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Changes in Practice Learning

Kenda Crozier and Charlene Lobo

Regulation of Nurse and Midwifery Education

The World Health Organization declared 2020 the year of the Nurse and Midwife and in December 2019 the Nursing and Midwifery Council (NMC) acknowledged 100 years of nursing registration in the United Kingdom. The model of hospital based 'training' of nursing, and the instigation of a register for qualified nurses in the 1919 Nurses Act, may have been the beginning of the professionalisation of nurses, but according to Davies (1977) it was also responsible for nursing shortages by restricting training places. In the century that followed we have seen changes to the Nurses and Midwives Act, the 'training' evolving from hospital control into higher education, and the registration of nurses moving from the responsibility of the General Nursing Council to the United Kingdom Central Council (with four country boards) to the current Nursing and Midwifery Council. The 1902 Midwives Act (England and Wales) established the Central Midwives Board to oversee the education and practice of midwives, thus beginning the route to professionalisation of midwifery. Today, nurses and midwives in UK practice under rules laid down in government legislation in the Health Act 1999 (UK) and Nursing and Midwifery Order 2001 (UK)[1] and subsequent amendments as statutory instruments. The need to educate more nurses to replace an ageing workforce and the requirement for

1 The Nursing and Midwifery Order 2001 (SI 2002/253).

Collaborative Learning in Practice: Coaching to Support Student Learners in Healthcare, First Edition. Charlene Lobo, Rachel Paul, and Kenda Crozier.

Companion website: www.wiley.com/go/lobo/collaborativelearninginpractice

clinical practice experience to support this poses a difficult problem for educators to reconcile.

Throughout the early part of the twentieth century, nursing education was in the control of hospital matrons and followed the principles of Florence Nightingale. Nursing tasks were repeated throughout the period of training to demonstrate competence and to ensure that nurses understood the servitude required of their role. In the 1940s, the Wood Committee Report sought to change nurse training by recommending recognition of the student status of nurses in training. It recommended larger nursing schools and a more academic syllabus. Both the General Nursing Council and the Royal College of Nursing were concerned over the continued ability of students to contribute to the staffing of hospitals during their training (Davies 1977) and resisted the recommendations. This concern was heightened with the introduction of free healthcare via the National Health Service in 1948 which increased demand on service. From the 1940s until the 1990s, a second tier nursing qualification known as the enrolled nurse existed in support of the registered nurse (RN). The enrolled nurse training was two years long as opposed the three year RN training (Seccombe et al. 1997).

In many ways the process of practice education in clinical and care settings is a means of socialising students into the 'ways of being' a nurse, midwife, or other health professional. This phenomenon was described in the 1950s by Williams and Williams (1959) in the USA. They described three processes for socialising students including: selfless service, scientific knowledge, and authoritarian control to produce nurses. This process of behaviour modification to achieve the required social norms largely served as the means to train nurses throughout much of the first part of the twentieth century. In the second half of the twentieth century, nursing students were still expected to work alongside qualified practitioners adapting to the required behaviour and attitudes to meet the outcomes of programmes; however, there was increased emphasis on scientific knowledge and research and rather less concern with emulating and modelling selfless service.

The 1972 Briggs (Department of Health and Social Security 1972) Report made major recommendations for the separation of nurse education from service, advocating an academic degree route into nursing. There was a distinction made between the caring role of nursing and the curing role of medicine. Nurses were deemed responsible for the physical, psychological, and social health of the patient. The model of

nurse education changed following the Nurses, Midwives and Health Visitors Act of 1979, from apprenticeship to education with a two part programme: an 18 month foundation followed by a further 18 months of practical training leading to registration. The disease focused, theoretical education was supported by time in the clinical environment on hospital wards where students could practise their nursing skills under the supervision of ward staff. The programme was no longer controlled by hospital matrons and clinical teachers began to appear on the wards to support student learning.

In 1983, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting was created, and nurses were enabled to register in four branches as registered general nurses (RGN), registered mental health nurses (RMN), registered learning disability nurses, or registered sick children's nurses. The intention was to streamline a very unwieldy register with many different parts.

Throughout the 1980s, concern was growing about nursing shortages, the low numbers of qualified nurses being produced in the UK, and the need to recruit nurses from overseas to fill vacancies. The Royal College of Nursing identified concern about high rates of attrition from nursing programmes and recommended Project 2000 as a way forward in which students would be supernumerary in the clinical environment and the emphasis was on learning and development of skills and knowledge (Rye 1985; United Kingdom Central Council 1986). Nursing schools moved from hospitals into higher education institutions, thus emphasising the separation from service. In 1999, the Department of Health (DH) reported on further changes for nurse education in a review of the role of nurses promising a growth in recruitment, better quality placements, and better support for students in practice (Department of Health, 1999).

The training of second level enrolled nurses was phased out during the 1980s and 1990s. Seccombe et al. (1997) reported to the United Kingdom Central Council (UKCC) on confusion over role boundaries between enrolled nurses and RNs and the difficulties for those who wished to convert to RN status. Over 80% of employers reported that where nurses did convert to RN, their grade and role did not change. The phasing out of enrolled nurses saw the more widespread introduction of healthcare assistants who received varying degrees of training for their role. The Willis Report (2015) identified that there were approximately 1 million healthcare assistants in the NHS supporting the work of around 330 000 RNs.

