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FINAL REPORT

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An investigation of the preparation and assessment for midwifery practice within a range of settings

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CONTENTS

Abbreviations

CPD - Continuing Professional Development

DoH – Department of Health

HEIs – Higher Education Institutions

LREC – Local Research Ethics Committee

MREC – Multi-centre Research Ethics Committee

NHS – National Health Service

NMC – Nursing & Midwifery Council

PREP – Post-registration Education and Practice initiative

SNMAC – Standing Nursing & Midwifery Advisory Committee

UKCC – United Kingdom Central Council for Nursing, Midwifery & Health Visiting

WDCs – Workforce Development Confederations

CHAPTER 1   <u>INTRODUCTION</u>

This project focused on teaching and learning in clinical practice. The research was an in-depth investigation of the experience of clinical education for student midwives and of the preparation and support in place for midwives who mentor students. A key emphasis for this study has been on the midwife mentors, as few studies have explored the nature of the contemporary mentor's role in midwifery practice. Research in this area was therefore timely, in order to obtain a national evidence base and capture the distinctive nature of becoming a midwife. The report provides a description of the national situation during the three years (from 2000-2002) so that recommendations can be made, based on models of good practice of mentorship and effective clinical education.

The expectations placed on mentors to supervise, teach and assess students have increased. Midwives must continue to deliver high quality care for women and babies whilst simultaneously teaching and supporting the student midwives. The research provides in-depth insights into how midwife mentors attempted to manage student preparation and assessment. It has been fascinating to explore the strategies key stakeholders have used in the provision of practice placements in a range of settings. In particular, this qualitative study provides detailed descriptions of ways in which midwives attempted to manage to combine the separate functions and demands of their roles. How they were prepared and supported in the mentoring role impacted, both explicitly and implicitly, on the students as learners.

The research focus reflects our commitment to midwifery education in practice. We believe that the education process is fundamental to the personal and professional development of learners and is directly linked to the quality of care for women and their families. The investment in mentorship in midwifery practice is currently very varied. The evidence points to the importance of valuing and investing in the midwives who are mentoring.

We hope that the research findings will promote discussion of creative ways of providing quality mentorship and developing initiatives in clinical education. The research reflects the complexities and challenges this presents for all involved but should also remind us how rich a resource our midwives are; particularly those with a formal mentoring role.

Background
During the past decade, women and their families have become key players in helping to shape the development of the maternity service. Government policies have acknowledged the importance of a 'woman-centred' service and the Changing Childbirth Report (1993) outlined the key principles which should underpin the provision of NHS maternity services. The three main principles outlined in the report are those of choice, continuity and control for all women using the service. One of the key issues which was identified in the report was the need to sensitively address the educational needs of midwives. The aim is to provide them with the necessary knowledge, attitudes and skills to provide the kind of midwifery care which is required by women, and which is consistent with current government policy.

Another fundamental change that has affected both the education and practice of midwives during the past decade is the move of education from the NHS into higher

education institutions. In addition, the working practices of midwives have changed to facilitate the introduction of choice, continuity and control for women, e.g. caseload practice. This has led to changing environments of care within which students learn to develop the necessary knowledge, attitudes and skills to provide midwifery care for women and their families. Concern has been expressed that these changes have led to students experiencing some difficulties in acquiring the skills required for effective, hands-on midwifery practice.

Since this research began in January 2000, there have been a number of government policy initiatives in relation to the health service and to midwifery education. The primary intention is to promote a modernising agenda within the NHS, including the maternity services, and to develop further the policies of the previous decade e.g. Changing Childbirth (1993), which placed women and their families at the centre of the maternity services. Key documents were Making a Difference (DoH 1999), Fitness for Practice (UKCC 1999) and the NHS Plan (DoH 2000).

This project has been developed to address the educational needs of midwives which have arisen as a result of the changes discussed here. It has a unique focus as it is the first national study which will provide evidence to inform the education and practice of midwives. This is in the interests of the mothers and babies who are using the maternity service now and in the future. It charts the realities of teaching and learning in midwifery practice over a three-year period. It has been a privilege to be involved with research work which has the potential to influence practice, policy and ultimately the women receiving care.

1.1 Aims
The main aims of the study were to investigate:

(i) the type of experience which both student and qualified midwives obtained in the practice settings (including NHS hospitals, community clinics, and the home);

(ii) the educational preparation and role of both student midwives and their mentors [1](qualified midwives) in *education* and *practice,* and to identify continuing educational need.

We therefore wanted to discover:
• how midwives are prepared and supported in their mentoring role
• the student experience of placements, their mentorship and assessment
• the impact of the mentoring relationship on the care of women.

1.2 Methods
A multi-method approach within a case study design was used in order to enhance the potential for obtaining reliable information on the range of issues that influence effective education and practice in midwifery.

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[1] The qualified midwives who supervise, teach and assess student midwives in the practice area are called mentors.

In order to reflect the range of geographical locations, systems of midwifery care and the range of pre- and post-registration midwifery education provision within England, five case study sites were chosen. Access agreement with a university and a minimum of one local NHS Trust was obtained within each site. Multi-centre and local ethics committee approval processes were completed and confidentiality of all participants was assured. Research midwives were employed to undertake local data collection within the case study sites. Methods of data collection included:

- initial and end of placement individual interviews with four student midwives and their mentors per case site;
- non-participant observation of each 'pair' of mentors and students;
- diaries completed by students and mentors;
- interviews with post-registration midwives;
- group interviews with student and qualified midwives;
- individual interviews with women;
- individual interviews with Lead Educators (formally Approved Midwife Teachers), Heads of Midwifery Services and Midwifery Tutors.

The key participants of this study were the student midwives and their mentors. The timing of each case study related to the students' clinical placement.

1.3 Reporting

The findings from all elements of the research project are presented within this report. Each chapter addresses a different aspect of the research.

Chapter 2 provides a literature review of the relevant research literature related to clinical teaching and learning.

Chapter 3 details the research methods and the process of analysing the findings from all of the different groups of participants and sources of information.

Chapter 4 outlines the case records of the five case study sites, looking at the ways in which care, preparation and support for teaching and learning in clinical practice were organised and experienced by the research participants.

Chapter 5 details the key themes arising from the in-depth data collected in each case study site from the pairs of student midwives and their midwife mentors. Views of a sample of women are also presented.

Chapter 6 provides a discussion of the findings and a comprehensive picture of teaching, learning and assessment in midwifery practice at the current time.

Chapter 7 presents conclusions and recommendations for midwifery education and practice.

CHAPTER 2   BACKGROUND

Introduction

This project was developed during 1999 and drew on work already undertaken by Professor Rosemary Pope related to midwifery education (Pope R, Cooney M, Graham L, Holliday M. (ENB 1996)[2]. This earlier project explored the continuing education needs of midwives following the publication of *Changing Childbirth* (DoH 1993) and the subsequent changes in the maternity services as midwives sought to give women choice, continuity and control during pregnancy and childbirth. Pope et al (1996) highlighted the education needs for the broad base of skills that support professional midwifery practice. and Gerrish et al (1997) suggested that the preparation and ongoing support of mentors[3] should mentors should be the subject of further research.

This project has taken took place during a time of continuing change within the health service. Midwives have been working in evolving conditions as the maternity services move to new ways of working to meet the needs of women and their families. and programmes of study have also changed, in order to prepare midwives with the knowledge, skills and attitudes to meet these needs. Midwives continue to demonstrate their commitment to high quality care. This study provides the opportunity to explore how they midwives who were mentoring, resolved the various demands of clinical work, preparation and assessment of students and their own continuing professional development.

This chapter, which deals with the literature review, will outlines the key changes that have occurred in the NHS and in midwifery education and practice in order to provide a context for the findings that are presented later in this report. The recent history will be used, highlighting the currency of this project, and drawing on other contemporary sources which have considered issues related to teaching and learning in practice settings. It is important to note that these other sources have tended to examine both nursing and midwifery within the same project. This project is unique in its focus on midwifery.

In this chapter, the review of the key literature is organised in the following sections: 1) the new NHS; 2) the maternity services; 3) the context for midwifery education; 4) teaching and learning; 5) assessment in midwifery practice.

2.1 The new NHS

The government is committed to developing a health service designed around the patient and has published a number of reports since 1998 culminating in *The NHS Plan* (DoH 2000) outlining its vision providing continuous improvements in services as well as changing the whole way the NHS and its partners work. The modernisation of the NHS is involving all staff in new ways of working and has created a degree of turbulence in the clinical areas as the changes in structures, processes and approaches have started to occur. These changes have impacted on all involved in the maternity services, including the midwives, students and mothers who are the focus of this study.

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[2] Pope R, Cooney M, Graham L, Holliday M. (1996)

A number of strategies have been implemented to achieve the Government goals., These include standard setting measures (e.g., National Institute for Clinical Excellence and National Service Frameworks) and the process of Clinical Governance, with the aim to assure of assuring the delivery of quality standards (DoH 1998b). The Government also identified that NHS staff are key to delivering its modernisation plans (DoH 1998c). The document entitled *A Health Service of all Talents: Developing the NHS workforce* (DoH 2000) sets out the strategy for maximising the skills and contribution of all NHS staff and the reviews of the way in which jobs are designed and care are delivered.

The above- mentioned report also advocates' that the needs of patients – in the case of midwifery, the women, - should drive the education and training agenda. This requires improved relationships between the NHS and education and training providers. Vocational and professional education and training frameworks need to be sufficiently flexible and coherent to respond to and support NHS changes and developments and to facilitate flexible career pathways for all staff. Partnerships between the NHS service and education providers are required to agree to the nature, volume and quality of education for existing and future staff developments in addition to providing good quality and relevant clinical placements (DoH 1999).

The report *Making a Difference* (DoH 1999b) provided guidance in relation to education, training and development to support the government's modernisation plans. The report sets targets for increased retention and recruitment of staff, training places and return to practice programmes. It also encourages wider and more flexible entry to health professional programmes, including increased access to pre-registration programmes through vocational training.

2.2 The maternity services

A number of reports over the past two decades have prompted the transformation of the maternity services (e.g. Maternity Services Advisory Committee 1982, 1984, 1985, RCM 1987, Health Committee 1992, DOH 1993, DOH 1999b, DOH 1999c, RCM 2000). These recommendations of these reports have had a major impact on the organisation and quality of care and on the role and scope of practice of the midwife. Within the context of on-going, substantial change within the health service, continued commitment is essential in order to ensure that the progress and improvements achieved to date are sustained and become more widespread (RCM 2000).

Making a Difference (DoH 1999b) expressed the government's commitment to support the contribution of nurses, midwives and health visitors to health and health care and identified many ways in which roles may be made more effective. Even so, the government also acknowledges that there were substantial staffing shortages are too high and has implemented improvement measures. Concern has been expressed that the problems facing the maternity services arise rather through chronic shortages in staffing and resources and low staff morale rather than lack of policy and organisational strategies to provide optimum care for women and their families (RCM 2000). The emotional work created from, for example, carrying a case load in the current organisational context is not sufficiently recognised (Hunter 2001). Additionally, some students may learn to manage emotion by adopting a task-orientated approach to care (Smith 1992) which impacts on their clinical learning.

The government's current strategy (DoH 1999b) highlights the need to develop more flexible patterns of working, opportunities for lifelong learning and to strengthen the links

between vocational training and pre-registration education. It promotes increased opportunity for support workers to access or 'step on' and 'fast track' pre-registration programmes (i.e. to enter an educational programme at a later stage based on prior knowledge and experience (Accreditation of Prior [(Experiential]) Learning AP(E)L) (NHSE 1999). The scheme will also be instrumental in achieving the goal to develop of developing a health care workforce which reflects the diversity of local populations and comprises staff from a range of social, ethnic and academic backgrounds.

Kirkham (1999) identified significant factors affecting the culture in which NHS midwives work. Midwives described a lack of positive role models offer support and a general lack of mutual support. The competitive business culture has created demands for increased flexibility. :

'The emphasis upon a flexible workforce and issues of skill mix in maternity services have made many midwives feel insecure.' (Kirkham 1999 : 734)

This feeling of insecurity, combined with rapid changes, has influenced the nature of midwifery teaching in clinical settings. Other significant influences on the role of the midwife have been; the increase in integrated care schemes, and the increase in midwives who work part-time. (Reid 1999) and the rise in the national Caesarean rate (Thomas & Paranjothy 2001). With the modernisation agenda and the response to Making a Difference (DoH 1999) the expanding role of the midwife, including involvement in public health, has created a need for flexibility of maternity services and curricula., combined with increased litigation have impacted on the role of the midwife and subsequently on the student experience.

2.3   The context for midwifery education

The excellence and quality of midwifery care provided for women in the United Kingdom is underpinned by the educational preparation of midwives. Education programmes are based on the outcomes identified under Rule 33 of the Midwives Rules (appendix 1) which require, by statute, that midwives practice in accordance with the Definition of a Midwife (appendix 2) and midwives directive 80/155/EEC (UKCC 1998) (appendix 3). It is within the remit of the midwife to provide and arrange all the maternity care for all women but with primary responsibility to women whose pregnancy, labour and puerperium are uncomplicated. with uncomplicated pregnancies,. and their status of midwives as independent practitioners is defined within legislation.

Key changes have occurred in midwifery education over the past two decades, both in relation to types of preparation for midwifery practice and to the location of this provision. These developments in midwifery education have occurred symbiotically with the innovations within midwifery programmes being facilitated by the incorporation (and relocation) of midwifery education provision within higher education institutions. Programmes for the preparation of midwives had developed from shortened programmes for registered nurses of twelve to eighteen months. There has been an increase in and to the general introduction of three or four year programmes of pre-registration midwifery education (direct entry[4]) [12]) which are awarded at diploma and degree level.

2'Direct entry' refers to programmes of midwifery preparation which do not require previous qualification as a nurse.

In order to provide midwives with the appropriate knowledge, skills and attitudes to effectively fulfil their role within the developing maternity service, considerable attention has been focused on the development of appropriate programmes of education. Strong emphasis has been placed on a balance of interpersonal / communication and clinical skills, the need for intellectual development, knowledge of the human sciences and the need to use scientific evidence in practice. All students are expected to become competent practising in both the community and hospital before registration as a midwife, and are also expected to be able to undertake the "Activities of a midwife" as outlined in the Midwives code of practice (UKCC 1998a).

Pre-registration students undertaking the three year programme have supernumerary status (80% of their time) with the consequent requirement for teaching and support in clinical environments during their preparation.   A common theme which is addressed through all the recent reports and reviews relevant to midwifery education and practice (e.g. UKCC 1999, Crow et al 2002) relates to the need for the effective integration of theory and practice at all levels within the educational system. There remains a strong impetus for all those involved in the provision of education both in higher education institutions and practice settings to facilitate education for effective practice.

There has been a debate within midwifery concerning the concept of the 'non-nurse midwife', e.g. Maggs (1994) Robinson (1996). It is acknowledged that the introduction of 'direct entry' programmes has highlighted a range of issues for qualified midwives, including the need to teach basic clinical skills in midwifery, for example, aseptic technique, infection control and vital sign measurement. These are all essential skills that midwives are now required to teach midwifery students who will have had no prior nursing experience. There has also been some discussion about phasing out the shortened (18 month) programme for nurses on the grounds that it is a lengthy and expensive way to prepare a midwife (SNMAC 1998). , However, the range of programmes remains available within England at the current time.

The capacity of existing midwifery staff to fulfil their own professional development needs and take responsibility for the effective preparation of the new generation of midwives is of significant importance. The Standing Nursing and Midwifery Advisory Committee (SNMAC, DoH 1998) noted that the profession is in transition as it "responds to the challenge of implementing women-centred care" and this role change necessitates that midwives re-learn old skills and develop new ones. For example, hospital midwives accustomed to immediate obstetric and technical support require confidence and competence to undertake homebirths; community midwives need to re-familiarise themselves with the highly technical hospital environment and management of women with complicated pregnancies. Midwives are required by statute (UKCC 1998a) to be competent to care for low risk women throughout pregnancy, birth and post-natal period and recognise and refer high-risk cases. These maternity care initiatives and innovations require that midwives develop new skills and the confidence to work with increasing autonomy and necessitates that midwifery education keeps abreast in order to effectively support this greater professional scope of practice (SNMAC 1998).

The views of midwives regarding their education and practice is are of considerable significance. In this respect, following a national research study undertaken in England, Pope et al (1996) reported that midwives and their supervisors identified several key issues as priorities for the continuing education of midwives. These included research, clinical skills, counselling/communication skills and general issues relating to professional

practice (e.g. ethic-legal issues). The most frequently identified clinical areas for continuing education and training related to those aspects of care which tend to be considered as 'enhanced role' activities for midwives, such as intravenous cannulation, and ultrasound scanning. and interpretation of fetal heart monitoring. Although identified as a continuing education need, there was much debate about the legitimacy of midwives undertaking such activities which were seen by some as leading midwives into 'medical territory' and opening the debate about the parameters of midwifery care and obstetrics. Similar issues aware rose regarding midwives' involvement in emergency situations as discussed in the Confidential Enquiry into Stillbirths & Deaths in Infancy (1996).

This raised the point issue of regarding midwives' capacity to make decisions about their own role and responsibilities in care provision, and to negotiate this with other members of the health-care team in relation to the provision of optimum quality care.

Furthermore, particular issues were identified in relation to involvement in care, and the consequent educational needs of midwives in varying circumstances. Practice-base and grade were clearly associated with involvement in technical and 'enhanced role' activities, as well as in relation to access to continuing education provision. (Practice-base refers to whether the midwife is based in community or hospital settings or works across a range of settings, often within some kind of internal rotation systems.). There were no significant differences in relation to continuing education needs between those midwives who were involved in assessing practice, and those who were not currently involved in such activities.

The above issues have implications for the quality of learning and assessment during student clinical placements as well as the support necessary for midwives to develop practice expertise and leadership as recommended by the government's NHS modernisation programme (DoH 1999).

Other key areas impacting on midwifery education are the introduction of outcome competencies for pre-registration midwifery education developed by the UKCC's Midwifery Committee (ENB 2001) following the review of nursing and midwifery education - Fitness for Practice (UKCC 1999), and the development of subject benchmarks (QAA 2001). At the time of this study (January 2000-December 2002) these developments were being discussed and were beginning to make an impact ion the delivery of education programmes.

