assessment should not be overlooked. If students believe that these suggestions would contribute to their learning and optimise reliability of assessment, then consideration should be given to embedding them into professional programmes. What more heartening conclusion to a programme can there be than when a student says, in the words of one of our Emergency Care participants (EC2):

"A colleague of mine summed it up nicely when we started. He said the thing about the degree isn't really arriving at the end with a tick in the box, it's the journey that's the most important thing and you do get out of it what you put in.... That journey, it was great as far as I was concerned".

Table 4: Recommendations for practice assessment

Preparation and feed-forward	<ul style="list-style-type: none">• Early and ongoing guidance• Timely guidance• Prepare students for placement to optimise experience• Students know placement in advance• Placement expects student and receives information pack• Vetting of placement and assessors• Opportunity for students to practise skills in a controlled setting• Opportunity to rehearse assessment methods
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Flexibility	<ul style="list-style-type: none"> • Avoid ‘ticking boxes’/ prescriptive elements without a clear purpose • Scope for individuality in assessment • Word counts need to enable students to expand on and explore learning • Flexibility in submission dates • Choice in placement • Alternative assessments (eg: discussion/ viva, accredited learning, electronic portfolio, direct observation, peer assessment)
Clarity	<ul style="list-style-type: none"> • Explicit, written guidance • Specific criteria • Examples • Talk to previous students • Clear moderation process • Clarity of expectations (eg: relationship with assessor/ milestones)
Consistency and reliability	<ul style="list-style-type: none"> • Assessment directly relevant to placement context • Parity of experience across cohorts/ placement contexts • Assessment throughout placement – avoid snapshots • Consistency and continuity of support and assessment throughout programmes/ placements • Use all available evidence • Triangulation of assessment methods/ people • Final marker should input into assessment throughout year/ placement • Uniform training processes for assessors • Experienced assessors
Contact and communication	<ul style="list-style-type: none"> • Increased contact between university and placement staff • Written contract between university and placement • Increased placement visits by academics • Action learning sets for students in placement to share experiences
Involvement of others	<ul style="list-style-type: none"> • Triangulation of views • Increased involvement of others to enhance reliability and authenticate assessment (eg: service-users/ clients, peers, academics, managers, other placement staff) • Opportunity to shadow others
Feedback	<ul style="list-style-type: none"> • Frequent meetings with clinical assessor • Formative checkpoints/ three-way meetings for feedback • Consistency in assessor/ person providing feedback • Consistency between feedback and grade awarded • Comprehensive record-keeping regarding progress • Specific, written feedback • Good, unbiased, reflective, before and after events/ placement, regular • Assessor to feedback on specific and broader issues • Students to proactively seek specific feedback • Guidance on how to improve • From a range of individuals for balance
Formalised assessment	<ul style="list-style-type: none"> • Direct observation • Increased formal clinical assessment to ensure competence • Self-assessment and assessment by others • Grading of practice • Balance between practical and academic assessments • The learning process is important

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2.1.2 WORK 2

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A Blended Approach to Evidence Learning in Professional Practice

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Abstract: Research and e-learning both need to have real-life usability in order to be of benefit. This paper analyses the journey followed as an electronic portfolio was introduced into the midwifery programme at a University in the United Kingdom. Underpinning this innovation were key findings from the literature and an ongoing study exploring “Assessment of Practice”. Due to a number of curricular changes required by the authors’ institution and the professional body, the decision was made to incorporate these – together with current evidence – into a blended portfolio for use by undergraduate midwifery students. The part-electronic, part-paper portfolio enables students to demonstrate the individual range of their practice learning activities and professional development, resulting in them being able to provide evidence of their competence prior to professional registration. The flexibility offered by the e-portfolio system empowers the learner and promotes autonomy in the gathering of their evidence, which they demonstrate through a system of hyperlinks. Clarity and consistency of multimedia guidance and facilities for regular feedback on progress are key features of the new electronic portfolio. The results of a set of longitudinal case-studies which are currently nearing an end at the Centre for Excellence in Professional Placement Learning had a major influence on the development of the blended portfolio. Student perceptions of the validity and reliability of the various practice assessment methods used in Midwifery, Social Work and Post-registration Health Studies in the University as well as the impact of the practice assessment process on their learning have been explored. Significant findings have emerged from this research with regard to the strengths and weaknesses of portfolios. The importance of students understanding the purpose of practice assessment as well as recognising its contribution to their learning and development has also been highlighted. In line with the authors’ focus on producing an evidence-based innovation, a pilot was undertaken of the blended portfolio, in which students with a range of IT (information technology) and learning styles were invited to experiment with the new format. Following the successful outcome of the pilot, the portfolio has recently been rolled out to midwifery students and the mentors who support them in their practice placements. The e-portfolio has been show-cased in the wider University, and a number of health and social work colleagues are keen to incorporate a similar assessment method into their programmes. It is considered that the principles of the blended portfolio and other findings from the research will be of interest to a range of other professions which have a practice component, and would be transferable across international boundaries.

Keywords: Portfolio, blended learning, professional, practice, assessment

1. Background

Midwifery is a profession which relies on a sound evidence-base in order to inform practice. It is also essentially a practical profession in which activities undertaken need to have a demonstrably clear purpose. Critical analysis and a reflective approach inform rationalisation of decisions and actions. It was on this basis that the midwifery team reviewed the practice portfolio and assessment process in use at the time, and these were therefore the origins of an innovative blended portfolio which is currently being used by first year students.

Eighteen months ago, the Midwifery degree programme at a University in the United Kingdom was undergoing revalidation – a five-yearly process which is the norm for this institution. At the same time, the professional body governing Midwifery in the United Kingdom set out a range of new requirements in an attempt to strengthen the validity and reliability of practice assessment. Many of these were already in use in the existing programme, but it was necessary to incorporate some of the changes into the new curriculum. One of the midwifery team was leading an ongoing extensive research project in a Centre for Excellence in Teaching and Learning at the institution, which was exploring the perceptions of learners on a number of health and social work programmes with regard to the methods and processes used in their curricula to assess practice – all of these programmes preparing the learners for registration with professional bodies. The findings from this research had been

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informing the assessment process not only in the relevant programmes but also in others in the faculty. It was therefore considered important to transfer these key findings to the Midwifery programme, at this time of review and revalidation.

The midwifery team took the approach of setting up a work-party to review the current practice portfolio and assessment process in the light of evidence both from the literature and from the "Assessment of Practice" study. The work-party comprised academics, clinicians and students and so represented the various views and needs of key stakeholders. Following discussion, it was decided that the format of the portfolio should be changed to make it more up-to-date, flexible and user-friendly. Initially, the intention had been to transfer in its entirety what was historically a large and cumbersome paper portfolio to an electronic platform. However, there were two major barriers to this: firstly the lack of ready access to computers in the clinical areas – particularly in community settings – and secondly the need for entries of profession-specific requirements and summative assessment to be signed by registered midwives and mentors – a process which was, at the time, not feasible due to available technology and non-communicative web-based systems in the various hospital and community Trusts. Enquiries were made with regard to palm-top computers, but the cost was prohibitive. A decision was therefore made to initially develop a blended portfolio in which the profession-specific and summative elements were retained in paper format, but the greater proportion of the portfolio – the evidence of learning and development – was to be moved to an electronic version. Crucial to both components of the portfolio was the embedding of the key principles which had been identified in the research and literature – enhancing the portfolio's functionality as a means of presenting valid and reliable evidence of learning and achievement.

2. Applying the evidence from the literature on e-learning and portfolios

Portfolios are commonly used in health and social work professions as a method of recording practice learning, as well as being a tool for assessment (Snadden and Thomas 1998, Baume 2002, Calman 2002, McMullan 2003, Melville 2003, Carraccio, 2004). Scholes et al (2003) identify difficulties for both students and assessors of matching evidence in portfolios to specific learning outcomes. It was this aspect which the work-party sought to address by developing a system whereby mapping of learning would be more readily achieved – and the use of an electronic system seemed to facilitate this.

The expansion of e-learning is one of the priorities within Higher Education. This term covers many different approaches, with the common theme of information and communication technologies. Clarke (2004) highlights that this wide range of approaches may incorporate different elements - for example interaction, learning resources, formal and informal learning. Scott (2003) identifies effective e-learning strategies as including online debates, problem-solving or interactive learning from real life situations. Several authors emphasise the need to be clear regarding the purpose of e-learning (Forman et al 2002, Washer 2001), and Washer cautions against the presumption that transplanting learning materials onto the web necessarily makes them as effective as the resources they are replacing. However, Forman et al explains how the diversity encouraged by e-learning is very good in terms of addressing specific needs. Williams (2002) suggests that more attention should be paid to the students' needs and attitudes, and Scott (2003) further expands on this aspect stating that success is linked to matching their needs and effective e-learning strategies. An understanding of the audience and their perception of the resources will help increase acceptability and effectiveness. It was for this reason that a stakeholder group was invited to form the work-party, and that a pilot of the new blended portfolio was proposed in order to evaluate whether the users' needs had been met. The value of portfolios in promoting learning has been recognised by a number of authors. Mountford and Rogers (1996) suggest that if reflections on practice form part of portfolio assessment, this process may also contribute to the student's learning. However, Scholes et al (2004) argue that unless outcomes are clear, the result may be that the student focuses too heavily on completing the portfolio rather than learning from the experience itself. The midwifery team were very keen to ensure that the students understood the purpose of completion of the portfolio – charting their growth and development throughout the course as well as demonstrating their achievement of programme and professional outcomes.

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Sit et al (2005), in their self-administered questionnaire of post-registration degree students, explored six aspects of on-line learning. They found high levels of respondents agreeing that they could take responsibility for their own learning and work at their own pace. Other aspects which facilitated learning were ease of navigation within the resource, supplementary face to face sessions and electronic communication with the lecturer. The greatest hindrance was the lack of opportunity for face to face discussion with peers and lecturers and confidence in their own ability. Key to the new midwifery portfolio was a system of providing regular feedback to students – either electronically or face-to-face – to ensure that they clearly understood the process and purpose of this method of learning and formative assessment. Several face-to-face group tutorials were also timetabled into the programme to explain the new resource to the students and clarify any queries.

3. Applying the evidence from the research: Study on “assessment of practice”

The Centre for Excellence in Professional Placement Learning (Ceppl) at a University in the United Kingdom is engaged in a number of activities to explore and support learning in professional placement settings. One of the research strands is investigating issues around “Assessment of Practice” - evaluating methods used in Midwifery, Social Work and Post-registration Health Studies. A multi-disciplinary team is undertaking a three-year longitudinal study which commenced in June 2006, following on from an exploratory study in which the foundations and focus of the main research project were established (Fisher et al 2009 – manuscript in preparation). Multi-centre Research Ethical Approval was granted for the study.

3.1 Methods

Semi-structured interviews have been undertaken with 14 students after submission of their practice documents at the end of each year of their programme, and these are now nearly complete. Single and cross-case analysis and synthesis of the qualitative findings from the finished case-studies is in the process of being undertaken using the ‘Framework Technique’ (Ritchie and Spencer 1994).

3.2 Aims

The overall aim of the project is to establish an evidence-based set of key principles and resources to guide assessment of practice, relevant across professional boundaries. The research questions explore student perceptions of the validity and reliability of practice assessment methods as well as the impact of the process on their learning experience.

3.3 Key findings

The longitudinal approach has enabled comparisons to be made both at different stages of development of the individual as well as between individuals and professional programmes. Overarching themes identified in the study have centred around:

- Purpose - The actual reason for assessment and relevance to learning. Students appreciated being able to demonstrate “achievement of learning” and “focus” rather than feeling they were merely “jumping through hoops/ ticking boxes”.
- Process - Methods used needed to be clear and consistent. Students were keen to avoid bulk of documentation and its associated workload, and wanted to be able to be individual and flexible in demonstrating their learning and achievement of outcomes.
- Preparation (or guidance) - Key to the students’ experience, contributing to their understanding of both the ‘purpose’ and ‘process’ of practice assessment. There was a need for consistency of information and appropriate timing of its delivery.

One of the key methods of practice assessment explored in the study has been the use of portfolios, which are common to all the professional programmes represented. Significant findings have emerged with regard to the strengths and weaknesses of this tool.

Positive aspects of portfolios have included:

- they can be valuable learning tools, increasing self-awareness and guiding objective-setting

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- they make the student think
- they motivate identification of learning
- checklists and objectives provide a focus
- they provide evidence of capability and record progress and achievement

However, they have also been viewed negatively by students:

- they may be prescriptive and restrictive
- learning objectives may be repetitive
- completing portfolios may cause anxiety
- they contribute heavily to workload and are time-consuming
- size may be an issue
- insufficient preparation in their use may be given, and timing of their introduction is an issue to consider
- there may be issues around confidentiality
- elements requiring self-assessment may be misjudged
- weighting of marks may be unbalanced
- there is a perception of “ticking the boxes”
- reflections are valuable, but there is the potential to “cheat the system/ twist the truth”, raising concerns about validity and reliability (as well as professionalism!)

The midwifery work-party therefore took on board the relevant findings in the development of the new portfolio. Following up on the wish of some students to reduce bulk, an electronic component was proposed. Separation of the formative and summative elements was intended to promote understanding of the purpose of both components. Explicit in both the paper and electronic components was very clear guidance, in a variety of formats (both text and audio-visual) - so that this would appeal to different learning styles, provide consistency of information and enable students (and their practice mentors/ assessors) to re-visit the guidance as required. It was considered that the e-portfolio would provide greater flexibility for students to demonstrate their individual learning, whilst the more prescriptive elements ensured that they progressed towards the required professional and programme outcomes. Key to the functioning of the e-portfolio was a system of hyperlinks whereby students mapped selected aspects of their learning activities in order to demonstrate their personal and professional development and evidence how they had achieved these outcomes.

4. The pilot study

4.1 Methods

A six-week pilot study was undertaken prior to roll-out to students on the new curriculum, which took place between April and June 2008. This period was chosen as students had maximum time on clinical placement, and therefore would have most opportunity to try out the new blended portfolio in this setting. Volunteers were invited from the student groups across all three years of the degree Midwifery programme, based in three of the seven clinical sites. Thirteen students initially volunteered, but one subsequently withdrew due to other pressures. At the start of the pilot the students were asked to rate their IT (information technology) ability on a five-point Likert scale of poor – excellent and also to identify which learning style best described them – theorist, pragmatist, reflector or activist (Honey and Mumford 1992).

Students were provided with copies of the summative paper component and access was provided to the formative e-portfolio. Purposely, no face-to-face training of students on the use of either element was provided at the outset of the pilot, as one aspect which the midwifery team sought to evaluate was the clarity and adequacy of the written guidance. However, support was available on request once the pilot had commenced.

Mentors were informed of their student's participation in the pilot via letter, and were also sent copies of the written guidance along with contact details should problems with the portfolio's use develop.

Lecturers linked to the three hospital Trusts involved in the pilot were briefed and available as additional support, whilst all 10 midwifery lecturers were given the opportunity to view both components of the portfolio.

At the end of the six-week period students, mentors and lecturers were sent a questionnaire comprising closed and open questions regarding both components of the portfolio.

4.2 Findings

Background data collected prior to the pilot identified a range of self-assessed IT skills from satisfactory to very good. No student considered their level to be poor or excellent. The range of learning styles covered all categories. Responses were received from eight of the 12 students completing the pilot. Six lecturers completed a questionnaire, and one response was received from a mentor.

Guidelines were evaluated very positively by all respondents, although several stated that they would have valued face-to-face training in addition. Regardless of self-assessed IT skills, many found that initial access and navigation of the e-portfolio was awkward, however written guidance in combination with practical application resulted in overall positive responses identifying that there was with minimal need for extra help. Importantly, participants had been able to access the e-portfolio from all sites - home, practice placement and university. The reduction in size of the paper component was seen as an improvement, and a new method of assessing proficiencies was evaluated well.

There was some concern about perceived repetition of one of the sections in both paper and electronic components. Not all participants used or were able to access the e-portfolio for various reasons. This was largely due to the timing of the pilot which had, of necessity, occurred at a point when students were also being required to complete their programme practice portfolios as well as academic assessments. Some specific technical issues were identified such as general appearance, editing and navigation between sections, and these comments were used to inform improvements to the final version.

Overall, participants from all user groups were positive about the introduction of an e-portfolio. The hyperlink system, although initially perceived as “tricky”, became easier with use, and students commented on the benefit of being able to demonstrate external links (eg: to national guidelines): *“Hyperlinks are good as it shows evidence of learning” (Student).*

Students liked the fact that the personal tutor would have access and provide formative feedback. Participants were very positive about the updated format, and students thought that it would be more convenient to access in the clinical area rather than carrying around their existing bulky portfolio. *“I think it is excellent and innovative” (Lecturer).*

5. Discussion

It was reassuring to note that the feedback was generally positive from all participants in the pilot study, as this contrasted with the findings of Williams (2002). In his exploration of psychology lecturers' and students' views of a new electronic system, there had been a discrepancy between the two groups' perceptions and evaluation of the method - the lecturers having been enthusiastic, but the students viewing the development negatively.

The students in our pilot represented a range of ages, IT ability and learning styles. These differences did not however appear to affect whether or not they were able to cope with the new format. Although the pilot group was small, these findings concurred with those of Wishart and Ward (2002). They explored attitude and locus of control in relation to e-learning, and found that mature students were slightly less likely to have used different software, be less scared of computers and in favour of their use – a finding which was perhaps surprising. However, these differences were not significant. No differences were found between the two age groups with regard to locus of control, which refers to the

extent to which an individual feels they are in control of events and their environment. Someone with an internal locus is therefore more likely to be positive towards computers and enjoy being in control,

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whereas those with an external locus of control may find computer use a very unsettling, emotional experience. Whilst Wishart and Ward found no differences between age, gender and profession, they recommended incorporating some less open-ended tasks to support those with an external locus of control. The current move to widen the entry gate to university admissions has resulted in a student group with mixed abilities and attitudes towards computer-based learning. The midwifery team is therefore very aware of trying to accommodate the various needs and levels of IT ability in the range of students undertaking the programme. Some of the midwifery e-portfolio therefore comprises set templates which need to be completed by the student as they progress through their programme, whereas other elements allow free range to the student's individual expression. The inclusion of a paper-based element also makes allowances for variations in ability, learning style and locus of control.

Having undertaken the pilot study, the midwifery team was reassured that the move towards a blended portfolio was educationally sound and acceptable to stakeholders. Further refinement of the e-portfolio took place prior to rollout to 'real' students, and the challenges of electronic systems provided steep learning curves for the team! A significant hurdle to be negotiated was the siting of the portfolio on a long-term system, as the students needed a guarantee that their e-portfolio would be safe and functional throughout their three-year programme. Web-based learning being as it is, the technology has constantly been changing, and the recent purchase by the University of a commercially produced e-portfolio system for use throughout the institution added yet another dimension. It was, however, decided that the custom-made e-portfolio created with the invaluable support of a faculty technologist would be used in the first instance as this seemed to better meet the needs of the programme.

One of the main priorities of the midwifery team has been to ensure that students use their portfolio as a means of learning, rather than a "box to tick". Two indispensable components of lifelong learning are self-motivation and self-directed learning. Regan (2003) and Fisher et al (2001) both highlight the need to match students' readiness for self-directed learning and the teaching method for optimum learning. Fisher et al suggest that the former is individualised and consists of a continuum rather than 'ready or not'. Our blended portfolio will enable students to travel this journey along flexible routes, although the destination has to be time-constrained and outcome-directed. Regan's (2003) mixed method study found a wide range of motivational factors influenced self-directed learning- the importance of the tutor role, intrinsic factors (personal goals, interest in subject) and extrinsic factors (pressures and rewards). Support in helping students to understand the process and purpose is therefore crucial. A number of opportunities for formal and informal tutorial support and feedback for both students and mentors has been built into both the blended portfolio itself and the process of introducing it to the users. The end-result will hopefully be an individualised portfolio which demonstrates the student's progress and growth as well as achievement of outcomes, and promotes the concept of lifelong learning.

6. Conclusion

Although this blended portfolio has been designed for midwifery students and incorporates profession-specific components, it is believed that the concepts and principles are transferable across both professional and geographic boundaries. E-learning has opened opportunities for being more innovative in the application of traditional learning and assessment methods, and it is important to make use of this flexible platform. However, inherent in technology are a range of barriers and pitfalls – not least its rapidly developing and dynamic nature. All too soon, what was at the cutting edge of developments is outdated. On the other hand, these very developments may enable some of the existing hurdles to be negotiated – and a fully electronic portfolio readily accessible to students and mentors in all sites is anticipated in the future. Midwives are used to reflecting and critically analysing current situations, using the evidence base and technology at our disposal to promote best practice. So we'll move with the times, as we embed this portfolio into the curriculum, and continue on our own journey of lifelong learning.

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2.1.3 WORK 3

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Chapter 3

ASSESSMENT OF PRACTICE

Margaret Fisher

INTRODUCTION

The Nursing and Midwifery Council (NMC 2009) requires practice to be assessed in all pre-registration midwifery programmes. A minimum of 50% of your programme will be spent in practice and its assessment is therefore a hugely important aspect of your preparation to become a midwife. Not only is practice an essential part of the preparation of midwives from a professional body perspective, but recognition for its contribution to overall degree classification is gaining importance. Valuing practice in this way therefore benefits you as a student (rewarding excellence), recognises those supporting you in practice and raises the profile of the profession. Increasingly women and their partners or families are being asked to contribute to the assessment of practice, and programme teams have developed a range of methods of capturing this vital perspective.

The Nursing and Midwifery Council 'Standards to support learning and assessment in practice' (NMC 2008a) and 'Standards for pre-registration midwifery education' (NMC 2009) are the main professional documents which set the requirements for practice assessment. Both are currently being reviewed so there may be changes to these in the future – it is important you keep up-to-date with any new publications. This chapter discusses the standards and principles, and terminology and processes are also explained. It is divided into sections which include:

- **Purpose**
- **Process**
- **Positives**
- **Pitfalls**
- **Preparation.**

As can be seen in my biography, practice assessment and mentorship are of particular personal interest. Findings from several research projects in which I have been involved have been included in this chapter where appropriate. These comprise: my Masters dissertation on midwifery mentors (Fisher 2008, 2009); a five-year study of practice assessment in midwifery, social work and emergency care programmes (referred to as 'CEPPL' – the Centre for Excellence in Professional Placement Learning

– a government-funded Centre at Plymouth University; Fisher et al 2011, CEPPL 2011) and a recent scoping activity of practice assessment processes in midwifery programmes throughout the United Kingdom (Bower et al 2014, Fisher et al 2015). References and electronic links to publications can be found at the end of the chapter for further reading.

This chapter will also explain the Fitness to Practise procedure which may, on occasions, be invoked if concerns are raised about a student's conduct or health when on a midwifery or nursing programme. The relevance of this to practice assessment will be discussed, along with links to other chapters in the book.

You may find the information a bit much to start with – so perhaps dip in and out until you are clear on the roles and processes and have some practice experience on which to pin it.

PURPOSE

Why does practice need to be *assessed*? It is important that you understand the reason for this; otherwise it runs the risk of being seen simply as a 'tick-box exercise' which adds to workload without any clear purpose (Fisher 2011). The NMC's requirement for midwifery practice to be awarded a grade which contributes to academic credits and therefore degree classification may be seen as a tangible outcome for students. This has gone some way to raising the profile of practice, and acknowledging its value (Bower et al 2014, Fisher et al 2015). It has, however, also made students very competitive and resulted in some losing sight of the true purpose. It is important to move beyond the mere numerical value and look at what is *really* being assessed and what this means. The assessment document will include a set of criteria, based on NMC requirements including skills, knowledge and attributes which you must achieve in order to progress to the next stage of your programme or be deemed fit to go on the register (more of this later). How well you are performing in relation to these criteria is vital for you to know so that you can work on any areas which are weaker while maintaining and continuing to improve those aspects in which you are stronger. The whole purpose is to ensure that you are practising in a way which is leading towards you becoming a safe, competent and confident midwife. Importantly, you need to realise that it is your *performance* which is being assessed and not you as an individual. Your *personality* will of course influence your performance, but you yourself are not being judged.

You may have your own views as to how well you are doing, but it is important to get feedback from practitioners who know what this registration really means. Of course, your sign-off mentors are all individuals and some are more effective at this role than others. Chapter 2 has highlighted how mentors can vary, although you will find that the vast majority are excellent and take the role very seriously (Fisher 2008, 2009). It is therefore important that the assessment tool used is fit for purpose and supports those measuring your performance to do so in a consistent and objective way (Fisher et al 2011). Midwifery programme teams around the country are currently trying to learn

'best practice' from each other, establishing a set of key principles and potentially a common grading matrix which can be modified to meet individual institutional requirements and curricula to further enhance this process (Lead Midwife for Education-UK group, Bower et al 2014, Fisher et al 2015). Some of the 'processes' discussed in the next section seek to overcome these variations, but because the complexity of humanity is involved there is inevitably going to be an element of subjectivity in your assessment.

This is where you need to focus on the *purpose*. Although you may want to have a grade in the 90's but your sign-off mentor thinks you should receive 70%, the overall message is that you are achieving, and doing so at a very high level. This should be of greatest importance to you in that your assessment is telling you that you are well on the way to becoming an excellent midwife. Likewise, if you are receiving a grade which is barely a pass, the clear message is that you need to do a lot of work in order to succeed in practice. You need to be discussing some key learning objectives with your sign-off mentor and personal tutor to ensure you are going to ultimately meet the requirements for registration as a midwife.

It is also very important for you to develop self-awareness, and the practice assessment process can encourage this. Sophie Denning, a 2nd year midwifery student at Plymouth University (PU), says that it is important that you

"Understand your role as a student midwife and what mentors will expect from you."

Even if your programme does not require formal self-assessment, make sure that you regularly review your progress against the set criteria and *honestly* measure your performance. If you have any doubts that you are 'making the grade' then speak to your sign-off mentor or personal tutor urgently and ask them to help you to devise an action plan to address any weaknesses. You might like to try out the hypothetical activity in *Box 1*. It is much easier for you to do this if you have personally acknowledged that you have difficulties than if someone has told you so; the motivation to improve will be much stronger (think of the basis of Alcoholics Anonymous). Self-awareness is a hugely important attribute to develop and will make you a much safer and better professional. 'Making Practice-Based Learning Work' (Marsh et al, accessed 28/2/15) is a useful resource designed for those supporting learning in practice, but also with some handy hints if there are any issues about your achievement in practice (though I am sure you won't need this).

BOX 1: Action plan scenario

You are three weeks into your first placement in community. Julie, your sign-off mentor, meets with you to discuss your progress. She says that you seem to be struggling in antenatal clinics. You don't appear to find it easy to relate to the women and are very hesitant in performing abdominal palpations.

Think about:

- What verbal and non-verbal 'messages' may you be demonstrating to give this impression?
- Why may you be behaving in this way?
- What actions do you need to take to make progress in this area in the remaining three weeks of your placement?

PROCESS

The NMC provides the *principles* for practice assessment but individual midwifery programmes will differ in their translation of these into specific documents and processes. There will, however, be elements which are common to all and will be explained further in this section:

- a) Practice placements
- b) Sign-off mentor (and perhaps co/ buddy/ associate mentors)
- c) Ongoing Achievement Record
- d) Assessment document
- e) Grading of practice
- f) Practice progress review meetings (usually referred to as 'tripartites' or 'triads')

a) Practice placements

These are of course fundamental to your programme, enabling you to learn, practise and refine the various clinical skills and professional behaviours which will be needed as a midwife. The fact that this book has been written is testament to the importance of practice placements in your midwifery course. It is, however, important that you recognise that the placements actually exist for the purpose of service to the public. You will be supported in experiencing a range of learning opportunities, but the needs of the service may at times conflict with your plans, and the former will take priority.

Other chapters in this book such as those covering 'Low risk', 'High risk' and 'Wider experiences' highlight the various placements and models of care you are likely to encounter as a midwifery student. Read these carefully to see how you can best plan your placement around the requirements of your practice assessments; devise appropriate learning objectives which will make best use of any specific learning opportunities and use your practice assessment document to focus on particular outcomes relevant to that placement. Discuss these with your sign-off mentor.

Audit and evaluation

The NMC requires all clinical areas in which midwifery (or nursing) students are placed to be audited as suitable learning environments (NMC 2008a). This is a partnership activity undertaken regularly by clinicians and academics. Part of this process will require student evaluations of placements to be completed. It is very important that you do this in an honest and detailed fashion, including both positive and constructive criticism. Please make sure that you let your personal tutor or an appropriate clinical staff member (ward or department manager or someone with responsibility for education) know if there is anything which needs attention. Take ownership of your feedback; it is part of becoming an accountable practitioner (see also the sections on escalating concerns in Chapters 1 and 5). Students are not able to be placed (and therefore assessed) in areas which are not appropriate and where there are insufficient or inadequately prepared sign-off mentors.

b) Sign-off mentor

This will be a very important person to you in every placement. It is the sign-off mentor who will be monitoring and assessing your progress while also (usually) being your main 'teacher' and 'advisor' and co-ordinating your learning activities. The role of 'sign-off mentor' was introduced by the NMC in 2006 and became a mandatory requirement in 2008 ('Standards to support learning and assessment in practice', NMC 2008a). This built on and formalised the previous role of the 'mentor' who was required to:

"...facilitate learning and supervise[s] and assess[es] students in the practice setting"

(English National Board for Nursing, Midwifery and Health Visiting 2001, p6)

A number of factors gave rise to this more formal role including an unacceptably high number of recently qualified nurses and midwives falling foul of the NMC Code of conduct and needing to be investigated at Fitness to Practise hearings (see the section at the end of this chapter for further explanation). In 2004 a study was commissioned into why mentors 'fail to fail' students (Duffy 2004), and this concept has continued to be discussed in more recent literature (Rutkowski 2007, Jervis and Tilki 2011). As a result, the NMC increased the emphasis on the accountability of the role. Along with this, the requirements for those responsible for assessing nursing and midwifery students as fit to go on the register were tightened up. Look at *Box 2* which lists these requirements. Because of the nature of midwifery and its statutory role as well as the degree of autonomy qualified midwives have, it was considered that a 'sign-off mentor' was in fact

required throughout the programme, at all 'progression points' (NMC 2009). This differs from nursing in which a sign-off mentor is currently only required in the student's final placement, although it is possible that this may align with midwifery in the future.

BOX 2: Requirements of sign-off mentors

Nurses and midwives who intend to take on the role of *mentor* must fulfil the following criteria:

- Be registered in the same part or sub-part of the register as the student they are to assess and for the nurses' part of the register to be in the same field of practice
- Have developed their own knowledge, skills and competence beyond registration i.e. been registered for at least one year
- Have successfully completed an NMC approved mentor preparation programme
- Have the ability to select, support and assess a range of learning opportunities in their area of practice for students undertaking NMC approved programmes
- Be able to support learning in an interprofessional environment – selecting and supporting a range of learning opportunities for students from other professions
- Have the ability to contribute to the assessment of other professionals under the supervision of an experienced assessor from that profession
- Be able to make judgements about competence/proficiency of NMC students on the same part of the register, and in the same field of practice, and be accountable for such decisions
- Be able to support other nurses and midwives in meeting CPD needs in accordance with the Code: Standards for conduct, performance and ethics for nurses and midwives (NMC 2008a).

A nurse or midwife designated to *sign-off* proficiency for a particular student at the end of a programme must additionally have:

- ✓ Clinical currency and capability in the field in which the student is being assessed
- ✓ A working knowledge of current programme requirements, practice assessment strategies and relevant changes in education and practice for the student they are assessing
- ✓ An understanding of the NMC registration requirements and the contribution they make to the achievement of these requirements
- ✓ An in-depth understanding of their accountability to the NMC for the decision they must make to pass or fail a student when assessing proficiency requirements at the end of a programme
- ✓ Been supervised on at least three occasions for signing off proficiency by an existing sign-off mentor
- ✓ A working knowledge of current programme requirements, practice assessment strategies and relevant changes in education and practice for the student they are assessing

Nursing and Midwifery Council (2008b) '*Standards to support learning and assessment in practice*' p 24, 27-28

What this means to you is that you will find that you have midwifery sign-off mentors allocated to you for the majority of your course, and it will be essential that they are the people who assess whether or not you have achieved at each progression point or on completion of the programme (NMC 2008a, 2009). You are expected to work 'under direct or indirect supervision' of your sign-off mentor for at least 40% of your practice time (equating to usually 2 days per week minimum). Note that your sign-off mentor can liaise with others who have worked with you; they do not have to physically work with you on every shift. This allows for periods of annual leave or part-time staff, for example. If they have an additional role (such as a manager) which means that they cannot work directly with you as much, it is their responsibility to ensure they talk to your co-mentors so that they can assess your progress.

Likewise, as you advance through your programme you will undertake more practice under reducing levels of supervision. An analogy I use when teaching Mentorship is the elastic lead used for dogs. To start with, you need to be working immediately alongside your sign-off mentor (or supervising midwife). Gradually, you will move away from them and undertake periods of care with them indirectly supervising you. On some occasions you may even be working out of sight (for example when doing your caseloading – see Chapter 6). You are, however, always 'attached' to your sign-off mentor and you can come swiftly back to them or they can follow you if, for example, a low risk situation becomes high risk. The 'elastic lead' of their registration number and therefore accountability for your practice – actions and omissions - will not be released until you complete your programme and are practising under your own PIN (Personal Identification Number). It is therefore a hugely responsible role to be a sign-off mentor, and you need to appreciate that different midwives will be happier to let that lead stretch than others; much will be down to their confidence in you, so it is important that you let them watch you until they are reassured of your capabilities, and make sure you always keep them informed about what you are thinking and actions you are proposing. If you are already registered as a nurse, it is extremely important to remember that you are practising under your midwifery mentor's registration and not your own as a nurse during your pre-registration midwifery programme. You must therefore follow the same principles.

FIGURE 1: Analogy for appropriate level of supervision by mentors. Reproduced with permission of Clare Shirley, third-year midwifery student, Bournemouth University.



Buddy/ associate/ co-mentors

In many placements you may also have one or more designated buddy/ associate/ co-mentors allocated to you (terminology will vary in different areas). It can be very valuable to have nominated additional midwives helping to support your learning and providing you with wider experiences and role-modeling. The team approach can also provide you with more continuity of mentorship, for example when your sign-off mentor is on annual leave. It is likely that your co-mentors will also be invited to contribute to the evidence supporting the decision of the sign-off mentor as to whether or not you have achieved in practice. In many instances your co-mentor may be working towards becoming a sign-off mentor themselves, so it is important you work with them and try to invite them to your tripartite/ practice review meetings if your programme allows for this. You may also find you receive a higher grade due to their verbal and written contributions adding to the pool of evidence.

c) Ongoing achievement record (OAR)

The NMC requires all midwifery students to have some form of practice record which is transferred between separate placements or clinical allocations (see NMC 2009 p22). This enables all those involved in your assessment to be able to see how you have progressed and contributes to the evidence for subsequent placements. In most cases

this will take the format of a practice portfolio which may be paper-based, electronic or a blended mixture. It may include for example:

- learning objectives
- reflections
- comments from others
- evidence of wider reading or attendance at in or extra-curricula study sessions
- record of European Union (EU) numbers (NMC 2009)
- your assessment document.