Globally, there has been a move to prepare nurses for the workforce through degree-level education. This is true for UK, Ireland and other European Union countries, USA, Australia and New Zealand, and for many on the Asian continent. This has been driven in part by changes in healthcare systems, the complexity of the health of ageing populations, and changes in the working patterns and roles of health professionals. The change from nursing apprenticeship models, where students were employed by hospitals and trained by tutors and nurses within the hospital nursing schools, to full-time degree education programmes, where students are paying for tuition and experience theoretical and practical education managed by universities, has evolved by process and policy.

In 2006, the Department of Health published 'Modernizing nursing careers' (Department of Health 2006), aimed at creating a more flexible workforce within a competency based system based on patient pathways. The nursing workforce would be presented with opportunities for career development, which could lead the changes needed in a twenty-first-century healthcare system. The report recommended raising the profile of the profession and creating clear career pathways. But it was not until 2008 that the NMC ratified plans to have an all-graduate profession of nursing by 2015, nearly 50 years after the Briggs Report. However, the concern over supply of qualified nurses into the workforce remained. The Willis Report on nurse education in 2015 made recommendations for nursing including: understanding of the role of the nurse in leading care and delegating to others; requirements for employers to properly use the graduate skills of nurses; recognition that registration on a nursing register is the beginning of a career journey; and support and provision for education and continuous professional development. The report also recommended the education of healthcare assistants leading to registration with the professional regulator. This led to the nursing associate education route being recognised by registration on the NMC register (Nursing and Midwifery Council, 2019) almost 25 years after the last enrolled nurse entered the register.

In relation to education, changes to practice education were recommended to improve quality, provide support for clinical academic careers to enable better support for students in practice settings, and to improve the evidence base for nursing education. Willis recognised the decline in nurse academic numbers and recommended that this should be reversed. Funding routes for nursing education were also singled out as an area that required urgent attention for sustainable workforce development.

The Return of the Apprentice

Recent government policy in the UK introduced a new model of apprenticeship (Nursing and Midwifery Council, 2018a,b) as a route into nursing. The model enables students to be employed by a healthcare organisation whilst on a nursing degree apprenticeship programme. The programmes are typically three or four years long. While the students on the programme are undertaking the 2300 hours of practice education, they will be supernumerary and will be released from their employment to attend theory learning. The programmes aim to encourage local recruitment to manage workforce demands, and employers have used the opportunity to develop staff who have been employed as healthcare assistants into nursing roles. This new apprentice model sits alongside the traditional university-based education with the same outcomes overseen by the regulator for nursing and midwifery nationally and is not without criticism, particularly in relation to a funding mismatch (Leary 2020). This system is similar to intern programmes in other countries identified by Budgen and Gamroth (2008). In addition, a new level of nurse, the nurse associate, has been introduced into the workforce with apprenticeship education and registration on the NMC register from 2019.

Clinical Practice Education

Successive reports into nurse education have focused on improving the quality of practice education. Securing the status of student nurses as learners rather than employees was intended to improve learning opportunities in the latter part of the twentieth century. The separation of the nursing faculty from the clinical environment has contributed to the perceived gap between theory and practice.

Learning in clinical practice has always been a critical component of student nurse education both nationally and internationally, with the quality of the clinical learning environment gaining increasing emphasis in recent years. In the UK, as elsewhere, alongside nursing shortages lies is a growing demand for clinical placements driven by greater numbers of student nurses and the decreasing availability of nurses to support learning in practice. The quality of the clinical learning environment has received further scrutiny since the Mid Staffordshire NHS Foundation

Trust Public Inquiry (Francis 2013) identified the extent of poor care in hospitals and raised questions over the quality of student learning experiences when exposed to such practice. Subsequent reports exploring nurse education, and practice learning in particular, have emphasised a need for improvement of the quality of learning environments and the quality of mentorship/supervision that supports students in practice (Willis Commission 2012, Robinson et al. 2012, Willis Report 2015, Ashton et al. 2016).

The Willis Commission (2012) identified inconsistency in the quality of practice experiences as a major concern and recognised the role of mentorship as crucial in practice education, not only in teaching, learning, and assessing but also in role-modelling good practice and leadership skills. The main barriers proposed were that mentors had insufficient time to spend with students, the increase in skill mix led to a lack of high-quality role models in practice, there was a lack of collaboration at all levels between higher education and practice that impacted on the support and training of mentors, and there was a general lack of investment in mentors and the clinical learning environment by many healthcare providers.

With increasing numbers of students and decreasing numbers of trained mentors, pressure on clinical practice areas was becoming unsustainable. In our own higher education institute (HEI), the University of East Anglia, an overview of student and mentor feedback in 2013–2014 showed mentors' commitment and the value of their role. However, a strongly emergent theme reflected 'the burden of mentorship' where mentors were faced with conflicting priorities in executing their nursing and mentoring roles, exacerbated by lack of time and increasing numbers of students. It was in this context of the realisation that one-to-one mentoring of students in practice was no longer financially or emotionally sustainable that the University of East Anglia instigated a new collaborative model based on real-life learning wards.