2.4 Teaching, Learning and Assessment in midwifery practice
Programmes to prepare midwives are set at diploma and degree level and students are expected to demonstrate achievement of these levels, both in theory and practice through the use of learning outcomes and theoretical assessments. The assessment of practice, and the complexities related to this activity, have been the focus of a number of research reports over the past decade, . for example:, Philips et al (1994), Elkan and Robinson (1995), Wilson-Barnett et al (1995), Gerrish et al (1997), Phillips et al (2000), Neary (2001) and Norman l et al (2002).

It is important to note that a lack of support during practice placements was identified as one of the reasons why midwifery students are leaving pre-registration programmes (UKCC 1999). Other reasons given included difficulties experienced in travelling to and from practice placements and personal and financial problems. A quick perusal of the

contemporary professional press identifies that these remain key concerns amongst students.

Philips et al (1994) discussed the development of competence in relation to professional development and noted that a newly registered practitioner may not be considered fully competent in their new role until they have begun to consolidate their course- based knowledge and been in practice for some time. They state that there is not a linear progression in competence and that development is not orderly. It may not be possible to conclude that at an externally pre-defined point every individual will have achieved competence in every aspect of practice at an externally pre-defined point..

There is also the issue that the maintenance or development of competence is may not be guaranteed and that competence is on a continuum along which it is possible to move backwards as well as forwards. It is not a "steady state, it is a fragile achievement and never a total accomplishment". This applies to both newly qualified and 'experienced' individuals and reflects the model developed by Benner (1984).

Elkan and Robinson's (1995) review of published research highlighted questions related to the share of teaching which occurs in practice areas, and Wilson-Barnett et al (1995) reported that quality of support was influenced by many factors, for example, a wide range of organisational issues. In their exploration of the role of the teacher/\lecturer in practice, Day and Fraser (1998) highlighted the importance of support for roles in practice being sustained and structured. The authors advocate for as much support being offered to the clinical curriculum as it is to the academic curriculum. The work is relevant in relation to the current exploration of formal and informal support systems for mentors.

The issue of the appropriate preparation and support for practitioners with responsibility for practice assessment was a key element addressed by Gerrish et al (1997). Their findings indicated that there were enduring concerns related to the availability and expertise of practice assessors. In a similar vein, Andrews and Wallis (1999), following a review of the literature, concluded that mentors in practice-placements tended to undertake a multi-functional role and consequently there is potential for role conflict. is great. The review also highlights the differences between pre- and post-registration students in relation to their needs in the practice settings.

Fitness for Practice (UKCC 1999) made wide-reaching recommendations relating to nursing and midwifery education, including placing more emphasis on the achievement of learning outcomes through group work, the application of learning in the workplace and the provision of evidence to validate competence. Learning which takes place in a practice context is considered as valid as learning in an academic institution/university. Self-assessment and assessment of performance in the workplace are important features of this approach as is the requirement that the student should keep evidence-based portfolios. The requirement to keep portfolios of learning has been a feature of midwifery education for a number of years and all programmes reviewed on this study used this as a learning approach.

Midwifery education programmes have devised quite complex forms of assessment of practice, integrating in various ways and to varying degrees, with assessment of theory, in order to encompass a broad view of competence. Criteria to assess competence have been developed locally in universities which take the statutory definitions of

competence set out in Rule 33 and the Activities of a Midwife as a starting point, or reference point, for their own much more detailed expectations (RCM/NHSE, 2000).

In addition, midwives who wish to notify their intention to practise are expected to fulfil their obligations under the Post-Registration Education and Practice initiative (PREP) which places emphasis on the midwife identifying her own needs for professional growth. and being expected to find appropriate updating opportunities based on individual need. Midwives are expected to be involved in the education of students as well as addressing their own learning needs.

Prior to April 2002, all practising midwives were required to be registered formally at the United Kingdom Central Council (UKCC). Registration is now one of the main functions of the Nursing and Midwifery Council (NMC) and registration is essential in order to work as a registered nurse, midwife or health visitor in the United Kingdom. The register is at the centre of public protection (UKCC, July 1999) and to remain on the register, all qualified midwives are required to record all professional development as proof that they have maintained and continued to develop their professional knowledge and competence.

As part of the Continuing Professional Development standard, all learning activity which was relevant to the midwives' work was to be documented as evidence in a portfolio (or personal professional profile). The standard demanded that two post-registration and practice (PREP) requirements affected individual registration as a midwife:

1) A minimum of 750 hours practice should have been undertaken during the three years prior to registering and
2) 2) At least five days (35 hours) of learning activity relevant to the midwives' work should have been attended.

A shared framework for health professional learning post registration has recently been developed, with the emphasis being on continuing professional and personal development (Pearson 2002). This has come about in the wake of, for example the NHS Plan, National Service Frameworks and the clinical governance agenda.

Lifelong Learning
Emphasis within all educational programmes (including post-registration education) is on lifelong learning. Throughout any formal education programme, the midwives who are studying for credits need academic and practical support in the form of mentorship and supervision. Clinical supervision provides an integral part of lifelong learning (UKCC 2001). This ideally begins with a comprehensive preceptorship programme and continues throughout the careers of practising midwives. Principles to support clinical supervision have been developed by the UKCC but were designed to be flexible to local needs:

"'The UKCC supports the establishment of clinical supervision as an important part of clinical governance and in the interests of maintaining and improving standards of patient and client care.'" (UKCC 2001).

In some places, group clinical supervision has been successfully established alongside statutory supervision, facilitating a 'vehicle for empowerment' (Kirkham & Stapleton

2000). The literature concerning clinical supervision emphasises the need for initiatives to be sustainable and also supportive so that midwives can focus on their central concern; woman-centred care.

Workforce Development Confederations have been implementing roles, particularly in Trusts, which offer additional support to qualified staff. Part of the remit is to manage the clinical education for skill mix purposes. New training roles of staff roles are emerging, some with 'development' of midwives as a part of their role, for example, Training and Development Co-Coordinators, Research and Development midwives, Consultant Midwives.

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2.5 Assessment of practice
Few national research projects have focused exclusively on the process of assessment of midwifery practice. Phillips et al (2000) explored assessment of student nurses and student midwives (as well as a sample of qualified staff) in a range of practice settings. The methods involved dialogic evaluation, with emphasis being on evidence from portfolios and vignettes. The main findings identified that: 1) the quality and effectiveness of assessment were very variable; 2) mentors were assessing within already heavy workloads; 3) continuous assessment of practice was not performed systematically systematic and lacked and often without progression plans. The authors also reported that and assessors also felt inadequately prepared to perform reliable assessments or to usefully link theory to contemporary practice.

Neary (2001) argues for a new approach to the assessment of student nurses' clinical experience. Based on Benner's work (1984) which explored the movement from novice to expert, Neary advocates for a conceptual model termed 'responsive assessment'. The model was developed primarily to match each student's professional development and personal growth and in response also to individual clients' needs. The model was based on research findings.

Neary (2001) used qualitative and quantitative methodology to help elicit understanding of use of the assessment process in use in one Higher Education Institution in Wales. Problems highlighted by assessor and student included difficulty in interpretations of assessment criteria, which was were seen as too 'objectives' focused. Students recruited to the study apparently revealed that they valued the reality of the practice experience highly in terms of a learning resource but preferred to be assessed on their care on a day-to-day basis rather than trying to meet only the college learning objectives.

Whilst partnership models have been suggested to help reduce the tension between education in Universities and assessment in clinical practice, difficulties persist in relation to issues surrounding validity, reliability, credibility and robustness of continuous assessment tools. Fairness in measuring and assessing competence has been explored in depth by Stuart (2003).

Norman et al (2002) maintain that no single method is appropriate for assessing clinical assessment in practice. The authors suggest that in order for nursing and midwifery students to accomplish the huge wide range of skills, attitudes and knowledge necessary to be competent and fit for practice, a multi-method strategy for assessment of clinical competence is necessary and needs to be standardised nationally. This will remains notoriously difficult in the absence of a useable 'gold standard' against which to measure competence of student midwives, based on observation of their practice. Simulated assessments show possible potential but require teachers who are clinically credible or lecturer-practitioners to conduct the assessments (Norman et al 2002).

Fraser et al (1998) developed an assessment matrix to assess the outcomes of pre-registration midwifery programmes. The matrix, based on Rule 33 (UKCC 1998**check date)) and Changing Childbirth (1993) was designed to assess competence and identify learning needs. The authors concede that:

'"The midwife's professional role is complex; competence must encompass capability across contexts of time, not merely individual performances' Fraser et al (1998:36)

2.6 Preparation of midwife mentors (who assess the practice of student midwives on a range of midwifery programmes).

Prior to April 2002, midwives were prepared to assess the competence of student midwives in clinical practice by attending the ENB 997 (Teaching and Assessing) course. The mode of delivery of this programme varied, but essentially midwives gained guided and thorough experience in teaching micro-skills in clinical areas (including the community) and in assessing and recording the clinical skills of student midwives in practice environments. The curriculum incorporated understanding the psychology of teaching and learning and practical elements such as planning teaching around the students' existing knowledge and ability (i.e. setting realistic aims and objectives for each individual student), based also on the women's needs. It is interesting to note that Neary (2001) found that practitioners suggested that they based their actions not on preparation programmes but on their own previous experience.

The guidance has been updated and a new framework (ENB 2001) developed to address the need for an effective means of preparation for qualified midwives responsible for teaching and assessing student midwives. The new framework also provides and which also provides a recognised route for appropriately trained staff to become lecturers/practice educators. 'The UKCC (1999) made a number of recommendations relating to the preparation of mentors and teachers which stressed the need for practice-based educators and lecturers to have dedicated time to be confident and competent in their teaching and mentoring roles', and recommended that 'the preparation of mentors should be formalised and be in line with best practice' (ENB, 2001:7).

The publication of the ENB guidance by the ENB (2001:9) also included an attempt to clarify terms used and identified 'mentor' as denoting ''the role of the nurse, midwife or health visitor who facilitates learning and supervises and assesses students in the practice setting'. This guidance replaces the earlier term of 'practice assessor' that had been used in midwifery education and practice (see appendix 4)..

2.7 Issues for investigation

In the light of the issues arising from the literature regarding the need for responsive and effective education programmes, it is timely to investigate the most effective means of providing student and mentor preparation and the nature of the practice experience. Assessment, in the sense of evaluation of practice achievement, necessarily comes after learning has occurred. It has therefore been important to investigate the following:

- the extent to which, and how, midwifery education effectively prepares midwives for contemporary practice;
- the experiences, knowledge and skills of mentors, both in relation to midwifery *education* and *practice;*
- how the midwifery profession might be most effectively enabled to combine the need to meet the demands of the changing scope of practice and to effectively manage student preparation and assessment.

CHAPTER 3   METHODS

Introduction
A multi-method approach within a case study design was used in order to enhance the potential for obtaining reliable information on the range of issues which influence effective education and practice in midwifery and to ensure that the information obtained reflects the needs of midwives, mothers and babies.

Information was obtained through:

- investigation of the types of education programmes and support available to student midwives;

- direct observation of the midwifery care which is being provided by both student midwives and their mentors (qualified midwives) to mothers and babies;

- interviews with mothers, midwives, maternity service managers and other professionals involved in maternity care (e.g., doctors);

- diary data kept by students and qualified midwives kept diary data on the care they provide to mothers and babies from a range of backgrounds and with differing health-care needs;

- post-registration midwives who were undertaking courses (see section 4.4 for detail of findings from individual interviews)..

3.1 National data sources
National data sources were used to provide an overview of midwifery educational provision, and the organisation of the midwifery maternity services. Information was obtained from the English National Board and a survey was undertaken of all midwifery education departments within Higher Education Institutions (HEIs) in England that offered pre-registration midwifery education programmes; including diploma and degree programmes of 3three or 4four years ('direct entry') and 18 month programmes for those registered on Parts 1 or 15 of the Professional Register. There were a total of fifty HEIs offering such programmes at the time of the survey and thirty seven responded (response rate 74%).

The senior midwife educator at each Higher Education Institutions was sent a questionnaire asking about the length of programmes and academic level; curriculum design and teaching and learning strategies; and the types of clinical learning experiences available to student midwives. This information was used to select the case study sites to ensure that the case study sampling decisions reflected the current situation in terms of geographical location, the type of midwifery care provided by the NHS, the needs of local populations of mothers and babies and the range of pre- and post-registration education provision.

3.2 Case studies
In order to obtain information on a national basis, five sites in England were selected. Criteria for selection included: whether sites were rural or urban; which pre-registration programmes were offered, for example, d, e.g. for example, inclusion of pre-registration

shortened programmes; and a range of philosophies and styles of teaching, including, e.g. problem-based learning.

The negotiation of access to undertake research in clinical areas was complex and intensive. In each site agreement was sought from the Higher Education Institution (HEI) and from at least one associated local NHS Trust providing maternity services. Access within the NHS Trust was negotiated via the Chief Executives and Head of Midwifery Services and via the Head of School and Approved Midwife Teacher within the HEIs. The two elements of approval from the HEI and NHS had to synchronise in order that the research could be undertaken within the proposed case study site. Inability to achieve either element resulted in the withdrawal of the research team from the site.

The NHS Trusts have been subject to government and local NHS initiatives which have resulted in a range of changes to existing organisational structures and processes, e.g. introduction of the Commission for Health Improvements, move to Primary Care Trusts and amalgamations of existing NHS Trusts. These changes have created demands on the clinical areas and on the staff which have mitigated against their capacity to accommodate the requirements of an external research agenda and have precluded a number of them from participating in this study.

Multi-centre Research Ethics Committee approval was gained in March 2000 as the research design indicated the intention to access five or more different sites for data collection. This approval was presented as part of the application process to all the Local Research Ethics Committees (LRECs) within NHS Trusts that had agreed to participate. In addition, the research team was required to make applications to each of the LRECs that oversaw the research activity within each of the NHS Trusts that were subsequently included in the study – a total of 12 applications. LRECs required various combinations of research study information and have different processes to consider research studies which have Multi-Centre Research Ethics Committee approval.

Each NHS Trust has its own structures and procedures for agreeing and monitoring external research access. The Research Departments within each NHS Trust was also approached with information concerning the study in order that they may fulfilled their obligations within the Trust and to the Department of Health for monitoring research activity. There was minimal evidence of a coherent approach to the management of requests from external research teams, with many of the key staff being unaware of which personnel should be informed in the event of such requests for access. Access to a case study site could take up to four months to negotiate.

It was anticipated that the data collection within each case study would be undertaken within a minimum of a three to four month period. The key factor in the case studies was the timing of the student midwife placements in clinical practice. Negotiations with the key personnel at each case study site were vital in ensuring that data collection was effective and efficient, including link tutors and practice placement co-ordinators.

The first case study commenced in July 2000 and data collection continued until June 2002.

3.3 Research Midwives

In light of the national reach of the research study and the design, which identified in-depth data collection methods, the project also incorporated the employment of local data collectors. It was decided that qualified midwives should be recruited to assist in the information gathering, particularly the observations of midwifery care provided. The midwives were recruited from the localities within which the case- studies were being undertaken, although care was taken to avoid the midwife being required to collect data within the maternity unit where they may be working or had previously/have worked.

National advertisements were placed within midwifery press on three separate occasions over the lifetime of the project and elicited positive responses. Contracts were offered on a flexible, part-time basis, for a three to four month time span and reflected to the geographical areas of the case study sites.

The posts were suitable for midwives who had current knowledge and experience in midwifery practice and who wished to develop their research skills and gain experience of working on a national research project. The majority of applicants demonstrated evidence of research activity, including research roles within randomised controlled trials (e.g. MagPie) and/or independent research undertaken for academic credit or award. The range of research experience and the interest generated amongst the applicants for these posts will be of interest to the midwifery profession.

The research team provided full training and support to the research midwives as, despite the benefits of their existing research experience, they needed to be familiarised with the particular research methods and the processes being used within this research project. An introductory pack was created which included the research proposal, the research schedules (for the interviews, diaries and non-participant observation), and examples from the literature relevant to each of the research methods used. (see appendix 4). The research midwives undertook an induction day at the Research Centre at the University of Surrey where they were able to further acquaint themselves with the research methods and the types of data that they could expect to collect. (e.g. examples of raw data from the pilot study were shared with the research midwives to give a flavour of responses..).

The five research midwives received ongoing support from a research co-ordinator based within the research centre throughout the period of data collection within the case study site. This took various forms including on-site visits and joint data collection by the research co-ordinator and midwife, email correspondence and telephone conversations on a regular (often daily) basis. The level of communication and support was negotiated in order to achieve the most effective use of resources. This was particularly relevant in order to focus the direction for questioning of research participants in the latter stages of the in-depth data collection, e.g. for example, during exit interviews and to ensure that all aspects of the research design had been addressed.

The research midwives worked under great pressure and but were able to adapt readily to a pre-ordained research focus. They had to remain flexible in their approach, knowing when to withdraw from a situation, and yet sufficiently enthusiastic and interested in the research themselves to attract others to become involved. The role called for tact, and patience and with concentrated and continuous effort in order to achieve access, recruit

participants and collect sound data. The project was fortunate to recruit a group of midwives who were effective and credible in these roles.

3.4   Data collection methods
All of the data collection tools were developed, piloted and refined by the research team. Literature relevant to midwifery and professional education, including educational research were used to inform the development of the semi-structured interview guides, a diary guide and non-participant observation schedule.   For an overview of data collected, see Table 2 (page 2736).

3.4.1 Curriculum documentation
A large number of documents were collected from each of the case study sites. These consisted of programme handbooks for the available midwifery programmes, but also and supporting documents, such as:

Portfolio of learning
Student policies
Module packs
Records of practice based learning
Updates for mentors
Clinical assessment documents.

These documents provided detailed information relating to the different programmes of education which the student midwives were undertaking within each case study site, including the aims, intentions and outcomes of each programme. The documents also highlighted the preparation and support available for students and their mentors in practice settings.

3.4.2   Interviews with midwives, teachers, managers and supervisors
A number of midwife teachers (including Approved Midwife Teachers), managers (e.g. Heads of Midwifery Services) and Supervisors of Midwives were invited to participate in individual interviews at each case study site. These were key personnel who were involved with and contributed to the teaching and learning in practice of student and qualified midwives. Interviews with Approved Midwife Teachers (now Lead Educators) and Heads of Midwifery Services were usually undertaken by the research co-ordinator at each site. The number of interviews reflected the type and scale of education and service provision within the case study site.