It will be a document which you will guard with your life.

Keri has the following 'Top Tips' for maintaining your OAR:

BOX 3: Top Tips for your portfolio of evidence

- *"Look at the learning criteria for each section of the portfolio when writing your learning objectives for the placement. It will help you to achieve the outcomes and provides your mentor with a structure for your learning."*
- *"Make sure you get experiences signed off in your practice portfolio by the member of staff you have worked with on the day, and update your online portfolio as soon after the event as possible."*

Keri Morter

2nd year student, Plymouth University, Plymouth, UK. Reproduced with permission of Keri Morter

d) Assessment document

This may form part of your OAR or be a separate document. The NMC has set out key elements which must be explicitly assessed in both theory and practice. The 'Standards for pre-registration midwifery education' (NMC 2009) explain the Midwifery Competencies and Essential Skills Clusters in detail (see also Chapter 1), but in summary they comprise the following:

Competencies (Standard 17, categorized as 'Domains' on pages 23-35):

- Effective midwifery practice
- Professional and ethical practice
- Developing the individual midwife and others
- Achieving quality care through evaluation and research.

Essential Skills Clusters (see pages 35-67):

- Communication
- Initial consultation between the woman and the midwife
- Normal labour and birth
- Initiation and continuance of breastfeeding
- Medicines management.

Future revision of the Standards may see some changes in terminology/ content – but inevitably these elements will remain core to practice assessment.

FIGURE 2: Example of a practice assessment document

The image shows a spiral-bound notebook with a practice assessment document. The document is a form with multiple sections, each containing a list of criteria for assessment. The criteria are written in a small font and are organized into columns. The form includes fields for 'Date', 'Sign-off Mentor', and 'Comment if not achieved'. The notebook is open to a page numbered 220.

You will find that your midwifery programme assessment document will map the skills, attributes and knowledge which are being assessed to these elements. The method of doing this will vary (Bower et al 2014, Fisher et al 2015). In most cases, assessment will be 'continuous' – in other words your sign-off mentor will be monitoring your progress throughout your daily practice against set criteria. This will either be through working with you yourselves or communicating with others who have been supervising you. Some programmes may include focused assessments of specific skills or activities, and you will be advised if this is the case and how best to prepare for them. There will be 'progression points' when completion of all relevant criteria will be measured and your development during that stage of the programme will be assessed. All midwifery students will therefore have demonstrated achievement of these professional requirements in order to be assessed as competent and fit for entry to the register on completion of the programme. Georgia Moffatt, 2nd year student at PU says that:

“Discussing with [my] mentor about how things are going constantly helps me understand where I am, and where I am going in regards to my learning objectives.”

As you can imagine, documentation of your development and achievement will take time. It is vitally important to keep up with this, otherwise it becomes a struggle for both you and your sign-off mentor and the purpose also becomes eroded. If you leave all your paperwork until your assessment time you will indeed feel that it is a ‘tick-box exercise’ and heavy workload. You may also find that the quality of both the evidence and the assessment itself is not as good. Busy practice and academic staff will become frustrated and irritated if documentation is not completed at the required time, and resultant delays in your assessment meeting will have a knock-on effect to other appointments and commitments.

Protected time

Acknowledging the associated workload and the importance of value being given to the assessment process and appropriate judgements being made, the NMC set out in their Standards (NMC 2009) the requirement for an hour per week of ‘protected time’ with your sign-off mentor to review your progress. This was designed to enable you to discuss your working towards your objectives for that placement, undertake focused learning and keep the relevant documentation up-to-date. In reality, you will find that it is near-impossible to achieve this on a weekly basis. When you are in a community setting you will generally find that you have more time (car journeys are very useful) to discuss how you are doing as you go along, however when you are placed in a busy maternity unit it can be extremely difficult to get together on a regular basis due to service commitments and shift patterns. What you and your sign-off mentor need to acknowledge is that protected time will not just ‘happen’. It will take planning and organisation in order to achieve it. You will also need the support of the rest of the team – and they should be prepared to do this as part of their communal responsibility towards education in practice (Fisher 2008). Although the needs of the women and service must always take priority, with sufficient structured planning you should be able to achieve this on a reasonably regular basis. Discuss with your sign-off mentor:

- What is the unit/ Trust approach to meeting this NMC requirement? Do they explicitly acknowledge the importance of it and are there any existing arrangements to help sign-off mentors and students to meet? Do they make allowances for sign-off mentors to have this time available during working hours or do they offer ‘time in lieu’ or a financial alternative if it is not possible to achieve this in usual hours?
- Is there an expectation as to how this should be documented?
- Is an hour a week appropriate or would a more flexible approach be easier eg: half an hour twice a week or a couple of hours a fortnight?
- What time of day tends to be better – is there a period when there is overlap of shifts and therefore more staff on duty, or the area tends to be a little quieter?

- What are your sign-off mentor's personal commitments (work and home life)?
- Look at the off-duty and check any 'booked' activities (if relevant to the clinical area) and staffing levels; identify suitable dates and times and write them on the off-duty next to both of your names (check you are allowed to do this with the rostering system locally).
- Discuss where to meet – it is usually best to take yourselves away from your usual work environment so that you are less likely to be disturbed. This is where the team's support comes in – they need to know when and where you are both going and may be able to cover more urgent work in your absence.
- Make sure you have all of your documentation ready for the meeting; this will make best use of the time and show your sign-off mentor that you are proactive about your learning. They and the team will be more supportive towards you if they know that you are making good use of these periods.

Remember that your sign-off mentor will have a range of other responsibilities in addition to mentoring you. Please treat them with consideration and respect and approach requests with diplomacy. Help them to fulfil their role by ensuring you communicate clearly, are proactive about arranging any meetings and provide them with documentation at their request so that they are able to keep this up to date.

e) Grading of practice

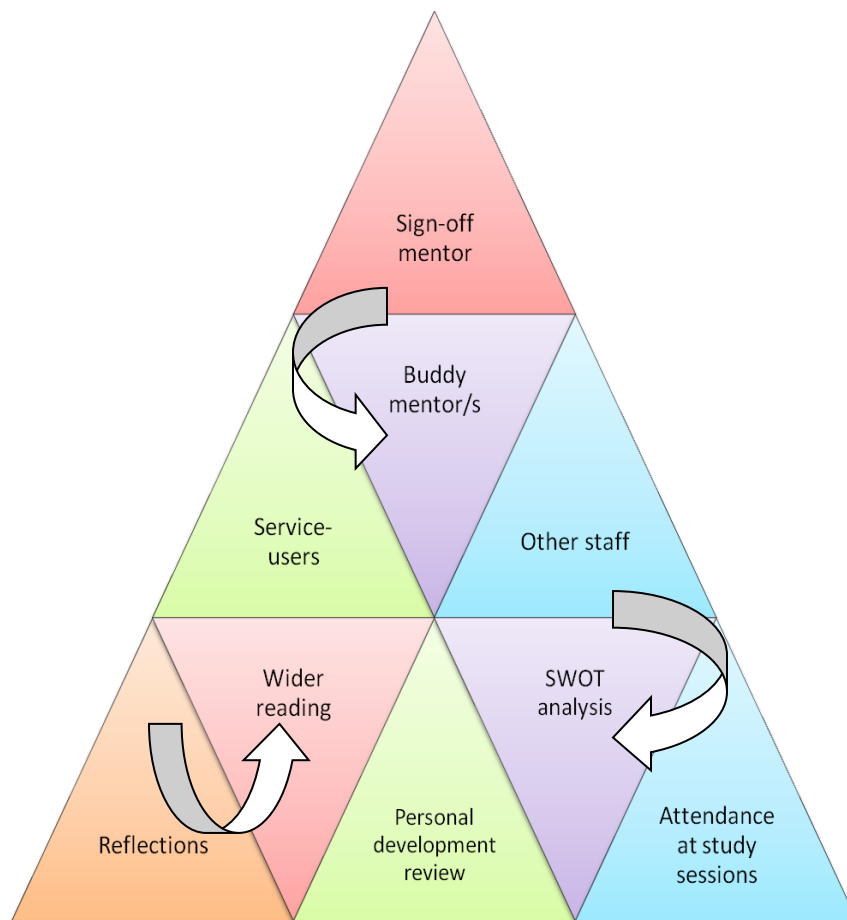
The NMC requires practice to be awarded a grade which contributes to the credits leading to the academic award (Standard 15 – Assessment Strategy, NMC 2009, p20-21). In some programmes this will be a specific mark or percentage; in others a classification such as AA, A, BB, B, C may be used. A matrix or guide for grading against specific criteria is likely to be included in your practice assessment documentation. In most programmes the sign-off mentor will be responsible for awarding the practice grade – although this may vary between institutions as some combine or replace this with input from academic staff; the sign-off mentor comments or individual assessment tasks providing the evidence needed to determine the ultimate grade awarded (Fisher et al 2015). The level at which you are expected to perform will increase each year – and you may find your practice grades therefore decrease if you do not work at a higher level, for instance dealing with more complexity or taking more of a lead in referring any deviations from normal. This reflects what happens in your academic assessments. In some institutions practice-related activities such as reflections may also contribute to the practice grade (Bower et al 2014, Fisher et al 2015).

Triangulation of evidence

The NMC (2009) requires the grade awarded to be based on clear evidence, and you will find that the process of documenting this will again vary in format in different programmes. Popular sources of evidence include reflections, learning from in-house or external study days and wider reading. You are also strongly encouraged to gain as many written accounts as you can from a range of other individuals with whom you have

worked (whether midwives or other professionals or support workers) as well as the women or families for whom you have cared. This 'triangulation of evidence' has been shown to be very beneficial in gaining a more accurate reflection of abilities and performance, enhancing the reliability of assessment (Fisher et al 2011). It is also a very important aspect of a registrant's practice, and has been included in the new 'The Code' (NMC 2015, standard 9.2) as part of the revalidation process. You may also find your grades are higher if you are able to provide a number of positive accounts from others. Please seek guidance from your programme team as to how best to access and document this evidence. Self-assessment and personal development techniques such as SWOT analysis (Strengths, Weaknesses, Opportunities, Threats), learning objectives and capability or professional development plans will also form a valuable contribution to this pool of evidence – see some useful websites at the end of this chapter. Think broadly. Victoria Shaw, first-year student at Plymouth University, shares the value of taking this proactive approach to her practice learning in *Vignette 1*.

FIGURE 3: Triangulation of practice assessment



VIGNETTE 1: Identifying your learning needs

“When first going out into placement each student is expected to undertake a SWOT analysis. The aim of this is to detect our own strengths, weaknesses, opportunities and threats. I decided that one of my weaknesses was my lack of clinical experience; I was worried that by not having any past experience it may put me behind others when it came to going out on placement. Although it is massively exciting to be going out on placement only 10 weeks into the course, it’s extremely nerve-racking. I know in previous years the students didn’t go out into practice until February, which means they had those extra weeks to practise their clinical skills before going on placement. Having been on placement for only a week I feel more confident in these already. It is evident to me that clinical skills can only really be taught and learnt thoroughly in the workplace. Practising them before going out on placement was helpful, in the sense that I had a rough idea of how to carry out some clinical tasks. In actual fact it was through practising in the real environment of the hospital that I really cemented my knowledge and had the opportunity to master some of these skills. I feel that learning practical skills whilst out on placement makes it a lot more real and I now have an understanding and appreciation of why they are done and how important they are. For example, learning how to do a set of observations; each time they are done they form the basis of a bigger picture.

The best advice I can give any new students preparing to go out on their first placement is to decide what your own strengths and weaknesses are. Make sure you have a clear idea in your mind of what it is you need to work on when you go onto placement, this way when a midwife asks you what it is you are hoping to learn from your first placement you have an answer for them. This will enable you to get the most out of your placement and have a clear idea of your learning objectives from the outset.”

Victoria Shaw

First-year student, Plymouth University, UK. Reproduced with permission of Victoria Shaw.

f) Practice progress review meetings (tripartites/ triads)

It is highly likely that you will find that review meetings form part of the practice assessment process in your institution. In most Universities this is called a 'tripartite' or 'triad' (Bower et al 2014, Fisher et al 2015). These normally take the form of a three-way discussion about your progress in practice between your sign-off mentor, an academic midwife such as your personal tutor and yourself, but a wide range of variations exist throughout the UK (Fisher et al 2015). Conversations may take place over the telephone or via e-mail. The majority of institutions, however, prefer face-to-face discussions as this is probably the most rigorous of the approaches. Disadvantages are that they can be problematic to arrange and are resource-intensive (Fisher et al 2011). As a result, some programmes choose to rely on written evidence from sign-off mentors and an academic tutor will meet with the student to review their documentation and perhaps combine this with awarding a grade (Fisher et al 2015). You may also be required to contribute to your own assessment.

The timings of these tripartite or practice progress meetings will vary, and some or all of the following may be used in your institution (Bower et al 2014, Fisher et al 2015):

- at the beginning of a placement to discuss learning objectives and any issues
- midpoint to discuss progress to date and how well you are moving towards achieving the objectives/ criteria
- at the end of a placement or at a specific time in the year when 'summative' assessment (ie: determination of achievement, or grading) takes place.

The role of the academic in these meetings is generally accepted as:

- ensuring you and your sign-off mentor understand the documentation
- monitoring your progress towards the defined criteria for the stage in your programme
- ensuring that the evidence is available in your documentation
- ensuring that any grades awarded reflect the evidence available – ie: moderate any awarded by the sign-off mentor or ensure that commentary reflects that required by the programme so that the academic can award the appropriate grade
- provide support to the sign-off mentor in making their decisions.

Section d) above and 5 below include tips on organising these meetings, which are a very important part of your practice assessment process. If your programme allows it, and the other attendees are happy, please remember to invite your co-mentors.

FIGURE 4: Tripartite meeting



Although the above is the usual interpretation of a tripartite meeting, some programmes may use this term in an alternative way (Bower et al 2014, Fisher et al 2015). As above, the people present most often include you, your personal tutor or academic assessor and a clinician (usually your sign-off mentor). However, the purpose may not be a review of your progress but instead a specific practice assessment. Read Lou Ellis' account of setting up her practice assessment 'tripartite' at Bournemouth University (BU) in *Vignette 2*.

VIGNETTE 2: A practice assessment

"My first assessment by a mentor was my postnatal tripartite which is an assessment on a postnatal examination of both mother and baby. This was conducted in the middle of my first year of training. To make the assessment easier for myself I chose a mother and baby who were low risk and who had both required minimal care and support. The woman had had her baby 7 days ago and was nearing the time for discharge from midwifery care. I was extremely nervous, in fact petrified of messing up as not only was my mentor to be present but also my academic advisor. I didn't get much sleep the days leading up to the assessment.

The day of the assessment arrived. We had received a message stating that on day 5 the woman's blood pressure was raised and she was feeling unwell and didn't know if she would be up to an assessment. This left me panicked as I did not want to do an assessment on a woman I hadn't previously met as I wasn't confident, and the idea of rearranging was devastating as it had taken weeks to pin down both my academic advisor and my mentor. However, after speaking with the woman she was feeling much better and as her blood pressure was normal the day before she was happy for the visit to go ahead.

Although I was glad the assessment was going ahead I was now nervous as my nice low risk assessment could potentially be more complicated. I remember shaking as I was walking to the house. Both my mentor and academic advisor were reassuring and supportive which helped. The visit was going well, I had checked the woman over and had just started checking her baby when I realised I hadn't washed my hands in between her and her baby. I verbalised this and got up and washed my hands. The visit went well with no other concerns. The assessment then needed to be marked between myself, my mentor and my academic advisor. I found it very difficult to mark myself as I knew that I had made a mistake by not washing my hands in between the mother and baby examination, and at that moment in time I was unable to see past my mistake and look at the areas that I had excelled in. In the end I just agreed with the overall mark that my mentor and academic advisor came up with as I lacked the confidence to discuss my good points.

Over the course of the three years I have had the opportunities to assess my own and others' work through similar assessments and I am now able to discuss which areas I have excelled in and which areas I feel that I need to improve in. This experience has been invaluable to me throughout my training as I am now able to reflect back on everyday situations and learn from them. Conducting tripartite assessments has given me the confidence to openly discuss with mentors and even challenge them if I feel I am being marked unfairly, especially if they don't look at the marking criteria first. What I learnt from this experience is that we are only human and everyone makes mistakes. This is okay as long as we recognise and learn from it. I've also learnt that it is important to recognise when you have done well and to be proud when you receive a high mark as it is often well deserved. The last three years have been a real learning curve for me, and now that I am nearly qualified I know that the real learning begins."

Lou Ellis

Third year student, Bournemouth University, Poole, UK. Reproduced with permission of Lou Ellis.

POSITIVES

Practice assessment provides you with many positive outcomes:

- ✓ A structure to your programme, helping you to build on your knowledge and experience
- ✓ An opportunity to see how far you have come and to celebrate achievements
- ✓ Praise and encouragement
- ✓ Increased confidence in your abilities
- ✓ Value given to your efforts and all those sacrifices you have had to make
- ✓ Reassurance that you are making progress towards or achieving the required criteria to become a registered midwife
- ✓ Can improve your overall profile towards your degree classification.

The CEPPL study on Assessment of Practice (Fisher et al 2011) specifically looked at Plymouth University midwifery students' experiences of *tripartites* (progress meetings) as one of the assessment methods, and students commented that they:

- ✓ Helped to clarify and focus learning objectives and expectations
- ✓ Were useful checkpoints
- ✓ Helped them to reflect
- ✓ Provided an opportunity to clarify issues
- ✓ Enabled constructive feedback to be given
- ✓ Found it useful to hear comments from their sign-off mentor and personal tutor
- ✓ Provided an opportunity to raise any concerns
- ✓ Were generally found to be supportive, relaxed and friendly.

Observed assessments similar to the one described by Lou in *Vignette 2* were likewise discussed in the interviews with social work students in this study. They were found to have the advantages of:

- ✓ Students benefitting from the opportunity to prepare them
- ✓ Inability to 'twist the truth'
- ✓ Developed the student's learning
- ✓ Provided valuable feedback.

Portfolios used in a range of professions likewise had many positives, including:

- ✓ Provided evidence of students' capabilities
- ✓ Encouraged students as they could see their progress
- ✓ Made students think
- ✓ Gave them confidence
- ✓ Were seen as a valuable method of recording feedback from people they had worked with
- ✓ Were a useful reflective tool.

Other forms of practice assessment used in your own institution will likewise have many wider benefits beyond the grade awarded. Passmore and Chenery-Morris (2012) state that the combination of good mentorship, an assessment tool and grading should help

students to progress. Try to use whatever methods your programme employs to help you develop as a student and future professional.

PITFALLS

Findings from the CEPPL study (Fisher et al 2011) on the disadvantages of progress review *tripartites* included:

- ✗ Difficult to arrange
- ✗ Likened to a 'parents evening'
- ✗ Found it challenging to express conflicting opinions
- ✗ Verbal comments from sign-off mentor at the meeting did not always reflect previous feedback
- ✗ Needed more feed-forward on how to improve as well as feedback.

The same study identified disadvantages of *observed assessments* as:

- ✗ Could be difficult to arrange
- ✗ Might need creativity to 'set up' the assessment which may not always reflect normal practice
- ✗ Could lack authenticity due to the pre-planning and selection of the 'service-user' (woman) involved
- ✗ The process of being observed could change the dynamics of the student-woman interaction

Disadvantages of *portfolios* included:

- ✗ Increased workload
- ✗ Time-consuming
- ✗ Needed forward-planning
- ✗ Potential for breaching confidentiality.

Don't be disheartened by these 'pitfalls' but use your awareness of them to help you to work out ways of reducing or preventing them. Usually forward-planning and clear communication will do the trick. Don't be afraid to ask your sign-off mentor or academic assessor for additional feedback if they are not giving you sufficient information, and ask that they provide specific examples to help you understand where you may have been going wrong.

Also ask them to provide you with specific guidance on how you can improve in the future. Remember that they are assessing your *performance* and not you as a *person*, so try to take constructive criticism as just that. Sometimes you may find that sign-off mentors have the view that if they don't say anything it means you are doing fine – but it is important that they tell you this, so ask them for positive feedback too. If you are having any difficulties in your relationship with your sign-off mentor please speak to your personal tutor, academic assessor or practice development midwife as soon as possible so that any issues can be addressed – a 'clearing the air' meeting will usually prove

very helpful for everyone and will hopefully enable you to continue working together in a positive way.

PREPARATION

By now you must be feeling rather overwhelmed with the rules, regulations and terminology surrounding practice assessment, and perhaps a little anxious about the processes – although hopefully also seeing their benefits. It is not unusual for you to find it difficult to understand all these concepts prior to your first practice placement. Be reassured that all of this will mean much more to you once you actually start using your practice assessment documentation and become familiar with the roles of those assessing you. It is also helpful to know some of the pitfalls you may encounter so that you can try to avoid them by careful planning and communication.

Box 4 provides you with some ‘Top Tips’ to prepare for your practice assessment. These prompts will hopefully guide you as you undertake your journey through your first and subsequent placements; you may wish to use them as a checklist. These ‘Top Tips’ are drawn from the longitudinal multiprofessional CEPPL study (Fisher 2011) and are readily accessible as a booklet (CEPPL 2011) via the link in the ‘Further Resources’ section at the end of this chapter. If this link does not work, look for POPPI (Plymouth Online Practice Placement Information) through a search engine and the sub-section on guidelines and policies in the ‘Health’ section. Note that there is also a checklist for staff on the reverse, so you can print this off and give your sign-off mentor a copy too. This booklet contains generic information which would be suitable for any programmes with a placement focus.

BOX 4: Top tips for preparing you for practice assessment

Before you go into practice (see also Chapter 1):

- ✓ Review the feedback you have received in earlier placements and build on this in developing your learning objectives.
- ✓ If you have a choice in your placement, ensure it will meet your learning objectives and assessment requirements.
- ✓ Check out your placement – location, expectations, available learning opportunities, people to contact, dress code, transport etc.
- ✓ Try to talk to previous or current students in this placement.
- ✓ Check that the placement is expecting you and that a designated sign-off mentor has been assigned to you as required by your programme.
- ✓ Visit or telephone the placement and introduce yourself to your sign-off mentor if possible.
- ✓ Check that the placement has the relevant current information about your programme and assessment (this is the University’s responsibility to provide and the clinicians’ responsibility

to access, but there is no harm in you confirming this so that your assessment is up-to-date).

- ✓ Make sure you know who to contact for support if you have problems – both in the placement and University.
- ✓ Try to plan around competing demands e.g.: practice and academic deadlines, personal commitments.

Early in your placement:

- ✓ Develop a learning contract in consultation with your practice assessor, based on your previous experience, the assessment requirements and the opportunities available in the placement.
- ✓ Set meeting dates with your sign-off mentor for regular feedback including a midpoint check on your progress and any summative assessments required.

Throughout the placement:

- ✓ Look out for and make best use of wider learning opportunities.
- ✓ Ask relevant questions and challenge practice appropriately to aid your learning.
- ✓ Be aware that your sign-off mentor has other demands on their time, and be flexible in your requests – remember that service-user needs take priority and your sign-off mentor also has a personal life.
- ✓ Obtain regular verbal and written feedback from a variety of sources e.g.: service-users, other staff.
- ✓ Find out how you are doing and how you can improve – asking individuals to be specific in their feedback.
- ✓ Clarify any questions you may have about your assessment criteria and documentation.
- ✓ Keep all your practice documentation up to date including portfolios, timesheets etc – don't leave it all until the last minute!
- ✓ Communicate any anxieties early and professionally to the appropriate person e.g.: sign-off mentor, supervisor, personal tutor or other academic
- ✓ Ask for support if you don't seem to be getting on with your sign-off mentor.

At your assessment point:

- ✓ Plan meetings, observations or other assessments in good time.
- ✓ Ask if there is anything you are unsure about.
- ✓ Make sure your documentation reflects the practice learning you have achieved.
- ✓ Obtain written reports from others as appropriate to support your evidence.
- ✓ Be open and honest in documentation and discussions.
- ✓ Accept the feedback given to you and make sure you understand the reasons for the judgement, asking for further information/ clarification as needed.
- ✓ Consider how to use the feedback constructively in identifying your future learning.

Source: Reproduced with permission of Centre for Excellence in Professional Placement Learning (2011) *Top Tips for Students: Your journey through Practice Assessment*.

FITNESS TO PRACTISE

This section is not meant to alarm you, but to raise awareness. It explains the Fitness to Practise (FtP) process which may, on occasions, be initiated if concerns are raised about a midwifery or nursing student's health or conduct which potentially compromises their status on the course or needs further investigation. The NMC requires a formal procedure to be in place in all higher education institutions providing professional programmes. This mirrors the Nursing and Midwifery Council's Fitness to Practise process which investigates allegations of a registered nurse or midwife falling foul of the NMC 'The Code' (2015). This recent professional publication has superseded the previous NMC 'Code' (2008b) and a specific booklet aimed at students: 'Guidance on professional conduct for nursing and midwifery students' (NMC 2011). You need to become very familiar with 'The Code' (NMC 2015) which comprises the standards expected of both students and registrants.

You may wonder why this subject has been included in Chapter 3. It may not appear on the surface that it relates to practice assessment. However, if you look back at the first section of the chapter in which the 'purpose' of practice assessment was discussed, you will see that it ensures that only safe, competent and professional students achieve registration as a midwife. To this end you need to develop sound knowledge as well as demonstrate the appropriate skills, behaviour and attitudes in order to become a registered practitioner. If a personal or professional aspect of your performance is causing concern there is the potential for the FtP procedure to be invoked. This will result from a specific incident or series of events which appear to breach an aspect of 'The Code' (NMC 2015). Although the NMC (2011) publication aimed at students has been superseded, you may still find it helpful to refer to the specific examples of key aspects of students' clinical or academic performance or a personal behaviour which are inherent in the new 'The Code'. The following list is drawn from NMC (2011) pages 7 and 8:

- ✗ **Aggressive, violent or threatening behaviour** (verbal, physical or mental abuse; assault, bullying, physical violence)
- ✗ **Cheating or plagiarising** (cheating in examinations, coursework, clinical assessment or record books; forging a mentor or tutor's name or signature on clinical assessments or record books; passing off other people's work as your own)
- ✗ **Criminal conviction or caution** (child abuse or any other abuse, child pornography, fraud, physical violence, possession of illegal substances, theft)

- ✗ **Dishonesty** (fraudulent CVs, application forms or other documents; misrepresentation of qualifications)
- ✗ **Drug or alcohol misuse** (alcohol consumption that affects work; dealing, possessing or misusing drugs; drink driving)
- ✗ **Health concerns** (failure to seek medical treatment or other support where there is a risk of harm to other people; failure to recognise limits and abilities, or lack of insight into health concerns that may put other people at risk)
- ✗ **Persistent inappropriate attitude or behaviour** (failure to accept and follow advice from your University or clinical placement provider; non-attendance – clinical and academic; poor application and failure to submit work; poor communication skills)
- ✗ **Unprofessional behaviour** (breach of confidentiality; misuse of the internet and social networking sites; failure to keep appropriate professional or sexual boundaries; persistent rudeness to people, colleagues or others; unlawful discrimination)
- ✗ **Criminal offences.**

You will see from this list that inappropriate use of social networking sites discussed in Chapter 1 would fall into this bracket; this is also specifically mentioned in standard 20.10 of 'The Code' (NMC 2015). This is a good example of what might be seen as a personal activity having a negative professional impact. Similarly, persistent failure to respond to constructive feedback and advice from your sign-off mentor or an academic could lead to invoking of the FtP process (also reflected in 'The Code', NMC 2015 in standards 9.2 and 22.3), or tampering with practice assessment documentation would constitute a breach of standard 10.3 – so you can see why it is relevant to this chapter. *Box 5* gives some real examples of issues which have caused concern and resulted in the instigation of an investigation in various programmes.

BOX 5: Examples of Fitness to Practise Cases

- ✗ Inappropriate use of social networking sites
- ✗ Persistent non-attendance
- ✗ Timesheet discrepancies including fraudulent signatures
- ✗ Other fraudulent documentation eg: sick notes, practice documents, extenuating circumstances forms
- ✗ Plagiarism
- ✗ Complaints from women or clinical staff
- ✗ Unsafe practice
- ✗ Drug errors or student administering drugs unsupervised
- ✗ Unprofessional behaviour
- ✗ Breaching confidentiality
- ✗ Breaching professional boundaries
- ✗ Inappropriate language
- ✗ Poor knowledge-base
- ✗ Aggressive behaviour

You will see from this list that some are clearly more serious than others. How far the FtP procedure progresses and the actions taken or penalties imposed will depend on this as well as the stage of the programme, the student's understanding and remorse and any contributory factors. Most stop at the early stages; very, very few would progress to the worst case scenario which would be removal from the programme and inability to achieve the goal of becoming a midwife (in contrast to the worst outcome for a qualified practitioner which would be removal from the register and loss of a job). Students who are on a shortened programme as they are already on the NMC register as nurses need to be mindful that if a FtP investigation is conducted during their midwifery programme this may also impact on their nursing registration. You also need to remember that what you were able to do in a nursing post may no longer be applicable while you are a student midwife (eg: your ability to administer medications without supervision), so be careful that you are very clear on your student status and professional boundaries.

Involvement in any stage of the FtP process is, of course, a very stressful time for the student (and those conducting the investigation). It is, however, an effective method of highlighting and addressing issues which – if they continued – could compromise a student's place on the programme or registration as a midwife, or worse still lead to a post-registration FtP or supervisory investigation. Much learning can be gained from being involved – a lot depends on the student's attitude and the support offered during the process. Students generally become much more self-aware and appreciative of the true meaning of professional practice, which will hopefully result in a safer and more competent midwife who provides high standards of care.

I hope that you feel informed rather than frightened by this explanation. It emphasises the importance of professionalism in the career you have chosen, and your heightened awareness will hopefully prevent you going down this route in the future. Throughout this book you will see this concept reiterated, and the chapters on 'Introduction to midwifery and the profession' and 'What next?' put this into context.

CONCLUSION

This has been a very full chapter which has covered a range of topics around practice assessment and Fitness to Practise. It is hoped that you have found the information helpful in clarifying terminology and processes. You may find some aspects of your programme differ from the examples given; there are many roads leading to the 'Rome' of qualification as a midwife. The core principles will, however, be consistent across all institutions. Do join in any meetings or forums your Trust may provide in collaboration with your University to have a say in your practice placements and assessments. An excellent example is 'Bridging the Gap' – a meeting attended by clinicians, academics and students in one of the Trusts linked to Bournemouth University.

Use your practice assessment to be much more than a measure of your achievement of set criteria. See it as a developmental tool and a yardstick for your professionalism. Be creative and broad in your thinking about how best to gain the experiences needed. Keep at the forefront of your practice quality and the “6C’s” (Department of Health 2012):

Care
Compassion
Communication
Commitment
Competence
Courage

– the outcomes and grades will then naturally be achieved.

To conclude with another quote from Georgia:

“It’s easy to criticise yourself. Just remember how far you have come, and how much you know!”

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FURTHER RESOURCES

Websites with useful frameworks eg:

SWOT analysis/ reflection models etc:

<http://www.businessballs.com/swotanalysisfreetemplate.htm>

Plymouth Online Practice Placement Information (POPPI):

<https://www.plymouth.ac.uk/student-life/your-studies/academic-services/placements-and-workbased-learning/poppi>

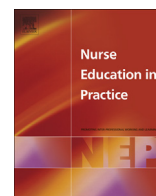
2.2 Enabling robust assessment processes

- 2.2.1 **WORK 4:** Fisher, M., Bower, H., Chenery-Morris, S., Jackson, J. and Way, S. (2017a) 'A scoping study to explore the application and impact of grading practice in pre-registration midwifery programmes across the United Kingdom', *Nurse Education in Practice*, 24 (May), pp99-105. <https://doi.org/10.1016/j.nepr.2016.01.007>.....160
- 2.2.2 **WORK 5:** Fisher, M., Way S., Chenery-Morris, S., Jackson, J. and Bower, H. (2017b) 'Core principles to reduce current variations that exist in grading of midwifery practice in the United Kingdom', *Nurse Education in Practice*, 3 (March), pp54-60. <http://dx.doi.org/10.1016/j.nepr.2017.02.006>.168
- 2.2.3 **WORK 6:** Fisher, M., Bower, H., Chenery-Morris, S., Galloway, F. Jackson, J., Way, S. and Fisher, M.M. (2019a) 'National survey: Developing a common approach to grading of practice in pre-registration midwifery', *Nurse Education in Practice*, 34, pp150-160. <https://doi.org/10.1016/j.nepr.2018.11.014>.....176
- 2.2.4 **WORK 7:** Way, S., Fisher, M. and Chenery-Morris, S. (2019) 'An evidence-based toolkit to support grading of pre-registration midwifery practice', *British Journal of Midwifery*, 27(4), pp251-257. <https://doi.org/10.12968/bjom.2019.27.4.251>.188

2.2.1 WORK 4

Fisher, M., Bower, H., Chenery-Morris, S., Jackson, J. and Way, S. (2017a) 'A scoping study to explore the application and impact of grading practice in pre-registration midwifery programmes across the United Kingdom', *Nurse Education in Practice*, 24 (May), pp99-105.
<https://doi.org/10.1016/j.nepr.2016.01.007>.

Candidate's contribution to authorship: 70%



A scoping study to explore the application and impact of grading practice in pre-registration midwifery programmes across the United Kingdom



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ABSTRACT

Grading of practice is a mandatory element of programmes leading to registration as a midwife in the United Kingdom, required by the Nursing and Midwifery Council. This validates the importance of practice by placing it on an equal level with academic work, contributing to degree classification. This paper discusses a scoping project undertaken by the Lead Midwives for Education group across the 55 Higher Education Institutions in the United Kingdom which deliver pre-registration midwifery programmes. A questionnaire was circulated and practice tools shared, enabling exploration of the application of the standards and collation of the views of the Lead Midwives. Timing and individuals involved in practice assessment varied as did the components and the credit weighting applied to practice modules. Sign-off mentor confidence in awarding a range of grades had increased over time, and mentors seemed positive about the value given to practice and their role as professional gatekeepers. Grading was generally felt to be more robust and meaningful than pass/refer. It also appeared that practice grading may contribute to an enhanced student academic profile. A set of guiding principles is being developed with the purpose of enhancing consistency of the application of the professional standards across the United Kingdom.