A subsequent review of nurse education (Willis Report 2015) identified continued inconsistencies with regard to the quality of practice learning environments but also highlighted examples of good practice, namely the Collaborative Learning in Practice (CLiP) model of practice education. The RCN (2016) commissioned a rapid review of evidence on nurse mentoring, and identified the Real-Life Learning Ward model (that originated in Amsterdam and is now running as CLiP within a UK university and

NHS partners) as one of the few models of nurse mentoring that adopted a system-wide approach. Recommendation 17 of the Willis Report (2015: p. 63) stated

> NMC should review its current mentorship model and standards, informed by the outcome of the RCN review and final evaluation of the Collaborative Learning in Practice model, and amend the standards relating to the requirement for one-to-one mentor support.

The 2018 NMC Standards for supporting student supervision and assessment do not name the model but closely advocate the main elements of the CLiP, recommending a system including practice supervisors, practice assessors, and academic assessors. It falls short of recommending a specific model of practice education leaving it to HEIs to decide this within their individual curricular models.

Establishing a Quality Learning Environment

There is a significant body of national and international literature that focuses on the quality of the clinical learning environment from both student and supervisor perspectives. Research exploring student nurse attrition has highlighted that placement experiences and the quality of support that students receive in practice can have a major impact on the student journey and significantly influence their decision to leave the course (Crombie et al. 2013, Hamshire et al. 2012). Ford et al. (2016) define quality learning environments as those that support both the students' learning and the staff that enable the learning.

There is a growing body of evidence supporting the view that quality clinical learning environments remain a complex, multifaceted phenomenon influenced by a number of interrelating factors (Jokelainen et al. 2011; Robinson et al. 2012). Predominantly, these are situated at the organisational level where they are influenced by the level of collaboration between HEIs and practice ensuring there is adequate staffing, adequate preparation of supervisors and students, adequate commitment from both organisations in relation to commitment through resources, and value placed on learning in practice (Robinson et al. 2012; Henderson

and Eaton 2013). At an individual level, it centres on the relationship between the supervisor and student, whether students feel welcomed and accepted and feel the environment is safe to learn (Courtney-Pratt et al. 2012; Sandvik et al. 2014; Ford et al. 2016), and supervisors having adequate time (Robinson et al. 2012; Clements et al. 2016; Sweet and Broadbent 2017) to execute their role competently and confidently (Jokelainen et al. 2011; Henderson and Eaton 2013; Ford et al. 2016).

Against this backdrop of changes in the healthcare environment and organisational redesign of the NHS has been a reorganisation of the funding for higher education and for nursing and health profession education. Despite the assertions by the Willis Report (2015) that a long-term funding model for nursing education was needed, a system of bursary support for health profession students was withdrawn by the Department of Health and Social Care in England in 2017. This bursary had provided financial support to students of nursing and midwifery who undertook programmes with a much longer academic year (45 weeks) than the norm (30 week). Practice education requires students to experience the 24/7 nature of healthcare, so opportunities for paid employment alongside a university programme were not possible. The news of this bursary withdrawal impacted application numbers for university nursing courses and drove down student numbers. These bursaries enabled students to afford transport or accommodation to support movement across practice settings, which were a requirement of all programmes. The UK Government in 2020 announced a new NHS Learning Support Fund grant scheme for health profession students to provide financial support in recognition of the financial pressures of travelling to placements or paying dual accommodation fees during placements.

The drive for a modern healthcare profession needs to be supported by both healthcare organisations and the HEIs in a partnership that shares a vision for nursing and midwifery careers in clinical practice, policy, and in academia. There is undoubtedly a workforce shortage in the NHS and this is mirrored in academia. Taylor et al. (2010) pointed out that the career paths open to nurses need to be supported by salary scales that mean movement between clinical and academic posts is not hindered by disparity. Currently, attracting high calibre nurses into education is difficult because their earning power is greater in health organisations. The workforce issues facing the NHS are also faced by academics in

higher education. Career pathways for nurses, which were identified in 'Modernizing nursing careers' (2006) need to be revisited in light of the recommendations from the Willis Report (2015).

As a final note, the planned celebrations for nursing were overtaken by the coronavirus (Covid 19) pandemic which impacted the NHS in the first six months of 2020. The NMC provided emergency standards for education and student nurses were called upon to join the NHS workforce as paid healthcare assistants while continuing their nursing education. Second- and third-year student nurses and midwives were offered the option of stepping into these new roles to continue their programmes. The supernumerary status of students was removed but learning was expected to be demonstrated. First-year students had their practice placements suspended. As we go to publication, the emergency standards are being removed, replaced by recovery standards in the process of a return to normality for nursing and midwifery education. The impact on thinking about practice-based learning has yet to be unpicked from this experience, but some concern is already being expressed (Leary 2020).

The extraordinary year in which we were producing this book reminded the world of the importance of the health workforce and particularly nursing. The impetus gained from this focus should be utilised to benefit the education of the health professions.

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