Two to three group interviews were also held with the qualified midwives within the NHS Trusts at each site. The Research co-ordinator and/or research midwife invited qualified midwifery staff to attend group interviews in each site at times and venues that were most convenient to the clinical staff. Access was negotiated with the key midwifery staff and attempts were made to ensure that all staff had the opportunity to contribute to the research, e.g. groups were held at different times of the day.

Key areas of questioning included the system of mentorship and preparation for mentorship, factors influencing learning in the clinical setting and issues related to the midwives' own professional development. The ability to ask several groups similar and related questions to several groups provided a reliable view of the context and coherence of the approach to mentorship within a case study site. And Information was also sought regarding local assessment processes.

3.4.3   Involving student midwives

The process of recruitment of the participants for this research project was essentially guided by the midwifery student clinical placements within their education programmes. The students undertaking their midwifery programme within a University can be placed in a number of NHS Trusts for their clinical experience and at different times of the year. (NB. The academic year for midwifery students is normally 45/52 weeks.) The process of recruitment involved identifying (through the Approved Midwife Teacher and/or University placement officer) where students were being placed with NHS Trust-bases (hospital or community setting), specific midwifery placements and general overall numbers of student midwives at each site.

The Research Co-ordinator for the site from the project team, liaised with the midwifery academic midwifery staff at the University and provided a brief overview of about the project to be distributed to student groups. This information also constituted the invitation to attend an information session about the project. The Research Co-ordinator visited the case study site and held information sessions with each group of students, incorporating students from all the programmes provided in midwifery at the University (for example, long and short degrees and diplomas).

The information sessions were scheduled to take place prior to the students' next clinical placement experience and provided the opportunity to give the students more detail about the project and the range of data collection methods, including the in-depth data collection. The students were able to ask any questions about the possible impact of the research, both in the short and longer-term. The sessions were held solely with the students to ensure their anonymity.

3.4.4 Group interviews with student midwives

Each group of students was invited to participate in a focus group interview. The discussion was guided by a semi-structured interview schedule and where possible was attended by the Research Co-ordinator and locally-based Research Midwife. The focus group interviews lasted approximately one hour and included questions about the balance between theory and practice, the learning of clinical skills and the assessment of practice, including the purpose and practices of mentorship and practice assessment. Confidentiality was maintained; each group was interviewed separately without the presence of academic staff. In this way, it was hoped that the students felt would feel free to talk about issues relating to their preparation and assessment for midwifery practice.

The students were very enthusiastic about the project and volunteered for both group interviews and in-depth data collection in large numbers. They Those who participated reflected the range of programmes available and provided a range of perspectives in relation to their stage of progression within their programmes.

3.4.5   In-depth data collection methods – recruitment of pairs

At the time of the information session, students were invited to volunteer for the in-depth data collection aspect of the project, bearing in mind their own commitments and considering whether their mentor within their next clinical placement would be interested in participating in the project. The students did not necessarily know the name of their allocated mentor at this time. Names, contact details and placement area were collected by the Research Co-ordinator. Although the intention was to involve 4four midwifery students within the in-depth data collection processes in each case study site, the Research Co-ordinator collected the names of all interested students as there were a range of factors which could affect the final selection of participants, not least their own choice.

Students were assured of the voluntary and confidential nature of their participation and that they were expressing an interest in the research process by providing their names and not entering into a binding contract. They were free to change their minds at any time and might not ultimately be contacted further depending on a whole range of factors, such as number and type of students volunteering within the case study site.

The students who were interested in participating in the in-depth data collection processes provided information to their mentors concerning the project and their proposed involvement at the commencement of their clinical placement. If the mentor was prepared to consider becoming involved, the student identified their mentor to the Research Co-ordinator and/or Research Midwife for further contact and discussions about the project.

Once consent had been gained from both the student and their mentor, the in-depth data collection processes (interviews, diaries and non-participant observation) were negotiated between the student, mentor and Research Midwife. Each of these data collection methods are outlined below.

Within each case study site, three/ or four pre-registration student midwives and their mentors were recruited to participate in the in-depth study. The total national data-set comprises of 19nineteen pairs. For an overview of student programmes, length and type of placement, see table on following page.

Table 1: Demographics of students

Student	Programme	Length	Type of Placement	Length of Placement
Case Study –– 1				
1	Diploma	3 year	Hospital	5 weeks
2	Degree	18 month	Hospital	7 weeks
3	Degree	3 year	Community	6 weeks
4	Degree	3 year	Community / Hospital	6 weeks
Case Study – 2				
5	Diploma	3 year	Community	12 weeks
6	Diploma	3 year	Hospital	12 weeks
7	Diploma	3 year	Hospital	16 shifts
8	Degree	3 year	Community	12 weeks
Case Study –– 3				
9	Diploma	3 year	Hospital	8 weeks
10	Diploma	3 year	Hospital	12 weeks
11	Degree	3 year	Hospital	6 weeks
12	Degree	3 year	Hospital	6 weeks
Case Study – 4				
13	Diploma	3 year	Hospital	8 weeks
14	Diploma	3 year	Hospital	10 weeks
15	Degree	4 year	Hospital	3 weeks
16	Degree	4 year	Community	8 weeks
Case Study – 5				
17	Diploma	3 year	Community	36 weeks
18	Diploma	18 month	Hospital	36 weeks
19	Degree	18 month	Hospital	12 weeks

3.4.6 Initial interviews with student midwives and their mentors

The student midwives and their mentors were interviewed individually at the commencement start of the clinical placement. The semi-structured interview schedule for the student midwives focused on their preparation for the clinical placement and their expectations of support and assessment. The mentors were asked similar questions but the focus was on their preparation for the role of mentor, their understanding of the programme of study and the student midwife's stage within it, including expectations of clinical confidence and competence. The support they would offer the student midwife and the identification of their own developmental needs was also discussed.

3.4.7 Diaries of student midwives and mentors' experience

The student midwife and the mentor undertook to complete a diary detailing their experiences in clinical practice over the same period of ten consecutive days. The use of diaries suits the exploratory approach of the research and draws on traditions of story telling within midwifery (ref needed)McHugh 2001). They participants were advised that they could complete these either through tape recording or written format. The choice of tape recording reflected the need to provide those who were participating in the research with the method that would be the least time consuming method. The majority of the participants chose this method.

The diaries were completed by the pairs of student midwives and mentors over the same period of ten consecutive days to increase the reliability and credibility of the data. Guidance was provided to participants in relation to the focus for their diary entries (See Appendix 4**). The data from the diaries have been transcribed and the entries for each day from both the student midwife and the practice assessor have been arranged to reflect each day that they worked together. This enabled comparability of the material.

There was very positive feedback from the participants concerning the completion of the diaries. All participants were keen and undertook a substantial commitment with the audio-diaries in particular producing rich data.

3.4.8   Observation

Information was obtained through direct non-participant observation of the midwifery care that was being provided by both student midwives and their mentors to mothers and babies. The observer ascertained permission from the women receiving care, remained unobtrusive and did not observe intimate care giving (Pretzlik 1994).

An observation schedule was developed to guide the data collection and to emphasise the activities and processes involved in teaching and learning in practice. Each observation period occurred whilst the student midwife and the mentor were working together within the clinical area and was arranged to reflect the range of areas and experiences available, e.g. hospital and community settings. The intention was to undertake the non-participant observation to coincide with the diary work.

The framework for the observation was timed event sampling. The research midwives took detailed notes of the interactions between the student midwife and the mentor over a three to four hour period on a maximum of three occasions during the clinical placement. The research midwife focused the observations on learning activities; how theoretical learning was applied to practice, teaching style, skills of the mentor and the impact of care for the women. The observation notes produced detailed accounts of both verbal and non-verbal interactions.

Where possible, formal assessment processes were observed and contextual details were also obtained. These included the management and practice area ethos, the organisation of care, staffing levels, skill mix and multi-professional working.

3.4.9 End of placement interviews with student midwives and their mentors

At the end of the clinical placement the student midwife and the mentor were interviewed individually, using. The interviews used semi-structured guides., which Generally, the timing of this interview encouraged reflection of the placement experience and enabled the researcher to clarify and explore in more depth issues that had emerged through the diary work and non-participant observation in more depth.

3.5 Telephone interviews with women

During the observation visits women were invited to participate take part in the research study by participating in a telephone interview, in most cases, a couple of few weeks after their babies had been born. The aims of the interview were to ascertain women's views and expectations of the midwives' role, as well as their attitudes to student involvement in their maternity care. The schedule was designed to take only 20 to 30 minutes of the woman's time, with an emphasis on simplicity and user-friendly language. The women were assured that choosing not to participate, would not affect their care in any way.

The research midwife contacted the mentor prior to contacting the women to ensure that they only included those women who had had safe deliveries of their babies. The women recalled the research project and their consent to participate. Most women were able to comment in general about the care that they received from student midwives.

3.6 Overview of data collected at each site

The following table below on the following page will provide an overview of the type and amount of data that was collected at each of the five case study sites.

Table 2: Overview of data collected at each site; including totals

	Method	Participant	Case Study Site

			1	2	3	4	5	Total
In-depth/pair data	Interview	Student - Initial	4	4	4	4	3	19
	Interview	Midwife / Mentor - Initial	4	4	4	4	3	19
	Diary	Student	4	4	4	4	3	19
	Diary	Midwife / Mentor	3	4	4	4	3	18
	Observation	Student & Midwife / Mentor	8	4	8	11	6	37
	Interview	Student – end of placement	4	4	4	4	3	19
	Interview	Midwife – end of placement	4	4	4	4	3	19
	Telephone Interview	Women	7	2	4	4	1	18
	Interview	Approved Midwife Teachers Midwifery Tutors Lecturers in Midwifery	3	5	4	4	3	19
	Interview	Head of Midwifery	2	1	1	2	1	7
	Interview	Post-registration Midwife	2	1	1	2	1	7
	Focus Groups	Students (6-10-20 participants per group)	3	3	3	3	2	14
	Focus Groups	Midwives (6-10 participants per group)	2	2	3	3	1	11
	Interviews	Additional Stakeholders	3	1	4	0	2	8
			\multicolumn{5}{c}{GRAND TOTAL}	**272**

3.7 Data Management and storage

The research team established comprehensive data management systems and the data were systematically stored for each case study site. Each tape and interview transcript was given a unique identification number and the data was filed and recorded in a database, which was accessible to the research team. This facilitated easy document retrieval and created effective handling of the data. All documents/transcripts were stored safely in accordance with the Data Protection Act (1998).

3.8 Data analysis

A comprehensive strategy for data analysis which reflects the case study approach was used (Yin 1994). The theoretical approaches that underpin the research questions, e.g. Eraut (1990) and Benner (1984) informed the data analysis and the different data sources were triangulated to strengthen the analysis. Latent content analysis was used as the content of the interviews, diaries and observation notes, including the main points and significant meanings, can be analysed in this way (Field & Morse, 1985). The data were subject to peer examination and review within the research team. Each case was analysed individually and then cross-case analysis undertaken.

3.9 Analysis of curriculum documentation

Documentary analysis was undertaken using the pre-registration midwifery documentation, which included including curricula documents, assessment of practice

documents and student handbooks. The framework for analysis drew on the current literature including professional regulations and guidelines and educational research, e.g. Gerrish et al (1997). The analysis was developed case by case and used to provide contextual information in the analysis of the remaining data.

3.10 Development of case study reports
The case study reports were developed through thematic content analysis of the transcribed interviews conducted with Approved Midwife Teachers, Midwifery Lecturers, lLink-tutors and Heads of Midwifery Services. The findings give an overview and description of the context of midwifery practice at the time of data collection (2000-2002) and in which midwifery education can be placed. The complete set of data was first analysed individually case by case and finally all the data was amalgamated and cross-case analysis was performed. The questioning in these interviews focused around mentorship, systems of care, education-service partnerships and factors that influenced the learning in the clinical setting. Findings have been organised around five key themes and are reported in chapter 4.5.

3.11 Analysis of in-depth data
Data analysis was undertaken on the transcribed notes from nineteen complete data sets from pairs of student midwives and their mentors. The total data set comprised verbatim transcripts or detailed notes from the initial interview, diary entries, non-participant observations and exit interviews.

A sample of transcripts was initially coded independently by three members of the research team into themes and categories. This process involved bringing order to the data, and organising it into more manageable patterns. This initial process comprised of labelling and classification of content. As Patton (1990) describes, 'Simplifying the complexity of reality into some manageable classification system is the first step of analysis' (p. 382). Patton also recommends using more than one person to code the data, as the results can then be compared and discussed which increases inter-coder reliability. Useful insights can emerge and Patton refers to this process as 'a form of analytical triangulation' (p. 383). The process also involved making joint decisions and judgements about what was really significant and meaningful in the data.

Some of the themes naturally derived from the questions that were asked in the interviews, the guidance given to the participants for completion of their diaries and from the observation schedules followed by the research midwives. Other themes emerged from comparing and contrasting the data from the pairs of students and midwives. The research team were able to look at incidents and relationships from a number of sources in order to validate obtained information. Finally, themes emerged from the in-depth data where participants were able to voice issues and concerns freely. This was the inductive part of the analysis where the themes and patterns stemmed out of the data rather than being pre-imposed before data collection or analysis.

The developed coding framework was then reviewed by a research midwife (not previously involved in this project) and a sample of data was 'test-coded' with the aim to test the clarity. The justified framework was then applied to all the remaining in-depth data. The framework provided the research team with structured guidance, which facilitated the analysis and strengthened the reliability of the findings.

3.12 Triangulation of data

The triangulation of these methods occurs at a macro level, providing a context for in-depth analysis and a full and more complete picture of the experience of both student and mentor in the practice setting. The triangulation can also occur at the micro level where data has been collected from various sources and perspectives relating to a single event and these different sources provide a depth and level of detail that may not be otherwise possible to achieve.

"…triangulation may be used not only to examine the same phenomenon from multiple perspectives but also to enrich our understanding by allowing for new or deeper dimensions to emerge" (Jick 1983: 138).

The nature of the data collected from and about mentor and student pairs demonstrates the benefits of combining non-participant observation with diaries and interviews. A multi-method design produces a rich evidence base and has enabled insights into aspects of clinical teaching and learning which often remain invisible.

3.13   Reflection on the methods, including limitations

Project size

The triangulation of methods enabled rich data to emerge from a variety of sources. This proved to be strength in the study. For example, without the observation notes and diary information from the 19 student/\mentor pairs, much activity concerning teaching and learning in the clinical settings may have been unrecorded and therefore lost. An example of this is presented in observation notes, which were correlated with a student's audio-diary. The student midwife being observed was in the second year of a three year degree and her placement was on an antenatal ward. The observation notes provide descriptive detail of the amount of physical contact and emotional input the student provided when one woman became anxious and tearful. The midwife mentor seemed unaware of the depth of interaction which had occurred when she was not present. The student's diary entry however, describes the tensions from the responsibility of caring for women when they are vulnerable. The diary provides the rich depth of feeling when the student fluctuated between feeling vulnerable and strong herself. This depth of human emotion and reflection on learning in practice would not have emerged from the observation notes alone.

It could be said that the sheer volume of information from the five case study sites amounts to 'information overload' (Pawson & Tilley 1997). The data were made more manageable for analysis through the research design process. Specific themes ran through all groups of research participants in the design of the semi-structured and focus group interviews. These included, for example, questioning most groups on their views on preparation for the mentor role, and learning and support of students, in particular, levels of student supervision. Within the in-depth data-collection process, the added information from, for example, the diaries and non-participant observation visits was valuable as it added complementary views concerning education in practice. This large data-set will add to the literature etc regarding clinical learning in midwifery practice and will be explored in more detail through future publications, and will providing a focus for further research.

Recruitment of student midwives

All participation in this project was voluntary, from permission to undertake case studies to permission and consent procedures from individuals taking part in the in-depth research processes. Whilst the voluntary nature of participation is a positive element in a national project of this size, there is the possibility of the introduction of an element of bias in that the subjects who volunteered were self-selected. To balance this, the research team and research midwives used a number of strategies in the recruitment process:

- Over-recruitment of student midwives who volunteered for the in-depth part of the project. Timing of each case study was dependent on the beginning of the students' clinical placements. The student focus groups were therefore held as early as possible in each case study. When students volunteered, they were not aware of which NHS Trusts the investigation was occurring in. The condensing down to four pairs in each site was dependent on certain criteria, for example, which Trusts had given ethical permission.

- Criteria for recruitment also included which programme the student was studying on. The aim was to obtain in-depth views from the range of midwifery programmes and see if there were major differences for students on the 18 month (shortened) degree and longer degree and diploma programmes. It is important to note that the intention was not to have a representative sample but to have a general cross-section of programmes included.

- The aim was also to gain an overall national view of student experience with different schemes of care, for example, case-loading and other integrated care schemes. At each case study site, the four pairs were usually studying on different programmes (perhaps (degrees and diplomas).

- An overview of practising in different settings. In some urban settings, for example, emphasis may have been on specialising on certain antenatal conditions at inner-city Trusts. In more rural settings (including GP surgeries and birth centres), there was exposure for students to different learning experiences.

Recruitment of mentors

There was also the potential for a self -selection bias to arise in the recruitment of the midwife mentors. In the majority of cases, the mentor was approached by their student midwife, who then provided contact information to the research midwife or co-ordinator to follow up if they expressed interest in participating in the study. The numbers of mentors recruited across the five case study sites provided sufficient data to demonstrate the range of issues, both positive and negative, related to teaching and learning in clinical practice.

STUDY DESIGN: CASE STUDY

SAMPLE: FIVE SITES IN ENGLAND

University   **Trust**

Lead Educator
(formerly AMTs)

Lecturers

STUDENT MIDWIVES studying for:

Degree & Diploma programmes
long (3-4 year) &
shortened (18 month)

Programme
Leaders

Link Tutors

Women

**MENTORS
(Midwife mentors)**

Head of Midwifery
services

Supervisors of
Midwives

Practice/Development/
Research Co-ordinators

POST REGISTRATION
MIDWIVES

Studying for courses with clinical outcomes

MIDWIVES

**Working in the community, teams, integrated care e.g. caseloads,
hospital trusts – on wards, core
low/high risk etc.**

CHAPTER 4   CASE STUDIES

Introduction
The aim of this chapter is to present the findings from the broad case study data, thus providing a backdrop to the in-depth data presented in Chapter 5. The case study data also provide a flavour of the ethos within Universities and NHS Trusts in the sample.