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Introduction

Since September 2008, the United Kingdom Nursing and Midwifery Council (NMC) has required all programmes leading to registration as a midwife to grade practice (NMC, 2009). The NMC sets the standards to be achieved, but the operationalising of these is the responsibility of the individual programme team in collaboration with clinical colleagues and subject to their Higher Education Institution (HEI) regulations.

In March 2013, the Lead Midwives for Education United Kingdom Executive Group (LME-UK) agreed that a sub-group of experienced colleagues with a shared interest in practice assessment would undertake a national scoping activity across the HEIs where pre-registration midwifery programmes are delivered. The LME role is a requirement of the NMC, having accountability and oversight for all matters pertaining to midwifery education in their institution. The LME-UK peer support group membership comprises senior educationalists from all 55 universities across the four countries who lead on development, delivery and management of midwifery education programmes, meeting separately from the NMC. This enables collaborative opportunities and integration of differing health policies across the UK (LME-UK Executive Terms of Reference (2014)).

The purpose of the project was to explore the range of methods of application of the NMC (2009) standards in relation to grading of

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practice across the UK. A survey evaluating assessment processes and views on the impact of grading of practice was undertaken through circulation of a questionnaire to the LME-UK group. No other study exploring midwifery practice assessment has been conducted on such a broad scale.

Background

The 'Standards for pre registration midwifery education' (NMC, 2009) require all universities in the UK to implement grading as a key aspect of practice based assessment in midwifery. The rationale is to place equal emphasis on practice and theory. Standard 15 (NMC, 2009, p. 21) identifies that:

- "Assessment of practice, which is direct hands-on care, must be graded.
- The grades achieved must contribute to the outcome of the final academic award.
- If the assessment of clinical practice involves a variety of components and the student fails to achieve competence in one of the components, then the student must fail."

The midwifery sign-off mentor is an experienced clinician who has undertaken additional academic preparation as well as been involved in the assessment process of a midwifery student on at least three occasions (NMC, 2008). In contrast to nursing, a sign-off mentor is required for all progression points. The Nursing and Midwifery Council (2009, p. 21) defines a progression point as: "a point (or points) established for the purpose of making summative judgments about safe and effective practice in a programme". The responsibility of this role is therefore very evident as sign-off mentors are essentially the gatekeepers to the profession from a practice perspective. Practice assessment brings with it challenges and rewards, and the lived experience of fulfilling a role which is paramount in ascertaining a student's competence is described in both midwifery and nursing literature (Duffy, 2004; Fisher and Webb, 2008; Fisher, 2009; Fisher et al., 2011; Jervis and Tilki, 2011; Marsh et al., 2005; Rutkowski, 2007; Skingley et al., 2007). Grading adds a further dimension in that not only is competence itself determined, but a scale measuring the level of performance in practice is also required (Chenery-Morris, 2010). Maxted et al. (2004) suggests that practitioners can find separating these concepts challenging. The process of grading practice is influenced by multiple assessors in the form of individual sign-off mentors. Interpretation of the grading tools used can challenge inter and intra-assessor reliability (Donaldson and Gray, 2012; Smith, 2007). Mentors have, however, found grading tools helpful for students who were not performing well (Heaslip and Scammell, 2012).

National Health Service (NHS) Education for Scotland (NES, 2008) noted that the range and breadth of practice assessments are diverse in contrast to greater similarity in theoretical modules. Gray and Donaldson (2009) recommended that ongoing evaluation and monitoring of grading processes should be undertaken, which is further supported by Heaslip and Scammell (2012) and Bennett and McGowan (2014).

The LME-UK group recognised from earlier discussions that a range of approaches was likely to be identified. It was therefore anticipated that a set of guiding principles to mitigate these factors in grading of practice may be a potential outcome of the project.

Project design

This descriptive evaluative survey sought to ascertain the varying practice assessment methods, tools and views across the full range of pre-registration midwifery programmes in the UK.

This particular approach was used in order to elicit in-depth details of the range of methods HEIs currently use when applying the NMC standards (2009) within the constraints of the individual institutional regulations across the four countries. The intention was to identify any perceived impact on degree classification and consider the experience of those involved in grading practice. This may help realise the contributory factors and impact of any inconsistencies in grading practice. As the LME-UK group had itself initiated this scoping activity as an internal evaluation and no other participants were involved, no ethical approval was required.

In order to elicit the information, three key areas were explored through circulation of a questionnaire: 1) the process of grading practice; 2) the impact of grading of practice on mark profiles; 3) clinicians' views on grading of practice (see Table 1).

This was circulated electronically via the professional network following an initial introduction at an LME-UK meeting. Colleagues were also invited to share the practice assessment tools used in their institutions. Subsequent rounds of requests for feedback were undertaken in person at LME meetings or electronically. A 73% response rate was achieved, totalling 40 of 55 universities and reflecting the whole geographic spread of HEIs providing pre-registration midwifery education across the UK (see Table 2).

The data was compiled onto a spreadsheet, categorised according to the questions and relevant institutions which were subsequently anonymised. The project team divided the questions for initial thematic analysis which was then cross-checked by the rest of the team.

Findings

The findings were categorised into: 1) The process of grading practice; 2) The impact of grading of practice on mark profiles; 3) Clinicians' views on grading of practice. A brief summary follows presentation of each section.

The process of grading practice

Practice placements where grading took place included community, labour suite, antenatal, postnatal and caseload holding. A combination of both formative and summative grading was used in most HEIs. Findings from the specific questions are identified below:

Table 1
Grading of practice scoping questionnaire.

1. For each year of the course/programme for both the long and the short courses/programmes:
a. When do you 'Grade practice'?
b. How do you 'Grade practice'?
c. What weighting is given to 'Grading of practice'?
2. Has there been any observable alteration to students' mark profiles since 'Grading of practice' was mandatory? (e.g.,: higher, lower, no difference)
3. From Annual Monitoring of the course/programme, how do clinicians view 'Grading of practice'?

Table 2
Profile of respondents.

Country	Number of HEIs	Number of respondents
England	47	34
Scotland	3	3
Wales	4	2
Northern Ireland	1	1
TOTAL	55	40 = 73%

When do you 'Grade practice'?

Only an open question was asked, leaving respondents to use free text to explain their processes. Quantitative data were therefore not available, but four themes emerged to reflect the differing approaches: (i) Twice a year; (ii) End of year; (iii) Variety throughout the year; (iv) Clinical practice modules.

- (i) **Twice a year** – If grading took place twice a year it was generally at the end of a six-month period or semester. In some instances a formative assessment was undertaken after the first six months and a summative after the second. In some cases each semester had a summative assessment with occasionally an average of the two grades used as the final mark.
- (ii) **End of the year** – Although in this theme grading took place at the end of the year in all cases, some elements may also have been assessed at the end of specific placements. All grades were reviewed at the end of the year and could be increased if further experience had been gained. In one case practice was assessed as pass/fail using competence measured against the five core midwifery Essential Skills Clusters (NMC, 2009) and a grade was then awarded for overall performance at the end of the year.
- (iii) **Variety throughout the year** – Not all HEIs graded practice every year, whilst others undertook formative or summative assessment after each practice placement throughout the programme.
- (iv) **Clinical practice modules** – In many institutions discrete modules were allocated to practice, with at least one being included in each year of the programme. As described earlier, frequency varied and practice was not always a summative component of the module assessment in either year one or two. All final year practice modules across all universities were, however, summatively assessed.

How do you 'Grade practice'?

The qualitative responses to this open question were categorised in a grid using terms such as mentors, grading tool, summative or formative point and types of grades. These themes were then adjusted to reflect an emerging alliteration according to six 'Ps' – (i) **People**, (ii) **Process**, (iii) **Point in course**, (iv) **Package**, (v) **Pass marks** and (vi) **Portfolio**. This is reminiscent of themes identified in an earlier multiprofessional study on assessing practice (Fisher et al., 2011) – process, preparation, purpose, placement, people and professional persona.

- (i) **People** – Clinical and university based midwives were involved in the process of grading practice across all HEIs, with clinical staff comprising mentors, midwives or sign-off mentors. Academics were referred to as lecturer, link lecturer, personal tutor or teacher, midwife teacher or university lecturer. In one university a supervisor of midwives was involved in the process. Only a couple of responses stated that the students had contributed to their practice assessment.
- (ii) **Process** – A range of processes in awarding grades were described. These included: grades awarded only by sign-off mentors; assessment of competence and provision of qualitative feedback by sign-off mentors which was subsequently graded by academics; clinicians marked and lecturers moderated, or a clinical educational meeting was arranged for moderation. A tripartite meeting (or triad) involving the student, sign-off mentor and lecturer was mentioned by seven universities. This could be face-to-face or over the

telephone. On some occasions grading was undertaken at this meeting while in others marks had already been awarded prior to the discussion. In some institutions it was unclear whether the grade was actually derived from practice or from a written piece of work to complement this.

- (iii) **Point in course** – Continuous assessment was mentioned by several respondents. Practice was commonly graded in the final week of placement, although a range of assessment points were used across the UK, as identified earlier. One respondent mentioned intermediate and final, but these terms were not qualified. One explicitly stated that assessment was at academic levels five and six only (i.e., years two and three).
- (iv) **Package** – The framework or tool used in practice assessment varied across HEIs. The most frequent terms describing tools included criteria, scoring tool, criterion referencing, percentages and aggregate scores. Some tools had up to 20 descriptors with five possible grades. Criteria assessed included both clinical skills and concept-based components, with knowledge, skills, attitudes, communication, co-operation, team work, reflection, problem solving and self-awareness being cited. One HEI specifically mentioned the close relationship between the NMC Essential Skills Clusters (NMC, 2009) and the assessment tool. Others commented on continuous assessment, signing of learning outcomes and NMC Domains (NMC, 2009). Some programmes used published frameworks such as Benner's 'Novice to expert' (1984) or Steinaker and Bell's 'Experiential taxonomy' (1979). Others devised their own framework, incorporating the '6Cs' (Department of Health (2012)). Two cited common assessment documents used in their region.
- (v) **Pass marks** – In compliance with NMC requirements, all HEIs ensured that if one element of practice did not pass, the whole assessment was deemed a fail and had to be achieved at second attempt (NMC, 2009). Pass marks were defined as 'D', 40%, 50% or a simple pass/refer. One rubric indicated a choice of grades within a band. Descriptive measures ranged from refer to excellent with up to five or six available scores, or A–F and AA–F. Several respondents stated that the academics undertook a formulaic calculation to convert these descriptive terms to numeric marks.
- (vi) **Portfolio** – Not all of the institutions used a grade which was derived only from direct assessment of practice in the placement. Other modes of assessment included portfolios or reflective accounts, caseload reports, viva voce and Objective Structured Clinical Examinations (OSCEs) such as hand washing and administration of medicines. One university incorporated ward and medicine management assessments in the clinical environment as part of the practice grade. As little as 10% of the grade could arise from clinical practice only; in this institution a portfolio and viva voce made up 90% of the practice grade. One tool had four elements marked by the mentor (contributing to 50% of the assessment) with another marked by mentor and lecturer comprising the second half. Another university determined achievement of practice competencies through confirmation by the sign-off mentor, with the portfolio itself comprising 100% of the practice grade.

What weighting is given to 'Grading of practice'?

This was again an open question, and general categorisation of qualitative responses took place. At least 50% of the practice module/s in the majority of programmes comprised grading of practice, but this attracted a variable number of credits. Between 10

and 60 of the 120 academic credits were awarded each year for practice across the UK, with some institutions increasing the credits incrementally as the years progressed, such as 20 in year one and 60 in year three. Some extremely complex calculations were used.

In summary, a significant lack of parity in the process of grading practice was demonstrated across UK pre-registration midwifery programmes. Although all institutions met Standard 15 of the NMC requirements for grading of practice (2009), there was a wide variation in approach. Timing included differing interpretations of 'progression points'. A range of modes of assessment attracting practice grades were described, and weighting was variable. There were notable differences in the assessment of observed practice in clinical settings and the extent to which this contributed to the overall practice grades. Although a sign-off mentor was always part of the practice assessment process, a number of other contributors were cited.

A diversity of frameworks or assessment tools were used, however commonalities in clinical skills and concept-based components as outcomes were noted.

The impact of 'Grading of practice' on mark profiles

Quantitative responses were sought to the question about whether there had been any observable alteration to students' mark profiles since grading of practice became mandatory, with options being provided. The results are shown in Fig. 1. The six respondents (15%) who said they were unable to comment explained that this was either because grading had been undertaken for over 10 years in their institution so it was not possible to make comparisons with previous academic profiles, or that grading had only recently been introduced. Half of the respondents ($n = 20$) stated that students' mark profiles were higher since practice had been graded. Fourteen (35%) stated that no difference was evident. Of note, no respondents said the profiles had decreased.

Themes which emerged in the qualitative responses to this question were categorised into: (i) Degree classification; (ii) Correlation between practice and academic modules; (iii) Grading profile; (iv) Increased confidence; (v) Moderating influences; (vi) Contributory factors.

- (i) **Degree classification** – The general view was that the positive impact on degree classification was acceptable and to be

expected as a minimum of 50% of the programme was practice-based. It was suggested that academic module profiles were often close to the next grading band and the practice module/s tipped them over into the next category as they often fell in the 70% + bracket.

- (ii) **Correlation between practice and academic modules** – Generally students who were academic high-achievers also gained high marks for practice. There were, however, exceptions to this: one cited a band difference (higher) for weaker students and another noted that some students who were less able academically but known to perform at a high standard in practice achieved grades reflecting this. The resultant altered profile was considered to recognise the importance of practice.
- (iii) **Grading profile** – The full range of grades was now seen and a more normal distribution curve was noted in a number of HEIs. One respondent stated that the profile of marks achieved by individual students across criteria showed variations which indicated that sign-off mentors were thoughtful about grades awarded, and that the range of grades across the cohort was reassuring of the process in placements across the region. However, one respondent stated that students did not always feel their achievements in practice were reflected in the grade awarded, thinking this should be higher. They also perceived a variation in the grading process between different mentors and personal tutors in their institution.
- (iv) **Increased confidence** – Nearly all respondents noted that as sign-off mentors became more familiar with the process and the assessment tool became more refined, they appeared more appreciative of the implications of giving higher grades and reserved these for 'exceptional' students. This increased confidence also resulted in enhanced decisiveness in constructive referral.
- (v) **Moderating influences** – Factors identified which appeared to enhance the 'moderation' of inflated grades and rigour of assessment included:
- Careful wording of grading frameworks or criteria;
 - Support from academics at implementation of a new assessment tool or process;
 - Formative grading opportunities which provided a benchmark for subsequent summative grading activities

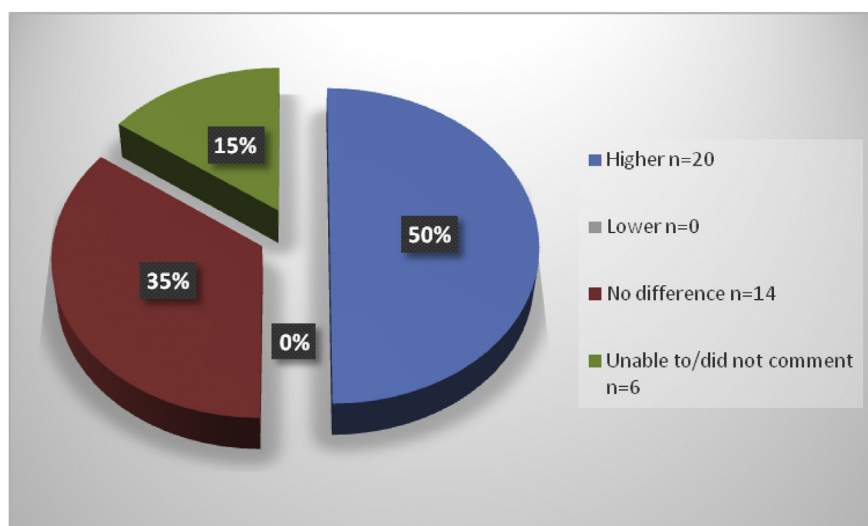


Fig. 1. Alterations to students' mark profiles.

and also enabled new sign-off mentors to practise these skills;

- In institutions where this was used, tripartite (or 'triad') discussions involving an academic, the sign-off mentor and student were valued as a moderation process, ensuring that grading aligned with the sign-off mentor's qualitative (written or verbal) evaluation of the student's performance;
- In institutions where other components in addition to pure clinically-based practice assessment were included, respondents considered that this helped mediate grade inflation yet maintained the focus on accredited practice.

(vi) **Contributory factors** – Two respondents noted that other initiatives could have resulted in the apparent improvement in profiles and awards over the past few years, such as a change to degree pathways and recruitment practices. This included the requirement for higher academic achievements for entry to many of the programmes, reflected in increased UCAS points (the UK Universities and Colleges Admissions Service rating system). It was also suggested that students' improved uptake of and responsiveness to formative feedback and feed-forward in theory and practice could contribute to increased marks.

In summary, the majority of respondents noted an increase in or maintenance of academic profiles since grading of practice was introduced. It was clear that these changes were generally welcomed by the academics, who considered that the increased emphasis on practice was a positive development. It was evident that as the grading process had become embedded, so sign-off mentor confidence had grown – and this was further enhanced by clear frameworks and processes. The importance of academics supporting sign-off mentors in their role in order to ensure a level of intra and inter-assessor reliability was highlighted, and a range of approaches was taken to address this. Some alternative influences were suggested which may have also contributed to the apparent increase in mark profiles.

Clinicians' views on grading of practice

Respondents were asked to draw on their experiences from internal quality monitoring processes and other interactions with clinicians in order to determine their perceptions of grading of practice. Qualitative responses were themed: (i) Being valued; (ii) Specificity; (iii) Partnerships; (iv) Challenges.

(i) **Being valued** – Nearly all respondents said that clinicians were positive about grading of practice and comfortable with the process. Reasons included especially:

- The value this gave to practice and its minimum 50% contribution to the programme;
- The opportunity to reward and value students who excelled in practice, contributing to their degree classification;
- The value this gave to the sign-off mentors as contributors to the assessment process and their role as professional gatekeepers.

(ii) **Specificity** – Clinicians were not keen on a pass/fail system and preferred the awarding of grades, considering this to be more robust; those who had experienced assessment of students prior to the implementation of grading were particularly vocal. Sign-off mentors felt grading acknowledged good practice across different domains and highlighted strengths and weaknesses in a way that was

comparable. They saw grading as essential to properly reflect a student's capabilities. They also liked the fact that students received instant feedback about their performance. Those who had experienced poorly achieving or failing students were positive about the assessment document enabling them to pin-point areas of weakness and make clearer decisions through having to award a specific grade. It was evident from the majority of the HEI responses that as clinicians became more confident in the process, so did their appreciation of grading.

(iii) **Partnerships** – Academic staff or link lecturers were considered very important to the assessment process. Their role included clarification of issues, support of sign-off mentors to make their decisions, moderation at tripartite meetings (where these occurred), or provision of general guidance at mentor updates and ad hoc encounters. Grading workshops were seen as very useful. Academics and clinicians appreciated collaborative partnerships and clinicians were positive about being consulted. There was a willingness of academics to modify assessment tools following clinician feedback regarding clarity. In one institution, clinicians had appreciated their workload being taken into account when they expressed a wish not to grade practice themselves – instead qualitative comments were awarded a mark by academics. Consultation was reported to have been commended by the NMC at validation events. Not all clinicians were equally enthusiastic about their increased role, however. One respondent commented that mixed opinions had been expressed by sign-off mentors about recent changes to the programme whereby they were now required to undertake grading which had previously been performed by an academic and supervisor of midwives.

(iv) **Challenges** – Challenges to clinicians and the grading process included:

- Time to complete documentation or undertake the grading process was considered a major factor.
- Tripartite meetings (triads) were resource-intensive although beneficial.
- Objectivity could be difficult – some sign-off mentors became too 'close' to students. Some found grading challenging as they felt this was a judgement on an individual rather than appreciating it was the student's performance which was being assessed.
- Some sign-off mentors were reluctant to award higher grades early in the course and needed guidance from academics to differentiate between criteria associated with different stages of the programme and to use the full range of grades. One respondent said that concern not to over-inflate grades could result in the opposite outcome. Lecturers worked hard with sign-off mentors to explain the concept of a normative curve.
- Some sign-off mentors still found it difficult to fail students. Students were noted to be very competitive.
- Some mentors found it difficult to provide face-to-face feedback and phrased comments differently in written and verbal forms – this could result in a discrepancy between qualitative comments and grades awarded.
- Clinicians in one area had been concerned about the move to an electronic portfolio, although another HEI said that the advantage of grading being electronic was that it was auditable.

In summary, responses to this question were largely positive about the feedback received from clinicians regarding grading of practice. Most described an increased satisfaction in the specificity

of assessment since grading had been introduced. It was clear that mentors took their role very seriously and felt valued for the contribution they made to the process. They appreciated partnership-working and support from academics. A number of challenges were highlighted including time constraints, objectivity, benchmarking, failing students, comment and grading congruence and the use of electronic portfolios.

Discussion

As the purpose of the project was to evaluate and elicit in-depth detail of the application of the NMC (2009) standards relating to grading of practice, quantitative data were considered of lesser importance and free text in response to open questions was encouraged. Therefore, although some quantitative data were produced, these were generally only used as a guide in relation to whether findings were unique to an institution or more widespread. No attempts were made to draw any within-group comparisons. The project group was more interested in establishing patterns of similarity or variance and ascertaining the possible causes and impact of inconsistencies through examining the emerging themes from the qualitative responses.

Key findings around timing, modes and academic weighting given to practice assessment demonstrated widespread variation in application of the NMC standards to pre-registration midwifery programmes across the UK. Similarly, the extent to which clinicians were involved and the emphasis given to the contribution of directly observed practice to the overall practice grade and therefore academic profile showed notable differences. Although all institutions complied with the core principles of Standard 15 (NMC, 2009), the wide variations in interpretation caused some concern. These were reflected in another published scoping exercise in nursing (Mallik and McGowan, 2007). The scale of this midwifery survey has, however, provided new information relating to the extent of these discrepancies.

The benefits and challenges of reflection, portfolios, observations and tripartite meetings in a range of professions are well documented in the wider literature (Doughty et al., 2007; Fisher and Webb, 2008; Fisher et al., 2011; Smith, 2007), and this study provided further evidence to support these. The findings also concur with the literature that support from academics is needed to enable those assessing practice to fulfil their role (Bennett and McGowan, 2014; Black et al., 2013; Fisher and Webb, 2008; Fisher, 2009; Gainsbury, 2010; Heaslip and Scamell, 2012). This is essential in order to avoid 'failure to fail' which continues to be an issue particularly in the nursing literature (Black et al., 2013; Duffy, 2004; Jervis and Tilki, 2011; Rutkowski, 2007). This project identified, however, that mentors become more confident in grading practice and use the full range of marks available as they gain experience – particularly when supported by academics. Although opinions are divided as to the academic's role in grading practice since they do not usually witness the student's performance (Passmore and Chenery-Morris, 2014), their role in tripartite or triad meetings may – as seen in this study – fulfil a combination of valuable educational and psychosocial support. Of note, a number of respondents stated that clinicians indicated that they found the grading process helpful in discerning levels of performance and specifying those students who were not achieving. This suggests that grading may empower clinicians to more effectively determine fitness to progress or enter the register as a midwife.

This study found that there appeared to have been a positive skew in the profile of midwifery students' marks and therefore degree classification since grading of practice became mandatory. This was a finding which has not previously been reported on such a wide scale. Whether – as suggested by some respondents – this is

a good thing as it emphasises the importance of practice, or whether it may reflect challenges of inter and intra-assessor reliability due to the range of individuals involved in the process is open to debate. A systematic literature review of grading in a range of professional practices also raised the issue of grade inflation (Gray and Donaldson, 2009). They found that this could be attributed to pressure by students, leniency of mentors, inadequate understanding of the impact of grading, a close student–mentor relationship and efficacy of the tool. Their later paper (Donaldson and Gray, 2012) offered ways to reduce this, such as development of a common practice assessment tool. Whilst a range of assessment methods were used in the programmes evaluated in this study, all incorporated a combination of concept-based and practical skills assessment. The importance of assessing all these criteria is supported in the wider literature and across health professions (Fisher et al., 2011; McLean et al., 2005; McLean, 2012; Nicholls and Webb, 2006). It is, however, important that there is parity in the measures used to assess competence at point of registration, or inter-assessor reliability and validity is compromised and the consistency of decision-making is put into question.

Separate to this project but happening at a similar time, funding was agreed by three UK Local Education and Training Boards to develop a common midwifery practice assessment tool between eight universities and their practice partners in London (Gillman, 2014). This initiative was in response to a request from the local Trusts after the successful implementation of a PAN London nursing practice assessment document in 2014. Similar unpublished work had previously been undertaken across six sites in the Yorkshire and Humber region of England, where a common midwifery practice assessment tool had been implemented and evaluated. A Scottish tool is also being proposed.

The design of this study was largely qualitative and statistical significance cannot therefore be defined, however the inconsistencies in interpretation and application of the NMC (2009) standards are unequivocal. Although some diversity is inevitable as the structures of curricula will differ, programme teams will have a unique ethos and university regulations will vary, it could be argued that a move towards greater equity of assessment would be good practice. It is therefore intended that a set of core principles and common grading matrix will be developed by the LME-UK group, drawing on the findings from this study. Work is already underway to refine these. As the NMC standards are currently being reviewed and the opportunity will therefore arise for teams to incorporate these principles into newly validated programmes, it is hoped that parity of practice assessment processes will thus be enhanced.

Conclusions

The LME-UK group benefits from opportunities for collaboration and sharing of projects which are perhaps unique due to the network of midwifery educationalists and institutions across the four countries. This facilitates dissemination of 'best practice'. This scoping activity was therefore important as it enabled a nationwide evaluation of methods, tools and views currently used to grade practice in midwifery programmes. The value of undertaking such a widely representative project cannot be underestimated, and some findings may be transferable to other professions and programmes.

There is the opportunity for key educationalists and professional regulators to embrace some of these concepts in future midwifery programmes. Ongoing efforts to address some of the inconsistencies highlighted in this study will promote greater parity in the application of professional standards across the four countries in the UK. This will enhance reliability in assessment of competence of future registrants, better fulfilling the partnership

responsibilities between clinicians and academics to be gatekeepers to the profession and thereby promoting protection of the public.

Ethical approval statement

None declared.

Role of funding source statement

None declared.

Conflict of interest statement

None of the authors have any financial or personal conflict of interest with other people or organisations which could bias this work.

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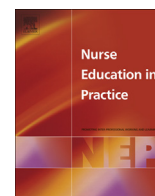
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2.2.2 WORK 5

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Midwifery Education in Practice

Core principles to reduce current variations that exist in grading of midwifery practice in the United Kingdom



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ABSTRACT

Aim: To reduce variations in grading of midwifery practice and enhance reliability of assessment.

Background: The first phase of a national project showed there to be widely ranging interpretation and application of professional educational standards in relation to grading of practice in midwifery. This raised concerns about reliability and equity of professional assessment. The second phase therefore sought to achieve consensus on a set of core principles.

Methods: A participatory action research process in two stages, using a Mini-Delphi approach. Educational leads from all 55 institutions delivering midwifery programmes nationally were invited to participate. **Stage one:** Questionnaire comprising 12 statements drawn from the findings of the initial phase of the project. **Stage two:** Face-to-face discussion.

Findings: Statements were categorised based on questionnaire responses: 1) Consensus, 2) Staged consensus, 2) Minor modifications, 4) Controversial. Consensus was achieved on 11 core principles through group discussion; only one was omitted from the final set.

Recommendations: All midwifery programmes nationally to incorporate the agreed core principles. Findings should be disseminated to the regulatory body to help inform changes to midwifery and nursing educational standards. The core principles may also contribute to curriculum development in midwifery and other professions internationally.

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1. Introduction

This paper presents the second phase of a national study investigating practice assessment in midwifery. The first phase comprised a scoping study which explored the interpretation and application of the United Kingdom (UK) regulatory body standards, particularly focusing on grading of practice (Fisher et al., 2016). A wide range of interpretation leading to a variety of approaches was evident in this earlier phase, raising concerns about reliability and equity of practice assessment in programmes leading to registration as a midwife. The second phase therefore sought to achieve

consensus on a set of core principles with the aim of promoting greater consistency nationally in the application of the professional standards. A participatory action research process was taken which comprised two stages: a questionnaire followed by face-to-face discussion, using a Mini-Delphi approach.

Although this study focused on the 55 higher education institutions (HEIs) delivering pre-registration midwifery programmes in the UK, the core principles which were developed will also have resonance with practice assessment approaches internationally as well as across other professions.

2. Background

The World Health Organisation (WHO, 2009) set global standards for the initial education of professional nurses and midwives, including the requirement for a balance between theory and

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practice components of the curriculum to be demonstrated. The International Confederation of Midwives (ICM, 2013) stipulates that sufficient practical experience should be included in midwifery programmes to attain, at a minimum, the ICM essential competencies for basic midwifery practice. These principles are incorporated in curricula across the globe; for example, the Australian Nursing and Midwifery Accreditation Council (ANMAC, 2014) requires an equal theory-practice ratio and the Midwifery Council of New Zealand (accessed 2017) stipulates a 55% proportion of practice. The 28 member states of the European Union are similarly required to provide a balance of theory and practical preparation in midwifery programmes (European Parliament, Council of the European Union, 2005). The Nursing and Midwifery Council (NMC) in the UK – currently still part of the EU – more specifically stipulates that a minimum of 50% of the programme must be based in practice. Direct hands-on care must be graded and therefore contribute to the academic award (NMC, 2009). This process must be undertaken by midwives who have received specific preparation and regular updating – termed ‘sign-off mentors’ (NMC, 2008 and 2009). The proportion of graded practice in the overall academic credits is not specified.

Other professions nationally and internationally – for example osteopathy, psychiatry, physiotherapy, medicine, nursing, social work and pharmacy – have a similarly strong focus on practice and its assessment (Abbey, 2008; Briscoe et al., 2006; Clouder and Toms, 2008; Dalton et al., 2009; Davis et al., 2009; Fisher et al., 2011; Fothergill Bourbonnais et al., 2008; Hadfield et al., 2007; Hay and O'Donoghue, 2009; Manning et al., 2016; Seldomridge and Walsh, 2006).

Assessment of practice determines whether potential registrants have embraced the requisite core clinical and practical skills as well as concept-based components such as communication, attitudes, knowledge, team-work, reflection, problem-solving, critical thinking, decision-making and self-awareness which are essential to their professional practice (Cassidy, 2008; Oermann et al., 2009; Sharpless and Barber, 2009). A European study exploring graduate employability highlights the need for this combination of skills (Andrews and Higson, 2008).

The tools and approaches used are therefore fundamental to the process of practice assessment, but the complexity of developing ones which are consistent, reliable and valid is challenging (Briscoe et al., 2006; Fisher et al., 2011; Seldomridge and Walsh, 2006). Mallik and McGowan (2007) published a scoping exercise of nursing and found a range of discrepancies in approaches, as did a commissioned study in Scotland (Lauder et al., 2008). Johnson (2008) considered the desirability of grading practice in competence-based qualifications, and reliability of this process has also been questioned (Cleland et al., 2008; Gray and Donaldson, 2009). London (2008) and Hay and O'Donoghue (2009) debated whether standardisation in assessment could in fact be achieved.

3. Methods

3.1. Aim

This second phase of the study sought to identify a set of core principles for grading of practice in midwifery. The aim was to enhance reliability of assessment by reducing variations which had been identified in the first phase.

3.2. Participants and ethical considerations

The grading of practice study was unanimously initiated by the Lead Midwives for Education United Kingdom Executive Group (LME-UK) – representing all 55 HEIs delivering pre-registration

midwifery programmes nationally (Way, 2016). A sub-group of five experienced midwifery academics with a shared interest in and track record of publication on practice assessment formed the research team, while all 55 LMEs were invited to participate throughout the study. Ethical considerations relating to informed participation and option to withdraw were addressed. The LME-UK group was kept fully apprised of the progress of the study, via JISCMail (a national academic mailing service which facilitates discussion, collaboration and communication within the UK academic community) or at the regular professional meetings. These forums also provided the opportunity for all the lead educationalists to contribute their views and responses to questionnaires and discussions, indicating their consent; they could similarly opt not to respond. Provision was made for those who had not been able to attend meetings to view draft outcomes and add their own comments. All data collected were anonymised on receipt by the lead researcher, prior to circulation to the study team for member-checking.

3.3. Design and data collection

The collaborative nature of the LME-UK group enabled participatory action research to be undertaken in two stages. Freire (1970) and Denscombe (2010) suggest this approach as an appropriate methodology to solve a particular problem in a progressive manner, enabling production of guidelines for best practice. A Mini-Delphi or Estimate-Talk-Estimate (ETE) approach (Green et al., 2007) enabled draft statements to be consulted on through use of a questionnaire in stage one and face-to-face discussion in stage two, until consensus on terminology was achieved.

3.3.1. Stage one

The findings from the first phase of the study (Fisher et al., 2016), in which a wide range of interpretation and application of the NMC standards had been demonstrated, were initially shared and discussed with LMEs at one of their meetings. This resulted in development of 12 draft statements (Tables 1–4) which were designed to capture what appeared to have been positive aspects and address variations. The statements were next circulated electronically as a questionnaire to the participants so that they could rate their views on these, using a Likert scale. Only four options were provided: strongly agree, agree, disagree and strongly disagree – a method adopted by Garland (1991) to encourage participant decisions. The questionnaire provided an opportunity for qualitative comments to expand on the quantitative data. Responses were received from 29 of the 55 institutions represented (52.73%).

3.3.2. Stage two

Following cross-checking by the study team, the collated data and suggested revised statements were shared at an LME-UK Executive Group meeting later in the year at which 32 members (58.21%) were present. Those statements which had not already achieved consensus were discussed further by the attendees. Adjustments were made until consensus was reached. The set of principles was subsequently circulated to the entire LME membership via JISCMail to enable those who had not been present to contribute their views. A few indicated approval and no objections were raised. A set of 11 core principles was therefore agreed as final (Table 5).

4. Findings

To facilitate presentation, the data from both the questionnaire (stage one) and the outcomes of the Mini-Delphi discussion (stage

two) have been combined under the relevant headings. The 12 draft statements are indicated in Tables 1–4, having been categorised according to the ratings responses in stage one:

1. Consensus – in which 100% agreement was indicated in both stages (Table 1);
2. Staged consensus – in which strong support was indicated in stage one and consensus achieved in stage two (Table 2);
3. Minor modifications – in which statements were supported in stage one, but minor adjustments were needed in stage two (Table 3);
4. Controversial – in which responses in stage one were mixed, and more extensive discussion was needed in stage two (Table 4).

Responses indicating ‘strongly agree’/‘agree’ have been combined, as have ‘strongly disagree’/‘disagree’ in presenting the findings from stage one. The final revised statements which formed the set of core principles may be seen in Table 5.

4.1. Consensus

Four of the 12 statements achieved consensus in stage one (100% agreed/strongly agreed; $n = 29$), so were ratified in stage two and remained as shown in Table 1. Qualitative comments included:

- “Clinicians were not just able to shape the tool to ensure that it was workable but took ownership and championed the tool and therefore implementation of the tool was very successful” (1a)
- “On line there are options for additional help points” (1b).

Table 1
Draft statements in category 1 (consensus).

Category 1: CONSENSUS	a) Clinicians should be involved in developing and monitoring assessment tools/processes	b) Sign-off mentors should be given clear verbal and written guidance on the assessment tool and criteria for grading the level of performance/competence	c) The full range of grades available should be encouraged	d) The correlation between qualitative comments and grade awarded should be clearly demonstrated
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Table 2
Draft statements in category 2 (staged consensus).

Category 2: STAGED CONSENSUS	a) Academic staff should provide opportunities to support sign-off mentors in their decision-making about a student's competence/level of achievement	b) A common set of grading criteria comprising qualitative comments which would attract different types of scoring (eg: %, mark, A-F etc depending on institutional requirements and programme preferences) would be helpful for all programmes to incorporate, standardising the measure of competence/performance in midwifery practice across the UK
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Table 3
Draft statements in category 3 (minor modifications).

Category 3: MINOR MODIFICATIONS	a) Assessment tools should explicitly state that a judgement is being made about the <i>performance</i> and not the <i>individual student</i>	b) Academic staff should moderate sign-off mentor grades/comments either in person at a tripartite or triad meeting or as a follow-up activity of the documentation (Note that this statement was subsequently excluded as already covered in final core principles 8 and 11 – see Table 5)
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Table 4
Draft statements in category 4 (controversial).

Category 4: CONTROVERSIAL	a) Specific grades or symbols should be awarded for ‘pure’ practice, rather than pass/refer, and these should reflect a continuum of development	b) If a practice module comprises other components, the ‘pure’ element should be a minimum proportion.	c) If non ‘pure’ practice elements are incorporated into a practice module, a clinician should participate at some point in the assessment or moderation process of other components together with academic/s	d) There should be a minimum credit weighting applied to practice modules throughout all midwifery programmes (Note that this statement was subsequently excluded in the final core principles – see Table 5)
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4.2. Staged consensus

Statements 2a and 2b (Table 2) had been strongly supported but not achieved consensus in stage one. These were, however, upheld in the Mini-Delphi discussion in stage two.

4.2.1. Statement 2a

In stage one, 90% ($n = 26$) had agreed and none disagreed, however 7% ($n = 3$) just made a comment or did not respond; one of these indicated neutrality. Qualitative comments noted that sign-off mentors had become skilled at making appropriate judgements, and assessment methods such as tripartite meetings (involving the student, sign-off mentor and educationalist) could facilitate this. Consensus was achieved in stage two that this principle should be upheld.

4.2.2. Statement 2b

Results from the questionnaire showed 86% ($n = 25$) agreement, 4% ($n = 1$) disagreed and 10% ($n = 3$) just made a comment or did not respond. Qualitative comments acknowledged that a common set of grading criteria would be best practice, but some respondents wondered whether this was achievable. On discussion in stage two, consensus was reached that a third phase of the study would seek to develop a generic grading rubric.

4.3. Minor modifications

These two statements were supported by the majority of respondents in stage one (90% agreed/strongly agreed; $n = 26$), but were discussed further in stage two.

4.3.1. Statement 3a

Some of the qualitative responses in stage one had suggested that when attributes such as over-confidence, personal hygiene and behaviour were being assessed, the *performance of the individual* was being judged. In discussion at the meeting in stage two, further clarification was thought necessary. This principle was therefore amended to:

*“Assessment tools should explicitly state that **performance** is being objectively measured against marking criteria which include knowledge, skills and personal attributes in the context of professional behaviour, rather than a subjective judgement on the student her/himself.”*

4.3.2. Statement 3b

In stage one, although there was 90% support for this statement, 7% (n = 2) disagreed and 3% (n = 1) stated neutrality. Qualitative comments encouraged moderation for quality assurance, however it was noted that this could be challenging. In stage two, it was agreed that statement 2a (Table 2), which had already achieved consensus, would also facilitate this purpose. Later discussion about statement 4c (Table 4) similarly comprised elements of statement 3b. It was therefore agreed that statement 3b (Table 3) was superfluous to the set of final core principles.

4.4. Controversial

The four remaining statements (Table 4) attracted more varied responses in stage one. These required more extensive discussion in stage two to address differing interpretations.

4.4.1. Statement 4a

Although 72% (n = 21) had agreed with the ethos of this statement in stage one, 21% (n = 6) disagreed and 7% (n = 2) just made a comment or did not respond. One respondent noted that some clinical skills (such as administration of injections) could be assessed as pass/refer rather than graded as they were either safe or unsafe. Another stated that a single grade for practice was appropriate providing parameters were clear that if one proficiency was failed, then the grade must be a referral/fail – complying with the NMC (2009) requirements. Not all respondents were clear about what was meant by ‘pure’ practice. Some stated that there was no such thing, as practice required underpinning knowledge as well as skills. The study team – along with many of the group members present – had understood this term to mean “direct hands-on care” as stated in NMC (2009, p21). Consensus was achieved that statement 4a would be adjusted to refer to ‘clinical practice’ as this appeared to have a common meaning to all present, and was in fact preferred to the NMC terminology:

“Specific grades or symbols should be awarded for clinical practice rather than pass/ refer, reflecting a continuum of development and meeting requirements of the NMC Standards.” (*currently termed by NMC as ‘direct hands-on care’ - Standard 15 of ‘Standards for pre registration midwifery education’ – NMC, 2009)*

4.4.2. Statement 4b

Participants had been asked to indicate the suggested minimum proportion if they agreed with this statement in stage one. Fifty-five percent (n = 16) had agreed, 17% (n = 5) disagreed and 28% (n = 8) just made a comment or did not respond. Qualitative comments in

the questionnaire again indicated some confusion about the term ‘pure’ practice. One respondent noted that her understanding was that practice should only be about practice, with no theoretical component, and should be assessed by clinicians. Another argued that even though theory and practice modules were assessed separately, theory underpinned practice and vice versa, so all modules were really covered by both. For those who agreed with statement 4b, proportions ranged from 20% to 80%, with 50% of those indicating a figure (n = 6) suggesting 50% of the module mark. Modification in terminology was agreed to reflect statement 4a, and consensus was achieved on a minimum of 50% weighting. This principle was therefore amended to:

“If a practice-based module includes elements other than clinical practice, it is recommended that the credit weighting for these additional elements should not exceed 50% within that module.”*

4.4.3. Statement 4c

Again, 55% (n = 16) had agreed with the principle in stage one, 24% (n = 7) disagreed and 21% (n = 6) made a comment or did not respond; one of these indicated neutrality. Two participants noted that clinicians may be used in viva voce or OSCEs (Objective Structured Clinical Examinations). The ‘neutral’ respondent suggested that some flexibility should be demonstrated if the academic was closely linked to practice. As for statements 4a and 4b, respondents had found the term ‘pure’ practice controversial. It was agreed by the participants in stage two to support the ethos of the statement, but to provide more scope for flexibility in application. The term ‘pure’ practice was therefore removed, and a broader principle was agreed through consensus:

“Quality assurance of grading of practice (ie: monitoring of inter-rater reliability) should be undertaken collaboratively by academic staff and clinicians experienced in assessment.”

As previously stated, the ethos of this amended statement also covered the principle of statement 3b (Table 3).

4.4.4. Statement 4d

In stage one, 72% (n = 21) agreed with this statement, 14% (n = 4) disagreed and 14% (n = 4) just made a comment or did not respond. Participants were asked to indicate the minimum suggested weighting if they agreed. Responses ranged from 30% to 80%, with the majority (53.3%) suggesting a proportion of 50% of the practice module. One further respondent had just noted ‘high’ and another stated they were ‘unsure’. Qualitative comments in the questionnaire inferred that HEIs may be reluctant to implement a weighting.

There was extensive discussion about statement 4d in stage two. Some participants suggested that a direct interpretation of the NMC requirement for a minimum of half of the programme to be practice-based would naturally translate to a 50% weighting. Although others upheld this general principle, they noted that there were diverse ways of managing this aspect during curriculum development and highlighted the challenges of institutional constraints. Some concerns were raised about grade inflation and the impact that increasing the proportion of credit weighting for practice could have on the overall mark profile. Most participants were, however, positive about the increased emphasis on practice which grading provided. Consensus was not able to be achieved. It was agreed to continue to be mindful of this matter, although the statement itself was excluded from the final set of core principles.

4.5. Core principles

The final core principles for grading of practice in midwifery programmes were ratified when no objections were raised by the members of the group who had been unable to participate in the Mini-Delphi discussion in stage two, following electronic circulation (Table 5). It was agreed to add core principle 1 to set the scene, as this was key to practice assessment in the NMC Standards (2008 and 2009):

5. Discussion

The first phase of the national study identified a wide range of interpretation and application of regulatory body standards for practice assessment in pre-registration midwifery programmes (Fisher et al., 2016). This second phase therefore sought to enhance consistency, particularly focusing on the grading element of the process. A level of standardisation was welcomed by the LME-UK group. It was suggested that this would help programme teams to address queries about grade inflation as well as enhancing quality assurance.

Consensus was achieved on a set of core principles (Table 5). It is considered that the chosen methodology facilitated this outcome. Participatory action research in two stages provided an opportunity for LMEs from all the institutions to contribute to problem-solving and decision-making through individual responses and group discussion. Although response rates were limited to 52.73% and 58.21% respectively, different institutions were represented in both stages. All members of the group had the opportunity to participate, and all were invited to make comments on the final set of core principles.

A strength of the questionnaire was the absence of a 'neutral' option in the Likert scales. Although there is some controversy about distortion of results in this approach, others argue that it reduces social desirability bias (Garland, 1991). Respondents had still been able to state that they were 'neutral' in their qualitative comments but had only chosen to do so on three occasions, providing a rationale for this view. Decisions of ranking were therefore predominantly decisive in stage one, and the detailed discussion which followed in stage two enabled further exploration.

Although it could be viewed as a weakness of the questionnaire design to have used the terminology 'pure' practice, the resultant controversy generated very productive discussion in stage two. This highlighted the differences in interpretation of what proportion of

'direct hands-on practice' was needed to form the assessed element of practice in programmes. The approach to practice not being "restricted to the provision of direct care only" reflects the stance in ANMAC (2009, p4), which was further broadened in their 2014 Accreditation Standards. The opportunity to deliberate the meaning and emphasis in stage two of the study resulted in an improved and shared understanding. This was an important outcome, having the potential to alter approaches to future programme development. The fact that the preferred term 'clinical practice' was embraced by participants and achieved consensus is of note. This may inform future educational standards both nationally and internationally.

As in the first phase of the study, the issue of grade inflation was again raised, due to the requirement for practice to contribute to academic credits (NMC, 2009). Gray and Donaldson (2009) also noted this phenomenon, as did a number of other studies. Paskausky and Simonelle (2014) found that 98% of student nurses in a study group of 281 received a clinical grade higher than their exam. Of these, 90% achieved B+ or greater, and the authors suggested this was indicative of grade inflation. This corroborated the findings from an earlier study (Scanlan and Care, 2004), in which 4500 student nurses' clinical grades were analysed. Similarly, 90% received a B+ and above, with 60% at A or A+. In the final placement, almost 80% were A or A+. A study of 204 American nursing students found that 95% of students were awarded practice grades of A or B, and only 5% a C (Seldomridge and Walsh, 2006). In the same country, a psychiatry survey noted that 20–30% of students' academic profiles were affected by grade inflation in clinical assessments (Briscoe et al., 2006). Scanlan and Care (2004) proposed that this could be harmful to the profession. Donaldson and Gray's systematic review (2012) cited a number of papers which contradicted this, however, suggesting that grading could enhance and motivate students' performance in practice. Manning et al. (2016) similarly found that the use of a pass/fail grading system did not result in a reduction in motivation or performance of the students. In the first phase of this study the LME-UK group was overall positive about the impact of grading on degree classification, as this demonstrated that practice was valued (Fisher et al., 2016). Various 'moderating influences' had been introduced in midwifery programmes to ameliorate this effect.

Participants commented on the value of using a range of modes of assessment to reduce the impact of practice grading on overall academic profile as well as to enhance reliability and validity. Seldomridge and Walsh (2006) similarly recommended the use of multiple methods for a more robust assessment. This approach was

Table 5
Core principles for grading of practice in midwifery programmes.

1. The NMC requires clinical practice* to be assessed by clinicians with due regard.
2. Clinicians should be involved in developing and monitoring practice assessment tools/processes.
3. Sign-off mentors should be given clear verbal and written guidance on the assessment tool and criteria for grading the level of performance/competence.
4. The full range of grades available should be encouraged.
5. The correlation between qualitative comments and grade awarded should be clearly demonstrated.
6. A common set of grading criteria comprising qualitative comments which would attract different types of scoring (eg: %, mark, A-F etc depending on institutional requirements and programme preferences) will be developed to enhance standardisation of the measure of competence/performance in midwifery practice across the UK.
7. Assessment tools should explicitly state that performance is being objectively measured against marking criteria which include knowledge, skills and personal attributes in the context of professional behaviour, rather than a subjective judgement on the student her/himself.
8. Academic staff should provide opportunities to support sign-off mentors in their decision-making about a student's competence/level of achievement.
9. Specific grades or symbols should be awarded for clinical practice* rather than pass/refer, reflecting a continuum of development and meeting requirements of the NMC Standards.
10. If a practice-based module includes elements other than clinical practice*, it is recommended that the credit weighting for these additional elements should not exceed 50% within that module.
11. Quality assurance of grading of practice (ie: monitoring of inter-rater reliability) should be undertaken collaboratively by academic staff and clinicians experienced in assessment.

(*currently termed by NMC as 'direct hands-on care' - Standard 15 of 'Standards for pre registration midwifery education' – NMC, 2009).

also supported in the multi-professional longitudinal study by Fisher et al. (2011), which explored a range of practice assessment methods and tools. Core principle 10 (Table 5) recommends that modes other than 'clinical practice' should not attract more than half the credits within practice-based modules. This reflects the value of a multi-method approach, which could have the benefit of reducing grade inflation whilst maintaining the emphasis on practice itself.

This study also recognises the importance of involvement of clinicians in the development and monitoring of practice assessment tools and processes (core principle 2, Table 5) - essential to promote understanding and ownership as well as ensure quality. The importance of providing clear guidance is also highlighted (core principle 3). Other literature supports this approach (Bennett and McGowan, 2014; Black et al., 2013; Briscoe et al., 2006; Fisher and Webb, 2008; Fisher et al., 2011; Gainsbury, 2010; Heaslip and Scammell, 2012; Paskausky and Simonelle, 2014; Scanlan and Care, 2004; Seldomridge and Walsh, 2006).

The first phase of this national study highlighted that grading appeared to empower sign-off mentors to more effectively determine fitness to progress or enter the register as a midwife (Fisher et al., 2016). Their increased confidence in the grading process enabled them to exercise discretion in using the full range of marks to either reward excellence or identify failing students. Clinicians value their role as professional gatekeepers – most taking the accountability of assessment very seriously (Fisher et al., 2011; Moran and Banks, 2016), despite this requiring courage in the face of worrying opposition at times (Black et al., 2013; Hunt et al., 2016). In stage two of this phase of the study, there was an interesting discussion relating to the objective measurement of *performance* in the context of professional behaviour (comprising knowledge, skills and attitudes) against a set of marking criteria, rather than it being a judgment on the student him/herself – resulting in core principle 7 (Table 5). If this focus is emphasised, it may assist clinicians to be more objective and courageous in making their decisions – especially if supported by academics (Black et al., 2013; Jervis and Tilki, 2011; Royal College of Nursing, 2016; Rutkowski, 2007).

The findings from this study support continuation of grading of practice, despite its challenges. Donaldson and Gray (2012) similarly conclude that it is beneficial. Chenery-Morris (2010) proposes that the process of grading is more important than its contribution to an academic award.

Maxted et al. (2004) suggested the need to develop new methods of assessment with known validity, reliability and predictive power. Donaldson and Gray (2012) recommended the use of rubrics to enhance reliability and reduce grade inflation. Core principle 6 (Table 5) was agreed as an outcome of this study. The third and final phase will therefore comprise development of a common set of grading criteria suitable for use throughout all midwifery programmes and with any practice assessment tool. This rubric will consist of qualitative comments to indicate levels of performance in practice, attracting scoring appropriate to individual institutions. Participation will be sought from a wider range of stakeholders, to include clinicians and students. Consideration will also be given to the inclusion of other professions.

6. Conclusions and recommendations

In contrast with the assertions that standardisation in assessment may not be achievable (London, 2008; Hay and O'Donoghue, 2009), this study has demonstrated – through collaborative consultation – that variations in approach can be reduced.

A series of stakeholder meetings is currently taking place in the UK prior to NMC consultations on draft standards to replace the

existing regulatory requirements for pre-registration education in midwifery (NMC, 2009) and nursing (NMC, 2010), as well as practice learning and assessment (NMC, 2008). Published findings from the first phase of this study have already been disseminated to the regulatory body. It is anticipated that the principles identified in the second phase will also contribute to the evidence informing these standards. The generic nature of many of these principles may also enable transferability to other professional programmes internationally where practice assessment is fundamental to registration.

The study group on behalf of the LME-UK Executive Group therefore suggests the following recommendations:

1. Midwifery programmes in the UK should incorporate the agreed core principles into curriculum development within the context of individual institutional constraints. Other programmes nationally and internationally may also choose to consider applying some or all principles to their own curricula.
2. Where integration of these principles is proving more challenging due to institutional constraints, the results of this study may be used to support rationale at internal validation events.
3. The NMC will continue to be kept updated with the published findings to contribute to the evidence-base for the new educational standards.

Conflict of interest statement

None of the authors has any financial or personal conflict of interest with other people or organisations which could bias this work.

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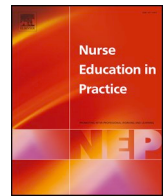
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2.2.3 WORK 6

Fisher, M., Bower, H., Chenery-Morris, S., Galloway, F. Jackson, J., Way, S. and Fisher, M.M. (2019a) 'National survey: Developing a common approach to grading of practice in pre-registration midwifery', *Nurse Education in Practice*, 34, pp150-160. <https://doi.org/10.1016/j.nepr.2018.11.014>.

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Midwifery Education in Practice

National survey: Developing a common approach to grading of practice in pre-registration midwifery

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ABSTRACT

This paper presents the final phase of a national project exploring grading of practice in programmes leading to registration as a midwife in the United Kingdom. The aim was to develop a generic framework for grading practice, enhancing standardisation while enabling flexibility in application of current and new educational standards. A mixed method on-line survey considered existing practice assessment tools, factors contributing to robust and reliable assessment and perceptions of two assessment tools developed by the research team: a 'Lexicon Framework' and 'Rubric', which were tested through scenarios. Participants included 170 midwifery and nursing academics, clinicians and students, representing 20 universities in the UK. Seven key themes emerged, from which an 'Evidence Based Model for Professional Practice Assessment' was developed. The proposed tools were overall positively evaluated and demonstrated a good level of reliability. A national tool to standardise midwifery practice assessment is recommended, and scope for transferability of our tools to all midwifery programmes and to nursing was identified. Other recommendations include engagement of key stakeholders in development of practice assessment documentation, and maintaining the professional purpose of grading practice as central to the process. A set of key principles for assessing practice is presented.

1. Introduction

This paper presents the findings from the third and final phase of a national project conducted by and on behalf of the Lead Midwife for Education United Kingdom Executive (LME-UK), comprising a group of senior midwife academics appointed by each of the 55 universities in the UK delivering pre-registration midwifery education – a requirement of the regulatory body, the Nursing and Midwifery Council (NMC, 2017a). Our five-year project has explored grading of practice in educational programmes leading to qualification as a midwife (LME-UK Executive, 2018), using a cyclical participatory action research process in which collaboration is key to achieving the end-goal (O'Brien, 1998). The first two phases have previously been published in this journal (Fisher et al., 2017a,b). This final phase comprised an on-line survey of

midwifery and nursing students, clinicians and academics across the UK.

Our findings and recommendations contribute to the evidence-base informing new standards for pre-registration midwifery education in the UK (NMC, 2017b). They have resonance in nursing and internationally for academics and clinicians who develop assessment documentation, facilitate learning or determine students' progress in professional practice settings.

2. Background

2.1. The professional context for grading of practice

Globally, both the World Health Organisation (WHO, 2009) and

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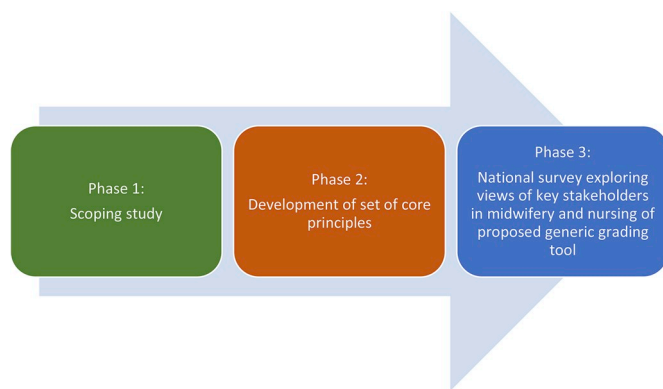


Fig. 1. National grading of practice in pre-registration midwifery project.

International Confederation of Midwives (ICM, 2013) stipulate a balance of theory and practice to ensure that essential competencies for basic midwifery practice are achieved, and the UK and other 27 members of the European Union, Australia and New Zealand have adopted these standards (Australian Nursing and Midwifery Accreditation Council, 2014; European Parliament, 2005; Midwifery Council of New Zealand, 2018).

Grading of practice, contributing to degree classification, is currently mandatory in UK pre-registration midwifery programmes (NMC, 2009), but this is not the case in nursing (NMC, 2010, 2018a). The education standards specific to midwifery are currently under review (NMC, 2017b), and it is unknown whether grading will continue to be stipulated by the regulatory body or become optional.

Midwifery practice in the UK must currently be assessed by registrants who have received specific preparation, annual updates and have worked on a regular basis with the student – termed ‘sign-off mentors’ (NMC, 2008). Roles for those supporting and assessing midwifery and nursing students in practice will, however, soon be changing. ‘Practice supervisors’ from the same or another profession will support and facilitate learning in the relevant setting, recording the student’s progress. A suitably prepared ‘practice assessor’, from the same profession as the student, will determine achievement based on this evidence (NMC, 2018c). For the purposes of this paper, its international readership and the current educational context, the terms ‘mentor’ and ‘assessor’ are used interchangeably to reflect the person accountable for judging performance in practice.

Application of the standards set by the NMC is the responsibility of the individual academic teams in collaboration with clinical colleagues and subject to their higher education institution’s regulations. In 2013, the LME-UK Executive identified that a wide range of approaches and interpretations of the NMC (2009) standards for pre-registration midwifery education was evident across the UK, reflecting experiences in other health professions (Lauder et al., 2008; Mallik and McGowan, 2007). The group sought to reduce these variations, focusing on achieving greater consistency in grading practice across educational programmes leading to qualification as a midwife. A ‘National Grading of Practice in Pre-registration Midwifery Project’ (Fig. 1) has therefore been undertaken by a team of previous and current LMEs with a common interest in practice assessment (LME-UK Executive, 2018).

2.2. Rationale for the final phase

The complexity of ensuring consistency, reliability and validity in practice assessment tools and approaches is challenging (Dalton et al., 2009; Fisher et al., 2011; Seldomridge and Walsh, 2006), and Maxted et al. (2004) has identified a need to develop robust new methods with greater predictive power and authenticity.

The findings from the scoping study in the first phase of our project (Fig. 1) supported a move to reducing variations in approach to practice assessment, thus strengthening the rigour of the process (Fisher et al., 2017a).

In the second phase, a Mini-Delphi process (Green et al., 2007) achieved consensus on a set of 11 core principles drawn from these findings (Fisher et al., 2017b). One has led to the third and final phase of our project:

“A common set of grading criteria comprising qualitative comments which would attract different types of scoring (eg: %, mark, A-F etc depending on institutional requirements and programme preferences) will be developed to enhance standardisation of the measure of competence/performance in midwifery practice across the UK” (Fisher et al., 2017b, p58).

3. Methods

3.1. Aim

The aim of the final phase of our project was to develop a generic framework for grading practice in pre-registration midwifery, enhancing standardisation while enabling flexibility regarding the awarding of specific grades or broader indicators of levels of attainment. This would accommodate variations and future-proof against changes to regulatory requirements, or institutional preferences, for graded or non-graded practice assessment.

It was proposed that the framework would be suitable for use throughout all midwifery programmes nationally and with any practice assessment tool, with potential to adapt it to other professions or countries.

3.2. Study design

This descriptive study comprised a mixed method on-line survey exploring participant views of their existing practice assessment tool, consideration of factors contributing to a robust and reliable assessment process and perceptions of two proposed assessment tools developed by the research team: a ‘Lexicon Framework’ and ‘Rubric’. Although the primary aim was to explore their application to midwifery, the research team decided to include nursing participants so that potential for transferability could be determined. Information about professional registration and stakeholder categories of academics, clinicians and students was identified at the start of the survey.

3.3. Development of the assessment tools – Lexicon Frameworks and Rubrics

Twenty-eight practice assessment documents were received from the LMEs, representing 37 of the 55 universities (67.2%) as common regional assessment tools were used in Yorkshire and Humberside and ‘PAN London’ institutions (Fisher et al., 2017a; Gillman, 2014). Terminology used was collated into a matrix for each academic level and the range of level descriptors for performance. The UK Quality Code for Higher Education (QAA, 2014) defines level descriptors as “A statement of the generic characteristics of outcomes of learning at a specific level of a qualifications framework” (p1). These frameworks provide international comparability of academic standards and are used by professional regulatory bodies (such as the NMC) to recognise qualifications; they are, however, deliberately broad to enable flexibility for awarding institutions. There are two parallel frameworks for higher education qualifications – one for Scotland and one for the rest of the UK. Academic levels for pre-registration midwifery qualifications are distinguished as levels 4–7 for England, Wales and Northern Ireland,

Table 1
Categorisation according to scoring systems in midwifery across UK universities.

Undergraduate Degree Levels 4–6; SCQF Levels 7–9	
Clear fail	(Very poor; Poor; 0–29%; F; 6)
Fail	(Unsafe practice; Inadequate; 30–39%; E/F; 7; 0–7; <u>1–3</u>)
Pass	(Satisfactory; Acceptable; 40–49%; D; 8–9; 8–10; <u>4–6</u>)
Good	(50–59%; C; 10–11; <u>11–13</u> ; 2)
Very good	(60–69%; B; 12–13; <u>14–16</u> ; <u>7–9</u>)
Excellent	(70–79/84%; A; 14–20; <u>17–19</u> ; 3)
Outstanding	(Exceptional; 80/85–100%; AA; <u>10–12</u>)
Masters Level 7; SCQF Level 10/11	
Unsatisfactory	(Not achieved; Fail; Unsafe practice; 45%; 0–7)
Satisfactory	(Adequate; Pass; 55%; 8–9)
Good	(Good pass; 65%; 10–11)
Very good	(Very good pass; 75%; 12–13)
Excellent	(Outstanding; Excellent pass; 85%; 14–20)

equating to Scottish Credit and Qualifications Framework (SCQF) 7–10/11 (QAA, 2014). Table 1 shows the range of scoring systems used in the documentation provided by the LMEs, and the generic categorisation adopted by the research team for the new assessment tools, using terms such as ‘fail’, ‘good’, ‘excellent’ for the level descriptors.

A visual representation of the frequency words appeared in each category was initially created in 'Wordles' or 'Word-clouds' (Feinberg, 2014) - see Fig. 2. They were next ranked using 'Word Count Tool' (Word Counter, 2017), with each word collated into its root form and derivatives. Those with highest frequency were transferred to a 'Lexicon Framework' and categorised according to their parts of speech: nouns (further segregated into their relevance to knowledge, skills, attitudes or 'other'), adjectives, verbs, adverbs and prepositions. A pragmatic approach was taken to categorisation when derivatives could be used in different contexts; the most common category of usage was applied, ensuring that this was consistent within and between academic levels. Key words were identified in a banner above each part of speech if they appeared in at least six of the seven level descriptors (Levels 4-6/SCQF 7-9) or all five of the descriptors in Level 7 (SCQF 10/11).

The sets of words in the Lexicon Frameworks were then converted to a generic range of statements relevant to ‘Knowledge’, ‘Skills’ and ‘Attitudes’ appropriate to the descriptor levels within each academic level, forming the ‘*Rubrics*’, for example: “Student demonstrates very good communication skills to underpin professional care and teamwork” (‘Skills’, level 5/SCQF 8, ‘Very good’).

The sets of Lexicon Frameworks and Rubrics were uploaded to the project website for participants to access during the survey.

3.4. Participants and ethical considerations

The survey was approved for national implementation by the ethics committee at the host university. It was confirmed that [Health Research Authority \(2018\)](#) approval was not required as clinical representatives were approached via university databases. The approval reference was made available on all survey documentation and the project website.

The LMEs acted as gatekeepers in their institutions across the UK, inviting midwifery and nursing participation from academics, clinicians involved in supporting and assessing learners and pre-registration students.

3.5. Data collection and analysis

An on-line survey questionnaire using ‘SurveyMonkey’ (Finley and Finley, 1999) included quantitative questions, qualitative comments and application of the Rubrics to grading scenarios. The links to the survey and project website on which the draft Lexicon Frameworks and Rubrics were located were included in an invitation email circulated by the LMEs to eligible participants, with a follow-up email a fortnight later.

The survey and assessment tools were piloted and refined with representatives from the stakeholder groups; all pilot data were excluded from the main survey.

Responses were anonymised at point of entry to the survey. Data were filtered according to the stakeholder categories and professions, enabling comparisons to be made within and between groups. Manual cleansing was undertaken where any discrepancies occurred.

Descriptive statistical analysis of quantitative components (giving numbers and percentages) and thematic content analysis of qualitative



Fig. 2. ‘Wordle’ depicting frequency of words used in the category ‘Outstanding’ for Level 5 (SCOF 8).

Table 2
Key for qualitative codes.

Symbol	Status or area of work	Examples
M	Midwife	RMA6 = Registered midwife employed by the university as a lecturer/academic member of staff
N	Nurse	RNC4 = Registered nurse working in the clinical setting and employed by a hospital or community trust/government/private and voluntary sector/other or is self employed
R	Registered	SM7 = Student undertaking a programme in preparation for registration as a midwife
S	Student	SN2 = Student undertaking a programme in preparation for registration as a nurse
A	Academic	
C	Clinician	

data was undertaken independently by the research team members and then cross-checked. Codes, themes and key findings were agreed by the full project team at a face-to-face meeting and follow-up email correspondence.

4. Findings

Key findings in each section of the survey are presented, comprising both quantitative and qualitative elements. Where appropriate, participant quotations have been included, and coding of stakeholder categories is identified in Table 2. Detailed findings are available in the full report from the final phase located on the project website (Fisher et al., 2018).

4.1. Profile of participants

There were 170 participants (following data cleansing) from 20 of the 55 higher education institutions and associated practice placements across the UK (36.36% institutional representation). The distribution of participants across England, Scotland and Wales is shown in Fig. 3. There were no respondents from Northern Ireland.

There were 134 midwifery and 36 nursing participants. Table 3 depicts the stakeholder categories (N = 170).

4.2. Main themes

Seven main themes were identified from the qualitative data. These are mapped to the relevant sections of the survey in Table 4, and

Table 3
Categories of participants.

	MIDWIFERY (n = 134)		NURSING (n = 36)	
Academics	64	n = 47.76% (37.65% of N)	15	n = 41.67% (8.82% of N)
Clinicians	14	n = 10.45% (8.24% of N)	8	n = 22.22% (4.71% of N)
Students	56	n = 41.79% (32.94% of N)	13	n = 36.11% (7.65% of N)

comprised:

- Human factors
- Art of mentoring
- Structure of the tool
- Ongoing guidance and support of the assessor
- Other factors
- Purpose of assessment
- Standardisation

4.3. Current assessment tools

A fairly low level of confidence in the validity and reliability of existing assessment tools was reported, especially the latter. Midwifery participants (48.51%) were more confident in their existing assessment tools than nursing counterparts (27.78%); clinicians in both professions were the most confident and students the least.

Participants were generally positive about the contribution of others to the assessment process, although five midwifery participants suggested that fewer people should be involved. Nursing participants were particularly keen for additional people to contribute to practice assessment.

A total of 55.88% participants agreed with the statement that ‘wording needs to be clearer/less ambiguous’, however this was rated by more clinicians and students than academics. Of the total participants, 58.82% identified that ‘there needs to be a clearer written explanation of how to award the grade/identify the level of performance’:

“Reliability can be impaired by individual differences of opinion. In order to improve this, the documentation needs to be more robust with less subjective areas – however, this is difficult as we are dealing with individuals and a lot of potential variables.” (RMA62)

‘More preparation is needed for those who are assessing practice’ was also popular (N = 55.29%), particularly with academics (53.13% midwifery and 80% nursing). It was suggested that constant

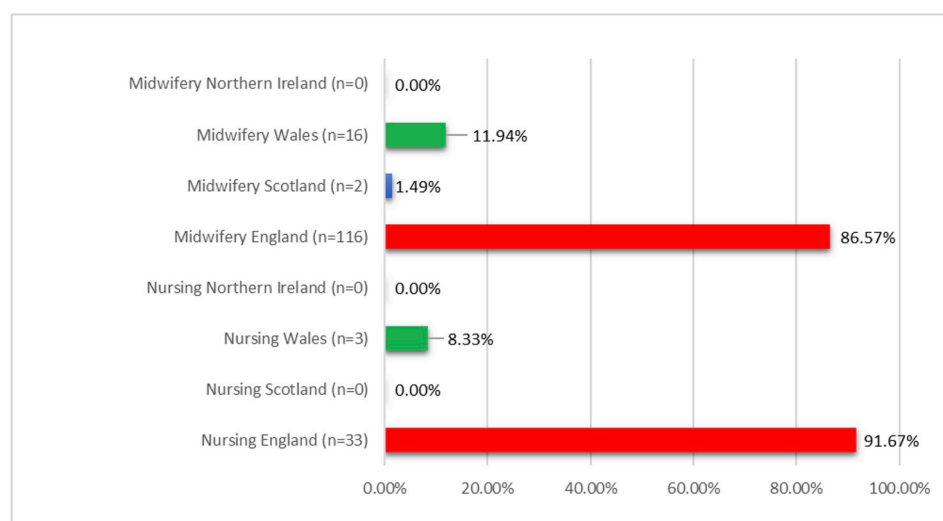


Fig. 3. Country in the UK in which participants were practising or studying.