To gain local information for each case study site, documents were gathered. These included Annual Public Health reports, which provided local population health statistics. It was possible to deduce general health trends of the clientele the midwives and students were caring for. Documents relating to the student midwives' curriculum were also collated and analysed.

The case study data were collected from individual interviews with a range of stakeholders (for example, academic and clinical staff). As mentioned in Chapter 3, data were also collected from group interviews. The focus group interviews with student midwives comprised 10-20 students per interview and took place at the Universities. Midwives took part in focus group interviews at the Trust sites, with the aim being to incorporate midwives working on the range of shifts at the NHS Trusts.

This chapter starts with an analysis of the focus groups as this is how the research team were introduced to the perceptions of the students of the 'live' issues regarding teaching and learning at the NHS Trusts affiliated to each University.

4.1 Focus group analysis - Student and qualified midwives

Student midwives

4.1.1 Balance of theory and practice
The students found it difficult to balance all of the competing elements of their courses. They found that there was a great deal of theory to cover, much of which they understood better when they had experience of clinical practice, *'it's fitting into place now'*. The examples provided indicated that the balance between theory and practice was very difficult to achieve for the majority of the students interviewed. To some extent this related to the complexity of midwifery practice – *'you don't know what will come through the door',* which was often at odds with the midwifery curriculum which moved along the continuum from 'normal' to 'abnormal' pregnancy and childbirth in a linear fashion.

For example, junior student midwives, whilst accepting that *'you can't learn everything in your first year',* were critical of the emphasis on 'normal': *'as soon as you go out, you're faced with high risk';* and on psychosocial rather than practical aspects of care: *'you learn how women feel but not how to treat them'.* They also expressed the need to know *'essential things like how to interpret blood results'* in order to gain a better understanding of care decisions made in practice and to cover issues in theory before they were involved in care, e.g. *'you can find yourself being asked to advise on breastfeeding in the community, before theories on breastfeeding and physiology of lactation'.*

This highlights the tension the students experience between the academic and practice settings in relation to expectations held by these different areas. The students had to navigate their course between the two environments, which were portrayed as holding different (and possibly separate) agendas. There was little indication that they felt appropriately prepared for the realities of clinical practice, nor that the midwives within the clinical settings were clear about the requirements of their programmes: *'it would be nicer if they had a clearer picture of what they should be doing with us'.*

There were examples given which indicated that individual midwifery lecturers were able to facilitate the transition between the two settings, but this did not appear to occur at an organisational level. The students suggested that links with the University whilst they were in practice may help to integrate theory and practice and gave examples where they had benefited from the opportunity to talk about actual cases and events with lecturers who came into practice settings for reflective sessions.

There were some examples provided where the students felt that clinical placements coincided with and reinforced theoretical instruction content, for example, community placements, but it was recognised that this degree of formal linking was difficult to achieve for all students. Long periods between placement experiences, 'block' placements and short week placements (2 or 3 days per week), and lack of regular contact between the university and clinical area were all mentioned as potential barriers to the student midwives achieving a balance between theory and practice.

However, it was in clinical practice that the student experienced the greatest pressure from the different elements of the course; they would be 'working', have academic assignments to complete and wished to 'read up' after their day in practice about the various aspects of midwifery care they had seen.

Students generally felt that assessments enabled the integration of theory and practice, but would prefer to complete more, smaller (in words) assignments that were more clinically focused and linked better with their own practical experiences. They may not have the opportunity to reflect each day with their mentor and wanted to read and reflect on what had happened each day:

'You have this guilt feeling that you can't go home and learn about what you really need to learn because you've got these essays that need doing.'

The students undertaking community placements found that they had more time to talk about theory, for example, 'social issues' as they could connect knowledge with their visits to the homes of women and their families. One midwifery student saw the integration of theory and practice happening through the explanation of midwifery decision making: *'Every time you have a mentor, everything you do is going through the theory'.*

Many of the issues related to the balance between theory and practice were exacerbated for those students undertaking the shortened midwifery programmes (18 months). Some described the tensions with linking their prior experiences and knowledge:

'The sociology and psychology modules are too long … we're already trained nurses'

Others expressed the need for more preparation for providing care to women and babies with health problems:

'As soon as you go out, you're faced with high risk. The link's not logical. High risk needs to be moved'

4.1.2 Learning midwifery practice

The students were asked about the acquisition of their clinical midwifery skills and from whom they learnt these skills. Many identified that they primarily learnt these skills in the clinical areas. They were motivated to seek out learning opportunities and *'took the good bits'* from all of the qualified midwives, *'I prefer to be shown by midwives that have done it for a long time and are very confident in that skill'*. Some described how they wanted to make the most of opportunities as they arose and were not always happy to wait, for example, until they were '3rd years', to be allowed to learn certain midwifery skills. The students who had the opportunity to learn essential midwifery skills within a clinical skills laboratory were very positive about this experience.

The students felt responsible for their own learning in the clinical area but recognised the tensions within this approach:

'The onus is on us to be more assertive about what we want to do and yet we're expecting to be taught in these practice placements – so perhaps it's developing our assertiveness skills being students.'

'Thought that midwives would go systematically through midwifery skills, but we find that the workload is high and can prevent this from happening.'

'Part of the course is learning to be a midwife, learn the culture – university and work culture, and you have to learn to play the game.'

Students found that time was a major issue; they and the midwives were 'so busy' and this affected the time they had to find out, and reflect on a daily basis. The students were also concerned that the learning strategies they had developed were not always exposing them to best practice – *'may not be learning skills the "right" way – the way it's supposed to be done'*. They felt that this could be addressed if the midwifery tutors came into the practice areas to teach these skills and where there were examples of this happening, the students realised the benefits that were derived from the opportunity: *'When your tutor comes out to work with you, that's when you almost learn more because your mentor doesn't have time to teach you'*.

It was clear from the data that the students were exposed to different midwifery practice in the variety of maternity service units associated with the Universities. This related to both organisational structure and individual midwifery practice. The students were aware of these differences and were required to practice in certain ways as outlined in unit protocols, e.g. the use of electronic monitoring on admission. At an organisational level, this raised issues of equity and parity of clinical experience as the students were aware that the different contexts of care were having an impact on the nature and content of their learning. The students were also concerned as they wished to learn evidence-based midwifery care and found the lack of coherence of approach between units potentially confusing. They were uncertain about the appropriateness of students introducing evidence-based practice.

At the individual level, students recognised that they needed to make re-adjustments between midwives who had their own personal ways of performing midwifery skills, e.g. *'some people don't deliver with their hands, some people deliver hands on, it's all very different'.* The senior students were better able to accommodate variations in practice and had the opportunity to develop their own style of practice.

Another key issue for the students in relation to their experiences in the clinical areas was the mixed message they were receiving from the qualified staff about their role and status within these settings. On the one hand they had talked about their supernumerary status in recognition of their learner role and yet on the other they identified themselves as '*an extra pair of hands', 'you just work as one of the team'* and as '*doing my own work and being a general dogsbody'.*

This last point highlights the number of comments about the way in which they were interrupted, in the midst of providing care, by midwives (other than their mentor) who required them to undertake an errand, for example, deliver a blood sample to a laboratory. They interpreted these actions as demonstrating a lack of understanding of their role and status, interfering with their learning and devaluing their contributions to the care of the women.

Issues of status were also expressed by students on the shortened (eighteen month) midwifery programme. Adjusting to the student midwife role from having previous senior positions was sometimes perceived as difficult:
'You feel de-roled … we can't carry keys or give Panadol'
Others described the difficulty of being assessed in 'communication skills' if they had held roles as senior nurses. The students generally cited the need for their mentors to respect their prior experience and to give feedback in ways that valued this practical knowledge.

Frustrations with gaining the numbers to qualify were also vocalised by some student midwives: *'We have to get 40 deliveries in 18 months. The others [on long pre-registration programmes] have three years.'* Students described the disruption which ensued if they needed to return to delivery suite (when officially on other placements) so that they had enough births recorded for registration.

4.1.3 System of mentorship
The system of mentorship, including the allocation of mentor responsibilities, was variable both within and between maternity units. The majority of students were not aware there was a system of allocation of mentors, how the system worked or whether any guidelines were used to establish student/mentor pairs and did not think that the midwives knew either. Some students had received notification about their placement and the identity of their mentor prior to commencing the placement and their mentors also knew about them before they arrived, (this reflected the particular arrangements that had been put in place in one of the NHS Trusts). However, the majority indicated that they were allocated a mentor on the basis of whoever was around when they arrived on their clinical placement.

There were concerns expressed by some that there may be too many students and not enough mentors to support them. The pressure was increased when the maternity unit was short-staffed or there were high numbers of part-time midwives or newly qualified midwives who required preceptorship themselves. Students at two of the five sites

appeared to have more issues with consistency of mentor relationship than the others. There were also examples of 'bottlenecks' (a high number of students in the placement areas at the same time), which were often exacerbated if the students were all seeking particular experiences, e.g. final year students trying to achieve their 40 deliveries or where students were able to *'just turn up'* in the placement area.

The students found assessment of their practice more meaningful when there was continuity of relationship with a mentor. Continuity of mentor also meant that they did not have to repeatedly describe their level of skills to a new mentor every day. Students felt that they were able to experience greater continuity of mentorship within the community placement.

Generally the students felt that *'mentors can be brilliant',* and that *'most mentors are careful about how they teach you because they know they're making midwives'.* They identified a 'good mentor' as someone who *'will sit down at the beginning and talk it through',* but they also acknowledged their own role and responsibility, *'depends on the mentor and student – if you're aware enough to highlight your own needs. If you're a bit subdued as a student then you're not going to seek it out or get on'.*

The senior students recognised that they were more effective in identifying those midwives who could help them learn as they gained knowledge of the maternity unit. In this way they were able to make the system work for them. They felt the mentorship system could be improved by greater standardisation of approach.

4.1.4 Assessment
The students identified that they were assessed by the midwives at the beginning of each new placement which is captured in the following extract, [there is] *'a certain time whereby they are trying to weigh you up and once they'd established where you were, often they felt more confident with you and you with them'.* This initial assessment drew on the midwife's own professional knowledge and standards of practice using tacit and experiential knowledge. There was minimal reference to the educational curriculum the student was following, *'midwives don't seem very certain that if you say, 'I'm in term 5', what exactly that means and how far your skills have developed.'* This did not affect perceptions of the validity of the assessment process, but instead recognised the expertise of the midwives and highlighted their shared conceptions of fitness for midwifery practice.

The students were asked about the practical assessments that were completed throughout their programme of study. On the whole they did not feel that the mentors were familiar with the documentation or the underpinning concepts and recognised that they were directing the mentors and to some extent their own learning.

It was clear that some students experienced mentorship as a joint enterprise as expressed in this extract: *'It's not just the midwife having to do it, it's a joint effort. I always find that action plans and agreed goals are more joint as opposed to her or me. It's a combination of both of us'.*

Comments were made about the language used within the documentation: much was classified as 'jargon', e.g. *'Does the student demonstrate understanding of the empirical knowledge required for midwifery practice?'* and *'Has the student demonstrated internalisation of such and such a concept?'* (The latter refers to the curriculum

framework used within a university.) The students also commented that the documentation changed frequently and recognised that this made it difficult for midwives to gain any real degree of familiarity with it.

As a result of this, many mentors were reported as asking the students for guidance on the completion of the assessment forms – *'where do you want me to sign?'* The students also reported that some mentors *'ticked the boxes'* whereas others might *'write a story'*. They found the lack of a standard approach frustrating and it affected their ability to identify their areas of strength and those areas for development.

This also raised issues about the usefulness of an assessment from one placement to inform them and their mentors in subsequent placements. There did not appear to be a formal system for the mentors, which enabled the continuity of assessment over several placements (although the students were certain that the mentors talked about them informally). The student and their tutor would know about the content of practice assessments over time but this information was not shared with the practice staff/mentors unless the student chose to disclose it. Students from all sites suggested that *'a brief profile'* could aid continuity between placement areas and mentors, *'they need to know an overall picture of what the student is like, what stage, what needs working on'*.

They indicated, however, that the mentors understood the serious nature of the documentation in assessing competence in midwifery and their importance in progression and achievement, and gave examples of students having failed practice placements: *'It must be quite frightening when you're responsible for students' actions – to feel free enough and confident in their own abilities to be able to pick up on any mistakes being made'*.

4.1.5 Contribution to mentors' own development

The students were uncertain about how mentors were prepared, although there was awareness that many had undertaken the ENB 997 (Teaching in Clinical Practice) course. In two of the sites, it was felt by students that midwives were well prepared for their role and responsibilities, *'they'll go through your book and they know exactly what they want to do with you'*. They recommended that the mentors received specific preparation on the assessment documentation in order to help them with practical aspects, for example, jointly completing the assessment documents and with interpreting the competence statements. Students also recommended that the tutors met with the mentors as well as the students as this would '*heighten the importance of the mentor to them and make their job a little bit more important'*.

In one site, the students gave the example of students from another university undertaking practice placements in the same clinical areas, accompanied by their tutor. They perceived that the experience of these students was different to their own – the students' learning appeared to be given higher priority and there were less interruptions to their care-giving.

The students were not clear about how they may contribute to the midwives continuing professional development. They felt that many midwives *'looked upon the student as an opportunity to learn more'* and that most midwives enjoyed having students because they were able to pass on their skills, *'that's part of what a midwife does – to pass on skills to others'*.

Students also recognised that their presence could place the midwives under pressure and that '*they may not get a choice if they get a student*' or a break from supporting students. The introduction of new programmes could also add to mentor stress and there were several comments made about the differing needs of students undertaking a variety of programmes, for example, 'direct entry' and shortened degrees, although the students were aware that support and guidance was being provided.

Some midwives were more comfortable with accepting the challenge and new information from students than others, '*it makes them query their own practice sometimes and they re-evaluate it and think, "well, I've always done that, but this might be an interesting change"*'. There was some indication of resistance amongst midwives to students and to the 'research culture' and that some midwives did not want to be a mentor. If this was the case or there was a personality clash, the students identified a range of formal and informal strategies they would use to ensure that their assessment was not affected. They felt that the most important factor was that the mentor wanted to have a student.

4.1.6 Differing experiences for students
The experience of mentorship was often characterised as dependent on the individual personality of the mentor and on the relationship that was developed between the students and mentor. This emphasis on the individual however, does not explain the differences in mentoring experience between the maternity units associated with the same university. The differences of opinion within some groups of students were quite marked and those who were having a positive experience were acutely aware of the benefits when they were discussing the issues within their group.

As some previous quotes show, there were some differences expressed in experience for those student midwives undertaking shortened, as opposed to longer three and four year programmes. These centred around their needs for realistic preparation for the role and the valuing of their previous experience by the midwives.

Midwife Mentors

4.1.7 Involvement in mentorship and preparation and support for role
The midwives were interested in the opportunity to discuss issues related to mentorship and made thoughtful contributions. They were aware of the importance of their role as mentors and generally enjoyed the opportunity to support students. It was both a positive experience and 'an overwhelming responsibility'.

The term 'mentor' has become the primary means of describing the qualified midwives who are responsible for teaching and assessing in clinical practice (as identified in Chapter 3), the definition of mentor has undergone changes during the lifetime of the project. The earlier case study sites were using both 'mentor' and 'practice assessor' to describe supporting roles, but by the time of data collection in 2002, the term 'practice assessor' had generally disappeared.

The midwives identified that the normal practice was for a midwife to be qualified for at least one year before becoming involved in supporting students formally as a mentor. There were several comments related to some midwives feeling that they (or others)

may need longer than a year to develop confidence in their own midwifery skills prior to taking on a teaching and assessing role. There was also recognition that the confidence to fulfil the role of mentor could be affected by the movement or rotation of a midwife to another area of the maternity service. Thus an experienced midwife who had recently moved to a new area may need a period of grace to regain confidence before taking responsibility for a student.

There was general agreement that midwives needed formal preparation to become a mentor and that this usually took the form of the Board approved course for teaching and assessing; ENB 997. Another frequently mentioned form of preparation was a two-day course provided by the local University and there was some variation, even within Trusts, of the proportion of staff who had undertaken either (or both) of these preparatory courses.

These courses were sponsored by the Trusts and all midwives were expected to mentor students on completion of these courses. There was some discussion about the general and specific preparation provided by the ENB 997, which indicated variations between different courses. For example some midwives perceived that there had been an emphasis on 'educational terminology' at the expense of 'practical teaching skills', whereas others had found the course useful in providing them with the skills and opportunity to practise teaching.

The system of allocation of students was variable and '*was often triggered by the student ringing to find out off duty*'. Some examples of good practice were developing within the case study sites and the identification of an individual, based in the practice setting, who was responsible for ensuring that students were allocated was particularly valued. There were fluctuating levels of student presence in the clinical areas, with midwives reporting that they could feel overloaded with several students each at some times and then have none for a while.

The midwives had played a major role in supporting nursing students undertaking their maternity care experience as part of their pre-registration programmes and expressed relief that this system was ending (within this sample of case study sites). They felt that this would enable them to concentrate on providing support to midwifery students.

Midwives also had concerns about the *'constant presence'* and *'lack of a break'* from students. This was often compounded by their lack of choice about taking a student. Their concern was exacerbated in relation to supporting junior students who required considerable attention and involvement, especially if the midwife herself held additional responsibility, e.g. shift leader or core member of staff in delivery suite. It was suggested that 'matching' the student to the mentor might alleviate some of these concerns and might be a more effective system. For example, it may be more appropriate for senior students, who were able to work with less direct supervision, to be allocated to be mentored by midwives with additional responsibilities. There was positive regard for the continuity of mentorship that was achievable in the community.

The midwives had mixed feelings about the assessment documentation. This reflected the differing, and often changing, programmes, levels and stages of the students and, in some cases, different University programmes that they could be exposed to at the same time. There was some indication that midwives were starting to be involved in the development of practice documentation with their University-based midwifery

colleagues. There were clear examples of midwives undertaking the often time-consuming process of completing the assessment documents in their own time due to the pressure of work. They did not feel that their time and commitment to the students, as evidenced by this activity, was recognised by their employer or by the University.

They did not feel that the documents reflected the realities of practice-based learning and assessment and were generally difficult to complete, *'you have to bend what you've done to fit in with the criteria'* and *'it's hard to relate it to practical things that we're trying to get the students to do'*.