Table 4
Mapping of thematic analysis.

MAIN THEMES	SUB-THEMES	Current Assessment Tools	Lexicon Frameworks	Rubrics	Additional Comments
(i) Human factors	Subjectivity	✓		✓	✓
	Personal interpretation	✓		✓	✓
	Mentor-student relationship	✓		✓	✓
(ii) Art of mentoring	Student's experience	✓			
	Understanding	✓	✓		✓
	Application	✓	✓	✓	✓
(iii) Structure of the tool	Accountability of role	✓			✓
	Simplification	✓	✓	✓	✓
	Differentiation	✓	✓	✓	✓
(iv) Ongoing guidance and support of the assessor	Quality assurance	✓	✓	✓	✓
	Accessibility	✓	✓	✓	✓
	Clarification and guidance	✓	✓	✓	✓
(v) Other factors	Preparation	✓		✓	✓
	Support	✓			✓
	Constraints	✓		✓	✓
(vi) Purpose of assessment	Involvement of others	✓		✓	✓
	Safe practice	✓	✓	✓	✓
	What to assess	✓	✓	✓	✓
(vii) Standardisation	Learning			✓	✓
	Transferability		✓	✓	✓
	Consistency			✓	✓

Table 5
Comparative ranking of factors contributing to robust and reliable assessment.

STATEMENTS	OVERALL RANKING	MIDWIFERY	NURSING
The focus should be on objectively assessing the student's performance in relation to knowledge, skills and personal attributes in the context of professional behaviour against set criteria, rather than just a subjective judgement of the individual	1	1	1
A clear set of statements needs to be provided, which is linked to specific grades/descriptors/symbols indicating level of performance (ie: a rubric)	2	2	4
The same assessment tool should be used nationally so that there is consistency	3	3	2
The assessment tool should be developed and reviewed by a team of key stakeholders (e.g.: clinicians, academics, students)	4	3	3
Academics should provide support to the clinicians who are responsible for assessing practice	5	5	5
Specific grades or symbols should be awarded, rather than pass/refer	6	8	6
Those responsible for assessing students should apply the NMC Code (2015) to the process	6	7	7
Students should contribute to their own assessment	6	6	8

reinforcement could reduce variations in grading. It was also highlighted that mentors needed to understand the importance of assessing the student's abilities at that point in their programme and not as a qualified midwife:

“Some mentors are unaware of how the grading criteria should be applied to students' clinical practice therefore grading students lower in first year thinking they are unable to achieve a high grade.” (SM39)

Factors which may contribute to a more reliable and valid assessment, drawn predominantly from the core principles in the second phase of the project (Fisher et al., 2017b), were ranked as shown in Table 5.

Assessing professional performance against set criteria rather than judgement of the individual was unanimously ranked highest in all stakeholder categories and both professions. Provision of a clear set of statements linked to specific grades, symbols or other descriptors of performance levels was ranked second highest overall and by midwifery participants. Introduction of a national tool was popular in both nursing and midwifery. Involvement of key stakeholders in the development and review of assessment tools was also ranked highly in all categories.

Views on grading of practice were mixed, receiving a particularly low score in midwifery. Some participants suggested that a pass or fail approach may be preferable, and others referred to the tendency towards grade inflation:

“There continue to be problems with mentors ‘failing to fail’ in practice and excessively high marks given when grading is used.” (RNA8)

However, grading was also perceived to assist in identifying a poorly-achieving student:

“When a student is good/ passing mentors decide what grade they want to give without reviewing the criteria. It is only when a student isn't doing as well as the mentor thinks they should that the criteria comes into focus for them.” (RMA61)

4.4. Lexicon Frameworks

The majority of participants indicated that there was scope for use of the Lexicon Frameworks. Clinicians were particularly positive about the potential to use them, either as the main tool for grading (80% midwifery) or when writing evidence to support assessment (70% midwifery, 71.43% nursing). Students were similarly positive about using the Lexicon Frameworks either when mentors or they themselves were writing evidence to support assessment of progress (48.74% and 44.68% respectively for midwifery and 50% for each in nursing). Some academics expressed confusion about their purpose, although 77.19% midwifery and 75% nursing academics considered they would be useful when developing new pre-registration programmes. Some participants suggested that the Lexicon Frameworks would ensure a fairer grade and help promote standardisation.

Suggestions were made to improve the Lexicon Frameworks further, including simplification, more discrete terminology for each level descriptor and providing examples. Value was seen in providing these electronically for wider use:

Scenario 2: Phoebe, who is completing her second year, applies theory to practice and her clinical skills are sound. She needs to be more proactive in explaining care decisions, especially when there are deviations from the normal. She undertakes conversations with women regarding options for pain relief and adapts her style to accommodate differences in women's prior knowledge when communicating with them. She has identified that she would like to be more confident in approaching members of the wider multi-disciplinary team in her next placement. What overall grade would you give this student, using the rubric for academic level 5 (SCQF 8)?

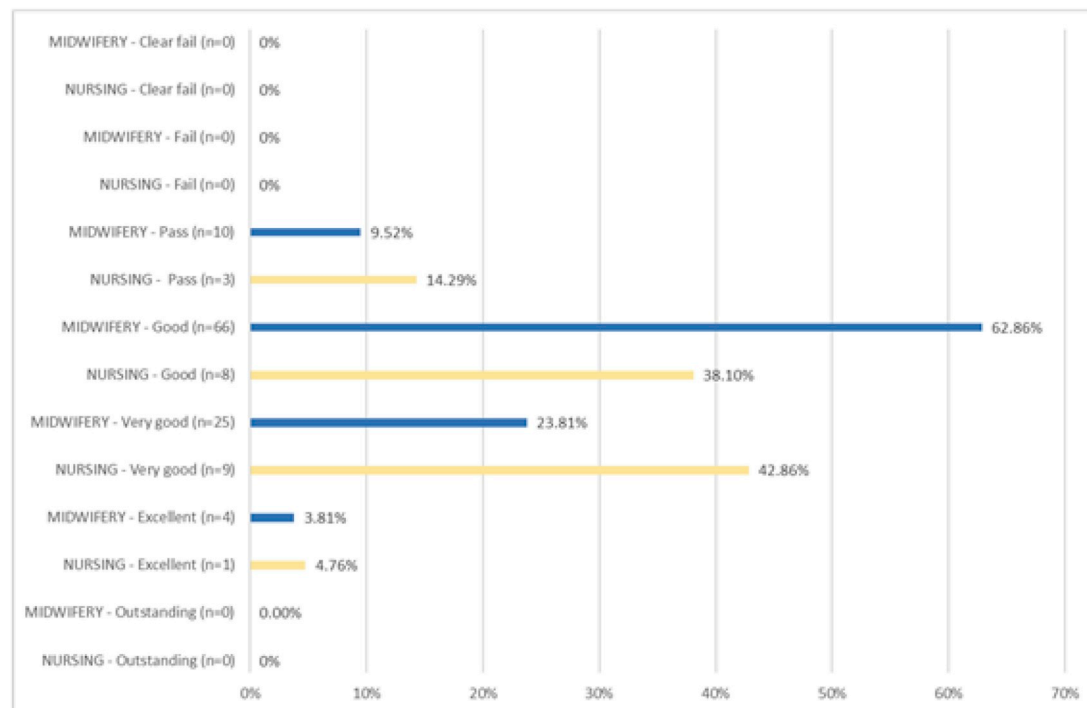


Fig. 4. Comparison between midwifery and nursing: Scenario 2 - Phoebe.

“Transforming the lexicon frameworks into a digital tool which students/assessors can access to evaluate work would be advantageous as this would encourage self-improvement in students and assist assessors in grading consistently.” (SM26)

4.5. Rubrics

Most participants found the Rubrics easy to use (midwifery 71.42%, nursing 66.66%). They were presented with four scenarios reflecting academic levels 4–7 (SCQF 7–10/11). An example is shown in Fig. 4, together with the comparative results from participants' grading.

The majority of participants aligned with the grade intended in the three scenarios for levels 4–6 (SCQF 7–9), demonstrating a good level of validity and inter-assessor reliability overall. Challenges were, however, evident in assessing ‘Alba’ at masters level (level 7; SCQF 10/11), with a wider range of grades being awarded (Fig. 5). It was concerning that 11 (19.64%) midwifery students failed to fail student ‘Grace’ at the end of her third and final year (level 6; SCQF 9), despite it being evident that her practice did not meet requirements and was clearly unsafe; one midwifery academic also passed her. ‘Grace’ was, however, failed by 88.57% midwifery and 85.71% nursing participants (Fig. 6).

Findings suggested that grading using the Rubrics could be fairly reliable, even if the assessor had not worked with the student – noting that the scenarios were hypothetical. The distribution of grades was similar in both midwifery and nursing, supporting the potential for other professions to contribute to assessment.

Responses were predominantly positive about the potential for the Rubrics to be used in both midwifery and nursing (see Table 6), particularly their scope for transferability across all institutions or programmes (73.33% midwifery and 71.43% nursing participants).

Participants again expressed an interest in introducing national assessment tools for midwifery and nursing, and positive comments were made about the potential for the Lexicon Frameworks and Rubrics to contribute to these:

“I think that standardisation of the marking procedure is vital. I’m currently on placement in a hospital that takes students from other institutions, and the difference between how we are graded is significant.” (SM37)

“I would be in favour of a standardised national approach to practice assessment and grading as there are so many models and approaches in use that I feel consistency would be beneficial to the profession and hopefully it could be evaluated more easily to ensure that the tool is

Scenario 4: *Alba is at the end of her three-year Midwifery programme, which she is undertaking at masters level. She is able to prioritise care for six women at a time on the postnatal ward, including those with complications. Her knowledge is sound and her practice is well organised, but she has a tendency to take a task orientated approach to her responsibilities. She is, however, caring to the women. Throughout her programme, Alba has shown a willingness to respond to feedback. What overall grade would you give this student, using the rubric for academic level 7 (SCQF 10)?*

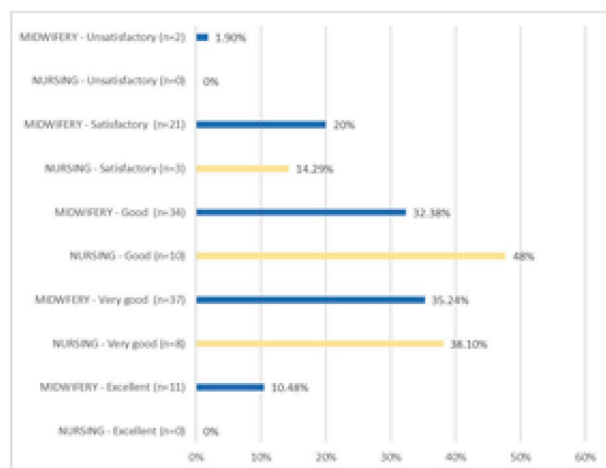


Fig. 5. Alba.

robust and valid.” (RMA1)

“Both the Rubric and Lexicon Framework appear simple to engage with and would assist in providing more detailed assessments of individual's practice. I would be happy if my University used these, and ideally it would/ could be used nationally in order to obtain more reliable and valid feedback on individual's practice.” (SN2)

Suggestions to improve the Rubrics were similar to those for the Lexicon Frameworks, along with practicalities in presentation and guidance on grading when performance fell across different level descriptors for the elements being assessed.

4.6. Additional comments

Comments reinforced previous themes and sub-themes. The ‘Purpose of assessment’ and appetite for ‘Standardisation’ were particularly apparent. Some comments focused on the proposed tools, while others were more generic.

Most participants were in favour of grading practice, but it was highlighted that its pitfalls could outweigh its advantages and it was important not to become fixated on the grade itself. It was clear that there was a need for explicit assessment tools for which mentors are trained.

Scenario 3: *In her final placement Grace, a third-year student, has forgotten to listen to the fetal heart when admitting women in labour on three separate occasions. The mentor, Tim, has had to remind Grace to undertake this care. On one occasion Grace had not anticipated birth despite changes in the woman's behaviour, and this resulted in a formal complaint. This has made Tim hesitant to leave Grace unsupervised with women. Tim does, however, note that Grace is always kind and compassionate to the women and works well within the team. What overall grade would you give this student, using the rubric for academic level 6 (SCQF 9)?*

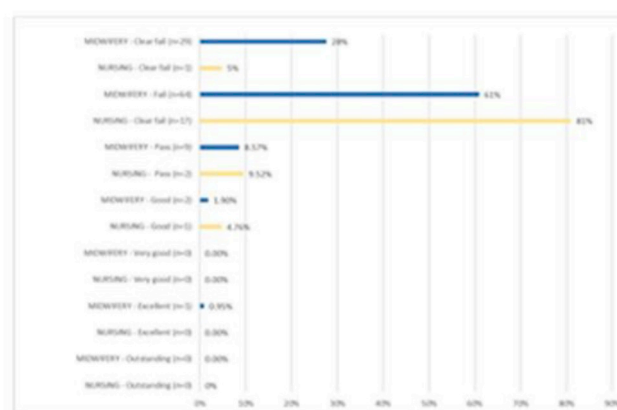


Fig. 6. Grace.

The importance of ‘learning’ was emphasised, with both students and mentors needing to understand and recognise performance and achievement in practice.

5. Discussion and project outputs

5.1. Enhancing the rigour of practice assessment

Engagement of key stakeholders in the development of practice assessment tools and documentation is clearly essential. The views of clinicians or students differed from those of academics in a number of questions; for example, clinicians and students appeared to have a clearer understanding and greater appreciation of the potential for the Lexicon Frameworks to be used to document evidence in practice, while academics seemed less sure about their purpose, although acknowledging that they would be useful when developing new programmes. Similarly, both clinicians and students highlighted the importance of clear wording, whereas academics focused on the need for preparation of those assessing practice. It was interesting that clinicians seemed most positive about the reliability and validity of existing assessment tools, as the people using these in practice. The views of all stakeholders should be considered to avoid assumptions being made on behalf of other groups.

It was significant that the highest ranked factor was to “objectively assess the student's performance in relation to knowledge, skills and personal attributes in the context of professional behaviour against set

Table 6
Comparison between midwifery and nursing: Potential use of Rubrics.

Potential use of Rubrics ...	MIDWIFERY (n = 134)			NURSING (n = 36)		
	Yes	Maybe	No	Yes	Maybe	No
As a 'stand-alone' practice assessment tool	45.71%	35.24%	19.05%	52.38%	28.57%	19.05%
In combination with existing tool	65.71%	26.67%	7.62%	66.67%	28.57%	4.76%
Across all institutions or programmes	73.33%	20%	2.86%	71.43%	1.90%	0.95%

criteria, rather than just a subjective judgement of the individual". The theme of 'Human factors' was strong, and the mentor-student relationship could constrain reliability of assessment:

"Some mentors are more harsh when grading students than others. Other mentors have also known some student midwives from when they were maternity assistants and have socialised with them outside of work, they have been known to grade these students very well, and I am not sure whether those students would have received the same grading from a different mentor who they did not know well." (SM41)

Importantly, participants were responding to hypothetical midwifery scenarios, measured against a criterion-referenced grid; the subjectivity of personalities who knew each other (i.e.: the 'individual') was therefore removed. Although a good level of inter-assessor reliability was demonstrated in most of the scenarios, it was interesting that grading by nursing participants was generally more accurate than midwifery. Lack of familiarity with the professional and programme requirements may have enabled nursing participants to be more objective in their measurement of 'performance' of the students against the set criteria in the Rubrics. This suggests that involvement of other professionals in contributing to the evidence, as required in the new education standards (NMC, 2018b; 2018c), may promote greater reliability in practice assessment in the future. Similarly, separation of the role of mentor into 'practice supervisor' and 'practice assessor' will mean that those assessing students may not spend as much time working together, thus potentially improving reliability by reducing the impact of 'Human factors'.

Clear sets of statements "linked to specific grades/descriptors/symbols indicating level of performance" were ranked second highest overall and in midwifery (Table 5), justifying introduction of both the Lexicon Frameworks and Rubrics. This aligned with the earlier phases of our project (Fisher et al., 2017a,b) as well as the wider literature which recommends the use of rubrics to enhance reliability and reduce grade inflation (Donaldson and Gray, 2012; Maxted et al., 2004).

Our findings corroborated other research that grading of practice continues to bring both benefits and challenges (Cassidy, 2008; Chenery-Morris, 2014; Doughty et al., 2007; Fisher et al., 2011; Gray and Donaldson, 2009; Heaslip and Scammell, 2012; Johnson, 2008; Oermann et al., 2009; Smith, 2007). Some of the more negative midwifery responses may have reflected concerns about the robustness and fairness of the mandatory grading process in this profession, whereas nursing participants' greater preference for grading might have been due to the absence of this as an NMC requirement (NMC, 2010, 2018a). The tendency towards grade inflation highlighted in this and other literature (Donaldson and Gray, 2012; Paskausky and Simonelle, 2014; Seldomridge and Walsh, 2006) may be advantageous towards students' academic profiles but can also be perceived as a negative outcome, reflecting the inconsistencies of individuals and tools. Some participants indicated a preference for pass or refer, although descriptors were deemed valuable in indicating levels of performance, identifying gaps and guiding students' learning.

The appetite for national 'Standardisation' in professional practice assessment was demonstrated across all categories of participants,

reinforcing views of the LMEs as well as findings in the wider literature that this would contribute to enhanced rigour of assessment (Cassidy, 2008; Donaldson and Gray, 2012; Fisher et al., 2017a; Gillman, 2014; Maxted et al., 2004). A national tool has been developed for physiotherapy in Australia and New Zealand (Dalton et al., 2009). In the UK, common assessment tools have been developed for midwifery across six sites in Yorkshire and Humberside, and 'PAN London' tools are used by eight universities and their practice partners in London (Fisher et al., 2017a; Gillman, 2014); further regional tools are being developed in nursing since publication of the new standards. A number of positive comments were made about the potential for our tools to be transferable across both midwifery and nursing professions and in all categories of participants.

5.2. Development of a conceptual model

An 'Evidence Based Model for Professional Practice Assessment' (Fig. 7) was developed to demonstrate the inter-relationship between the themes and sub-themes which emerged (Table 4). This puts the 'Purpose of assessment' as central, surrounded by factors which contribute to robust and reliable assessment, but mindful of the 'Human factors' and 'Other factors' which may have a negative impact.

Our study has highlighted that grading tools are very challenging to create. Even if the 'Structure of the tool' appears valid, reliability remains an issue. 'Human factors' of 'subjectivity' and varied 'personal interpretation' may compromise reliability and validity, and the 'mentor-student relationship' is significant.

The 'Art of mentoring' requires 'understanding' and correct 'application' of the assessment tool and process, with 'accountability' a vital aspect of the role. To achieve this, 'Ongoing guidance and support of the assessor' is needed.

'Other factors' also influence robust and reliable assessment. Although 'involvement of others' was generally seen to be beneficial, this could also compromise consistency. Other 'constraints' included staffing levels, time together for mentor and student or opportunity for academics to support those responsible for assessment.

Participants in our study were very clear that they wanted greater 'consistency', and there was a real appetite for 'Standardisation' to enhance quality and reliability of practice assessment. Our proposed tools demonstrated some potential for 'transferability'.

The 'Purpose of assessment' became increasingly important as our study progressed. It was evident that grading of practice – however that may be defined – needs to be part of a meaningful process, and not an end-point in itself. It was clear that 'learning' was essential, and that any form of grading should clearly indicate gaps in students' performance and provide guidance on how to improve this. Fixation on the grade itself should be avoided.

5.3. Strengths and limitations of our study

A number of respondents only completed the section on demographic information. It is assumed that they did not keep both the survey and website documents open (as per instructions) and therefore

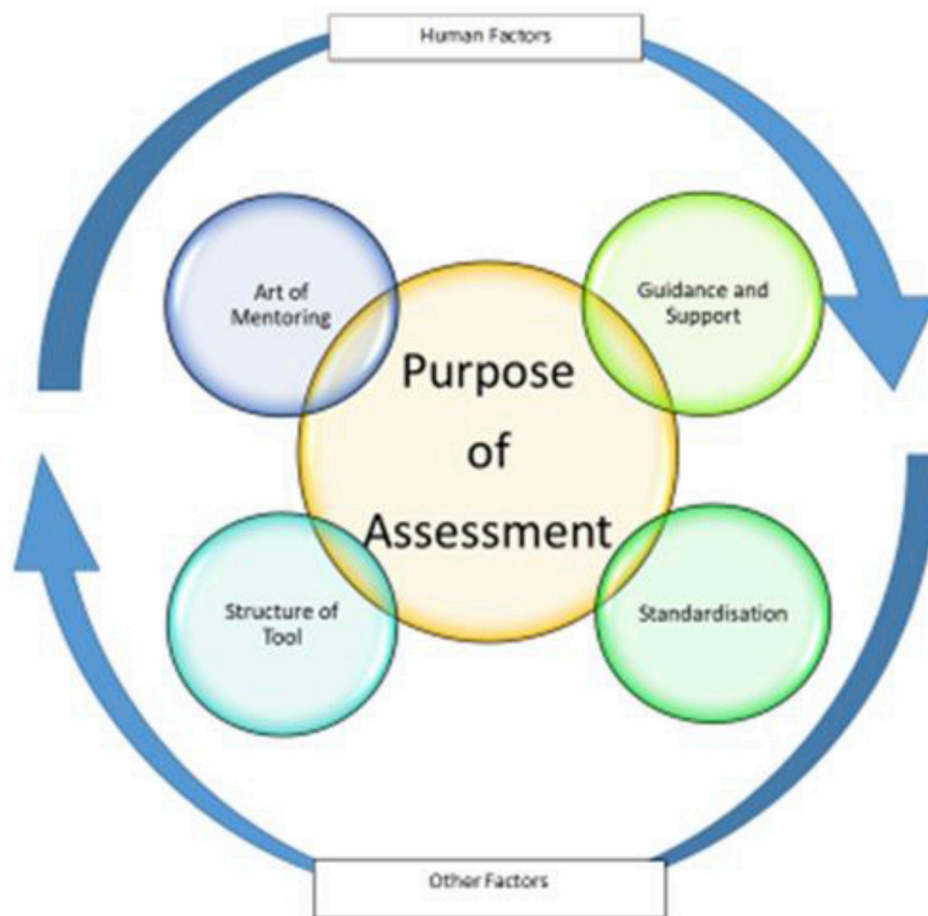


Fig. 7. An evidence based model for professional practice assessment.

exited the survey before these sections could be completed. Exclusion of these participants ensured that the data presented were accurate and meaningful.

Although participant numbers were lower than had been hoped for a national survey, proportions of stakeholder groups were generally representative of the number of institutions delivering pre-registration midwifery programmes in each country. Nearly four times as many midwifery participants responded than nursing, which was understandable due to the title and focus of the survey. Similar proportions of academics and students participated in each of these professions, facilitating descriptive analytical comparisons, although the lower numbers in nursing resulted in a greater impact on percentages (Faber and Fonseca, 2014). The trends when highlighting commonalities and differences were considered more important than the statistics themselves, however. Qualitative components enhanced the findings, with consistency in many of the comments and suggestions strengthening the evidence base as well as facilitating future modification of the assessment tools.

Representation from 20 universities meant that a wide range of experiences of different assessment tools and approaches was reflected. This, as well as inclusion of key stakeholders, enabled some generalisability of findings. Involvement of nursing participants provided objectivity and broadened application.

Despite the average survey completion time of only 14 min, participants were clearly thoughtful about their decisions and comments. They were able to evaluate the Lexicon Frameworks and Rubrics within this time-frame, and to demonstrate application of the latter through completion of the scenario assessments. This suggests that the tools were readily understood, increasing transferability.

5.4. Recommended key principles for assessing practice

The project team recommends the key principles shown in Table 7 for assessing practice, based on the results of this survey.

5.5. Practice Assessment Toolkit

The project team is in the process of developing a 'Practice Assessment Toolkit', including modified Lexicon Frameworks and Rubrics as well as the key principles and model. This is designed to be used flexibly across midwifery programmes, and may be of particular value to teams developing practice assessment tools or individuals providing evidence of student performance – whether the student themselves, their assessor or those contributing to the evidence towards decision-making. The toolkit will enable adaptation to current or future professional requirements, institutional preferences and any approach to awarding specific grades or indicating levels of performance. On completion, it will be uploaded to the project website, which has open access (LME-UK Executive, 2018). Our resources will enable versatility while following common principles of practice assessment, with scope for transferability to other professions or countries.

5.6. Future research

- It is intended to evaluate use of the 'Practice Assessment Toolkit' and application of its constituent elements after the new NMC standards have been implemented across the UK.
- It is recommended that research into the assessment of midwifery practice at masters level is undertaken. This could include the

Table 7
Key principles for assessing practice.

KEY PRINCIPLES FOR ASSESSING PRACTICE
<ol style="list-style-type: none"> 1. Stakeholder participation is essential in the development and use of practice assessment tools (students, academics and those supporting and assessing practice); 2. The purpose of assessment needs to be understood by all stakeholders to enable achievement of learning and professional requirements, and this needs to be at the forefront of any decisions about how best to assess practice and grade (or not) performance; 3. The art of mentoring is about the development and maintenance of professional relationships in practice to enable learning; 4. The accountability of the assessor is to ensure the professional requirements are met, to ensure safe and competent practice at point of registration; 5. Any tool used needs to be as simple as possible while clearly differentiating between programme stage and levels of student performance; 6. Mentors need to differentiate between pass and fail, but also determine levels of performance to facilitate student progress and promote learning; 7. The focus needs to be on objectively assessing the student's performance in the context of professional behaviour against set criteria, rather than a subjective judgement of the individual (ie: criterion-referencing against the stage of the programme and professional requirements, not norm-referencing or measuring against individual expectations); 8. It is essential that knowledge, skills and attitudes are taken into account as these are all intrinsic to professional practice; 9. It is important that correct usage of words provides documentary evidence for others to objectively assess the student and determine level of performance; 10. Those contributing to the evidence need to understand the purpose of the assessment and their role in aiding decision-making; 11. Mentors (or practice and academic assessors) need to focus on feedback and feed-forward to guide the student's progress rather than on the grade; 12. It is important to use the full range of grades or level descriptors to guide improvement or reward achievement; 13. Individual institutions need to prescribe how a grade is determined if performance falls in different categories; however failure in any aspect or component should be deemed a failure; 14. Ongoing guidance and support of those supervising and assessing students in practice is needed – this may be written, electronic or in person.

challenges and benefits, how this is defined and differentiated from undergraduate expectations and best educational management.

6. Conclusions

The results from our survey not only comprehensively covered grading of practice in midwifery at national level, but built on general literature around practice assessment. We have also developed an evidence based model and set of key principles for assessing practice.

We have produced a set of tools which provide consistency in terminology relating to assessment of levels of performance in practice. They have demonstrated potential for recording evidence to support a mentor's decision or student's self-assessment, as the main tool for grading or when developing a practice assessment document for a new pre-registration programme. They may be used as the basis for a standardised approach in midwifery which could be modified to align with professional body or institutional requirements. It has also been suggested that they would have the potential to be transferable to nursing. Our findings may therefore contribute to the new pre-registration midwifery education standards and influence programme development across higher education institutions in the UK and beyond.

Conflict of interest statement

None of the authors has any financial or personal relationships with other people or organisations which could inappropriately influence (bias) this work.

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Ethical approval details

Faculty of Health and Human Sciences Research Ethics Committee, University of Plymouth approved the survey for national implementation on 10th November 2017, Reference number: 17/18-838.

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respond to the survey and test our proposed tools – adding valuable insights to the pool of evidence around assessment and grading of practice in the UK and beyond.

Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.nepr.2018.11.014>.

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2.2.4 WORK 7

Way, S., Fisher, M. and Chenery-Morris, S. (2019) 'An evidence-based toolkit to support grading of pre-registration midwifery practice', *British Journal of Midwifery*, 27(4), pp251-257. <https://doi.org/10.12968/bjom.2019.27.4.251>.

Candidate's contribution to authorship: 35%

An evidence-based toolkit to support grading of pre-registration midwifery practice

It is well documented (Heaslip and Scammell, 2012; Bennett and McGowan, 2014) that grading practice is not an easy task and can be open to subjectivity, ambiguity, confusion and grade inflation (Donaldson and Gray, 2012). Midwives have a responsibility to support and educate student midwives in practice (Nursing and Midwifery Council (NMC), 2018a). This may include making a graded assessment of practice (NMC, 2009), but all midwives will need to contribute measurable evidence that focuses on the student's performance during their period of 'practice supervision' (NMC, 2018b). This article explores some of the specific outcomes of a three-phase project that led to the development of a practice assessment toolkit. This toolkit may be used as a guide when developing practice assessment documents or to assist those writing evidence of student progress and assessment (Fisher et al, 2019a). A key emphasis of the toolkit is that 'student assessments are evidence based, robust and objective' (NMC, 2018b:9).

Background

The UK-wide Lead Midwife for Education United Kingdom Executive is a national group of senior midwife educationalists who represent the UK higher education institutions that deliver midwifery programmes leading to NMC registration. The group was made aware in Spring 2013 of the growing issues attributed to grading practice and the challenges that midwives often faced when making a graded assessment of a student's performance. Lead midwives for education (LMEs) were ideally placed and willing to address the issues at a strategic level to make a difference for practitioners, students and academics alike. Ensuring that students were assessed in a robust and consistent way was seen to be crucial in providing safe and effective care. A working group of interested LMEs was established and embarked on a three-phase project (Figure 1), firstly to undertake a scoping exercise of processes and views on approaches to grading midwifery practice (Fisher et al, 2017a); secondly to identify a set of core principles for grading of midwifery practice (Fisher et al, 2017b), and finally to develop a UK-wide, generic framework for grading

Abstract

Grading of practice has been incorporated into the Nursing and Midwifery Council's midwifery education standards since 2009. The literature identifies that grading practice can be fraught with challenges not least related to subjectivity, inconsistency, lack of transparency and grade inflation. An established group of UK-wide lead midwife educators recognised these challenges and through completing a three-phase project, developed an evidence-based practice assessment toolkit which aims to facilitate consistent, robust and objective grading of student practice. It is suggested that this toolkit may be useful to those developing practice assessment documentation or writing evidence to reflect a student's progress and achievement in practice

Keywords

Evidence-based toolkit | Practice assessment toolkit | Pre-registration midwifery practice | Grading practice | Higher education institution

midwifery practice (Fisher et al, 2019b). It was felt that this action was timely as the NMC was beginning to review the pre-registration midwifery education standards (NMC, 2009) and the outcomes of the project could therefore provide an evidence base for best practice in terms of assessing the knowledge, skills and behaviour of students in the clinical environment.

Midwives practising in the UK will be aware of the newly published NMC (2018b) standards, which set out what the NMC expects for the learning, support and supervision of students in the practice environment, as well as how students are assessed for theory and practice.

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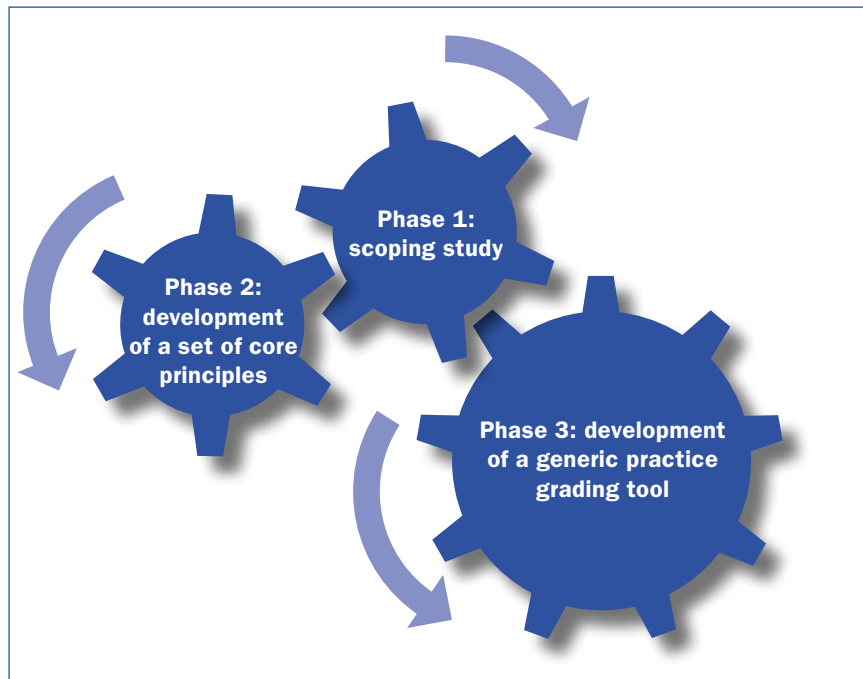


Figure 1. The three phases of the project

These standards replace the role of the mentor and sign-off mentor (NMC, 2008) with a practice supervisor, practice assessor and academic assessor (NMC, 2018b).

The new standards resulted from a major review by the NMC of its education standards to ensure they were future-proofed and fit for purpose (NMC 2018b; NMC 2018c). A practice supervisor supports and supervises midwifery students in the practice learning environment. This may not be a midwife; for example, the practice supervisor may be a paediatric nurse if the student midwife has a placement in the neonatal intensive care unit. However, the practice assessor is a clinical midwife who makes and records objective, evidenced-based assessments on conduct, proficiency and achievement, so it is important that the practice supervisor can document clear and comprehensible evidence that details the student's progress so the practice assessor can make this judgement. An academic assessor is a midwife academic who again makes and records objective, evidenced-based assessments on conduct, proficiency and achievement but also recommends progression (NMC, 2018b). The term 'sign-off mentor' is used in this article to reflect the period during which the study was undertaken, but can equally be applied to these new roles and principles.

Phase 1: how was practice assessed?

The first phase comprised a descriptive, evaluative survey, which aimed to determine the variety of ways in which practice was being assessed, the tools that were being used and the views of practitioners using the tools (Fisher et al, 2017a). A response rate of 73% was achieved, meaning

40 of the 55 higher education institutions represented by the participating LMEs. The results confirmed that there was a significant lack of parity when grading practice. Table 1 identifies some of the similarities and differences under six emerging themes.

According to LMEs, clinicians were positive, identifying that their contribution to grading practice made them feel valued and that they had a responsibility as 'gatekeepers' to the profession. When awarding a student a grade, LMEs reported that many sign-off mentors felt that grading practice gave them a legitimate way to highlight students' strengths and weaknesses. Some reported that sign-off mentors were more discerning with practice grades, reserving the higher grades for the outstanding student, while others noted that a grading process meant that sign-off mentors were better able to identify struggling students.

Challenges were also highlighted, such as the length of time it took to consider and write comments congruent with the grade, which sometimes led to lack of consistency between the grade and comments. Participants also commented that some sign-off mentors did not appreciate that terminology of level descriptors reflected the stage of the programme and were hesitant to award a higher grade when students were early on in their training. That said, when asked if there had been any noticeable difference in the students' grade profiles since grading practice had been introduced, half of the respondents ($n=20$) suggested there had been some degree of grade inflation. This finding concurs with evidence identifying that the majority of grades tend to cluster at the top of the grade scale (Edwards, 2012; Chenery-Morris, 2017). LMEs whose higher education institutions had not seen a recent difference in practice grades had often been grading practice before 2009.

Concluding this phase of the project, it was clear that there were inconsistencies in the interpretation and application of the NMC (2009) standards. The project team acknowledged that complete alignment of documents was not expected, due to innovation and inevitable differences in how higher education institution developed curricula. However, there was a view that some of the inconsistencies could be addressed in order to promote greater parity in how the NMC standards were applied. This would also be an opportunity to develop a set of principles to improve clarity, fairness and robustness for the student and sign-off mentor when practice was being assessed. These considerations fed into phase two of the project.

Phase 2: core principles for grading practice

This phase of the study aimed to identify and agree a set of core principles for grading practice, aiding quality

Table 1. Key similarities and differences in how midwifery practice was graded

Themes	Similarities	Differences
People	Mentors, sign-off mentors, lecturers	<ul style="list-style-type: none"> ● Supervisor of midwives ● Student self-assessment
Process	Every university had a process but there was limited similarity	<ul style="list-style-type: none"> ● Graded by sign-off mentor only ● Qualitative comments by mentor which were then graded by lecturer ● Moderated by lecturer ● Tripartite meeting ● Written work graded
Point in the course	Graded in final week of placement	<ul style="list-style-type: none"> ● Range of assessment times throughout the year ● Continuous assessment ● Academic level 5 and 6 only
Package (tool)	Two regional assessment documents	<ul style="list-style-type: none"> ● Novice to expert framework (Benner, 1984) ● Steinaker and Bell's (1979) experiential taxonomy ● NMC essential skills clusters (NMC, 2009) ● NMC domains (NMC, 2009) ● Knowledge, skills and attitudes (NMC, 2009) ● 6Cs (Department of Health, 2012)
Pass mark	If one element of practice did not pass, the whole assessment failed	<ul style="list-style-type: none"> ● Percentage categories (40%, 50%) ● 'Pass' or 'refer' ● Descriptors ranging from 'refer' to 'excellent' ● A–F and AA–FF ● Formula calculations to convert descriptors into numeric marks
Portfolio	Not every university used a portfolio as part of the assessment of practice so limited similarity	Universities used a variety of portfolios, reflective accounts, objective structured clinical examination (OSCE), viva voce and other assessments rather than solely clinical practice to grade students

NMC: Nursing and Midwifery Council

assurance and seeking to address concerns raised about subjectivity and grade inflation. The latter issue continues to be of national interest across all university programmes as the Government seeks to address concerns over the growing number of first-class degrees (Weale, 2018). The project group also wanted to improve assessment reliability by reducing the identified variations (*Table 1*). This phase of the study used participatory action research methodology (Freire, 1970; Denscombe, 2010). Data were collected via an online survey questionnaire followed by a group discussion with LMEs using a mini-Delphi approach (Green et al, 2007), to achieve consensus on terminology. Details of the design, data collection and results are reported by Fisher et al (2017b). Eleven core principles for grading midwifery practice were agreed (*Table 2*). The study findings recognised the importance of sign-off mentors being involved in developing the practice assessment tools (Principle 2), and that clear guidance on the assessment tool and the grading criteria should be a requirement (Principle 3). These two core principles have since been identified in the new NMC standards, where all curricula need to be developed in

partnership with relevant stakeholders (NMC, 2018c) and objective, evidence-based assessments must provide constructive feedback to encourage professional development (NMC, 2018b:10).

Phase 3: a generic framework for grading practice

The final phase of the project brought together findings of the previous two phases to develop a generic framework for grading midwifery practice. Two proposed assessment tools devised by the project team were used: a lexicon framework and rubric. The lexicon framework (*Table 3*) includes keywords relevant to undergraduate and postgraduate academic levels that may be used to indicate levels of performance in practice. The rubric (*Table 4*) comprised statements representing levels of performance in practice for undergraduate and postgraduate academic levels, mapped from the lexicon framework. One of each, at academic Level 5, is provided in *Tables 3* and *4*, with examples of their application (*Boxes 1* and *2*).

Reports on findings from this final phase (Fisher et al, 2019a; 2019b) have shown that the majority of feedback

Table 2. Core principles for grading practice in midwifery programmes

1. The NMC requires clinical practice* to be assessed by clinicians with due regard
2. Clinicians should be involved in developing and monitoring practice assessment tools/processes
3. Sign-off mentors should be given clear verbal and written guidance on the assessment tool and criteria for grading the level of performance/competence
4. The full range of grades available should be encouraged
5. The correlation between qualitative comments and grade awarded should be clearly demonstrated
6. A common set of grading criteria comprising qualitative comments that would attract different types of scoring (eg percentage, mark, A–F), depending on institutional requirements and programme preferences, will be developed to enhance standardisation of the measure of competence/performance in midwifery practice
7. Assessment tools should explicitly state that performance is being objectively measured against marking criteria that include knowledge, skills and personal attributes in the context of professional behaviour, rather than a subjective judgement on the student
8. Academic staff should provide opportunities to support sign-off mentors in their decision-making about a student's competence/level of achievement
9. Specific grades or symbols (rather than 'pass' or 'refer') should be awarded for clinical practice*, reflecting a continuum of development and meeting requirements of the NMC Standards
10. If a practice-based module includes elements other than clinical practice*, it is recommended that the credit weighting for these additional elements should not exceed 50% in that module
11. Quality assurance of grading of practice (ie monitoring of inter-rater reliability) should be undertaken collaboratively by academic staff and clinicians experienced in assessment

NMC: Nursing and Midwifery Council; *'direct hands-on care' (NMC, 2009)
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received from clinicians was positive. It was identified that the lexicon framework could be used as the primary tool for grading practice particularly when it came to writing evidence, with some suggesting it would enable more transparent and fairer grading. Students also responded positively, remarking that they could use the tools to self-assess their own practice. Areas for improvement included simplification of language and provision of examples to aid clarification. Feedback on the rubrics suggested they could aid consistency of grading, even if the assessor had not worked predominantly with the student (as will be the case with the new NMC standards), and there was scope for transferability across professional programmes. Findings strongly supported introduction of a national assessment tool in both midwifery and nursing, and many regions are working to develop these.

It was clear from the final phase of the study that learning was seen as important, that both students and sign-off mentors needed to understand and recognise achievement in practice, and that grading was only a small part of this. Therefore, providing feedback to students on their strengths and areas to develop in a comprehensive and easily accessible format should be the main focus, rather than the grade.

Conclusion

The initial aim of the project was to understand the similarities and differences in approaches to grading practice among higher education institutions across the UK, and identify if there could be a generic approach to aid consistency of assessment. The three-phase project provided the evidence needed to develop a practice assessment toolkit to ensure that student assessments are evidence-based, robust and objective. The development of the toolkit is timely due to the NMC's publication of the standards for student supervision and assessment (NMC, 2018b), and so has particular relevance to practice supervisors when writing evidence to reflect a students' performance that can be used by the assessor.

The practice assessment toolkit can be found on the project website (Fisher et al, 2019a). This includes an explanation of how it can be used, levels of performance that may be relevant in a range of higher education institutions, word clouds to provide visual representation of terms and the modified lexicon frameworks and rubrics. **BJM**

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Table 3. Lexicon Framework example, academic level 5

	Fail	Pass	Good	Very good	Excellent	Outstanding
Knowledge	Keywords: knowledge, evident(ce), understand(ing), inform (ed/ation), theory(etical), awareness, opinion, insight(ful), research					
Skills	Keywords: practice, able/ability, skill, care, act(ion/ive/ively), task, preparation, initiative, decision, competent(ce/ly)					
Attitudes	Keywords: behaviour, manner, compassion(ate), approach(able), philosophy, choice, perception, empathy(etic)					
Other	Keywords: woman, student, family, partner, colleague, NMC, time(s/ly), supervise(ion), standard, require(ment), midwife(ry), workload, support, resources, situation, team, guidance, prompt, guideline, complication, range					
Adjectives	Keywords: professional, direct, clinical, verbal, individual, own, verbal, written					
	Unable Poor Insufficient Ineffective Inappropriate(ly) Inconsistent Unsafe(ly/ty) Little Limit(ed/ation) Unclear Inadequate Reticent Unwilling	Safe(ly/ty) Basic Essential Adequate Acceptable	Appropriate(ly) Accurate(ly) Significant(ce) Relevant Good Sound	Professional(s) Effective(ly) Clear(ly) High Very good Confident(ce/ly) Responsive Sensitive(ly/ity)	Wide Excellent Complete(d) Proactive Different Positive(ly) Collaborative Motivated	Very High Comprehensive(ly) Outstanding Complex Exceptional(ly) Reliable(ity)
Verbs	Key words: show, document(ation), demonstrate(ion), develop(ment), respond, learn(er/ing), reflect(ive/ion), perform(ance), communicate(ion), lack, need(s), apply(ication), manage(ment), provide, record, work, underpin, seek, make, identify					
	Lacks	Begin(ning) Link	Participate Recognise(ition) Identify(ication)	Plans Prioritises Rationalise	Anticipate Evaluates	Modify(ication) Improves(ment)
Adverbs	Occasional(ly)				Consistently	Always

Source: Fisher et al (2019a). Reprinted with permission

Box 1. Example assessments using the practice assessment toolkit

Example 1: Johan **demonstrates limited** knowledge; however when asked, he can **explain** the rationale for the **care** he is giving using **evidence** from NICE. He is **unable** to **prioritise** his **workload** and needs direct **supervision at all times**. He is **professional** in his interactions with **women** and their **families** but **inconsistent** in **recording** his findings.

Example 2: Estefania can **plan** and **prioritise** her workload; when the **activity** is high she is **proactive** in **anticipating** the requests of **women** for discharge, **demonstrating awareness** of the **complex** nature of maternity **care**. Her **documentation** is **always** completed to a **high standard**.

For a second-year student at level 5, Johan would refer to 'fail' in practice, whereas Estefania would be awarded 'excellent'.

Table 4. Rubric example, academic level 5

	Fail	Pass	Good	Very good	Excellent	Outstanding
Knowledge	Unable to demonstrate sufficient knowledge and understanding to underpin safe practice	Knowledge is limited, but adequate to inform safe practice	Evidence of sound knowledge and understanding to underpin safe practice	Evidence of very good theoretical knowledge which is applied to practice	Demonstrates excellent theoretical knowledge which consistently underpins practice	Outstanding evidence-based knowledge is consistently applied to practice
Skills	Limited ability to perform common clinical midwifery skills and/or unsafe practice is demonstrated Demonstrates inadequate skills in woman-centred, compassionate care and/or inappropriate communication	Occasionally demonstrates limitations in some clinical skills, but ability is overall satisfactory Student acts and communicates effectively in providing compassionate care to the woman/ family	Demonstrates good ability in performance of normal clinical midwifery skills Able to provide effective care, seeking to meet the woman's needs through informed choice	Evidence of ability to perform effective clinical skills in a range of situations Student demonstrates very good communication skills to underpin professional care and teamwork	Skilled in normal clinical practice and is developing the ability to identify complications under supervision Demonstrates evidence of excellent professional communication skills and anticipation of needs	Consistently outstanding performance of normal clinical skills, responding appropriately to risk Consistently cares for women at a high standard, demonstrating outstanding communication and team-working skills
Attitudes	Evidence of lack of insight in the student's understanding of professional behaviour Student demonstrates a poor attitude towards guidance and feedback	Student demonstrates appropriate professional attitudes Student responds appropriately to guidance and feedback	Student clearly demonstrates a professional approach and compassionate manner Student uses initiative to self-assess and seek appropriate support	Student's behaviour and approach show evidence of appropriate adaptability Student is competent in reflective practice	Student demonstrates sensitivity to individual situations, showing a high level of insight Student critically evaluates their own learning and development	Student consistently demonstrates sensitivity and empathy in complex situations Student consistently analyses own performance and rationalises modifications
Under minimal supervision	Does not achieve all the NMC standards/ requirements	Achieves all the NMC standards/ requirements	Achieves all the NMC standards/ requirements well	Very good achievement of all the NMC standards/ requirements	Excellent achievement of all the NMC standards/ requirements	Outstanding achievement of all the NMC standards/ requirements

Source: Fisher et al (2019a). Reprinted with permission. Key: **high frequency**; medium frequency

Box 2 shows how these phrases correspond with an assessment of practice in the community (Jade) and on the antenatal ward (Lizi), using colours to match comments with the rubric

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Box 2. Example assessments using Table 4

Example 1: Community

Jade is **compassionate and professional in her approach to women**. She **uses her initiative and seeks support appropriately**. She **demonstrates good clinical skills**, for instance her abdominal examinations are almost always accurate in antenatal clinics. **She shows sound knowledge** to support her care.

Grade: **Good**

Example 2: Antenatal ward

Lizi has **demonstrated outstanding knowledge** about antenatal conditions such as pre-eclampsia. She researches any condition she encounters and **provides consistently outstanding evidence based care in complex situations**. She is highly reflective of her own practice and **evaluates her care, demonstrating sensitivity to individual situations and needs**.

Grade: **Outstanding**

Key points

- Midwifery practice assessment documents used across UK higher education institutions are not always easy to interpret and lack parity and consistency
- Lead midwife educators across the UK took a strategic approach to address the challenges attributed to grading practice
- Eleven core principles for grading midwifery practice were developed to aid clarity, fairness and robustness for the student and the midwife confirming the student's performance
- An evidence-based practice assessment toolkit was developed with particular relevance for those supervising students on a daily basis when writing evidence to inform summative assessment of their progress and achievement

CPD reflective questions

- Does it matter how well a student performs in practice, or should they just be deemed 'competent' or 'not competent'?
- What skills do you think you need to develop to accurately record a student's performance in practice?
- How confident are you in assessing a student's performance based on written and verbal evidence from others, and how can you address any anxieties relating to this?

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2.3 Embedding positive attitudes to professional scrutiny

2.3.1 **WORK 8:** Fisher, M. and Stanyer, R. (2018) 'Peer mentoring: Enhancing the transition from student to professional', *Midwifery*, 60 (May), pp56-59. <https://doi.org/10.1016/j.midw.2018.02.004>197

2.3.2 **WORK 9:** Fisher, M., Child, J., Williamson, G., Pearce, S., Archer, J., Smethurst, Z-L., Wenman, S. and Griffith, J. (2019b) 'The 'Reality of Revalidation in Practice' (RRiP) project – Experiences of registrants and preparation of students in nursing and midwifery in the United Kingdom: A descriptive exploratory survey', *Nurse Education Today*, 82, pp21-28. <https://doi.org/10.1016/j.nedt.2019.07.001>202

2.3.1 WORK 8

Fisher, M. and Stanyer, R. (2018) 'Peer mentoring: Enhancing the transition from student to professional', *Midwifery*, 60 (May), pp56-59.

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Peer mentoring: Enhancing the transition from student to professional

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ABSTRACT

Objective: to share the experience of a model of peer mentoring in a pre-qualification midwifery programme

Design: description of the framework and benefits of the model

Setting: University and practice

Participants: third year midwifery students

Interventions: practical activities meeting regulatory body requirements in a pre-qualification mentorship module

Measurements and findings: informal evaluations by students of key activities undertaken during peer mentoring demonstrated a range of positive outcomes. These included enhanced confidence, self-awareness, interpersonal and teaching skills, team-working and leadership – factors also associated with emotional intelligence. Students developed an appreciation of the accountability of the mentor including making practice assessment decisions. They stated that the learning achieved had aided their professional development and enhanced employability.

Key conclusions and implications for practice: this module equips students with skills for their future role in facilitating learners and contributes to development of a 'professional persona', enhancing their transition to qualified midwives. The Peer Mentoring Model would be easily adapted to other programmes and professional contexts.

Introduction

Students need 'significant others' to facilitate their professional journey towards registration. Support, effective communication, coaching in the art and science of practice and robust assessment are essential skills for those guiding the process.

'Mentors' who fulfil this role in the United Kingdom (UK) are required to meet set 'outcomes' prescribed by the Nursing and Midwifery Council (NMC, 2008 – see Fig. 1), and normally undergo preparation in the first few years after registration as a nurse or midwife. This paper, however, seeks to demonstrate the advantages of developing the required skills *prior* to qualification through an innovative 'Peer Mentoring Model' embedded in a mandatory module in a midwifery programme. It is apparent that mutual benefits may be gained from sharing or having recent experience of that same professional journey.

Background

Our current programme seeks to enable 'Midwifery 2020' students

to be fit for purpose and practice; potential leaders in an ever-changing professional, social and political context (Department of Health, 2010). It was agreed to include preparation for the role of mentor, ensuring maintenance of the International Confederation of Midwives (2013) 'Global Standards for Midwifery Education' (2010 - amended 2013, p.2 & 3) through 'the higher level of preparation for midwives in their region' – future-proofing against funding or organisational changes. This decision has proved to be wise in view of imminent regulatory changes which will be discussed later. It also appears to have had an impact on professional development which has the potential for wider application.

Peer Mentoring Model

A 20-credit degree level module (a discrete unit comprising theory and practice which makes up a sixth of the academic component of the third year of the midwifery programme) was developed. Certain mandatory peer mentoring 'fieldwork' activities are timetabled, contributing to the 30 practice hours stipulated in the NMC standards (2008). Others are optional or student-initiated, with individuals

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1	Establishing effective working relationships
2	Facilitation of learning
3	Assessment and Accountability
4	Evaluation of Learning
5	Creating an environment for learning
6	Context of practice
7	Evidence-based practice
8	Leadership

Fig. 1. Mentor outcomes for nurses and midwives. (Standards to support learning and assessment in practice, Nursing and Midwifery Council, 2008, p. 25–26).

selecting those they find most appropriate for their needs, availability and interests. Due to the emphasis on practice, the module is introduced to students at the start of their second year so that they can gradually build up a portfolio of ‘mentoring’ hours while developing the skills needed to meet the ‘outcomes’ for mentors (Fig. 1). The ‘Peer Mentoring Model’ shown in Fig. 2 illustrates how the theoretical elements of the third-year module (comprising seven taught days, directed study and an assessed essay) underpin the practice activities – both of which enable the student to move towards their mentorship role following qualification as a midwife. Examples of these mandatory and optional activities are outlined below, supported by students’ comments from module evaluations.

Activities and impact

Buddies

The module is introduced at the start of the second year so that students have ample opportunity to engage in a range of peer mentoring activities. One of the first is their allocation to new students as ‘buddies’ in their clinical area. Although this is one of the mandatory activities, practicalities are up to the individual pairings; some restricting this to emails and others meeting regularly or undertaking teaching sessions. Many build positive relationships, but students also recognise the challenges:

Can put lots of effort into ‘mentor’ role, but may not get anything back – has to be a two-way relationship.

Peer teaching day

A timetabled day in the third-year module provides students with an opportunity to prepare and deliver a short teaching session on any topic to their peers. Some choose midwifery-related subjects such as artificial rupture of membranes, while many teach hobbies and skills e.g.: cooking, sign-language, crafts. Students apply many of the NMC outcomes (2008 – Fig. 1) while considering learning styles, preparation and time management. Each group member is also expected to provide written evaluations – facilitating development of constructive feedback skills. This day is always filled with laughter and creativity, attracting many positive comments:

I especially enjoyed the peer learning day, this module has changed the way I think about the role of a mentor and enlightened my perception on mentorship, feedback and grading;

The peer teaching day has given us the confidence, knowledge and abilities to plan and carry out the observation and nurses teaching day.

Observation day

Third-year students organise an orientation day to the clinical environment for new students, prior to their initial placement. Formalisation of this day as a mandatory element of the module has resulted in improved organisation and more effective team-working:

Good and helpful to work with peers and compromising on issues – increased professionalism.

Senior students appreciate how valuable they found the day as recipients, and are keen to build on these experiences, providing a range of activities including tours of the units, demonstration of equipment and placental examination. Some invite contributions from senior managers or arrange registration with hospital libraries. Students also discuss practice portfolios, devise quizzes and provide ‘goody bags’. The day is frequently cited as one of their most useful experiences, requiring application of skills such as leadership and promoting a positive learning environment.

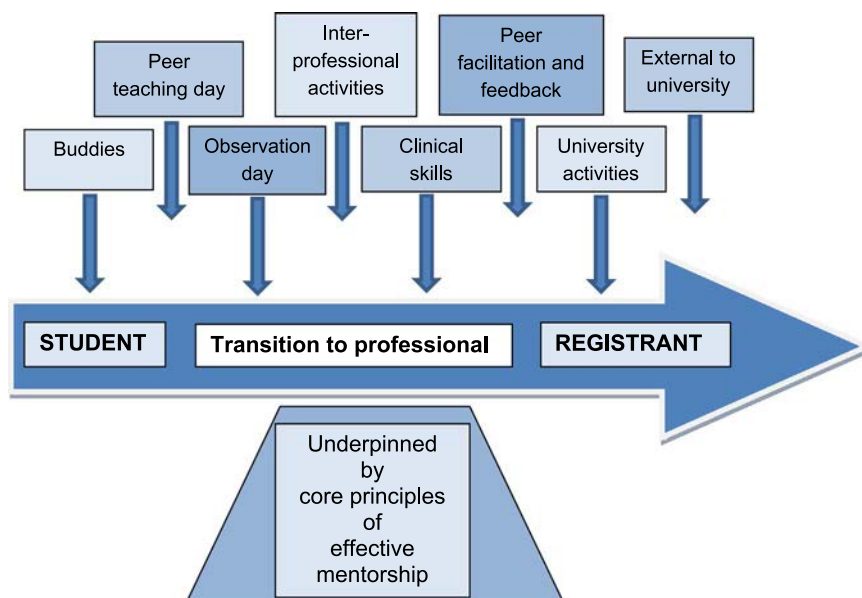


Fig. 2. Peer Mentoring Model: facilitating transition from student to professional registrant.

"I feel I can appreciate further what responsibility mentors have and how difficult it can be to have a student, especially in terms of failing them. I feel that being a student now allows me to grow into the mentor I would want to have in the future."

"This module has really helped me to think more like a qualified midwife who may have students in the future and how I would like to practice as a mentor, especially having had some not so nice experiences with my own mentors. I feel that doing this module whilst being a student is really beneficial."

"The module has facilitated very good professional discussions about contemporary issues in midwifery and aided our development towards professionals from students. Reflecting upon our own experiences of being mentored and then discussing how we can take the positives into our future mentorship and how we can avoid the negatives has been useful."

"I have noticed my increased confidence and sense of responsibility towards others since taking on the role of mentor, there is a sense of having something to offer that is valued... Before beginning to mentor I expected others to be responsible for my learning and the culture of the work place. I now feel empowered to take more responsibility for these myself."

"I am now beginning to feel more prepared for the role of mentor. Although I am finding these sessions really insightful to reflect on my experience as a student, I do feel that my professional persona is beginning to develop, and I can see myself in the role of mentor."

"I feel this module will really pay off in the future and has already benefitted us as a cohort to apply for jobs."

Fig. 3. Student perceptions of the impact of the pre-qualification mentorship module.

Inter-professional activities

A popular initiative finds some students opting to participate in an inter-professional day, during which they share the role of the midwife with junior students by preparing and running 'stands' in a carousel format. Learning is mutual:

Realised I had more knowledge than I thought;

Really enjoyed – built my confidence in teaching.

Clinical skills

The involvement of students on the module in teaching clinical skills to first year midwifery cohorts is regularly evaluated very positively by those who take part. The experience leads to self-realisation of their personal and professional development including mastery of clinical skills:

Feeling confident to teach year one skills showed me how far I have come.

Able to see how much I had grown as a professional.

There are a few coveted opportunities to take on the examiner role for mock OSCEs (Objective Structured Clinical Examinations), and this experience really enriches students' perspectives concerning assessment:

I had the opportunity to help out at a mock OSCE day for the first years. This was a brilliant experience and has helped me to develop my ability to assess and provide constructive feedback in relation to practice – a skill that I can carry forward and use as a mentor upon qualification!

Peer facilitation and feedback

The parallel-running third year 'obstetric emergencies' module sees some students opting to run peer teaching and mock OSCE sessions – benefitting from revision while further developing their teaching and feedback skills:

Useful to get feedback from colleagues and good learning how to give constructive feedback.

University activities

Students wishing to engage in wider university-led initiatives such as student representatives or ambassadors find that they can apply the skills they are learning on the module to these activities:

Good experience of acting as advocate for other students [Student representative].

Valuable experience is also gained by PALS leaders (Peer Assisted Learning Scheme – Keenan, 2014), who run sessions for junior peers in which they pass on their experience - helping them to get the most out of their course both academically and in practice. Whilst the first years gain support and reassurance, the PALS leaders develop their skills in communication, tact, talking confidently in front of large groups and taking account of individuals' needs; all of which are vital to the qualified midwife and future mentor's role:

Facilitates the opportunity to be creative in learning techniques.

External to university

Several students also choose to undertake the required hours by participating in external activities, including career days run by their host hospitals or local schools. These are particularly useful for developing skills in professional role-modelling and facilitating learning for 'strangers' from a wide range of backgrounds:

Ignited passion about degree and career when speaking to potential students of the future about my experiences.

Discussion

The 'Peer Mentoring Model' (Fig. 2) has potential to be transferable internationally and across professions. Not only does it provide a structured and flexible framework for those with a future responsibility for supporting, teaching and assessing learners, but it also appears to have an impact on development of the student's professional persona – demonstrated in the insightful comments in Fig. 3. The links between mentorship skills and professionalism have also been recognised by Nettleton and Bray (2008) in their research involving nursing, midwifery and medicine. Vertical peer mentoring in a Texan medical school has similarly been shown to promote professional identity, enhance leadership skills and benefit future careers (Andre et al., 2017); this was, however, limited to an academic context, while our model broadens this to practice.

The model also appears to promote emotional intelligence – development of skills such as self-awareness, communication, leadership, self-regulation, team-working and motivation not only enables those supervising students to be more effective in their role, but also potentially enhances their own professional practice (Nicholls and Webb, 2006). A recent meta-analysis by Miao et al. (2017) found that an increase in 'organizational citizenship behavior' and reduction in 'counterproductive work behavior' could be achieved by training employees in emotional intelligence skills – particularly in the health care sector.

A formal evaluation is proposed which will explore the pre- and post-qualification impact of the module, gaining views from a range of stakeholders. This is particularly pertinent in the context of imminent changes to mentorship in the UK, including the potential for inclusion of an educational component in future pre-qualification nursing and midwifery curricula (NMC, 2017a, 2017b). A recent paper by Duffy et al. (2016, p.168) highlights the need for 'succession planning for mentorship', and it is suggested that the 'Peer Mentoring Model' achieves this - equipping all new registrants with the necessary skills and attitudes.

Conclusions

Although some pre-qualification students find it difficult to see themselves in a mentoring role while still on their own journey, the majority respond positively to the challenge. The evidence suggests that formalising peer mentoring during pre-qualification programmes not only benefits the recipients, but also contributes to professional development. In the words of one of the module participants:

Transition from student to midwife has begun.

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Conflict of interest

None declared.

Ethical approval

Not applicable.

Funding sources

None declared.

Clinical trial registry and registration number

Not applicable.

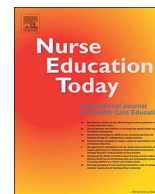
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2.3.2 WORK 9

Fisher, M., Child, J., Williamson, G., Pearce, S., Archer, J., Smethurst, Z-L., Wenman, S. and Griffith, J. (2019b) 'The 'Reality of Revalidation in Practice' (RRiP) project – Experiences of registrants and preparation of students in nursing and midwifery in the United Kingdom: A descriptive exploratory survey', *Nurse Education Today*, 82, pp21-28. <https://doi.org/10.1016/j.nedt.2019.07.001>

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The ‘Reality of Revalidation in Practice’ (RRiP) project - Experiences of registrants and preparation of students in nursing and midwifery in the United Kingdom: A descriptive exploratory survey

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ABSTRACT

Background: Renewal of healthcare registration or license to practise is becoming increasingly common, worldwide. Evidence regarding the experience of nursing and midwifery revalidation in the United Kingdom is limited. Preparation of students for the process has not yet been considered in the literature.

Objectives: To explore registrants' experiences of undertaking or supporting colleagues through revalidation. To consider preparation of pre-registration students for this future professional requirement.

Design: A descriptive exploratory study comprising an on-line survey.

Setting: A university in the southwest of England and associated clinical placements.

Participants: Nursing and Midwifery Council registrants, comprising 40 university staff and 40 clinicians; 36 pre-registration nursing and midwifery students.

Methods: Participation in an anonymous on-line survey was invited via university databases. Descriptive statistical analysis of quantitative data used a combination of software and manual methods. Qualitative data were manually coded and categorised into themes through inductive reasoning.

Findings: Most experiences of revalidation were positive. Reflective discussions resulted in mutual learning, particularly if partners were chosen by the registrant. External scrutiny was welcomed. Some registrants questioned involvement of line managers and alignment with performance review, seeking to avoid a ‘tick-box exercise’ and conflicts of interest. University staff felt better prepared and more positive than clinicians. Pre-registration curriculum activities preparing students included writing reflections, maintaining portfolios, practice assessment and discussions about the revalidation process. Midwifery students seemed better prepared than nursing peers. Key themes of ‘Professional values’, ‘Preparation’, ‘Process’ and ‘Purpose’ and a range of positive influences and potential hazards informed development of a conceptual model.

Conclusions: The purpose and process of revalidation is enhanced if confirmation is undertaken by a registered nurse or midwife of the individual's choice. Preparation of students for future revalidation is facilitated by role-modelling of positive attitudes and explicitly linking relevant pre-registration curriculum activities to this process and purpose.

1. Introduction

Following a series of serious failings in clinical care and leadership in the United Kingdom (UK) health sector (National Health Service

England, 2013), a key report recommended that all health professionals undertake revalidation (Francis, 2013). Strengthening of the existing process to reaffirm validity of continued registration was introduced by the Nursing and Midwifery Council in April 2016 (NMC, 2019), but

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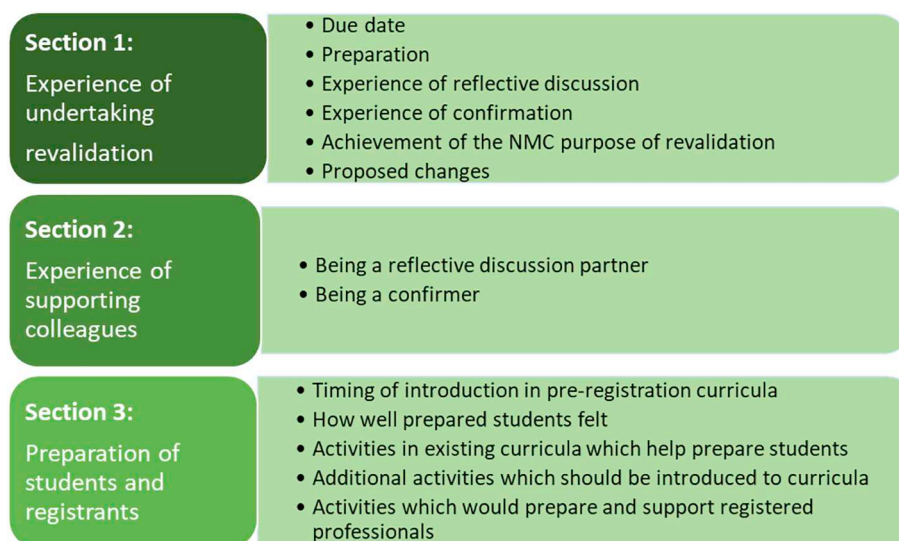


Fig. 1. Survey structure and question topics.

research into this approach to revalidation is currently very limited. The ‘Reality of Revalidation in Practice’ (RRiP) project was instigated in autumn 2017 to explore registrants’ experiences of revalidation and consider preparation of students for this future professional requirement. There will always be a first time for new registrants, but this concept has not yet been considered by the NMC or in the wider literature.

2. Background

Globally, regulators are mandated to protect public safety by ensuring that healthcare professionals are competent to practise at point of registration and beyond, but these approaches vary. Boulet and van Zanten (2014) explain that regulators in Australia, Mexico and the UK accredit individual academic programmes leading to initial professional registration. Entire educational institutions are approved by regulators in most South American and some Asian and African countries. The importance of maintaining competence beyond initial registration has been highlighted by Casey et al. (2017) in an Irish study, and the American Nurses Credentialing Center’s Commission on Accreditation (ANCC, 2012) identified that links between continuing professional development (CPD) and positive patient outcomes in nursing have been demonstrated in several studies. Scales to evaluate competence have been used for senior nurses in Japan (Akamine et al., 2013), and as self-assessment tools to facilitate employment of nurses across European Union countries (Cowan et al., 2007). Regulators are increasingly requiring registrants to maintain entitlement to practise through a formal process of renewal; the usual term being ‘revalidation’, while physicians in Australia and New Zealand and nurses in North America refer to ‘recertification’ or ‘relicensure’ (Merkur et al., 2008; National Council of State Boards of Nursing, 2011). Commonly, evidence of practice hours and continuing learning is required, including educational activities, peer and patient feedback and – particularly in medical professions – some form of assessment (Archer et al., 2018).

Every three years, nurses and midwives in the UK are now required to provide evidence for revalidation. The NMC (2019, p6) seeks to thereby “encourage a culture of sharing, reflection and improvement” which “strengthens public confidence in the nursing and midwifery professions”. Evidence comprises: 450 practice hours (or 900 if registered in both professions), 35 hours of CPD, five sets of feedback relevant to their scope of practice, and five reflective pieces; all of which must be applied to the professional Code. Reflections are discussed with a ‘reflective discussion partner’ (RDP), who must be an NMC registrant. A

‘confirmer’, who does not need to be an NMC registrant and is commonly a line manager, affirms that the evidence presented meets the requirements for revalidation. The RDP and confirmer may be the same person, if NMC registered. On completion, the registrant submits an on-line application to maintain their registration; no original documents are required. The NMC (2019) quality assures the process by sampling applications, and may require further evidence as part of ‘verification’.