Ongoing support for the mentors was considered to be available on request from the University and there were differing perceptions on the visibility and role of the midwifery tutor in practice settings. Four of the case study sites gave individual examples of good practice, with one site indicating active and positive relationships between the majority of midwifery tutors and clinical staff. The midwives would appreciate structured input and support in teaching clinical skills from tutors whilst the students were on placement.

In addition, they would find it helpful to have regular meetings with midwifery tutors to review aspects of student training. For many of the midwives, the educational preparation had changed considerably from their own experience and they needed *'to be clear about the expectations of what students are to achieve'* and what was expected of them as mentors.

4.1.8 Factors which influence learning in the clinical setting
There were a range of factors which influenced learning in the clinical setting, including (i) the student - stage of training, exposure to midwifery care in previous clinical placements, length of placement, motivation, and other commitments (including paid work); (ii) the workload, including increasing incidence of providing midwifery care for women with medical conditions, being shift leader / co-ordinator; (iii) the relationship between the mentor and student; and (iv) the experience of mentor. The last point was discussed in relation to the issues of the perceived validity of midwives' knowledge, which may be based on practical, experiential knowledge rather than 'research-based'.

The midwives found that regular use of the assessment documents could help to make them more accessible and that they could play a key role in setting learning objectives for the particular placement experience with the students. The midwives felt that the learning in the clinical setting was essentially student-led. They relied to a large extent on the student telling them what they needed and expected to learn on their clinical placement.

Midwives did not necessarily know or perceive that the theoretical input of the students was reflected in practice. This was particularly the case at the beginning of programmes when students were focusing on 'normal' pregnancy and childbirth, but their actual experiences in clinical setting were bringing them into contact with the range of women and their babies that used the maternity services.

Midwives discussed their individual responsibility for ensuring that students absorbed the importance of essential midwifery skills and that they played a key role in not only developing these skills but in placing them as a high priority. The students who were near the beginning of their programmes and who had no previous nursing experience required the teaching of basic skills. In some groups, the midwives were beginning to

discuss the way in which the 'culture' of the staff and unit affected the students 'learning of midwives skills' and behaviour: *"if you stay with the patients, you find your students will stay with them"*.

An example of the process of negotiation in setting learning objectives was described during an interesting discussion in one focus group. The midwives were discussing different ways of setting learning objectives, with some expecting the student to arrive at the placement with objectives already completed, whilst others expected these to be established after they had the opportunity to assess the student for a couple of days. They would then be better able to provide an individual assessment and guide learning objectives appropriately.

One midwife described how she worked in partnership with the student:
'Students can't always come with expectations and learning objectives completed – they do not necessarily know what they want to learn. It's important that they have a part in it. It's better to work with them and ask them what they need. And after you've worked with them for a couple of shifts, then we get together and I say 'I want you to sit down and write what your strengths and weaknesses are, and where you think you need to develop' and then we work on those. And I may put a few in myself and say 'well, I think you need to develop this as well'.

The midwives described a process of assessment of each student who required *'close supervision'* at the beginning of the placement, and then, if everything goes well, this level of supervision was reduced. The process depended on the confidence of the mentor.

However 'experienced' the midwife might be, they were all aware of their responsibilities and accountability to the women primarily and then to the student. They needed to assess the student prior to deciding the level of supervision required as, in some instances, when a student was new to an area this could be problematic:

'You can be meeting a student for the first time and she's says it's her 39th delivery, but I've never set eyes on her before. Now she should be, more or less, delivering without my assistance at all – I mean, I've never met her, so do I take her word for it (nervous laugh) or do I do what I do?'

'If you don't know the student, you don't know what she's going to say in response to a question!'

The midwives suggested that there needed to be greater continuity of information about individual students between placements which would guide them in their initial assessment of the student, facilitate the setting of individual learning objectives and guide the mentor and help to identify any problems / areas for development:

'You could do with a summary or report from their last mentor about their progress so far – or from the school.'

'Room for improvement could be included for the next placement so you could see where you have to concentrate, so you're not wasting a week or two getting to know your student, you've got objectives from day one'.

The midwives differentiated between students in terms of their stage or year in their programme and not in relation to the different programmes they may be undertaking, e.g. diploma or degree. Many of the midwives identified that they were undertaking further academic study themselves and did not differentiate between themselves in their abilities as midwives.

The midwives all agreed that the woman's needs took priority over the student's learning needs but it was accepted that the women may benefit from the interaction (questions and answers) between the student and the midwife. Most women were happy to have a student. Midwives had to learn *'not to butt in'* and *'allow them [students] to be a bit responsible for themselves'*. The midwife was instrumental in facilitating acceptance of the student by women, e.g. in a community setting, one midwife used the strategy of saying that the student was 'here to observe'.

4.1.9 Midwives' own professional development

Generally midwives expressed that mentoring students influenced their own professional development in a positive way and that they found mentoring to be a challenging and positive experience. They *'enjoyed getting it right for them'* and felt responsible for them. '*We all want them to do well – they are a reflection on us.'* The students were keen to learn, kept the midwives informed and encouraged them to be up-to-date, often bringing the latest evidence-based knowledge into the practice areas. The students could act as a catalyst for reflection on midwifery practice and also reinforce the midwives' own knowledge and help them gain confidence.

There was some discussion over the relative benefits of continuous mentorship for students and midwives versus a more flexible model in which the student would benefit from working with a number of mentors. This was in part associated with the need to balance their own and the student's needs, but was also indicative of the amount of work and emotional effort that midwives gave to the relationship. The midwife was required to give lots of explanations, particularly to junior (and non-nursing) students, which could be time-consuming. The midwives appreciated knowing a student over time, but this did not necessarily mean that they had to maintain an exclusive relationship with them.

The notion of continuous mentorship was also exacerbated by the fact that the midwives were often also 'shift leaders' or acting in a management capacity. This could reduce their availability to the student. They were however, able to meet the range of student learning needs through their knowledge of the team of midwives and could refer students to midwives who had developed specialist areas of interest.

The midwives expressed their commitment to their own professional development and many (within this sample) were undertaking (or had undertaken) study for academic award. They had concerns about their ability to access continuing professional development (CPD) opportunities, which were met in a number of ways ranging from in-house sessions (including mandatory sessions) and study days to support for academic award. For the latter, they received a combination of time or funding but rarely both. It was suggested that being given an extra study day may recompense them for being mentors.

It is important to note that the student group interviews comprised students undertaking practice placements in all of the associated maternity units, whilst the focus groups with midwives were held in one or two of these maternity units which contained students

undertaking the in-depth data collection processes. The data indicate that some maternity units provided a safe and supportive learning environment for student midwives, where the experience of mentorship did not rely on an exclusive relationship with one midwife.

Summary of focus groups

Students expressed:
- The need to feel prepared for the realities of clinical practice
- The need for more guided reflection on practice
- The need for regular contact between the University and clinical setting
- The need for clarification of the term 'supernumerary' (and recognition of prior professional skills of midwifery students on shortened programmes)
- The need for familiarisation by the mentors of students' curriculum documents and knowledge of stage of training (to appropriately plan the learning)
- The importance of the mentor *wanting* to have students

Midwives found:
- Mentoring positive and simultaneously an 'overwhelming responsibility'
- Confidence (to practise and mentor) was affected by internal rotation
- The midwives who mentored needed to be prepared to teach *and* assess
- Responsibility for student allocation should rest with a designated person in the clinical area.
- The need for a break from students, especially if constantly offering high levels of supervision
- Recognition was needed by employers of length of time necessary to complete all student assessment documentation
- A raised profile of the link tutor would help with, for example, setting learning objectives with students
- Role modelling as a professional midwife was a major responsibility
- They were generally accountable to the women as priority, then the students
- The need for a summary profile of each student
- The role of mentoring was generally positive but emotionally challenging

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4.2 Case Study Reports

This section will give an overview of the intentions of the curriculum and of the strategies for teaching and learning that are in place for midwifery placements, as interpreted by management and teaching staff. (Quotes have not been included as it was felt important to protect the identity of all participants.)

The following topics will be covered with a description of practices and approaches across the five case study sites:

- Systems of care
- The allocation of mentors to students
- How midwives are prepared and updated for their mentoring roles
- What strategies have been put in place to support students and mentors in practice

4.2.1 Systems of care

Students in all the investigated case study sites were exposed to a variety of care settings and systems of care, such as midwifery and consultant-led units, community and hospital-based placements, birth centres, team care, as well as individual midwives holding their own case loads, providing continuity for women. There were examples of hospitals with combined antenatal and postnatal care and units where complicated and uncomplicated cases were separated.

The midwifery students were also exposed to a culture that was constantly changing; there were mergers of NHS Trusts and changes to the way care was delivered. In addition, many maternity units were short staffed, owing to midwives being on maternity leave or long term sickness and this often led to high numbers of agency and bank staff being employed. This was particularly noticeable in the latter stages of the research. The rise in midwives working part-time had a significant impact on mentorship, particularly with regards to continuity of mentor for the students. Some Trusts had a very large junior workforce to recruit from and this affected the skill mix of midwives who were mentoring and supporting students on their practice placements. The student midwives therefore had to learn to deal with changing environments and to transfer their newly acquired learning experiences and skills between different systems of care, as they moved through their programmes of training. Additionally, they needed to learn and adapt to different cultures on each placement; for example midwifery versus consultant-led units and complicated versus low-risk units.

Midwives from all the case study sites rotated on a regular basis between wards, in and out of community and in some cases onto night duty. Most often this happened between every three to nine months and included all members and levels of staff. More senior midwives with management responsibilities appeared to rotate with less frequency. This had implications on the students' learning experience and continuity of mentors. Clinical management staff often suggested that the rotation system did in fact aid students learning as midwives rotated to update their midwifery skills. Students expressed that this strengthened their learning experience.

4.2.2 System of allocation of mentors to student midwives

All of the Universities had some sort of administrative function or dedicated allocation office, that held responsibility for co-ordinating allocations of practice placements for students. This was most often seen as an allocations department or 'office' or in some

Higher Institutions the individual tutors sent out lists of students to the clinical areas. Four out of the five case study sites held an active database, either at the University or in the clinical area, which contained the names of mentors and assessors and their subsequent training and mentorship updates. One case study site did not hold a database and this appeared to cause difficulties, primarily for the teaching staff from the University. According to the University this was due to the lack of IT-skills in the clinical area. Individual lecturers held all training records and the clinical area was criticised as having poor record- keeping. At this particular institution, if a lecturer had to step in and cover another lecturer's work, he or she had to go around the clinical area and ask all the individual midwives about their mentorship training.

All of the investigated clinical areas had a designated person who was responsible for allocating students to mentors. This could be the senior midwives, ward-managers or team-leaders, co-ordinators or the person responsible for organising the off-duty. It appeared that the clinical areas always tried to make sure that a midwife did not continually mentor a student and it was seen as important to give them a break from their mentoring role. Many of the midwives did not want to have to mentor one student exclusively. It was generally accepted that the students would learn from a variety of midwives to be able to compare and contrast their experiences of learning. For this reason, some tutors and managers preferred that students did not keep the same mentor if they returned for a second placement.

There was very little evidence that particular midwives were matched up with students for any reason other than being convenient in terms of timing of the student's placement. In some sites, the person who was responsible for allocating students would locate a midwife who was available and had mentor preparation and would try to ensure that the student's placement did not coincide with the mentor's planned holidays or other influencing factors. In one area, attempts were being made to match students on degree programmes with midwives who already had a degree.   In another site, midwives were matched with student midwives according to age. This was only apparent because there was a general shortage of mentors between the ages of thirty and fifty. This particular site had a large group of midwives close to retirement, as well as many newly qualified midwives.

There was evidence of high expectations by clinical midwifery managers that students should work the same shifts as their mentors and this included the night shift. Students were sometimes referred to as 'awkward', when changing and swapping their shifts and subsequently not receiving continuity with their named mentor.

Guidelines at the case study sites were variable regarding how long a midwife should have been qualified before officially mentoring a student. Some areas expected the midwives to complete a preceptorship period of between 3 to 9 months before taking on students. In other areas, it was expected that midwives would practice for at least 2 years in order to be able to consolidate their practice and training. It appeared that the ideal would be for all midwives to have practised for two years before taking on the mentoring role. However, the reality with changing staff profiles and a younger workforce had forced them to accept midwives with less experience.

All midwives were expected to mentor students as it was seen as part of the professional role to pass on skills. In all case study sites, both full and part-time midwives were encouraged to mentor students. Provision of continuity for students was found to be

more problematic when the midwives worked part-time. In some cases, continuity of mentor also became an issue if the midwife mentors worked full time but were undertaking study modules and were absent from the clinical area for one day a week.

There was no evidence of differences in allocation of 18 months and three-year students, nor between degree and diploma midwifery students. The same qualified midwife could be mentoring a direct entry diploma student during one placement and an 18-month degree student for the next.

Two of the five case study sites made clear distinctions between mentors and assessors. The definitions followed the ENB directives where the mentor was seen as somebody providing the student with support and direction and the assessor was responsible for the clinical assessment and required adequate training.

4.2.3 How midwives are prepared and updated
Midwives at all the sites had to complete a planned induction programme or preceptorship period for between three to nine months and it appeared that few would mentor students during this time.

Most of the sites required their assessors to either hold the ENB 997 (Teaching in Clinical Practice) course, or to attend an assessors/mentor workshop at the University. These workshops appeared to be variable in length. Examples of between one and three days were available, but a two-day workshop seemed to be the most common approach. Some places had been running a three-day course, but as the midwives became more accustomed to the curriculum and working with students, the courses had been reduced in length. The midwives in the clinical area appeared to have the opportunity to feed back on the quality of these mentorship-training programmes in regular educational meetings.

Although most sites required some sort of mentorship training, there was evidence that midwives were both mentoring and assessing students without any training. At one site, the link tutor would spend up to half a day with individual midwives updating on the various courses, assessment strategies, tools of competence and the University's expectations of midwife mentors.

One University provided an open learning pack based on the traditional ENB 997 course, which had been distributed among midwives. This was not assessed or monitored and it appeared unclear to what extent this resource was utilised among midwives. Another site was in the process of producing an open learning pack in response to midwives' needs for more flexibility. Other areas with newly validated programmes had employed link co-ordinators for a limited period of time to train and update the midwives for mentoring students on the pre-registration programmes and to spend approximately one day per week in each teaching hospital.

Updates were generally held every 12 to 18 months and lasted from one hour up to half a day. The updates were most often held in the clinical area at the request of the midwives and there was evidence that tutors and link-lecturers often attempted to accommodate the needs of the clinical area, for example run sessions throughout the day, where midwives could pick the time most suitable to them.

4.2.4 How midwives are supported in their roles as mentors

The midwifery managers in many clinical areas were very supportive of mentorship and encouraged their midwives to attend the training and updates. This was monitored through supervisory visits and annual appraisals. Other sites relied more on their midwives' familiarity with the current curricula, as they themselves had undertaken programmes within the system (Higher Education Institution) and were already aware of assessment strategies and models of learning.

It was recognised both in the clinical areas and by the Universities, that taking on and coaching students helped midwives to develop professionally. However, the teaching role was often found to be a challenging and demanding role, as midwives have multiple responsibilities; mentoring and supervising students, co-ordinating wards and being responsible for providing high quality care for women. At the same time, there appears to be agreement that it is now becoming easier for midwives to support students, as more midwives now hold degrees and academic training themselves. It was felt that midwives today are developing an understanding of evidence-based practice and can 'empathise' with the academic work of students.

There was evidence of different approaches being taken to support the midwives in their mentoring role. One hospital had employed a research development midwife to support and update other midwives on the latest evidence based research. This was seen as part of their professional development, but also as an aid to describe and explain their practice to students working on their wards.

Many of the academic staff in the Universities clearly believed that it was primarily the midwives in practice who facilitated students learning in clinical settings. They viewed this relationship as being crucial to students' development of clinical skills and confidence in practice. The lecturers saw their role as supporting the mentor/student duo but had limited resources. There was an increasing need, therefore, for mentors to spend time on a one-to-one basis with their students. It was found that this need was often not recognised by the clinical managers. The needs of the clinical area would often override the learning needs of the students. To compensate for this tendency, some of the midwifery lecturers were trying to spend more time with the students in practice and teach by the bedside, to 'relieve' the mentors of some teaching responsibilities.

The importance of the visibility and availability of link-lecturers was stressed across all the investigated sites. It appeared that in many areas, link-lecturers tried to spend increasing blocks of time in practice and that this was seen as beneficial both for students and midwives. The clinical area also emphasised how important it was that the link-lecturers were approachable and one example was given where tutors could be e-mailed directly by clinical staff. This was seen as very helpful, as it facilitated communication between the two areas.

There was feeling expressed among many of the lecturers and teaching staff that the support was available for the mentors if they were prepared to access it. But it was also recognised that when the midwifery lecturers visited the clinical area, the mentors often did not have time to talk or discuss student issues with them, due to low staffing levels and busy wards. Additionally, lecturers described feeling awkward about booking appointments with the midwives in clinical areas (or even leaving voicemail messages), as they were aware of how busy the midwives were.

4.2.5 Strategies to support students learning in practice

The need to provide support for students while in practice was clearly recognised. The University staff expressed a wish to 'have a high profile clinically' and they stressed the importance of students being 'seen to be supported clinically'. Providing such support also helped them maintain their own clinical skills and to gain credibility with the students. There was considerable variation in how much time the lecturers were enabled to spend in the clinical settings. Some Universities allowed their teaching staff to spend up to twenty-five days a year in the clinical areas to update their skills to aid professional development, assist in student assessment and to support both mentors and students. Others had a commitment to spend twenty percent of their working time in practice. There were also examples of areas where teaching staff had not been in the clinical areas for prolonged periods, due to issues with honorary contracts. Many tutors expressed a wish to work more closely alongside their students in practice and to provide more individual support, but University structures and management were not always supportive of this. Other work commitments and heavy workloads sometimes prohibited teaching staff from working in the clinical areas.

There was general agreement among the range of groups of respondents (e.g. lecturers and midwifery managers), that the learning needs of eighteen months and three-year direct entry students were different. On the shortened course the students already had an understanding of the culture of the health service, while on the longer programmes the students needed more time and patience to understand ward cultures and to develop skills and confidence. There was also an awareness of the different learning needs between students on the same programme and the importance of taking account of students' personal lives and individual experiences. Examples were given of young students who might have recently moved away from home and mature students with children of their own. The levels of support that these different student groups required were seen as very different.