Current evidence of the experience and effectiveness of NMC revalidation is limited. Interim findings from the first two years of an external evaluation commissioned by the NMC are predominantly quantitative, comprising a longitudinal survey of 4345 registrants undertaking revalidation (Ipsos, 2017, 2018). Despite being a national evaluation, only 25 telephone interviews of RDPs and confirmers, and 8 case studies have been conducted. Three peer-reviewed publications specifically discussing revalidation have been identified since its implementation in 2016, two of which have emerged since our study was undertaken. One article described preparation of academic staff (Attenborough, 2017), a small study of 10 academics explored the impact of revalidation on professional identity (Attenborough and Abbott, 2018a), and an analytical paper debated registrant versus employer responsibility for CPD (Lanlehin, 2018). All existing literature has found the revalidation process to be generally positive, with reflective elements particularly valued. The potential for a ‘tick-box’ approach has, however, been highlighted. Contribution to the impact on public confidence has been questioned.

The survey presented was conducted by a research team based at a university in southwest England, comprising academic nursing and midwifery staff, a nursing student and the lead of the national evaluation of medical revalidation. The aim was twofold: to explore registrants’ experiences of undertaking or supporting colleagues through revalidation, and to consider preparation of students for this future professional requirement.

3. Methods

A descriptive exploratory approach was adopted, purposefully selecting representation from a wide range of participants in a university and associated clinical settings who would best inform the research aims (Creswell and Poth, 2018). A study undertaken by Gill et al. (2013) found that the on-line platform ‘SurveyMonkey’ proved an efficient method of data collection in health research. The team therefore used this software, dividing the survey into three sections (Fig. 1). Throughout the survey, participants were invited to expand on

Table 1
Profile of participants.

Categorisation	University staff	Clinicians	Pre-registration Students (third year)
Total participants: N = 116	40 (34.5%)	40 (34.5%)	36 (31%)
Nursing registrants: N = 69	33	36	N/A
Midwifery registrants: N = 11	7*	4*	N/A
*Included 4 dual registered participants, with midwifery the main registration under which they were practising: 1 university staff, 3 clinicians			
Nursing registration (pending): N = 31	N/A	N/A	31
Midwifery registration (pending): N = 5	N/A	N/A	5
Respondents to Section 1 (see Fig. 1): N = 44	25	19	N/A
(4.1: Experience of undertaking revalidation)	19 nursing 6 midwifery	16 nursing 3 midwifery	
Respondents to Section 2 (see Fig. 1)			
(4.2: Experience of supporting colleagues)			
N = 20 Reflective discussion partners (RDP)	11	9	[10 – anomaly]
N = 13 Confirmers	8	5	[1 – anomaly]
Respondents to Section 3 (see Fig. 1)			
(4.3: Preparation of students and registrants)	Variable	Variable	Variable
N = variable – see Tables 2, 3, 4, 5			

quantitative responses through free text qualitative comments.

Interactive collaboration to inform research design is recommended by Creswell and Poth (2018). Roundtable discussions at an earlier local stakeholder event therefore informed development of two research tools used in the third section. These comprised check-lists of ‘activities’ relevant to preparation for revalidation. One related to pre-registration nursing and midwifery curricula, such as reflections and portfolios. A modified list focused on the post-qualification context.

Representatives from the stakeholder groups tested functionality and quality of the survey questions in a pilot. At their suggestion, additions were made to the above research tools. Respondents confirmed that the survey was easily completed between 5 and 20 min, and that they were appropriately diverted to relevant sections. All pilot data were excluded from the main survey.

3.1. Participants and ethical considerations

The project was approved by the University Ethics Committee. A convenience sample of participants based at the university included NMC-registered staff and third year students who were undertaking a programme leading to registration as a nurse or midwife. Qualified staff undertaking further studies, alumni and attendees at local revalidation events who had expressed an interest in participating in this research represented clinicians. Prospective participants were accessed via university databases and there were no exclusion criteria. Individuals were only able to complete the survey once. Participation was voluntary; a ‘submit’ button confirmed consent to include data at the end of the survey, but respondents were able to exit at any stage. To ensure anonymity, internet provider addresses were automatically removed at point of entry and password-protected access to original data was limited to the principal investigator. To avoid bias, participant codes were only applied to qualitative data on completion of analysis (e.g.: SM3 = student midwife, RNC4 = registered nurse clinician, RMNU3 = dual registered midwife and nurse university).

3.2. Data collection and analysis

Administrative staff circulated the invitations and survey link via university or work email addresses. This facilitated access to participants, while avoiding researcher bias and maintaining confidentiality. A reminder was circulated a fortnight later. It is not possible to state the response rate as it was unknown how many contacts were still current or duplicated on other lists. Anonymised responses were filtered via the survey software and manually checked on a spreadsheet. Data were cleansed and re-filtered for nine nursing students who identified their

base as a clinical area rather than the university, resulting in initial mis-categorisation as registrants.

Although some comparisons were made within and between categories of participants, correlational tests were not performed as determining statistical significance was not the aim of the study, and the total population was unknown. Descriptive statistical analysis of quantitative data was undertaken; totals are presented as numbers and percentages. Satisfaction and confidence levels were determined through nominal scales. Frequencies of responses in section three were ranked by the researchers.

Thematic analysis examined the patterns in qualitative data which were initially manually coded by individual researchers. Creswell and Poth (2018) advocate structural corroboration to promote reliability of interpretation. Inter-coding and categorisation of themes, through inductive reasoning, were therefore subsequently agreed in a team meeting.

4. Findings

A total of 116 participants responded, comprising 40 university staff, 40 clinicians and 36 pre-registration students. Professional categorisation and total respondents to each section are shown in Table 1. Quantitative and qualitative findings are presented according to the survey sections. Coding is shown in italics; participant quotes are included as examples of qualitative responses.

4.1. Experience of undertaking revalidation

All registrants and final year midwifery students knew when they would need to revalidate, but not all final year nursing students were sure. Of the 80 registrants, 55% (N = 44) had undertaken revalidation and completed this section (see Table 1). Categories comprised 25 university staff, 19 clinicians, 35 nurses and 9 midwives (of whom 3 were also registered nurses). Percentages are calculated according to the sample sizes in each category, unless indicated otherwise.

A trend was noted towards university staff and midwifery registrants feeling better prepared than their clinical and nursing colleagues respectively. Of the 44 registrants, 60% university staff (n = 15), 26.3% clinicians (n = 5), 77.8% midwifery (n = 7) and 37.1% (n = 13) nursing participants stated that they felt ‘very well prepared’. More university participants sought and received support than clinicians (84%, n = 21 versus 52.6%, n = 10); 13 registrants (29.5%) had not accessed this. ‘People’ providing support included line managers, organisational revalidation leads and supervisors of midwifery. Participants also accessed NMC guidance, attended employer

workshops and viewed examples from colleagues (*'learning from others/ experience'*). Challenges included *'time'* to prepare documentation and difficulty in arranging meetings with confirmers.

Of the 44 registrants undertaking revalidation, 35 (79.6%) experienced concurrent reflective and confirmation discussions. A code of *'choice'* was identified; some participants stated that they were able to select their RDPs and confirmers, while others were enforced through *'lack of opportunity'* or local policies. Registrants expressed a preference for individuals who understood the registrant's scope of practice, although five (11.4%) stated that line managers were too busy or had another focus. Some deliberately chose *'trusted'* colleagues with a different perspective or who were external to their place of work, *'appreciating differences'*:

"We knew each other well and it was 'safe'. I knew I could be totally honest. It was also helpful as she was external to my place of work, so there was no hidden agenda."

(RMNU3)

Revalidation could be used as a lever to gain further CPD opportunities and peer feedback was valued. Collegiate reflective discussion was perceived as particularly beneficial; *'learning from others'* through open, honest and frank conversations promoted development:

"It encourages reflection in a more formal and productive manner rather than the more stagnant rumination which has become the default position of many older nurses."

(RNC24)

'Professionalism and accountability' was a frequently recurring code. This included comments about taking the process seriously, selecting evidence reflecting the full range of participants' roles, maintaining a professional focus and enjoying being challenged. A desire for *'governance/scrutiny'* of the process, ensuring an *"equitable and authentic approach"* (RMU4) and avoiding *'inconsistency'* was expressed, and some participants were disappointed that they were not required to submit original evidence to the NMC.

Although all participants expressed satisfaction with the reflective discussion, nominal scales indicated that university staff were often more satisfied than clinicians, with 88% ($n = 22$; $N = 25$) stating they were *'positive'* or *'very positive'* about the experience, compared with 68.4% ($n = 13$; $N = 19$) clinicians. One participant had *"already closed the reflection"* (RNC16), so did not gain further learning, and four (9.1%) expressed concerns about a *'tick-box'* process:

"Just felt it was going through the motions."

(RNU30)

Six (13.6%) participants exercised *'choice'* by holding separate reflective and confirmation discussions. An interested and supportive confirmer who understood and explained the process was considered particularly important. Some participants expressed concerns about potential conflicts of interest:

"I believe that there is a risk that there can be a conflict of interest between an employer being a confirmer particularly in areas where there are staff shortages."

(RMU6)

When all participants who had revalidated ($N = 44$) were asked whether they considered that the NMC purpose had been achieved, responses were mixed; 54.6% ($n = 24$) saying that this had been *'fully achieved'*, 31.8% ($n = 14$) *'partially achieved'* and 13.7% ($n = 6$) *'not achieved'*. There were doubts about the impact of revalidation on public confidence. Negative comparisons were made with midwifery supervision, which was perceived as having been a more valuable process. This statutory requirement included annual reflective discussions and documentation audit, but was discontinued by the regulatory body shortly before our survey took place (NMC, 2017). Concerns about the potential for revalidation to be a *'tick-box'* exercise were again

highlighted. It was, however, suggested that it was *"a step in the right direction"* (RNU5), with potential for positive influences on practice and patient care. The focus on reflective discussion, application of the NMC Code and increased study opportunities were beneficial:

"Because of revalidation there has been a huge increase in availability of study days and learning new information which is beneficial for practice and in turn patient care."

(RNC34)

Thirty-one participants (70.5%; $N = 44$) indicated that they were *'happy with how things went and would not make any changes'* for their next revalidation. Thirteen (29.5%) would, in future, keep up to date with collating evidence, write reflections as they went along and ensure that they chose someone to be their RDP and confirmer with whom they could be totally professionally open. Twenty-three (52.3%) had already made changes to practice, including developing action plans, being more mindful of opportunities to reflect and share experiences with colleagues and actively seeking peer review. These responses were coded as *'professionalism and accountability'*.

4.2. Experience of supporting colleagues

Although 30 participants stated that they had acted as a reflective discussion partner, 10 were pre-registration students; one of whom said they had also been a confirmer. This meant that they erroneously completed this section rather than being redirected, as was intended for students. The student data were excluded and this misconception is discussed in Section 5. Of total registrants ($N = 80$), 20 (25%) had acted as RDPs and 13 (16.3%) as confirmers (see Table 1).

Registrants felt empowered by supporting their colleagues (*'respect/being valued'*). They highlighted the importance of listening carefully and recognising that there was no right or wrong way of approaching reflection, provided that the NMC Code was applied. They valued *'learning from others'*, commenting that reflective discussions promoted mutual learning. They also felt that supporting a colleague with whom they did not normally work facilitated objectivity, and found it beneficial to discover the variety of roles and practice contexts, *'appreciating differences'*:

"It was very interesting to have insight into the experience of my peer, she had the same job role as myself but in a completely different ward environment. We had shared issues and I valued the opportunity to discuss strategies and experiences."

(RNC24)

Participants highlighted good practice in scheduling adequate *'time'* for the meeting and suggested it was helpful to map documentation against the NMC Code in advance. Responses concurred with the NMC (2019) principle that the agenda should be driven by the registrant, with RDPs and confirmers promoting safety and support by being non-judgemental and open, enabling constructive discussion:

"Ensure protected time, ensure agenda is driven by the registrant seeking revalidation, ensure registrant understands the process and why it is in place. The experience must not be just a paper exercise."

(RMU4)

Challenges highlighted by participants included: registrants being reluctant to prepare or leaving this to the last minute, inconsideration regarding other demands, inadequate insight and reflection, inappropriate evidence, failure to follow guidelines and one request for a confirmer to complete the registrant's documentation. Three (15%, $N = 20$) stated that the confirmer should not be a line manager but a respected colleague - noting that confirmation could potentially become a *'tick-box'* exercise if the reflective discussion had been undertaken separately. *'Preparation'*, *'workload'*, *'choice'*, *'respect/being valued'* and *'professionalism and accountability'* were identified as codes.

Table 2
Ranking of existing activities in curricula, according to profession.

Overall ranking	Activity	Overall responses (N = 88)		Nursing responses and ranking (N = 73)		Midwifery responses and ranking (N = 15)	
1	Writing reflections	84	95.5%	1	69 = 94.5%	2	14 = 93.3%
2	Developing reflective thinking skills	83	94.3%	1	69 = 94.5%	2	14 = 93.3%
2	Keeping a portfolio or e-portfolio	83	94.3%	3	68 = 93.2%	1	15 = 100%
4	Gaining feedback from others to contribute to practice assessment	73	82%	4	59 = 80.8%	2	14 = 93.3%
5	Being assessed by others in practice	69	78.4%	4	59 = 80.8%	11	10 = 66.7%
6	Developing a positive approach to lifelong learning	68	77.3%	6	55 = 75.3%	6	13 = 86.7%
7	Developing a professional approach to being assessed by others	67	76.1%	8	53 = 72.6%	2	14 = 93.3%
8	Including service-user feedback in the curriculum	65	73.9%	6	55 = 75.3%	11	10 = 66.7%
8	NMC proficiencies/competencies	65	73.9%	8	53 = 72.6%	7	12 = 80%
10	Learning about evidence-based practice/research	64	72.7%	10	52 = 71.2%	7	12 = 80%
11	Using the NMC Code in classroom sessions	59	67.1%	11	48 = 65.8%	10	11 = 73.3%
12	Undertaking self-assessment formally or informally as part of practice assessment	58	65.9%	12	46 = 63%	7	12 = 80%
13	Role-modelling by/discussion with mentors and others in practice about revalidation	49	55.7%	13	40 = 54.8%	13	9 = 60%
14	Discussion with (student) peers about revalidation	39	44.3%	14	33 = 45.2%	10	6 = 40%
15	Participation in Schwartz Rounds or other structured reflective discussion	36	40.9%	15	27 = 37%	13	9 = 60%
16	A specific taught session/s or workshop about revalidation	33	37.5%	16	26 = 35.6%	16	7 = 46.7%
17	Regular 'drip-feeding' of the importance/process of revalidation during relevant theory sessions	32	36.4%	17	24 = 32.9%	15	8 = 53.3%
18	Other activities (qualitative comments), including:	6	6.8%	18	4 = 5.5%	17	2 = 13.3%

● Familiarisation with NMC web-page
● Clear lectures outlining what revalidation is

4.3. Preparation of students and registrants

All midwifery students ($N = 5$; 100%) felt 'fairly' or 'very well prepared' for their future revalidation. Of 31 nursing students, only 18 (58.1%) responded to this question. Of $N = 18$, none felt 'very well prepared', 13 (72.2%) 'fairly well prepared' and 5 (27.8%) 'not at all prepared'. 'Preparation' included: reading the NMC website, attending a revalidation event or session at university, discussing experiences with registrants and completing portfolios or reflections. Several nursing students commented that revalidation had not been discussed in their course or placements.

Participants were asked to indicate which 'activities' in the existing pre-registration curriculum, from a list of 18, helped prepare students for revalidation (Table 2). A total of 88 responded (75.9%; $N = 116$). Highest ranking was attributed to those 'activities' which contributed to the development of reflective skills, followed by practice assessment. 'Developing a professional approach to being assessed by others' and 'self-assessment' were ranked respectively higher for midwifery than nursing participants. Structured activities were consistently ranked lowest, including 'regular drip-feeding' during theory, 'a specific taught session' and 'structured reflective discussion'. Participants additionally identified familiarisation with the NMC website and clear lectures outlining revalidation.

Participants were next asked to identify from the same list 'What additional activities should be introduced to help pre-registration students prepare for revalidation?' (Table 3). Eighty-seven participants contributed (75%; $N = 116$). Minimal additions were identified by midwifery respondents, but many were selected by nursing participants. Although many 'activities' already existed in curricula, it was suggested that lack of knowledge of the process meant that links were not readily created:

"I believe my degree course has equipped me with the necessary skills to be able to revalidate. I do not know the process of revalidation, if I were more aware of the process I could simply continue the way I have been taught throughout practice. However, this is likely to falter now as I have no clear awareness of the process I should be following." (SN2).

From the list of 'activities' relevant to registrants, participants were

asked to identify those they considered most useful in preparation for revalidation; 100 responded (86.2%; $N = 116$). 'Protected CPD time' was ranked highest, closely followed by 'keeping a portfolio' and 'gaining feedback from others'. Key differences in ranking were noted between midwifery and nursing for 'developing a professional approach to being assessed by others', and 'having a named lead for revalidation' (Table 4).

Table 5 shows that across all categories of participants responding to a question about optimum times to introduce students to revalidation ($N = 107$), the first and final years were identified. While 8 (57.1%; $N = 14$) midwifery participants favoured the first year, 49 (52.7%; $N = 93$) nursing respondents chose the third year; the latter option was particularly popular amongst students of both professions. It was suggested that links with curriculum 'activities' such as reflections, maintaining portfolios and providing feedback to registrants should be highlighted from the start of the programme. 'Preparation' needed to be meaningful, relevant and accurate and the 'purpose' needed to be clear. It was important for students to become familiar with the 'process' and language involved, developing good habits which would be ongoing throughout their careers:

"Ideally this should be student led but they should be revalidation ready on completion of the programme."

(RMU4)

4.4. Thematic analysis

Layering of increasing levels of abstraction through inter-relation of codes and themes, as advocated by Creswell and Poth (2018), was achieved through team discussion. Four key themes were identified. Throughout the survey 'Professional Values' were found to be central to a meaningful experience of revalidation for all stakeholders, comprising codes of 'professionalism and accountability', 'respect/being valued' and 'appreciating differences'. The 'Process' was facilitated through adequate 'Preparation', which included appropriate 'activities' and adequate 'time'. 'Choice' of 'people' supporting the 'Process' enabled 'learning from others/experiences'. This avoided a 'tick-box' exercise and promoted achievement of the 'Purpose' of revalidation. A 'Conceptual

Table 3
Ranking of activities to introduce to curricula, according to profession.

Overall ranking	Activity	Overall responses (N = 87)		Nursing responses and ranking (N = 73)		Midwifery responses and ranking (N = 14)	
1	No additions – all listed in previous question as already included in the curriculum	37	42.5%	1	28 = 38.4%	1	10 = 71.4%
2	A specific taught session/s or workshop about revalidation	28	32.2%	2	27 = 37%	3	1 = 7.1%
3	Role-modelling by/discussion with mentors and others in practice about revalidation	17	19.6%	3	17 = 23.3%	0	0
4	Regular ‘drip-feeding’ of the importance/process of revalidation during relevant theory sessions	14	16.1%	4	14 = 19.2%	0	0
5	Discussion with (student) peers about revalidation	12	13.8%	5	11 = 15.1%	3	1 = 7.1%
6	Developing reflective thinking skills	9	10.3%	6	9 = 12.3%	0	0
7	Other suggestions (qualitative comments), including:	7	8%	13	4 = 5.5%	2	3 = 21.4%
	<ul style="list-style-type: none"> • Mock revalidation exercise/reflective discussions/confirmations eg: in year 3 (X2) • Use of professional websites, CPD activities and journals eg: RCM, RCN • Attending NMC workshops • More discussion in preceptorship period 						
8	Writing reflections	6	6.9%	7	6 = 8.2%	0	0
8	Developing a positive approach to lifelong learning	6	6.9%	9	5 = 6.9%	3	1 = 7.1%
8	Using the NMC Code in classroom sessions	6	6.9%	7	6 = 8.2%	0	0
8	Participation in Schwartz Rounds or other structured reflective discussion	6	6.9%	9	5 = 6.9%	3	1 = 7.1%
12	Gaining feedback from others to contribute to practice assessment	5	5.7%	9	5 = 6.9%	0	0
12	Developing a professional approach to being assessed by others	5	5.7%	9	5 = 6.9%	0	0
12	NMC proficiencies/competencies	5	5.7%	13	4 = 5.5%	3	1 = 7.1%
15	Being assessed by others in practice	4	4.6%	15	3 = 4.1%	3	1 = 7.1%
16	Keeping a portfolio or e-portfolio	3	3.4%	15	3 = 4.1%	0	0
16	Including service-user feedback in the curriculum	3	3.4%	15	3 = 4.1%	0	0
16	Undertaking self-assessment formally or informally as part of practice assessment	3	3.4%	15	3 = 4.1%	0	0
19	Learning about evidence-based practice/research	1	1.1%	19	1 = 0.01%	0	0

Table 4
Ranking of activities which help prepare registrants for revalidation.

Overall ranking	Activity	Overall responses (N = 100)		Nursing responses and ranking (N = 84)		Midwifery responses and ranking (N = 16)	
1	Protected CPD time	79	79%	1	65 = 77.4%	1	14 = 87.5%
2	Keeping a portfolio or e-portfolio	75	75%	2	64 = 76.2%	3	11 = 68.8%
3	Gaining feedback from others to contribute to practice assessment	70	70%	3	58 = 69%	2	12 = 75%
4	Writing reflections	67	67%	5	56 = 66.7%	3	11 = 68.8%
4	Communication about revalidation internally in the organisation	67	67%	4	57 = 67.9%	9	10 = 62.5%
6	Developing reflective thinking skills	66	66%	7	55 = 65.5%	3	11 = 68.8%
7	Developing a positive approach to lifelong learning	63	63%	8	52 = 61.9%	3	11 = 68.8%
8	Discussions with colleagues about revalidation	62	62%	9	51 = 60.7%	3	11 = 68.8%
8	Having a named lead for revalidation in the organisation	62	62%	5	56 = 66.7%	18	6 = 37.5%
10	Preparation sessions for those who wish to act as reflective discussion partners/confirmers	61	61%	9	51 = 60.7%	9	10 = 62.5%
11	NMC provided information (websites/emails)	58	58%	11	49 = 58.3%	13	9 = 56.3%
12	A specific taught session/s or workshop about revalidation	53	53%	12	44 = 52.4%	13	9 = 56.3%
13	Developing a professional approach to being assessed by others	52	52%	13	41 = 48.8%	3	11 = 68.8%
14	‘Open door policy’ to the person who will be the reflective discussion partner/confirmer	51	51%	13	41 = 48.8%	9	10 = 62.5%
15	Learning about evidence-based practice/research	49	49%	13	41 = 48.8%	16	8 = 50%
16	Undertaking self-assessment formally or informally as part of practice assessment	48	48%	16	40 = 47.6%	16	8 = 50%
17	Participation in Schwartz Rounds or other structured reflective discussion	46	46%	17	36 = 42.9%	9	10 = 62.5%
18	Using the NMC Code in classroom sessions (e.g.: post-registration students) or workshops in workplace	45	45%	17	36 = 42.9%	13	9 = 56.3%
19	Other suggestions:	7	7%	19	3 = 3.6%	19	4 = 25%
	<ul style="list-style-type: none"> • ‘Mock’ reflective discussions/confirmations • ‘Champions’ to mentor those who are anxious • Formal integration within more frequent reflective practice sessions • Documents from the same institution available as examples • Protected CPD time • A registrant-centred approach to selecting activities • The NMC to refrain from making revalidation sound so complicated, and easier to upload the information • Development and support of a clinical career pathway 						

Table 5
Suggested timing of introduction to revalidation in pre-registration curricula.

	Nursing (N = 93)	Midwifery (N = 14)	Registrants (N = 73)	Students (N = 34)
First year	36 (38.7%)	8 (57.1%)	36 (49.3%)	8 (23.5%)
Second year	5 (5.4%)	0 (0%)	2 (2.7%)	3 (8.8%)
Third year	49 (52.7%)	6 (42.9%)	34 (46.6%)	21 (61.8%)
After registration	3 (3.2%)	0 (0%)	1 (1.4%)	2 (5.9%)



Fig. 2. Conceptual model of revalidation with professional values at the core.

Model of Revalidation with Professional Values at the Core was developed to visually represent these concepts (Fig. 2). The four main themes were located centrally, with arrows demonstrating their inter-relationship. Codes reflecting positive contributions to revalidation encircled these, coloured green to represent growth. Codes identified as hazardous to the experience of revalidation and its intended purpose were coloured amber and placed on the perimeter of the model.

5. Discussion

Views of NMC revalidation were, overall, positive - confirming findings by Ipsos (2017, 2018) and Attenborough and Abbott (2018a). Similarly, reflective elements and CPD were highly valued. The opportunity to share experiences with fellow registrants was identified as a particular strength of the process. The responsibility of employers to support registrants in maintaining their competence through CPD reiterated recommendations by ANCC (2012), Casey et al. (2017) and Lanlehin (2018).

A desire for external perspectives was evident in our study. Ipsos (2017, 2018) highlighted similar demand for credibility, transparency and regular verification by the NMC. In contrast, some registrants failed to engage sufficiently with the revalidation process and attempts at manipulation were likewise reported by Attenborough and Abbott (2018a). Some unfavourable comparisons were made with what was perceived as the more authentic and credible scrutiny of midwifery supervision, in which, prior to its dissolution a year after revalidation was introduced, annual reviews had been mandatory (NMC, 2017).

In the period April 2017 to March 2018, the NMC (2018) reported that 68.7% confirmations were undertaken by an NMC-registered line

manager, 27% by an NMC registrant who was not the line manager, 3.5% by a non-registrant line manager and 0.8% by 'others'. The NMC (2019) currently recommends that confirmation is undertaken by line managers and aligned with appraisal. Our study, the national evaluation of medical revalidation (Archer et al., 2018) and Ipsos (2017, 2018) have, however, identified tensions in this approach. It can result in conflicts of interest, disparate agendas and a 'tick-box' process, in which the professional focus may not be central. Participants in our survey highlighted the benefits of incorporating the reflective discussion and confirmation in one meeting with a registrant of their choice; facilitating collegiate learning and maintaining the focus, while optimising resources. This is, however, only possible when the confirmer is also an NMC registrant. We therefore recommend that the latter should become mandatory, with employers supporting the revalidating nurse or midwife's choice of colleague.

Exploration of the student perspective and activities which promote preparation for, and engagement in, the revalidation process has addressed a gap in the literature. The anomaly of some nursing students incorrectly identifying that they had fulfilled the roles of 'reflective discussion partners' or 'confirmers' - suggesting misunderstanding of terminology - was of concern, as was the high proportion who did not know when they would first need to revalidate. Midwifery students seemed more prepared than nursing peers, although a lower response rate to this question from the latter limits interpretation. Attenborough and Abbott (2018b) explored perceptions of professional identity through semi-structured interviews of five nursing and midwifery students in another university, including a question about their knowledge of revalidation. All were able to explain the process, although some did not realise that educator roles fulfilled NMC practice requirements. These gaps in knowledge emphasise the importance of 'professional socialisation', which is facilitated through leadership of more experienced practitioners (Frankel, 2008). We therefore recommend that registrants in academic and clinical settings should role-model positive attitudes and encourage discussion about revalidation. Introduction in the first year and more focused preparation in the final year of pre-registration programmes is recommended. The links between revalidation and curriculum components which promote reflective scrutiny and continued learning need to be made explicit. Our conceptual model may contribute to understanding that the purpose extends beyond achievement of pre-registration programme requirements into future professional careers.

A number of limitations in this study restrict generalisability, although strengths are also evident. Researchers were based at one university, and participants were recruited from the same site and its associated clinical placements. Efforts were made to reduce bias by ensuring anonymity and triangulating independent data analysis. Collaboration with stakeholders and the team approach enhanced authenticity of research design and interpretation (Creswell and Poth, 2018). Differences in quantitative findings between academic and clinical settings need to be interpreted with caution as proportionate representation of clinicians was much lower. The smaller numbers of midwifery participants also had greater impact when comparing professions (Faber and Fonseca, 2014). Although findings from open questions in a survey have limitations, qualitative responses from 80 registrants have contributed to the body of knowledge around NMC revalidation which is currently primarily quantitative (Ipsos, 2018). The research team intends to undertake a second phase of the RRiP project to explore some of the findings in more depth through focus groups, including the reasons some registrants select an external RDP or confirmer. It is also recommended that qualitative research at national level is undertaken to compare experiences between professions and places of employment.

6. Conclusions

Findings from this survey corroborate many of those in the existing

literature and add new insights by considering pre-registration preparation for revalidation. A model for a meaningful continuum of engagement from the pre-registration period through to professional careers has been developed. Essential to revalidation's success is an appreciation of the professional purpose of the process, valuing of individuals and awareness of potentially compromising factors. These principles may transcend international boundaries when considering maintenance of professional registration and competence.

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Ethical approval

University Faculty Research Ethics Committee ref no: 16/17-758.

Declaration of Competing Interest

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CHAPTER 3: EVIDENCE OF CONTRIBUTION

3.1 Role in collaborative works

WORK 1: 'Assessment in practice' project (November 2005 – November 2010)

- I led a multi-professional team of academics, clinicians, students and service users representing midwifery, post-registration emergency care (paramedics and nursing) and social work at the University of Plymouth, exploring pre-registration practice assessment.
- I led all dissemination activities, including interim reports, publications of the book chapter presented and a book commissioned by the publishers, numerous national and international conference presentations and development of additional resources.
- Substantive contribution to Work 1 = **80%**

WORK 2: Pilot practice portfolio (April 2008 – July 2009)

- I led a small team of midwifery academics and clinicians in the evaluation of a pilot electronic portfolio which I had developed in partnership with a technologist at the University of Plymouth.
- I led wider dissemination of the findings, including publication of the paper presented and conference presentations, with contributions from colleagues and a midwifery student.
- Substantive contribution to Work 2 = **90%**

WORK 3: 'Assessment of practice' chapter (February 2013 – December 2015)

- I co-edited a book on midwifery placements with a colleague from another university. Chapter authors included midwifery academics and clinicians from the Universities of Plymouth and Bournemouth and students contributed to each chapter. The chapter included in the thesis is one of three I authored.

- I was sole author of the work presented, but invited contributions from students to the 'vignettes', 'top tips' and illustrations.
- Substantive contribution to Work 3 = **100%**

WORKS 4-7: 'Grading of practice in pre-registration midwifery' project
(March 2013 to April 2019)

- I led a team of six senior midwifery academics from a range of universities, representing the 55 Lead Midwives for Education in the United Kingdom (LME-UK Executive), with whom we collaborated throughout the project.
- I led on all publications including those presented, with the exception of Work 7, for which I was second author having delegated this to another team member while I compiled the refined evidence-based toolkit.
- I led wider dissemination of the findings, including numerous national and international conference presentations in a team approach. I alerted the professional body to the various publications. I created an open access project website, hosted on the University of Plymouth extranet, comprising all research outputs.
- Substantive contribution to Work 4 = **70%**
- Substantive contribution to Work 5 = **80%**
- Substantive contribution to Work 6 = **85%**
- Substantive contribution to Work 7 = **35%**

WORK 8: Peer mentoring article (November 2017 – March 2018)

- This work was drawn from my experiences as lead for a pre-registration module on mentorship from 2015 – 2018 at the University of Plymouth.
- I invited a colleague to contribute a small proportion of the article as she had supported me in accessing peer mentoring opportunities for midwifery students.
- Substantive contribution to Work 8 = **95%**

WORK 9: 'Reality of Revalidation in Practice' (RRiP) project (November 2016 – July 2019)

- I led a team of eight nursing, midwifery and medical academics and a mental health nursing student at the University of Plymouth in a survey exploring registrant experiences and the preparation of students for the new nursing and midwifery revalidation process.
- I led on publication of the work presented.
- I led wider dissemination of the findings, including national and international conference presentations. I alerted the professional body to the published work and created an open access project website, hosted on the University of Plymouth extranet.
- Substantive contribution to Work 9 = **95%**

3.2 Declarations from co-authors

Declaration from co-author: Contribution to publication (WORK 1)

Dear Tracey,

I am in the process of compiling my research portfolio for Doctor of Philosophy on the Basis of Prior Published Works. The title is: “*Engaging, enabling and embedding professionalism through scrutiny of practice in healthcare*”. The below co-authored paper is a part of my portfolio. Can you please confirm that for the following publication my contribution was **80%**:

Fisher, M., Proctor-Childs, T., Callaghan, L., Stone, A., Snell, K. and Craig, L. (2011) ‘Assessment of Professional Practice: Perceptions and Principles’, in Wergers, C.E. (ed.) *Nursing Students and their Concerns*. Hauppauge, New York: Nova Science Publishers, pp1-36. Available at:
http://www.novapublishers.org/catalog/product_info.php?products_id=22965

Many thanks and kind regards,

Margaret

Please insert your signature below:

A handwritten signature in black ink, appearing to read 'Tracey Proctor-Childs', is written over a light blue horizontal line.

Tracey Proctor-Childs, second author

**Declaration from co-author: Contribution to publication
(WORK 2)**

Dear Alison,

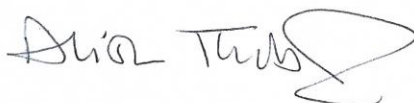
I am in the process of compiling my research portfolio for Doctor of Philosophy on the Basis of Prior Published Works. The title is: "*Engaging, enabling and embedding professionalism through scrutiny of practice in healthcare*". The below co-authored paper is a part of my portfolio. Can you please confirm that for the following publication my contribution was **90%**:

Fisher, M., Thoburn, A., Arkinstall, T., Proctor-Childs, T., 2009. 'A Blended Approach to Evidence Learning in Professional Practice'. In: Salajan, F. (ed) *Proceedings of the 4th International Conference on e-Learning*. Reading: Academic Publishing Limited, p114-120.

Many thanks and kind regards,

Margaret

Please insert your signature below:

A handwritten signature in black ink, appearing to read 'Alison Thoburn', with a stylized flourish at the end.

Alison Thoburn, second author

Declaration from co-author: Contribution to publication (WORK 4)

Dear Sam,

I am in the process of compiling my research portfolio for Doctor of Philosophy on the Basis of Prior Published Works. The title is: “*Engaging, enabling and embedding professionalism through scrutiny of practice in healthcare*”. The below co-authored paper is a part of my portfolio. Can you please confirm that for the following publication my contribution was **70%**:

Fisher, M., Bower, H., Chenery-Morris, S., Jackson, J. and Way, S. (2017a) ‘A scoping study to explore the application and impact of grading practice in pre-registration midwifery programmes across the United Kingdom’, *Nurse Education in Practice*, 24 (May), pp99-105.

<https://doi.org/10.1016/j.nepr.2016.01.007>

Many thanks and kind regards,

Margaret

Please insert your signature below:

A handwritten signature in cursive script that reads "S. Chenery-Morris". The signature is written in dark ink on a light-colored background.

Dr Samantha Chenery-Morris, co-author

Declaration from co-author: Contribution to publication (WORK 5)

Dear Sue,

I am in the process of compiling my research portfolio for Doctor of Philosophy on the Basis of Prior Published Works. The title is: "*Engaging, enabling and embedding professionalism through scrutiny of practice in healthcare*". The below co-authored paper is a part of my portfolio. Can you please confirm that for the following publication my contribution was **80%**:

Fisher, M., Way S., Chenery-Morris, S., Jackson, J. and Bower, H. (2017b) 'Core principles to reduce current variations that exist in grading of midwifery practice in the United Kingdom', *Nurse Education in Practice*, 3 (March), pp54-60. <http://dx.doi.org/10.1016/j.nepr.2017.02.006>

Many thanks and kind regards,

Margaret

Please insert your signature below:

A handwritten signature in black ink, appearing to read 'Susan Way', with a horizontal line extending to the right.

Professor Susan Way, second author

Declaration from co-author: Contribution to publication (WORK 6)

Dear Sam,

I am in the process of compiling my research portfolio for Doctor of Philosophy on the Basis of Prior Published Works. The title is: “*Engaging, enabling and embedding professionalism through scrutiny of practice in healthcare*”. The below co-authored paper is a part of my portfolio. Can you please confirm that for the following publication my contribution was **85%**:

Fisher, M., Bower, H., Chenery-Morris, S., Galloway, F. Jackson, J., Way, S. and Fisher, M.M. (2019a) ‘National survey: Developing a common approach to grading of practice in pre-registration midwifery’, *Nurse Education in Practice*, 34, pp150-160. <https://doi.org/10.1016/j.nepr.2018.11.014>

Many thanks and kind regards,

Margaret

Please insert your signature below:

A handwritten signature in cursive script that reads "S. Chenery-Morris". The signature is written in dark ink on a light-colored background.

Dr Samantha Chenery-Morris, co-author

Declaration from co-author: Contribution to publication (WORK 7)

Dear Sue,

I am in the process of compiling my research portfolio for Doctor of Philosophy on the Basis of Prior Published Works. The title is: “*Engaging, enabling and embedding professionalism through scrutiny of practice in healthcare*”. The below co-authored paper is a part of my portfolio. Can you please confirm that for the following publication my contribution was **35%**:

Way, S., **Fisher, M.** and Chenery-Morris, S. (2019) ‘An evidence-based toolkit to support grading of pre-registration midwifery practice’, *British Journal of Midwifery*, 27(4), pp251-257. <https://doi.org/10.12968/bjom.2019.27.4.251>

Many thanks and kind regards,

Margaret

Please insert your signature below:

A handwritten signature in black ink, appearing to read 'Susan Way', with a horizontal line extending to the right.

Professor Susan Way, lead author

Declaration from co-author: Contribution to publication (WORK 8)

Dear Rachel,

I am in the process of compiling my research portfolio for Doctor of Philosophy on the Basis of Prior Published Works. The title is: “*Engaging, enabling and embedding professionalism through scrutiny of practice in healthcare*”. The below co-authored paper is a part of my portfolio. Can you please confirm that for the following publication my contribution was **95%**:

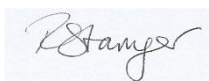
Fisher, M. and Stanyer, R. (2018) ‘Peer mentoring: Enhancing the transition from student to professional’, *Midwifery*, 60 (May), pp56-59.

<https://doi.org/10.1016/j.midw.2018.02.004>

Many thanks and kind regards,

Margaret

Please insert your signature below:

A handwritten signature in cursive script, appearing to read 'R Stanyer', on a light blue background.

Rachel Stanyer, second author

Declaration from co-author: Contribution to publication (WORK 9)

Dear Jenny,

I am in the process of compiling my research portfolio for Doctor of Philosophy on the Basis of Prior Published Works. The title is: “*Engaging, enabling and embedding professionalism through scrutiny of practice in healthcare*”. The below co-authored paper is a part of my portfolio. Can you please confirm that for the following publication my contribution was **95%**:

Fisher, M., Child, J., Williamson, G., Pearce, S., Archer, J., Smethurst, Z-L., Wenman, S. and Griffith, J. (2019b) ‘The ‘Reality of Revalidation in Practice’ (RRiP) project – Experiences of registrants and preparation of students in nursing and midwifery in the United Kingdom: A descriptive exploratory survey’, *Nurse Education Today*, 82, pp21-28. <https://doi.org/10.1016/j.nedt.2019.07.001>

Many thanks and kind regards,

Margaret

Please insert your signature below:

A handwritten signature in black ink, appearing to read 'J. Child', written on a light blue grid background.

Dr Jenny Child, second author

3.3 Publications not included in thesis

Candidate's other publications not presented as the body of work (most recent first):

Fisher, M., Bower, H., Chenery-Morris, S., Galloway, F., Jackson, J. and Way, S. (2019c) *Practice Assessment Toolkit*. National 'Grading of Practice in Pre-registration Midwifery' Project. Available at: <https://www.plymouth.ac.uk/research/national-grading-of-practice-in-pre-registration-midwifery-project> (Accessed: 3rd September 2020).

Fisher, M., Bower, H., Chenery-Morris, S., Galloway, F., Jackson, J., Way, S. and Fisher, M.M. (2018a) *National Grading of Practice in Pre-registration Midwifery Project: Report on final phase on-line survey (Phase 3)*. United Kingdom: LME-UK Executive. Available at: <https://www.plymouth.ac.uk/research/national-grading-of-practice-in-pre-registration-midwifery-project> (Accessed: 4th October 2020).

Fisher, M., Archer, J., Child, J., Clarke, R., Griffith, J., Pearce, S., Smethurst, Z., Wenman, S. and Williamson, G. (2018b) *The Reality of Revalidation in Practice (RRiP) Project: Phase One Report*. Plymouth: University of Plymouth. Available at: <https://www.plymouth.ac.uk/research/reality-of-revalidation-in-practice> (Accessed: 4th October 2020).

Fisher, M. (2016) 'High-risk midwifery placements', in Cescutti-Butler, L. and **Fisher, M.** (eds.) *The Hands-on Guide to Midwifery Placements*. Chichester: John Wiley & Sons Ltd, pp103-131. Available at: <https://pearl.plymouth.ac.uk/handle/10026.1/6548> (Accessed: 3rd September 2020).

Fisher, M. (2016) 'Wider experiences', in Cescutti-Butler, L. and **Fisher, M.** (eds.) *The Hands-on Guide to Midwifery Placements*. Chichester: John Wiley & Sons Ltd, pp151-173. Available at: <https://pearl.plymouth.ac.uk/handle/10026.1/6549> (Accessed: 3rd September 2020).

Fisher, M. (2014) *Mother Initiative Tutorial: Normal labor: The first stage*. The Global Library of Women's Medicine. Available at: http://www.glowm.com/resource_type/resource/tutorials/title/normal-vaginal-delivery---stage-1/resource_doc/1665 (Accessed: 3rd September 2020).

James, A. and **Fisher, M.** (2014) *Mother Initiative Tutorial: Normal labor: The second stage*. The Global Library of Women's Medicine. Available at: http://www.glowm.com/resource_type/resource/tutorials/title/normal-vaginal-delivery---stage-2/resource_doc/1675 (Accessed: 3rd September 2020).

James, A., and **Fisher, M.** (2014) 'Mother Initiative Tutorial: Normal labor: The third stage'. *The Global Library of Women's Medicine*. Available at: http://www.glowm.com/resource_type/resource/tutorials/title/normal-vaginal-delivery---stage-3/resource_doc/1685 (Accessed: 3rd September 2020).

Wade, M. and **Fisher, M.** (2013) *Principles of Practice Assessment*. Available at: https://xerte.plymouth.ac.uk/xerte/play.php?template_id=190 (Accessed: 3rd September 2020).

Fisher, M., Proctor-Childs, T., Callaghan, L., Stone, A., Snell, K. and Craig, L. (2011) *Assessment of Professional Practice: Perceptions and Principles*. New York: Nova Science Publishers.

The Ceppl Assessment of Practice Team (2011) *Top Tips For Students: Your journey through Practice Assessment/ Top Tips For Staff: Guiding your student through their Practice Assessment Journey*. Plymouth: University of Plymouth Faculty of Health. Available at:

https://www.plymouth.ac.uk/uploads/production/document/path/8/8314/CEPPL_practice_assessment_tips_for_Students_and_mentors.pdf (Accessed: 3rd September 2020).

Whitworth, M., **Fisher, M.** and Heazell, A. (2011) *Green-top Guideline 57: Reduced Fetal Movements*. London: Royal College of Obstetricians and Gynaecologists. Available at: https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_57.pdf (Accessed: 3rd September 2020).

Fisher, M. (2009) 'How can midwifery sign-off mentors be supported in their role? An evidence-based discussion of the challenges facing clinicians, managers and academics'. *MIDIRS Midwifery Digest*, 19(3), pp319-324. Available at: <https://insights.ovid.com/midirs-midwifery-digest/mmwd/2009/09/030/midwifery-sign-off-mentors-supported-role-evidence/3/00115386> (Accessed: 2nd September 2020).

Fisher, M. and Webb, C. (2009) 'What do midwifery mentors need? Priorities and impact of experience and qualification', *Learning in Health and Social Care*, 8(1), pp33-46. <https://doi.org/10.1111/j.1473-6861.2008.00193.x>.

Fisher, M. and Moore, S. (2005) 'Enquiry-based learning links psychology theory to practice', *British Journal of Midwifery*, 13(3), pp148-152.

Fisher, M.L. (1999) 'Fetal activity and maternal monitoring methods', *British Journal of Midwifery*, 7(11), pp705-710.

Fisher, M.L. (1999) 'Reduced fetal movements: a research-based project', *British Journal of Midwifery*, 7(12), pp733-737.

Conference presentations relevant to programme of research (most recent first):

1. **Fisher, M.**, Bower, H., Chenery-Morris, S., Galloway, F., Jackson, J. and Way, S. (2021) 'Developing an evidence-based toolkit to support practice assessment in midwifery' [oral presentation], *32nd ICM Triennial Congress [International Confederation of Midwives]*. Bali, Indonesia, 1/6/2021 (postponed from 21-25/6/2020) [abstract accepted].
2. Way, S., **Fisher, M.**, Chenery-Morris, S., Galloway, F., Bower, H. and Jackson, J. (2019) 'Developing A Set Of Key Principles To Achieve Consistency In Assessing Pre-registration Midwifery Competence In Practice In The UK' [oral presentation], *EMA 2019 (European Midwives Association Conference)*. Malmo, Sweden, 29-30/11/2019.
3. **Fisher, M.**, Galloway, F. and Jackson, J. (2019) 'Introducing an evidence-based *'Practice Assessment Toolkit'*: Enhancing consistency and rigour of practice assessment in midwifery and nursing' [theme paper presentation], *2019 NET Conference*. Keele University, 3-5/9/2019.
4. **Fisher, M.** (2019) 'Promoting workforce sustainability: Embedding a culture of positive attitudes to lifelong learning and professional scrutiny' [theme paper presentation], *Research Festival: Workforce sustainability in health professions*. University of Plymouth, 24/1/2019.
5. **Fisher, M.**, Child, J. and Clarke, R. (2018) 'A pedagogical framework to embed a culture of professional values and growth in nurses and midwives' [theme paper presentation], *2018 NET Conference*. Cambridge, 4-6/9/2018.
6. **Fisher, M.** (2018) 'Embedding a culture of professional values into the continuum of revalidation' [workshop], *Research Festival: Shaping Cultures*. University of Plymouth, 25/1/2018.

7. **Fisher, M.** (2018) 'The RRIp project: 'The Reality of Revalidation in Practice' [seminar], *Research Festival: Shaping Cultures*. University of Plymouth, 25/1/2018.
8. **Fisher, M.** and Nelmes, P. (2017) 'One year on: Plymouth University and NMC progress' [oral presentation], *Revalidation Seminar @Plymouth University*. University of Plymouth, 7/6/2017.
9. **Fisher, M.** and Way, S. (2016) 'Grading Practice: A common framework to aid consistency and parity across midwifery education programmes in the United Kingdom' [theme paper presentation], *5th EMA [European Midwives Association] Education Conference*. The Queen Elizabeth II Centre, London, 2-3/12/2016.
10. **Fisher, M.** (2016) 'Setting the Scene: NMC Revalidation Purpose and Process' [oral presentation], *Plymouth University Revalidation Conference*. Plymouth, 20/4/2016.
11. Bower, H., **Fisher, M.**, Jackson, J. and Chenery-Morris, S. (2014) 'Grading practice in midwifery education: developing autonomous midwives for the future' [theme paper presentation], *International Confederation of Midwives 30th Triennial Conference*. Prague, Czech Republic, 4/6/2014.
12. **Fisher, M.**, Mutton, L. and Callaghan, L. (2010) 'Growing Professionals: Positives and Pitfalls of Assessing Practice' [workshop], *Ceppl Transforming Learners, Transforming Lives Conference 2010*. Plymouth, 14/4/2010.
13. **Fisher, M.** and Thoburn, A. (2009) 'A blended approach to evidence learning in professional practice' [theme paper presentation], *4th International Conference on E-learning*. Toronto, Canada, 16-17/7/2009.
14. **Fisher, M.** and Stone, A. (2008) 'Applying the evidence: portfolio assessment in midwifery' [theme paper presentation], *9th Annual Interdisciplinary Research Conference*, Dublin, 5-7/11/2008.
15. **Fisher, M.** (2008) 'Midwifery e-portfolio' [oral presentation], *Plymouth University E-portfolio Showcase Event*. Plymouth, 29/9/2008.
16. **Fisher, M.** (2008) 'How do we measure student achievement during placements?' [invited speaker], *2nd Conference of the DIETS Thematic Network*. Frankfurt, Germany, 26/9/2008.
17. **Fisher, M.** and Proctor-Childs, T. (2008) 'How reliable is the assessment of practice, and what is its purpose?' [round-table discussion], *IQB-EARLI/Northumbria Assessment Conference*. Berlin, Germany, 27-29/8/2008.
18. **Fisher, M.**, Arkininstall, T. and Carson, M. (2008) 'Creating the links: The Midwifery e-portfolio' [oral presentation], *VC Teaching and Learning Conference*. Plymouth, 4/7/2008.
19. **Fisher, M.** (2008) 'The Midwifery e-portfolio' [oral presentation], *NMC Education Roadshow*. London, 13/5/2008.
20. **Fisher, M.** and Proctor-Childs, T. (2007) 'Students' experience of the process of practice assessment; a multi-professional case study from Social Work, Midwifery and Emergency Care' [theme paper presentation], *NET2007 Conference*. Cambridge, 4-6/9/2007.

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- Amazon (2020) 'Customer reviews: The Hands-on Guide to Midwifery Placements (Hands-on Guides)'. *amazon.co.uk*. Available at: <https://www.amazon.co.uk/Hands-Guide-Midwifery-Placements-Guides/dp/111871251X> (Accessed: 28th September 2020).
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- Argyrous, G. (2007) 'Statistical Methods for Health Data Analysis' in Saks, M. and Allsop, J. (eds.) *Researching Health: Qualitative, Quantitative and Mixed Methods*. London: SAGE Publications Ltd, pp197-222.
- Aston, L. and Molassiotis, A. (2003) 'Supervising and supporting student nurses in clinical placements: the peer support initiative', *Nurse Education Today*, 23(3), pp202-210. [https://doi.org/10.1016/S0260-6917\(02\)00215-0](https://doi.org/10.1016/S0260-6917(02)00215-0).
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- Attenborough, J. and Abbott, S. (2018a) 'The impact of Nursing and Midwifery Council revalidation on the professional identity of academic staff in a higher education institution: A qualitative study', *Nursing Open*, pp1-9. DOI: 10.1002/nop2.224.
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- Bachan, R. (2017) 'Grade inflation in UK higher education', *Studies in Higher Education*, 42(8), pp1580-1600. <https://doi.org/10.1080/03075079.2015.1019450>.
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<https://pubmed.ncbi.nlm.nih.gov/19791676/>.
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<https://doi.org/10.1016/j.colegn.2015.08.002>.
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APPENDICES

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APPENDIX 1: Amazon customer reviews (Screenshot 28/9/20)

amazon.co.uk/Hands-Guide-Midwifery-Placements-Guides/dp/111871251X

Apps Occ health portal Room bookings Handbook Teachin... Student regulations... Student Handbook... Employee Self-Serv... Health and Wellbei... Work at home

Customer reviews

★★★★★ 5 out of 5

2 global ratings


5 star	100%
4 star	0%
3 star	0%
2 star	0%
1 star	0%

How are ratings calculated?

Review this product

Share your thoughts with other customers

Write a customer review



Top reviews from United Kingdom

clare morris

★★★★★ **Perfect pocket guide to dip in and out of - realistic and packed with good advice for any stage of your programme.**

Reviewed in the United Kingdom on 31 December 2015

Verified Purchase

This pocket guide is a really great little book for student midwives to dip in and out of at any stage on the programme, whether you're a first year just about to start your first placement, a second year struggling to maintain your enthusiasm or a third year preparing to apply for jobs. Beautifully presented and clearly written, it really is very easy reading and provides a realistic overview of what students can expect on placement and how to seek support. Some of the in the content is covered by university curriculum but with the fast pace of the course and the amount of information to absorb, it is easy to 'forget' the advice so this book is an ideal go-to book to seek answers and advice. The inclusion of various vignettes from current students and newly qualified midwives are particularly reassuring and encouraging as it can become too easy to lose sight of the ultimate goal of becoming a safe and competent midwife and get caught up in the demands and, at times, anxieties of the course. I'd highly recommend this book, it's worth every penny.

4 people found this helpful

Helpful Comment Report abuse

Miss Faye Doris

★★★★★ **Midwifery placements text**

Reviewed in the United Kingdom on 24 January 2017

Verified Purchase

An excellent publication which was easy to purchase via Amazon

Helpful Comment Report abuse

Type here to search

21:29 28/09/2020

APPENDIX 2: LME testimonial (Shared with permission)



8th September 2020

RE: Testimonial in relation to research undertaken by Margaret Fisher

Margaret Fisher's research exploring grading of practice in programmes leading to registration as a midwife in the UK has provided a set of nationally applicable principles for assessing practice across a wide range of health care programmes. The development and evaluation of different assessment tools (in the practice assessment toolkit) has particularly supported academic and clinical team members and demonstrated reliability in student assessment methods. This work has informed the development of current national NMC standards for student assessment and been taken up nationally by other HEI's offering midwifery programmes.

On a local level Margaret Fisher has made a significant contribution to the team, taking the lead on issues related to clinical placements specifically in relation to grading in practice, enabling smooth and efficient implementation of new NMC standards for student supervision and assessment (SSSA), and effective development of an electronic on-going achievement record for midwifery students.

On a national level Margaret Fisher has been a key member of the group developing a national tool to standardise midwifery practice assessment; her input has been evidence-based due to her research into this area. During the COVID emergency period, the practice assessment toolkit she developed has been particularly beneficial and used by other HEI's nationally, since NMC emergency standards required implementation of SSSA in all areas; in some cases with very little "lead-in" time.

Margaret Fisher has made significant contributions to organisational decisions as a result of her research, depth of knowledge and experience. Most recently this has been in relation to programme development in view of updated NMC standards for pre-registration midwifery programmes and NMC standards of proficiency for midwives.

Heather Hopper
Lead Midwife for Education
University of Plymouth
Contact details: heather.hopper@plymouth.ac.uk

APPENDIX 3: MORA project lead testimonial (Shared with permission)

From: Gillman, Lindsay <L.Gillman@sgul.kingston.ac.uk>

Sent: 23 September 2020 14:34

To: Margaret Fisher <M.Fisher@plymouth.ac.uk>

Subject: Re: Testimonial re Practice Assessment Toolkit

Dear Margaret

Thank you for your email. I am very happy to provide evidence of both your contribution to the Midwifery Practice Assessment Collaboration (MPAC) and to acknowledge the impact of the work of the LME Executive project 'Grading of Practice in pre-registration midwifery', in informing the Midwifery Pan London Practice Education Advisory Group decisions regarding the original practice assessment strategy.

I can also confirm that you have taken an active part in the national Midwifery Practice Assessment Collaboration (MPAC) since its inception in July 2019 and that your expertise in midwifery practice assessment has informed the group discussions and final assessment strategy decisions. In particular, your contribution to the design of the practice assessment rubrics in the Midwifery Ongoing Record of Achievement (MORA) has been invaluable.

To whom it may concern: I am happy for this communication to be used as evidence towards Margaret's PhD and/or Impact Case Study, together with my name and details of the organisation

Please do let me know if I can provide any further information.

Kind regards

Lindsay

Lindsay Gillman

Midwifery Pan London Project Officer

Associate Professor

Department of Midwifery

Kingston and St George's Joint Faculty of Health and Social Care

KHKH0007 Kenry House

Kingston University

Kingston Hill Campus

Kingston upon Thames

Surrey

KT2 7LB

Email: l.gillman@sgul.kingston.ac.uk

APPENDIX 4: Letter from NMC (Names removed to maintain confidentiality)

From: XX @nmc-uk.org>

Sent: 30 January 2019 11:19

To: Margaret Fisher <M.Fisher@plymouth.ac.uk>

Subject: recent publication in Nursing Education in Practice

Dear Margaret,

Please see attached a response from XX (Director of Education and Standards) at the Nursing and Midwifery Council re your recent publication in Nursing Education in Practice.

Many thanks,

XX

EA to XX, Director of Education and Standards
Education and Standards Directorate



Nursing and Midwifery Council
23 Portland Place
London W1B 1PZ
www.nmc-uk.org

020 7333 9333 (switchboard)

30 January 2019

Dear Margaret

Thank you for notifying us of your recent publication in Nursing Education in Practice entitled 'National Survey: Developing a common approach to grading in practice in pre-registration midwifery'. Congratulations on this piece of work and the subsequent publications.

As you will be aware, NMC midwifery education standards are moving towards becoming outcome-focussed, and this will give the flexibility to enable AEs to be more innovative in their approach to programme design and assessment. Additionally, we welcome collaborative approaches to midwifery programmes that are evidence-based and promote quality and robustness.

We look forward to your feedback on the draft midwifery standards of proficiency and programme standards in the forthcoming consultation, which commences on the 12 February 2019.

Please pass on our congratulations to all who have contributed to this work.

Yours sincerely

XX

APPENDIX 5: LME response to NMC 'Future Midwife' consultation

(Names removed to maintain confidentiality of individuals. Please note that the yellow highlights were in the original email.)

From: NMC Lead Midwife for Education Discussion Group <NMC-LMESRG@JISCMail.AC.UK>
on behalf of XX@CARDIFF.AC.UK>

Sent: 08 April 2019 13:05

To: NMC-LMESRG@JISCMail.AC.UK

Subject: From XX - useful information

Dear all

Please scroll down: really useful information on LME role that is important for responding to NMC Future Midwife consultation.

Many thanks to XX for sending this to the group. She collated this for the CoDH Future Midwife paper (but it was not used effectively in that paper!).

We can use it in our responses.

Kind regards / Cofion gorau

XX

From: XX@manchester.ac.uk]

Sent: 03 April 2019 13:02

To: XX@cardiff.ac.uk>

Subject: FW: Work on Future Midwife Paper - see some stuff that may be useful below

Hi XX

I remembered some stuff I sent to CoDH re LME role (see below) - it was never included but this may help as a start to develop the argument for retaining / strengthening the role in the future. See below. I will do some more work on this and keep in touch.

BW

XX

[Name removed for confidentiality]

Reader in Midwifery

NMC Lead Midwife for Education

The University of Manchester

XX section on the LME from last week is excellent and I think the section on consistency can be strengthened using Fisher et al's work on grading in practice.

The LME role is unique to health care professionals in the UK and provides opportunity for review of midwifery education across the 4 countries of the UK. Fisher et al's (2017 a,b) research provides a comprehensive and national review of the processes used in grading in practice in midwifery programmes across the UK. This study provides an excellent example of the unique role of the LME network, and how this role can be used to provide parity, and reliability, in the implementation of professional standards (Fisher et al 2017a, b). This example illustrates the potential of the LME role in critically reviewing midwifery education, and enhancing consistency in the future development of the midwifery profession,

The references are :

Fisher M Way S Chenery-Morris S Jackson J Bower H (2017a) Core principles to reduce current variations that exist in grading of midwifery practice in the United Kingdom. Nurse Education in Practice. 23,54-60.

Fisher M Bower H Chenery-Morris S Jackson J Way S (2017b) A scoping study to explore the application and impact of grading practice in pre-registration midwifery programmes across the United Kingdom. Nurse Education in Practice. 24,99-105

[redacted]

I hope this is helpful

Best wishes

[Name removed for confidentiality]

Senior Lecturer (Teaching) in Midwifery

NMC Lead Midwife for Education

Programme Director BMidwif (Hons) 2013

The University of Manchester

APPENDIX 6: Entry in 'Midwives' journal

News

KEEP A LOOK OUT FOR...
Baby Lifeline's new UK standardised home birth bag for midwives was launched by Linda Bassett and Leonie Elliott, stars of BBC's *Call the Midwife*. Six NHS trusts have been trialling the bag and contents – check on its progress at babylifeline.org.uk/home

Assessment toolkit

Grading of practice in pre-reg midwifery

Completed earlier this year, the findings of the Lead Midwife for Education UK Executive's national project are available at bit.ly/LME-UK_report

The five-year project's aim has been to identify and remedy some of the variations in applying the current NMC standards for pre-registration midwifery education (2009) to programmes across the approved education institutions.

Not only is this work contributing to the evidence base informing the new NMC standards, it has also informed the *Practice Assessment Toolkit* - an evidence-based set of resources designed to be used flexibly and developed from the project that can be used:

- In conjunction with existing practice assessment tools
- When developing practice assessment documentation for new programmes
- When writing evidence to record students' progress
- For students writing learning objectives or self-assessing their progress
- To aid assessors in objectively determining levels of performance and achievement in practice.

MORE INFO
This resource and further information on the project can be found at bit.ly/pre-reg_grading

GLOBAL
Research and prevention
The Centre for Global Women's Health

'Midwives' May 2019. p8

RCM.ORG.UK/MIDWIVES
MAY 2019
8



APPENDIX 7: SSSA Evaluations summary

SUMMARY OF EVALUATIONS OF STUDENT SUPERVISION AND ASSESSMENT (SSSA) PREPARATION SESSIONS

NMC APPROVAL EVENT

March to May 2019, representing all clinical areas in University of Plymouth footprint

Number of evaluations in sample:

Barnstaple	17
Cornwall	4
Exeter	6
Plymouth	40
Taunton	20
Torbay	24
Yeovil	15

A. What was particularly useful about the session?

THEME	SUB-THEMES	RESPONSES
	All of it	2
PROCESS	Learning about the new system of student supervision and assessment/ rationale	89
	New tools/ grading criteria useful/ illuminating/ built confidence in assessment	20
	Clarity about individual roles of practice supervisor/ assessor/ academic assessor and expectations	19
	Grading system – using key words/ phrases	9
	Writing reports as an assessor/ objectivity	4
	Rubric template to help grade	2
	Learned about changes with regards to E-OAR and online timesheets	1
PRACTICAL PREPARATION	Workshop activity made it very clear/ excellent	14
	Session well-delivered/ clear/ informal/ open	11
	Examples/ scenarios useful in giving idea of writing statements for evidence	10
	Interactive practice and discussion/ 'having a go' at assessing	9
	Handouts and additional resources	5
	Group sharing of positive and negatives/ reflecting	3
	Much better session in smaller groups and not part of mandatory day	3
	Information was emailed in advance	1
	Flexible link tutor in meeting needs of group	1

OUTCOMES	Feel adequately prepared/ understand how to undertake student supervision and assessment	4
	Very positive changes/ reduce anxiety/ improve smoothness of transition	2
	Responsibility of everyone, not just assessor/ mentor	1
	Pleased that students will get variety of experience	1
	Acknowledgement of mentor feedback about what may or not work	1

B. What will you take forward into practice?

THEME	SUB-THEMES	RESPONSES
	All of it	7
PROCESS	Use the new grading system/ toolkits – much easier/ model will work/ relevant to year or stage	25
	The new system of NMC standards/ differences between roles/ knowing what to do	24
	Use written communication/ key words/ correct language so that common understanding/ reduce bias/ improve inter-assessor reliability	21
	Use/ like Wordles to help practice assessment	6
	Everyone is responsible and will be able to contribute to the student’s assessment	5
	How to confidently/ correctly assess/ grade a student	4
	Being detailed and objective/ not just positive in writing comments so that assessed accurately	4
	Helping students understand the process as a practice assessor	3
	To continue to have input from academic assessor/ tutor as this is invaluable	3
	Giving feedback to students/ help improve	2
	How my feedback can affect/ achieve an appropriate student’s grade	2
	Rubrics are useful	2
	Changes happening to electronic OARs	2
	New names for supervisors/ assessors	1
	Very good to have different supervisor and assessor	1
	Assessing students more on knowledge base than focus on clinical skills	1
	Work with student before signing off	1
	Do things in a timely way if not meeting standards	1
	Open line of communication	1
	Support from previous mentors to help supervisors	1
	Communication with assessor if concerned	1
	Working together to grade	1
	Not keen on how assessor does not work with the student	1
	Review the standards/ read information prior to introduction to practice	6

PRACTICAL PREPARATION	Do workbook	5
	Need to become familiar with key words	2
	Need for own copies of tools	2
	Discussion with Education Lead/ HOM/ Matrons re practice assessor allocations	2
	Need to access POPPI and check emails more frequently in future	1
	Trust has added own restrictions eg: won't be practice supervisor until 6 months qualified	1
	One more tripartite then I will get done ASAP before these changes	1
OUTCOMES	Excited/ embrace the changes/ positive portrayal	6
	I feel equipped for the role/ will apply myself and improve my skills	5
	I'm able to 'spread the word' to colleagues about the new process	5
	Confidence and knowledge about 'mentorship'	4
	It will become easier/ be proactive	2
	Working with students I will be more up to date	1
	The change in the system does not involve extra work for the midwives	1

C. What improvements can be made?

THEME	SUB-THEMES	RESPONSES
	Nothing/ none identified	58
PROCESS	A clearer forward plan regarding how assessment will be built into practice/ more useful when Trusts have developed their own model; after Sept 19 future updates may give additional information	5
	Ensure allocated time to be an assessor	2
	Continue with grading rather than pass/fail	2
	To be able to practise grading based on supervisor feedback	2
	Lexicon more limited/ less useful tool	2
	Rubric 4 – find it difficult to pass a student who shows evidence of <i>limited</i> underpinning theoretical knowledge	2
	Student expectations/responsibilities	2
	I would like to understand more about learning objectives	1
	Unsure about lack of continuity for student which may result in them holding back and shying away from tasks	1
	Only being assessed at the end of the year could lead to delayed SMART targets	1
	More safety for the assessor if having to countersign supervisor comments	1
	More meetings with assessors to share our experiences	1
	Worry that assessor role may be given to Band 7 midwives only – I am experienced as a sign-off mentor and hope to feel valued in future	1

	Produce small laminated booklet for reference to toolkit	1
	One guide to the grading to be used/ decided	1
	Clarity with supervisor/ assessor role	1
	What will happen with triennial reviews?	1
PRACTICAL PREPARATION	More time to discuss the workshop part/ practise using tools in scenarios	14
	Location/ venue not ideal	6
	Group activity initially confusing/ could have been explained better	6
	Slides to be less busy/ dry/ repetitive	5
	A practical example prior to completing new format of assessment/ more examples (real-life)	3
	Electronic handouts	3
	Computer screen projected onto wall/ working Powerpoint	2
	Facilities/ refreshments	2
	Handouts to be given out (were sent electronically)	1
	Keep update in the working place (community) and remove it from mandatory day	1
OUTCOMES	What we need to know/ clarity of grey areas will evolve with time	4
	Will need to see how it works in practice	2

APPENDIX 8: Practice Assessment Toolkit benefits

(Shared with permission)

From: Angela Thompson <angela.thompson@plymouth.ac.uk>

Sent: 15 September 2020 09:57

To: Margaret Fisher <M.Fisher@plymouth.ac.uk>

Subject: Toolkit feedback

Dear Margaret,

Hope you enjoyed your leave.

Feedback below as requested. Please let me know if this isn't what you were looking for.

I have utilised the practice assessment toolkit based on evidence from the National Project, Grading of Practice in Pre-registration Midwifery (Fisher et al 2019) in my academic practice since January 2019. Initially this was in the education of clinicians in preparation for the implementation of the new Standards for Student Supervision and Assessment (NMC2018). I have since had the opportunity to see its advantages in grading practice as well as inadvertently its benefit during the COVID pandemic and the implementation of the emergency standards (NMC 2020).

I have been able to witness the use of the Lexicon frameworks and Rubrics as a documentation guide in clinical practice throughout the student's placements as well as a key framework during the final grading assessment. The tools were used in by both myself, as academic assessor, and the practice assessors. It was particularly helpful that they were easily accessible in the student's OAR which is useful during busy periods and ensures that the documents are utilised in practice.

During the COVID-19 pandemic they were particularly helpful when students moved to different practice areas and worked with different supervisors at sometimes short notice. The framework ensured that there was consistency. Assessors found the documentation clear and were able to match this within the frameworks to ensure a fair grade was awarded.

Best wishes

Angela Thompson

Midwifery Lecturer and Admissions Tutor.

Room 105, 7 Portland Villas.

Drake Campus

University of Plymouth.

APPENDIX 9: Trust email re PAT transferability (Shared with permission)

From: MORGAN, Katherine (TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST)
<katherine.morgan3@nhs.net>
Sent: 15 February 2019 08:33
To: Margaret Fisher <M.Fisher@plymouth.ac.uk>
Subject: Practice Assessment Toolkit

Hello Margaret,

RE; Practice Assessment Toolkit

I attended a Trust NMC Standards group meeting today to discuss the changes in relation to assessing and grading of students in line with the new standards.

During the meeting I discussed your Practice Assessment Toolkit and the Trust were very keen to implement this, they particularly liked the idea of using standardised terminology and language.

Within maternity I am keen to design a notice board with many elements of the toolkit, which I am sure will help to raise awareness of the NMC changes in standards and support practice supervisors and assessors to facilitate consistency when providing evidence.

I just wanted you to know Margaret, thank you,

Kind regards,

Katherine Morgan

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Torbay and South Devon NHS FoundationTrust
"Working with you, for you"