Other mechanisms which had been introduced to support students learning in practice across the case studies included:

- The importance of having a named mentor and students working a majority of their shifts with this mentor.
- The participation of tutors in interviews and assessment of students.
- The availability of hospital resource rooms and libraries for teaching and learning, where students were encouraged to use this resource.
- The use of filofaxes and skills profiles to guide students learning in practice.
- The use of reflective sessions and 'clinical incidents sessions' where students could reflect on practice as well as support each other.
- The introduction of 'student profiling forms', which were brought into the clinical areas by the student. This document identified who the students were, their strengths and areas requiring further development.
- Many of the Universities had 'student learner councils', where student representatives, clinical staff and tutors would meet to discuss placement issues, such as uniforms, induction week and mentorship.
- One University had introduced a 'Critical incident discussion'. Senior clinical staff were included on the assessment panel and the approach was seen as one method to assure students' competence in practice. Students were given an emergency

situation and then had to give a 20-minute presentation. This development appeared popular among the clinical staff, as they felt it was easier to question and discuss issues with students in this way.

- In one area the Workforce Development Confederation had funded the recruitment of Placement Support Midwives. The main purpose of the role was to support the students, but other responsibilities included providing research updates to the qualified midwives and supporting their training needs.
- Regularly inviting students to in-service training and meetings in the clinical area.

4.3 Curriculum Summary

Introduction
Curriculum documents from five HEIs (Higher Education Institutions) were reviewed. A large number of documents from each institution were submitted to the project and included definitive curriculum documents, student handbooks, student portfolios and documents relating to individual modules.

Documents relating to the student experience on pre-registration courses were examined to extract information relating to a number of questions including assessment of practice, student support and integration of assessment of theory and practice.

Curriculum documents tended to expand more on the aims, objectives and content which related to learning in the HEI while there was often little detail provided on learning in clinical practice. It was evident that achieving integration of theoretical teaching with clinical experience was an important goal of the curriculum and ways of achieving this were being explored. Theoretical teaching often followed a chronological continuum from 'normal' or low risk childbearing to 'complicated' or high-risk childbearing, which did not necessarily reflect the students' actual experience of care delivery.

Documents supporting assessment of practice at some case study sites were complex, detailed and appeared complicated to use. Two HEIs however, had developed clearly identifiable practice modules which were assessed by practice- based assessment tools and evidence-based accounts. Issues could be identified by students' views arising from their practice experience.

Most documents included some detail on the role and preparation of the mentor and assessor. In one there was a statement referring to the ENB (1996) stipulation requiring the separation of the roles of mentor and assessor but that "an individual may undertake both roles but would need to be able to recognise when they are formally engaged in a specific role". Another HEI had renamed the 'assessor' as a 'mentor' and introduced another term, the 'associate mentor'. The associate mentor was to act as a friend and guide and promote high standards of woman-centred care. A third HEI clearly distinguished between mentors and assessors, the mentor being expected to actively collaborate with the assessor. The assessor was required to work with the student for a minimum of two shifts per week. At one HEI there was reference to a combined mentor assessor role. At this institution student assessment in clinical practice was a tripartite process in which the link lecturer took an active part. One HEI did not include any details on the role or preparation of clinical mentors or assessors in the validation documents of student handbooks.

In many documents, much emphasis was placed upon what was expected of the student in terms of their professionalism and commitment. There were often statements on working in partnership with women, women-centred care, the need for personal growth, self-awareness, sensitivity, holism and the need to take into account social, psychological and spiritual dimensions of women's lives. These statements were often embedded within a feminist ideology. One practice assessment document stated that learning was achieved when "the experience begins to affect the lifestyle of the student". However, the support available to students coping not just with the demands of University life and study, but also with the intense emotional and physical demands of clinical practice, was rarely acknowledged or explored. There tended to be a

downplaying of the stresses of clinical practice and little specialist support. One HEI stated in the document that it was extremely rare for a student to be discontinued for academic reasons and that "wastage" from the programmes was very low. It noted that the most common reason for leaving was lack of support at home, domestic difficulties and mismatch between expectations and the reality of the role of the midwife. The demanding nature of work in the clinical area was also acknowledged. Another HEI, in a student handbook, referred to the possibility that the student may be involved as a witness to an incident in clinical practice where they are an observer and not a participant and be asked to write a statement of events. Students were advised not to worry but to seek the advice of a tutor. There was often no reference to the possibility of the student's involvement as a participant in care.

One HEI referred to "difficulties in providing timely and appropriate tutorial support and guidance to students who are off campus for substantial periods" and there was reference to the fact that "students may encounter personal and/or professionally challenging or distressing situations". Some HEIs included detail on University support systems such as Welfare, Support or Chaplaincy Services. They also identified the role of personal tutors, link tutors, Trust-based mentors and the student's peer group. However there appeared to be no independent source of support which provided familiarity with the clinical area but who was not required to sit in judgement of the student, as mentors are often required to do. Peer support, while valuable for some students, may be seen as an inappropriate source of support to others.

Documents tended to emphasise disciplinary processes rather than more caring processes that support and encourage students through the courses and which acknowledges their own needs and life experiences. For example, at one HEI, there was a detailed 'Professional behaviour procedure for pre-registration midwifery students'. This was to be " ... used when behaviour, attitudes and conduct give rise to concern …" The disciplinary procedure was given prominence as it took up four pages in the students' progress record.

Table 3: Curriculum Summary

	Site 1	Site 2	Site 3	Site 4	Site 5
Programmes Offered	Diploma Midwifery 3 year Degree Midwifery 3 year *Degree Midwifery (shortened)*	Diploma Midwifery 3 year Degree Midwifery 3 year	Diploma Midwifery 3 year Degree Midwifery 3 year	Diploma Midwifery 3 year Degree Midwifery 3 year Degree Midwifery 4 year	*Diploma Midwifery 3 year* *Degree Midwifery (shortened)* *Diploma Midwifery (shortened)*
Support systems available (as stated in documentation)	• Clear criteria regarding mentoring. • The 'mentor' is re-defined as the Associate Mentor – refers to a fairly informal relationship (friend, guide). • A year tutor works in collaboration with the personal tutor and a link lecturer.	• University student welfare, support service and the Chaplaincy service. • Personal tutors act as advisors and mentors throughout the course. • Midwifery Lecturers maintain close links with the maternity units. • College days to debrief and reflect. • Students encouraged to contact personal tutor, clinical link tutor (email and voicemail facilities) • Joint appointee available at one of the four participating maternity units (both clinical and educational responsibilities)	• Established student-counselling service. • Trusts have bereavement counselling services. • Emphasis in documents on what is expected of the student (how to adhere to certain codes of conduct and professional behaviour) • On entry to academic programme students are allocated a cohort tutor who will act as tutor/academic mentor.	• Counselling and welfare services within the campus. • Students are timetabled to meet with their academic mentor for at least ½ hour per semester. • On clinical placements students are allocated a named clinical mentor assessor who guides and supports the student. • The link lecturer spends time working with the students in the clinical area.	• Students have a 'stage tutor' for the whole of their programme on their placement site. • They also have a personal tutor. • Support is provided in the practice areas by mentors "who provide support and guidance to the student".

	Site 1	**Site 2**	Site 3	Site 4	Site 5

Assessment of Practice (as stated in documentation)	• Mentor assessor – requires specific preparation. • Study days on facilitating teaching are provided. • A Module at Level 1 which runs over two semesters is assessed by 100% Practice Assessment using a Practice Based Assessment tool.	• The mentor supervises the student for specific placement. • Expected to actively collaborate with named assessor to assist in summative assessment process. • The assessor has at least one year post-registration experience and has undertaken an approved course such as ENB 997. • Assessors are required to attend annual half day updates. • Practice assessment documents contain Guidelines for Basic Level of Practice Competence (Knowledge, Skills and Professional Approach). • Separate competence statements for Foundation Students, the Developing Student and the Consolidating Student.	• Students assessed in the clinically based modules on their ability to achieve the competencies required by Rule 33. • They are required to demonstrate learning in clinical-based practice by the use of woman-centred care scenarios or critical incidents. • Clinical assessment tool builds a performance profile for each student at given points. • The tool consists of statements which clinical practitioners, acting as assessors match against the performance of students.	• Two-day mentor assessor preparation programme plus half-day updates annually. • Midwives are actively encouraged to complete the ENB 997. • Student assessment on clinical practice involves a tripartite process (link lecturer with the clinical mentor and taking an active part in the assessment process).	• Refers to ENB (1996) which requires separation of the roles of mentor and assessor. • The mentor provides support, advice and guidance to the student and is selected by the student. • There is set criteria for selection of assessors and it is undertaken in partnership between education and practice. • Assessors undertake a programme of preparation. • Clinical assessment consists of three tools, which become a portfolio of learning: a criterion referenced assessment grid (CRAG); a clinical experience log and a clinical development record.

		• Assessor required to award students an overall grade for performance in clinical practice (contributes to final degree classification – A, B, C or D).			

4.4 **Post-registration midwives undertaking continuing education and modules for professional development**

4.4.1 Introduction
The initial intention when this project was designed was to recruit midwives who were undertaking courses with clinical outcomes. The plan was that the midwives would be invited to participate in the same data collection process as the pre-registration students i.e. diaries, interviews and observation. Due to pressures of work for midwives in the clinical areas, individual interviews were performed instead with seven midwives who were undertaking a range of programmes and modules. Although there were possible limitations in not being able to triangulate methods in this case, the midwives provided valuable information related to the experience of studying whilst also continuing with the whole midwifery role. There is evidence from this research that studying for clinical courses and mentoring are very demanding for midwives. The midwives expressed their need for support, guidance and ongoing mentoring during and following their post-registration courses.

4.4.2 Post-registration programmes offered to midwives in the case study sites:
In each case study site, the research team collected information regarding which courses were available for registered midwives employed at the selected Trusts. A substantial mixture of in-service study days were provided in most Trusts.

The longer programmes and modules across the five case study sites included:
Neonatal Resuscitation
ENB R71 Development in Contraception & Reproductive Sexual Health
First Examination of the Healthy Newborn
Parent Education
Communication
ENB 997 (Developing Teaching & Assessing in Clinical Practice)

Because these courses were primarily offered through the Higher Education Institutions, they may not have coincided with the timing of case studies. The research aims focused primarily on students on pre-registration student placements. However, the interviews with this small sample of post-registration midwives raised interesting issues around how they combined studying with clinical work and also how they used and updated their new knowledge in their clinical practice. The views of qualified midwives' continuing education opportunities have been discussed in more detail in section 4.1.9.

4.4.3 Structure of courses and practical issues
The structure of post-registration courses offered in the five case study sites varied. For example, examination of the healthy newborn entailed attendance at a study day once a month for six months, supervised examinations of babies and production of a portfolio.

One ENB 997 course consisted of five consecutive days (for 15 credits at diploma level).   A midwife at one Trust said; "*It was all done in my own time*". She described the amount of work she had completed for only a small number of credits.

One Family Planning course was provided under a Sexual Health module. The course consisted of a number of study days at the University and then twelve practical sessions at clinics. These were half day clinics between 2pm to 8pm and organised through the

University. During the six month course, the students were expected to present two seminars, three essays and six reflective papers.

Some sites provided full funding, and offered midwives half the time they needed for study and attending courses. These midwives were also offered two paid study days per year. In order to qualify for this study time, the conditions at one site were that the midwives booked the courses a year in advance. Other sites provided no funding but enabled the midwife to have time off for study sessions and clinics.

4.4.4 Preparation and allocation of a mentor/assessor
For most of the post-registration courses, the midwives needed a designated mentor/assessor. The mentors were sometimes working in community clinics, for example, family planning clinics or, for example with the Communication course, the tutor from the University visited the practice placements. In some places, midwives were able to choose their own mentor. Some mentors had not attended formal mentor training and had difficulty in completing the practice documents:

'My mentor wasn't trained as a mentor. She didn't go on the two-day refresher course just before, because this course was a new course just started, and she wasn't updated on it so she found it hard to fill in my portfolio.'

If working five days a week, for example in clinic situations, midwives (especially those with senior responsibilities) described the difficulties with meeting their assessors in practice:

'The tutors were alright but again, if you went ad hoc, it was difficult because they might be lecturing and you had to make prior arrangements … difficult to make because I'm working five days a week, Monday to Friday here … so I found that unless you were able to push yourself, then it was hard to get support.'

4.4.5 Maintaining skills learnt on the course
The midwives mentioned the need to update in order to retain skills learnt on intensive modules. Some described problems with attending update sessions following courses such as 'examination of the healthy newborn infant'. These sessions may be as frequent as once a month. To maintain skills in examination of the healthy newborn baby, one post registration midwife (with some management responsibilities) encouraged a rotation for midwives to do routine neonatal examinations:

a) to help with efficiency of workload (with the aim of discharging babies to the community without routine examination by a paediatrician); and
b) for updating purposes of the midwives who had studied on this module.

There were advantages to managers undertaking clinical modules. Through having deeper first hand information and experience regarding the programmes, some had reorganised aspects of the service locally, with perceived benefits for the women and families. Other managers were also describing local plans to incorporate their newly learnt skills into the workforce.

One midwife in this sample was working five days a week, studying for a higher degree and working with the Bank once a week in order to maintain family planning skills she

had gained on the course. She described the lack of facilities to update herself following completion of a family planning module.

Emphasis was generally on midwives being self-directed and maintaining their portfolios following the courses. This took dedication and time management. Support from other midwives (peers) was used to help maintain skills. One midwife stated that she would also appreciate active guidance from other managers in order to implement the ongoing practising of skills in practice (for example, with reference to the examination of the healthy newborn).

4.4.6 Other issues
There were difficulties with being students as well as being qualified midwives; most of the midwives described the difficulties with maintaining academic standards, particularly at level three. Those midwives who managed caseloads found the return to studying most problematic. '*You don't always want to go home and start reading books*'. Some midwives felt they needed to be more assertive in order to manage their studying.

One midwife described concerns regarding gaining access to libraries*: 'I could only have gone when I'm going to lectures … but because it's a University library and a topic has been chosen, all the books have gone.'*

Some midwives cited that they felt uncomfortable being observed, for example, doing fifteen supervised newborn examinations in the practice setting in which they were known. Conversely, other midwives (particularly those in management positions) described how the additional visibility from being present in clinical areas and having 'hands-on' with clients, increased their credibility with peers.

Summary points
A range of courses were on offer through the Universities. Some were reported as being intensive. These were completed on top of other in-service training, their midwifery workload and mentoring responsibilities.

- Some midwives found combining studying and achieving a higher level of clinical work demanding
- Returning and adapting to student status and being assessed in practice skills
  was found to be difficult for some, particularly if the assessments occurred in their own work setting
- There were difficulties with obtaining adequate time off for studying and time off for some courses
- If working full time and studying, there were problems with accessing mentor support, building in assessments and thorough feedback on performance.
- Updating skills following completion of a course demanded planning and commitment from the midwives
- There were positive benefits described by some, of expanding their skills base in such a way that they made a positive contribution to the skills profile in their work environment

CHAPTER 5   KEY THEMES FROM IN-DEPTH DATA

Introduction

This chapter provides a summary of the findings from the pairs of midwives mentoring and their students. Nineteen student and midwife pairs contributed to the study from five case study sites in England[6]. All the midwives in the pairs had been qualified for at least three years and many had been qualified for much longer. They were often managing the clinical environment, supervising a number of staff and delivering clinical care, in addition to fulfilling the role of mentor and assessor to a student midwife. The commitment and energy required of them on a daily basis was enormous. There was a generally expressed belief from the midwives that they felt competent and confident in their practice and ability to teach midwifery skills. Some expressed anxiety on how 'up to date' and research aware they were and valued the mentoring relationship with students as a source of this particular form of knowledge. For many there was a symbiotic quality to the relationship, which was seen as a partnership, contributing to the development of both participants.

Students were generally placed with experienced midwives and the more junior midwives were least able to express confidence in their practice. Where this was the case potential difficulties were overcome by the midwife acknowledging her limitations in respect to teaching the student and the student felt supported and confident in her mentor as they sought the information together.

Midwives were generally conscientious and seemed willing to pass on their knowledge and skills. They were often working in circumstances of heavy workload, fear of litigation, poor staff morale and minimal provision within the working day for the time required to mentor and assess. Many very experienced midwives were working part time, an issue often raised by the midwives themselves. However, students in the study valued these midwives as mentors. The success of the students' placement experience, whether mentored by a full time or a part time midwife, depended not just on the mentor but also on the total learning environment and the community of midwives within the establishment.

Reading the data collected and in particular the transcribed student diaries, one could not fail to be impressed by the immense dedication, application and commitment to learn and provide a woman-centered service, exhibited by midwifery students. It was clear that hard work and attention to detail was required of them in clinical practice where they were often on a steep learning curve on a daily basis for most of the placement. The strain of going home to attend to course work and read up on the events of the day at times seemed excessive. Many also referred to the impact of this on their home commitments and how they juggled child care within a system which, in many cases, was erratic and lacking in forward planning.

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[6] All names given in the following data have been changed to protect the identity of the participants recruited for this in-depth element of the research. The students' stage of training has only been included in those instances where it was considered to be relevant.

As one would expect, every mentoring relationship was unique. Some relationships exhibited more signs of strain than others. The ability of the midwife/student pair to communicate openly and reflectively with each other was an important ingredient in the successful functioning of that relationship. It was very noticeable where the midwife and student had established this communication channel that the student felt cared for, supported and facilitated in her learning. Midwives spoke of their need to trust that the student would communicate with them and recognise when they needed help, particularly when working independently. Students spoke of their need to receive daily feedback, praise and encouragement from their mentor. There were examples where these components were missing and students were left feeling unsure and anxious. Students were clear that being a mentor required commitment to the role and that not all midwives should be mentors. Midwives were clear about the value of having breaks from the mentorship role and the inadequacy of the preparation, guidance and support there was in the mentor system.

The in-depth data is a portrayal of the complexity of the student/mentor working relationships. If we had taken a snap-shot in time, for example a one off interview only, we would have minimal reflection on what went on for the students and the inherent challenges for the midwives.

The next section will describe the key themes and underlying categories that emerged from the richness of the in-depth data. The table below provides an overview of the thematic structure:

Table 4: Overview of Thematic Structure

Theme	Role modelling	Learning and teaching styles	Assessment of practice	Emotional support
Category	• Same/different mentor • Shadowing/echoing • Stages towards autonomy	• Learning processes • Relating theory with practice • Management of learning processes	• Point of reference to assess learning and the learners • The impact of assessment - continuous versus staged	• Mutual respect and effort involved in mentoring

5.1 ROLE MODELLING: Same/different mentor

5.1.1 Generally students were establishing new mentoring relationships with midwives on each placement. Apart from the very junior students, student midwives had often met the midwife who was to be their mentor as a member of the team. Achieving continuity of mentor during the programme was often not possible owing to work patterns and organisation.

5.1.2 Students valued continuity of mentor both during a placement and on returning to a placement. Benefits of continuity of mentor were clearly expressed and included:

gives them confidence on returning to a placement to know that their mentor already knows them

facilitates development in their midwifery practice as less time is spent building a relationship from scratch

mentors more accurately identify the students' skill level and make a realistic assessment

facilitates discussion of tragic and distressing experiences in practice.

5.1.3   Midwives also were pleased to develop close mentoring relationships and were often aware of qualitative differences in the relationships students might have with midwives with whom they were working for brief periods. They could see the student develop and mature. Students who had a number of different mentors over the course of a year highlighted how some mentors more accurately identified the students' skills level than others. This was an important mentoring function and was important for boosting the students' confidence on a placement:

'Keeping the continuity of the mentor has really enabled her [the mentor] to see my development, it's enabled her to have confidence in me from a very early stage. If I had gone to another mentor, it perhaps wouldn't have been so beneficial to me and I would have to have started from scratch building a relationship.' (student)

5.1.4   Hilary, a midwife qualified for more than 10 years (previously a nurse, who had recently completed a diploma), was a shift leader on Delivery Suite while mentoring Munira, in the third year of a three year diploma. They worked closely together at least three days a week. The student's learning needs were addressed during the placement and she received much praise from the mentor particularly for the supportive care she gave women. The midwife was very thoughtful and reflective about her role as a mentor and she appeared highly motivated.

5.1.5   Students sometimes had the opportunity to request a mentor with whom they had previously worked. Claire (second year diploma), had the opportunity to work on the postnatal/antenatal placement with a midwife she had previously worked with on Delivery Suite and had continuity of mentor from Christmas to April. The student said this was planned by her as the mentor moved at the same time as she did and she had swapped placements. The midwife did not have a student at the time:

'It did not interfere with anybody else's placement and the midwife was happy, so I actually engineered it myself.' (Student)

Joelle the midwife who qualified in the early 90s, was anxious about mentoring as she (the midwife) was part-time. Claire, when asked about this said:

'It doesn't worry me. Joelle does three days a week and it doesn't worry me as much as it does some of the other students in that she's not a full time mentor. A lot of the other students are much happier to have mentors who are full time midwives so that they can work. For example, if Joelle is working Wednesday and Thursday when I'm at college, that means I can't work with her that week so I've got to book other days with somebody else or I'll work the weekend or whatever to fit in.' (Student)

The student was very positive about her learning experiences and mentoring and learnt from the other midwives on the placement too. Claire had initially started on the ward with a different mentor who had only been qualified a short time and:

'After the first couple of shifts I thought it might not be as beneficial as having somebody who's been qualified for a while.' (Student)

Vanessa, a student, at the start of her second year of a Dip HE, was not so happy with part -time mentors and felt that this contributed to some instances of poor mentorship. Vanessa recalled:

'It's important to latch onto one. So to have a full time mentor is great. On delivery suite people did not know I was going to be there or I would have two mentors assigned to me or no mentors at all. We all had the same problems. It was frustrating … I am lucky with Vanessa, she is one of the very few full timers so I try my best to follow her full time shift.' (Student)

5.1.6 The midwife rotation system in maternity units can affect continuity of mentoring and it was possible that students could start a placement with one mentor who would then leave that particular placement. This created difficulties because the midwives needed to perform individual assessments of the student. One midwife stressed the difficulties in taking over from another midwife as mentor. These were expressed as a worry that the student would feel sh*e 'had to prove herself again'* and *'go backwards*' (Midwife) in terms of independent practice. The needs of the unit may also impact on the mentoring function. Irina, a midwife, found that although she was full-time she was frequently taken off one placement area to work on another and so was not doing full time hours with the student.

5.1.7 Students felt a strong sense of responsibility towards clients. For example, one student noted that some midwives asked whether she had done any deliveries while some assumed she had. This student felt it was important to volunteer this information:

'I say because I don't want to compromise a mother and baby. I'd rather look an idiot.' (Student, second year diploma)

Many students also expressed the need to spend time with women in a relaxed atmosphere. It was felt that the midwives could facilitate this need and students described how it enhanced the care that they provided for the women:

'Last Thursday we weren't quite as busy and we spent quite a long time with each woman and it was very nice and we were chatty and it was so much nicer and I feel it's a much better service to the women when the midwives are relaxed. It's better for the student as well. I felt that I could talk last week. I could really talk and say what I wanted to say and I wasn't wasting time or anything like that.' (Student)

5.1.8 Poor mentorship can affect a student's performance, leaving a student feeling incompetent and lacking in confidence. There was a suggestion that not everyone wants to be a mentor. Students referred to a reduction in learning support when not on duty with their designated mentor. Where possible students would make great effort to work alongside their mentor. This could involve them deviating from the planned experience programme. Naomi (Student) had previous poor mentoring. On a second placement to

Delivery Suite, she decided to accompany her mentor on several shifts on community for giving postnatal care to women. The student rationalised this by explaining that although she required Delivery Suite experience, she received very poor guidance and learning when in the care of other midwives on Delivery Suite. She reasoned that she should accompany her mentor in her work and get to know her, as this mentor would be doing the assessment report.

5.1.9 Barriers that might reduce continuity of mentor included midwifery rotation systems (to nights or to another practice area), part time posts, sickness and students' family commitments. However the quality of the mentor support was related more to the relationship established between the pair. Susanna (six months into an eighteen-month course) explained:

'I was really worried before this placement. I thought I was really behind because I didn't have a mentor. Penny was really good when we started and asked me what I wanted to achieve on the first day and we got it straight from the first day.' (Student)

5.1.10 Margaret (first year degree student finishing her first community placement) had a difficult and anxious time during this allocation due perhaps to a combination of her own insecurity and lack of life skills (straight from school), communication difficulties with her mentor and also the mentor's own stress. The mentor seemed largely unaware of the nature of Margaret's anxieties and her own role in augmenting them. Giane, the midwife, said:

'I know her strengths, I know her weaknesses and we've already talked about weaknesses. So we have a very open relationship I feel and I'm very honest with her and she does take it on board very, very well … But that is quite scary doing the grading, … it's just communication skills …'

Margaret [student] meanwhile said:

'Communication, she said I wasn't communicating but my side of it is that I find it very hard. She's a very outgoing person and she's very much there and in with it and she wasn't giving me a chance...she never allowed me to get near the door [to speak to the client in her own home]...She said about chatting to them - well I felt silly saying 'How are you feeling? when she had already said it.'

Her tutor supported her in developing assertiveness skills:

'They said I needed to be more assertive and just go in there which if I had known before, I would have done before the interview - but putting it on me at the interview really pulled me down' (Student)

Despite the traumatic nature of the placement, Margaret acknowledged that she had learnt a lot during the placement and had undergone a maturing process regarding the development of confidence and assertiveness skills. Giane had been very conscientious about teaching her 'correctly'. Giane talked a lot about her exhaustion and how much additional effort was required in taking on a student. Margaret was looking forward to a change in mentor particularly as an opportunity to observe how other midwives communicate with clients.

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5.2 ROLE MODELLING: Shadowing/echoing

5.2.1   Students watched their mentors very closely while they were delivering midwifery care, for instance, if the student thought that the mentor was a particularly good communicator she would observe closely for 'tips'.

They absorbed the subtleties of care management for example:

> how to maintain a relaxed, calm, friendly manner in front of parents when 'backstage' there are conflicts and tensions.
> how to develop a professional approach to women. It was noted that some students have to learn to be comfortable touching a woman's abdomen during examination:

'That's really hard and until they have learnt to be comfortable then you can't really teach them anything else and you can't teach that in the classroom.' (Midwife)

5.2.2   A change in attitude and approach was noted to have evolved from a broadly 'you watch me and then follow' approach to an awareness that mentorship is about two-way communication. One of the mentors (midwife) noted:

'I think the students have a lot to offer. They cover quite an amount of theory which I know I am outdated on so I think we can learn from each other … I've gone onto a different sort of wavelength now and use the students as a resource and they are helping me as well.' (Midwife).

5.2.3   Students were selective in the aspects of a midwife's practice which they planned to incorporate into their own practice. They were very diplomatic when they saw aspects of practice which they considered inappropriate and did not challenge the midwife directly and at the time, preferring to wait for a more opportune moment. For example, one student appeared distressed at the midwife's attitude to clients from different cultures. The student did not challenge or criticise the midwife regarding this although gave this aspect of practice much consideration privately. Other examples of student dilemmas regarding clinical practice which arose from a requirement to shadow or echo the behaviour of a midwife mentor, happened during management of labour, for example, positions in labour, nutrition in labour, second and third stage management practices.

5.3 ROLE MODELLING: Stages towards autonomy

5.3.1   Importance was attached to feeling confident and portraying confidence in front of the client. A relationship with a client was best developed when the client felt trust in the student:

'When relating to clients it is the level of confidence you portray. If you show any kind of weakness they will pick on it.' (Student, third year diploma)

Students needed to feel fully supported in clinical practice to develop this confidence. It also helped if the midwife was able to impart her confidence in the student's skills to the client.

5.3.2 Portraying confidence in front of doctors was also important in progression towards autonomous practice. Claire, halfway through her course and with a previous career, was asked about her most positive learning experience. She replied:

'learning about basic things like CTGs early in the course'
and:
'developing the confidence to talk through things with SHOs or registrars … I've never had a confidence problem dealing with senior people but find this so different, something that I have had to learn from scratch. I've felt completely at a loss for what to say. I'm like a child. I have to work it out in my head and repeat ten times before I say it which is ridiculous really but it's something that I'm sure will come with time … I get all the information out, it's never in the right order. If they ask for something in the notes I can never find it because there is no proper order …' (Student)

At this particular occasion, the student's mentor spotted that she was in difficulties '*sort of spinning on the spot…and came and bailed her out'*. (Student)

5.3.3 Students were enabled by midwives to work autonomously when the midwives who were mentoring had time to assess the student's abilities in practice. The midwife needed to trust the student to carry out the procedure accurately and also to be able to identify and say when the student was not sure about a finding:

'Nice that I felt that she trusted me to do it rather than feeling that she needed to instruct me to do anything.' (Student)

Midwives who were mentoring, described the different approaches they used to informally assess the practical skills and abilities of their students:

*'Today I have worked with a senior student midwife for the first time. I was informed that she only requires minimal supervision. I decided to work alongside her today as I am ultimately responsible for her actions and wish to satisfy myself that she is capable of unsupervised practice.' *(Mentor*)*

5.3.4 Midwives could aid development towards autonomous practice by being able to identify situations where the student was floundering and needed help, and by being able to keep quiet and let the student interact with the client. For example, one student, six months into the shortened course, was clearly lacking in confidence. On one occasion when there was difficulty with delivery of the baby's shoulders, she stepped back from the delivery to let the mentor take over. The student was told by the midwife:

'It's just a case of getting my confidence and I need to learn to pull harder' (Student)
and also noted:
'Nice to be working with Penny again. Somebody who knows where I'm at and lets me do things I'm confident with and tries to push me to do other things as well …She knows where my weaknesses are and we're trying to build on them.' (Student)

Encouragement by midwives increased the feeling of autonomy for some students through recognition of students' prior experience:
[The student] also had the opportunity to use one of her skills acquired in her former job. We had a lady on the ward who had a medical condition and [the student] performed a 12 lead ECG on this lady. I think it's important to recognise that student midwives do

have other skills. I think so often they're just categorised as student midwives and no real credit is given for skills they've acquired in different jobs. It's very important to recognise that they do have skills and experience before they come to do their midwifery training" (Mentor to student on shortened midwifery programme-audio-diary)

5.3.5 Lack of continuity of working with a named mentor caused stress. For example, one student identified that her mentor had a lot more confidence in her now (early second year and third placement on Delivery Suite) *'but I think it is because she knows me so well.'* (Student)

The student went on to refer to an atmosphere of defensive practice:

'When I've worked with other mentors I'm more or less standing in the corner and I find that frustrating … Because it is as though they do not trust me. I feel untrusted … it does not do a lot for your self-esteem … It's not their fault. It's obviously their practice that is going to be in question if anything happened because they are responsible. I'm only a student. So I can understand that. But I do find it frustrating when I know I can do things and they're running around like headless chickens and I say I'll do this, I'll do that and they say 'no, I'll do it.' (Student)

Conversely students found that midwives who did not know them, had raised expectations of their knowledge and abilities.

5.3.6 Students in their final year of the programme were often afforded considerable opportunities for working autonomously in practice by reporting back to the midwife if there were any problems. This was seen in community care and also on the ward. One ward based midwife stated that she gave herself a larger workload than the other midwives on the shift as she had a senior student who would be expected to work with little supervision. This midwife explained that she thought it better if students took responsibility at the end of the programme rather than wait until they qualified. The student reported that she was happy about this level of responsibility but at times felt overworked and was also given additional tasks to do by other midwives *'because she was in a white [student] dress'* (Student)

5.3.7 Some issues which arose from this style of working include:

  . heavy workload for the student was compounded by requests to run errands for other midwives. (Low status on the ward tended to leave the student relatively powerless to control her own workload)
  Treating the student effectively as another member of staff may deprive student of learning opportunities. The needs of the ward seemed to over- ride the teaching. A midwife commented *'I couldn't afford for the two of us to be in there with her [the woman] all the time'*.
  The business of the ward may prevent the mentor from teaching the student thoroughly.
  There can be an ongoing tension and irritation concerning the requirement for the midwife to countersign the student's records in clinical files.

5.4 LEARNING & TEACHING STYLES: Learning processes

5.4.1   Teaching was often ad hoc and unstructured relating to client needs at the time. There was little reference to a specific curriculum although the student may have come to a placement with a list of topics. Mentors hoped to provide students with 'hands-on' experience dictated by events on the placement area. Theoretical teaching did not generally match up to learning practice on placement, for example one student voiced her indignation :

*'We deal with all the normal don't we and we don't seem to see a lot of normal on Delivery Suite … just starting to do variations but they teach you normal before teaching you all the problems … to send you to Delivery Suite without any knowledge of the abnormal …it was worse the first time round. I suppose it's not so bad because I've seen a lot of it alread*y' (Student, six months into eighteen month course)

Claire, halfway through her course**,** had just studied high risk pregnancy. Speaking about diabetes as an example, she noted that:

'High risk pregnancies are sent elsewhere ...a problem...we only get to do it in theory. [Students are] clamouring to get some experience with this woman [who has diabetes] before she goes because we know [she is going to be transferred] ... There is nowhere really other than the classroom to get experience. So it does mean that our learning cycle isn't completed.' (Student)

While Claire noted the possibility of seeking placements in other areas at the end of the course she also considered that that was dependent on completion of '*delivery numbers'* and also her family commitments locally.

5.4.2   While it was very important to have a clearly identified mentor on a placement and to work closely with that midwife, students reported learning from other midwives on the placement, for example, '*checking the epidural trolley'* and a comment *'I am starting to learn by watching other midwives how epidurals are set up.*' (Student)

5.4.3   Students approached an unfamiliar clinical environment differently. Some wanted to stand back initially and observe while others wanted to '*jump in'.* It was important to students that they were not overly anxious that they were going to be severely criticised about mistakes. One student put it like this:

*'The anxiety that I have is possibly with a couple of midwives who don't like me very much. Then I tend to make mistakes for some reason.' (*Student)

The student approached other midwives on the placement for reassurance regarding her practice. Reflection on the minor errors subsequently generated some teaching and learning.

5.4.4   Students often seemed anxious about their inexperience. Gaps away from practice exacerbated this, leading to a crisis of confidence for which the student needed reassurance from her mentor. Confidence building was considered to be an important part of learning. Margaret's anxiety level in her first term could be attributed to her lack of knowledge:

'It's quite scary because I'm only in my first term and thinking - I'm dealing with women and information and you're just repeating what you've heard your mentor say rather than definitely knowing it in your head - you don't always know exactly the reasons and that is a bit scary' (Student, first year degree)

5.4.5   The heavy workload experienced by students was an often repeated theme:

'[the course] it has straight from the start bombarded you and I haven't been able to get into it slowly. It's straight in at the deep end … fitting everything in and reading journals and assignments … ' (Student)

5.4.6   Organisational difficulties in the way clinics were run provided negative learning experiences. If the clinic was very busy the students described feeling unable to use the learning opportunities as they arose, due to pressure of time. Getting to grips with the minutiae of clinical practice such as making phone calls and filling in blood test forms was often best achieved if time was allowed for the student to do this. Learning how the system works and learning by doing rather than observing was important in this area and promoted a sense of achievement. Margaret also described how a heavy workload in busy clinics prevented her from developing skills as *'they were always rushing and the midwife would do the antenatal to get it done more quickly'* (Student)

Margaret described how she had to develop assertiveness to initiate her own contribution to care.

5.4.7   Learning may be a very traumatic process and students frequently recounted how they dealt with the stressful events in midwifery practice. Students placed emphasis on their need to 'talk things through' with their mentors and often there were no opportunities to do this, leaving the student worried and scared. However students noted that experiencing an obstetric emergency is *'something you can't learn from a textbook',* they learn from the experience. (Student)

5.4.8   Clear communication between student and mentor was necessary to facilitate learning and it was important to identify this at the beginning of a mentoring relationship. Clear communication could be hard to achieve. Greta, entering the third year of a three year diploma, commented in her diary that the midwife:

' … asked me did I feel like I was doing enough on the ward and did I have any questions. I always found this hard because you ask questions as you go along. Sometimes it seems like you're not really interested but quite a lot of things in the third year you already know.' (Student)

Her mentor, qualified three years with a degree by 'direct entry', reflected that:

'I probably hadn't been as straight forward with her as I should have been. I put it in ways like 'is there anything you want to ask me?', 'is there anything you're not quite sure about?'... I put it like that rather than saying 'I don't think you ask me enough questions.' (Midwife)

The midwife stated that she thought the student was competent and managed quite well, but wished *'she'd been a bit more enquiring'.*

In some observation sessions, the student was left to work independently with her own case load of postnatal women who'd had caesarian section. The mentor did not enter the four-bedded bay where the student had been allocated for that shift. There was little opportunity for the student to observe the midwife, minimal teaching and very little communication. The student asked very few questions. Occasionally the pairs would discuss management of situations such as breast feeding support.

It was evident that effective communication between students and midwives was a key factor influencing the success of the student/mentor relationship and this need was recognised by many of the mentors:

'So it made me realise as well that obviously the learning experience can vary depending upon the personality of the student and the mentor and that a good learning experience hinges upon you being able to communicate together effectively and also to appreciate the different ways of working and not to think that something is wrong if somebody's a different temperament to yourself and has a different way of operating.' (Mentor)

5.5 LEARNING & TEACHING STYLES: Relating theory with practice

5.5.1   There was evidence that mentors who were themselves studying were able to relate research-based theory to practice. They were likely to work with the student to search out information about issues in practice and were willing to discuss issues they were unsure about. Mentors did not have to know it all and it was valuable when midwife and student shared the task of finding out answers to questions. Midwives generally felt very confident in their own practice (qualified three or more years). They seemed happy to learn from students and also to impart their own clinical knowledge and demonstrate clinical skills. Katrina, a midwife for ten years with a nursing background, diploma, ENB 997 and aquanatal course, worried that her knowledge regarding research-based practice was not updated enough for the needs of her student, despite feeling confident in her own skills. The teaching of basic skills such as blood pressure measurement also caused her anxiety.

5.5.2   There was a feeling that not all topics were taught in the right order in the classroom. For example when learning about 'basic things like CTGs' early in the course, most of the teaching came from mentors rather than the college. More college teaching on these topics would have been valued at this time rather than on topics such as genetics. Students relied on midwives and textbooks to fill in gaps in their learning on issues happening in practice.

5.5.3   One student (early second year) reflected that on her Delivery Suite placement she had:

'learnt a lot of technical stuff because there has not been a lot of normal births unfortunately, which will stand me in good stead for the future. So really I should have been concentrating on normal but it is very difficult to do in the type of obstetric unit that I've been working in all the time.' (Student)

5.5.4   Students experienced considerable conflict when the college emphasised aspects of research based practice that were not carried out in clinical practice, for

example, the practice associated with the observation of perineal healing or light diet in labour:

'It's a bit of a struggle because what we think of as practice maybe the midwives may not. So my theory might not quite fit in with what we should be doing on the ward.' (Student, early third year of diploma)

5.5.5 Theory taught in class often provided the foundation for developing clinical practice and could be tried and tested for efficacy, for instance, changing positions in labour. There could also be criticism of some tutor-led teaching *'it's all sort of flowery, positive and laid back in college'* (Student, early second year, diploma)

An example centred around 'directed pushing' in labour. The student recounted how the tutor explained how 'women know their own bodies'. However the student observed how sometimes women want to push when the cervix is 7 cms dilated on examination and are told not to, while at other times the student observed that women might need to be directed to push at full dilatation of the cervical os.

5.5.6 Students reflected critically on practice, which they considered to be lacking in an evidence base and which they did not consider they were in a position to change. There was evidence that students could be 'told off' by midwives for, for example, encouraging women to change positions in labour or bringing a bean bag into the room. Vanessa (student, early second year, diploma) observed that the midwives were very '*pro-syntometrine*' and were not keen to manage the third stage of labour physiologically. Greta (student, third year diploma) reflected in the interview that she would not be able to carry out the sort of research based practice advocated by tutors as it would be 'frowned upon'. She gave examples relating to Delivery Suite for example, light diet in labour and electronic monitoring.

On occasions there seemed to be mixed messages relating to theory and practice in the clinical area. While emphasis was placed on the student feeling free to question practice and routines, there were times in observation data when the student was left worrying about knowing the various policies in place. Corinna, qualified three years by direct entry, stated that she wanted the student to feel free to question practice and routines. Corinna felt that tutors were out of touch with reality on the ward.

5.6   LEARNING & TEACHING STYLES: Management of learning processes

5.6.1   There was considerable variability in mentor allocation. Some institutions provided students and mentors with names and contact numbers before the placement commenced, leaving it up to the individuals to get in contact.

Students felt that the onus was on them to contact the mentor. Other institutions left it to the student to find her own mentor on each placement which placed considerable strain on the student. Some mentors did not seem aware of any particular system of student allocation and identified that they had little say in student allocation. In some clinical areas midwives had natural gaps between mentoring students while in others, midwives described feelings of being overburdened with having the responsibility to mentor students all the time, from many different courses. In the latter situation midwives craved free time and a break from mentoring students as well as the opportunity to work independently as a midwife again.

5.6.2 Mentors were often engaged in several different roles at once, for example, mentoring, preceptorship and being delivery suite coordinator. This reduced the time available for mentorship of the student and affected the quality of the mentor relationship.

Students picked up impressions, which may have been unfounded regarding how mentors were matched with students using criteria such as 'age'. While students may have felt that they had no choice of mentor most midwives were regarded as potentially good. One or two may be '*just not very good with students.*'

5.6.3 Students would have welcomed more planning ahead in placement allocation. Childcare was a particular problem when changes to placement allocations were made at the last minute. Earlier planning of placement details and off-duty, perhaps several months in advance, would have facilitated planning continuity with a mentor. Hilary explained that she wanted:

'More planning ahead, more stringent placement plan possibly. I expected to have everything sorted out up to about May this year [speaking in January] then I could have a timetable knowing exactly where I was going so that childcare can be sorted and be as close to my mentor as I can.' (Student, second year diploma)

5.7   ASSESSMENT OF PRACTICE: Point of reference used to assess learning and the learners

5.7.1 Assessment documentation provided a background context to assessment and end point stages in the course. In practice, mentors took a much more individualised approach, based on the students' own previous experience, the clinical situation and their learning needs. Mentors tended to rely on their own personal experience with the student. One mentor taking over from another mentor reported how she managed this process which she did not like. She did not want to '*take the student back and start supervising everything they do*' (Midwife), as it was seen as a backward step for them. Instead she discussed this issue with the previous mentor and also '*watched the student to make sure that the things that I liked to be done are being done as well.*' (Midwife)

Occasionally, midwives expressed reluctance in having too much prior information about a student from other sources, as they preferred to make their own judgements. '*Too much information may cloud your judgement.*' (Midwife)

5.7.2 Students felt that staff (other than the mentor) tended to overestimate how much the student knew and that students could be left to continue with work when the placement was busy. This could leave the student feeling vulnerable to the repercussions of any mistakes that they might make, which could blight their training and so they tended to resist this pressure.

'I think in some ways it's good because you are able to develop some things like apply your theory to practice, put your own stamp on things, but then at the same time if you are doing things that are not the way that you ought to be doing them, there is nobody to say or to question what you are doing or to show you … I think that you do need somebody there to say. I can see an improvement … So I think sometimes it is frustrating because you think I've still got two years left to go and a lot to learn and you

do not want to make a mistake … and be burdened … making a mistake that shouldn't be made when you are on your own when you should be with somebody else really' (Student, second year degree)

5.7.3 Assessment documents were not seen as very helpful by a number of midwives**.** For instance Katrina considered the criterion referenced system in use to be *'waffle'.* Another midwife commented that she thought differences between degree and diploma were not relevant. Many of the aspects on an assessment form were difficult to judge, for example, communication. One midwife stated that she passed students on this anyway, following a discussion of aspects surrounding it.

5.8 ASSESSMENT OF PRACTICE: The impact of assessment - continuous versus staged

5.8.1 Assessment was carried out as an ongoing process and was usually verbalised by the mentor. At the outset of the placement some pairs came to an agreement to give each other feedback on a continuous basis. The mentor provided generalised support which was confidence boosting to the student, expressing the belief that the student would become a 'good' midwife.

Joelle was very impressed by her student (second year diploma): *'she's brilliant, so good, exceptional'.'* (Midwife)

Joelle described how she taught as she went along, asking the student questions and observing her communication and technical skills.

5.8.2 On busy placement areas where the mentor and student were not able to work closely together, the mentor expressed her ability to observe the student, even when the student was not aware. Ongoing evidence of assessment was apparent to the student when the midwife allowed her to carry out procedures on her own. Students highlighted the level of trust within relationships with mentors when this happened and took it as an indication that they were making good progress. The named mentors took their professional role seriously and were concerned that they were able to account for their actions within an environment of litigation and defensive practice.

5.8.3 Penny, a midwife qualified for more than 5 years, illustrated stages in this process and identified how this ongoing assessment was managed:

'She [the student] is still at the stage where she does need a lot of support. You can leave her for a short period of time but you couldn't leave her for a long period of time. In the case of a labouring woman I can come out and do something but then I have to go back in to see what she is doing and with the partogram and is she doing the observations and is she keeping an eye on what is going on as well as observing the whole case.' (Midwife)

Susanna, the student, was six months into the shortened eighteen month course. She appeared very nervous during interview. Susanna spoke very positively of this mentoring experience which contrasted with her 'bad' experiences previously. There was reference to the sad and traumatic experience of one student's first day on placement which unusually was on Delivery Suite. She had been present at the birth of a baby who was stillborn (undiagnosed). Susanna recounts:

'I had problems on my first Delivery Suite placement as my mentor went sick so I didn't have a mentor after an incident. I didn't really have a mentor then but the university went out of their way to make sure I had a mentor for my next placement.' (Student)

There appeared to be very little trust expressed by the mentor in this pair.

5.9   EMOTIONAL SUPPORT: Mutual respect and effort involved in mentoring

5.9.1   Evidence relating to emotional support was variable among pairs. In some cases there was evidence of midwives' concerns for the students as individuals (and they did not set students tasks to complete after shifts, such as finding information on various topics). The students' home circumstances were often such that there was very little time or energy left to do additional work on top of set assessments and this approach was appreciated. Midwives and students were often exhausted and learnt to recognise this in each other where the mentoring relationship was good.

There was a suggestion that midwives felt threatened when a student asked them a question they did not know the answer to. Mentors who approached students' questions with openness (for example, admitting any lack of knowledge and prepared to help students find the answers to questions) were viewed very positively. Students who were able to communicate clearly to mentors and clients were valued by the mentors who then felt confident that these students would recognise situations beyond their abilities and would ask for help.

5.9.2   The role of mentor was viewed with variable degrees of enthusiasm by different midwives. One midwife suggested that good mentors are 'born not made.' While courses such as the 997/998 were helpful, mentors did need to have commitment and enthusiasm. The data indicated that support structures to facilitate mentors in their role are also crucial.

Midwives required the mentor preparation and update sessions to put more emphasis on issues relating to relationship aspects of mentoring such as:

    Provision of support and feedback to students
    Development of the student towards autonomous practice
    Integrating theory and practice issues such as how to deal with difficult questions
    What to do when '*you have a student you don't get on with'*

5.9.3   Considerable effort was expended by midwives during the process of mentoring and this needs to be acknowledged. There was often no time for formal assessment on busy placement areas such as Delivery Suite. Informal assessment was ongoing but more formal completion of the assessment booklets could not be completed during duty hours. A student stated *'I've got to go and see her in my own time to get that book written up.'*   A midwife from another pair described how she had to pay additional childcare costs in order to start early and fulfil her role as mentor.

5.9.4   Midwives also need to be given time to debrief students. There was evidence of a lack of acknowledgement regarding the stresses and traumas experienced by students and the absence of a support system to sustain them. Students described how they needed somebody to talk to about the traumatic events which happened on Delivery

Suite but it was often too busy. There was evidence that students who were invited to complete a diary for this project, used the tape recorder to debrief. For example, one student was very involved in several clinical events and afterwards she described herself as "*shell shocked*" and crying *'shock, shock, horror … frightening'* (Student, second year diploma)

Dealing with a fetal death, she described the mother as weeping uncontrollably. On another occasion having stayed after her shift had finished to wait for a woman to deliver, the baby had been born in a very poor condition. The student described how *'everybody was too busy, [she was exhausted] but wanted to talk about it straight away'* (student). The co-ordinator sent her home where she 'broke down'. This was the first very ill baby she had seen and she said *'You need to be able to sound off, to reflect'* (Student). A midwife sat down to talk to her four or five days later. The student described how she did not want to talk about it in class *'in case I get upset in front of twelve other women'* (Student)

5.9.5 Some midwives referred to the exhaustion they felt when they were given no breaks from mentoring. Student-free periods when the midwife could develop her own practice were considered important. Midwives expressed the wish to look after women by themselves and *'Not have to teach anybody. Not having anybody listening to what you say.'*(Midwife)

Katrina, a midwife for 10 years, expressed a level of despondency and disillusionment during an interview. Recent closure of a local mini obstetric unit had altered midwives' practice dramatically. She considered that there was increased medical involvement and that midwives were losing their skills and confidence. She also expressed that there was unfair distribution of students among midwives and that she was tired of teaching. None of this was referred to by the student, who was very positive regarding her experience of mentoring and teaching at the end of her first year of her course.

A specific need for pre-registration students (particularly those on shortened programmes) seemed to be for the mentors to avoid being 'patronising' to them. Many students expressed a need for constructive advice and criticism, balanced with gentle positive stroking and a sense of optimism;

'…she's been really supportive but in an unobtrusive way. But I know that if I've got a problem, she's always there and she's always supported me. And she doesn't belittle my questions and she's instructive but not in a patronising way and I think she's a really good assessor and mentor. And I've really enjoyed working with her and she's really built my confidence back up. And I really feel as though I can do this-I can! Everything will be okay and it will work out alright' (student midwife-shortened programme).

WOMEN'S VIEWS
5.10   Views of a sample of women who had used the maternity service
The focus of the research has been on the students and midwives and how they organised their education in practice. However, the women's views have been important for revealing how the women recruited to the study perceived educational activity during their maternity care. Some women were able to recall the working relationship between the midwife mentor and student midwife and the subsequent effect on their perceptions of care, both physical and emotional.

Although the telephone interviews with women were short (usually 15-20 minutes), their memories of teaching and learning during care were varied. Interestingly, there was minimal literature available on women's views of student midwives' involvement in provision of maternity care.

The women were all recruited (following written information and consent) from the observation visits. Through the range of observation notes, there is rich evidence available when observation visits took place at different times of day, for example, early, versus late evening. Detailed notes portrayed the reality in some settings, for example, in one, a radio was apparently on in the background. The door buzzer then went at the same time as the phone ringing. In midst of this, the bleep-holder had arrived to verify staffing. This level of detail of activity portrays the interruptions to daily work in clinical settings.

In another visit, which occurred in a delivery suite setting, the television was apparently on, with the programme 'Robot Wars' playing loudly. The woman was described as being distressed with pain in the first stage of her labour. The observation notes describe the rising anxiety of the partner who was present, and the verbal and non-verbal communication between the midwife mentor and student.

The observation sessions provided an ideal medium for witnessing communication skills in action, for example, how midwives offered information regarding analgesia to women in labour and how students responded to this by role modelling verbal and non-verbal behaviour.

5.11 Findings from the telephone interviews with a sample of women
All women who were interviewed stated that they were happy to talk about their experiences of pregnancy and birth. As was found in other research studies described in the literature, many women recalled a large amount of detail regarding the interactions and subtle incidents which occurred during some of their maternity care.

5.12 The main care giver
In nearly all cases, the midwife was the main care-giver and women expressed satisfaction with the care provided. Women for whom it was their first baby, stated that they would have preferred to see the same midwife throughout the pregnancy and possibly for the birth. Most women who were multiparous (had other children) and had used the maternity service before, were content to see a team of midwives.

A small number of women had long stays in hospital for complications in their pregnancies. One woman described how seeing the same midwife on the ward, then for her induction and in the first days after the birth was helpful to her;

'I was really relaxed because I knew her.' (Woman 7)

5.13 Identifying the student midwife
A few students introduced themselves as students, or the women ascertained student status from their name-badges. Most students were introduced to the women by the attending midwife. Women were sometimes aware of the programme the attending student was studying on and occasionally knew if students were at the beginning or end of their course; ;

'I didn't really fancy a student but I was glad to meet a student I knew. You need to gel with the person looking after you. They let the trainee take on the role as the student was at the end of her course. The midwife backed her. The student was with me in theatre, bless her. She held my hand all the way through. The midwife was always there to support her' (Woman 4, describing a student on 18 month programme).

5.14 Skills
Nearly all women stated, using a variety of words that they were impressed with the skills of midwives. Many said they were 'very good'.

Some women noticed hesitation by students and signs of fear or anxiety. One woman noted a student's hesitation with giving a sub-cutaneous injection following a Caesarean section:

'There was one point where I had so many different injections (I can't remember what the injection was for) but the student was going to give me the injection and she actually said to me "I've not done this before" – and that took me back a bit and I thought "uh oh".' (Woman 6)

Later in her interview, the woman reflected on the confidence level of another student who was involved in her care:

'A student midwife came up to me the following day with no-one around (no other midwife with her) and said "I've got to give you this injection" – but she was so confident she just did it and never said she'd done it before or anything else, and I felt quite happy about that …   I think actually to be fair she'd been a nurse and was training to be a midwife so that was probably why she was so confident with needles'. (Woman 6)

One issue which links with the category 'stages towards autonomy' in the in-depth (pairs) data concerns the difficult situation when students were expected to act as an advocate for the woman but actually felt unable to. One woman, who had had a Caesarean section, described her relationship with her named midwife:

Woman: '… *I didn't find my midwife very helpful actually. She was very negative about various aspects of my pregnancy … She instilled a lot of kind of fear and anxiety in me which I probably didn't need'*

Researcher: How did the student react?

Woman: *'The student didn't do anything unless the midwife asked her to … she just listened'* (Woman 11)

The women did generally remember the practice style of midwives and students working in pairs. At an antenatal visit at a community clinic, one woman recalled:

'Whereas (the midwife) was busy chatting away doing things and at the same time, with the student, it was more along the lines of, do one thing, do the next thing, she seemed quite compartmentalised … and even things being 'boxed' … that doesn't worry me – from the point of view that she's concentrating on what she's doing and she's going to do it right'. (Woman 5)

5.15 Emotional support

Generally, women felt that emotional support would be offered from the midwives and students if requested. One woman's response echoed this:

'*I did feel …that if I needed it, it would be there*' (Woman 1)

Generally women were sensitive to brusqueness from the midwives. Conversely women used language filled with positive enthusiasm when midwives and students offered extra support or noticed if, for example, women were tired or unusually withdrawn in the early postnatal period.

5.16 Support from the student midwife

The emotional support provided by the student midwives was appreciated by the women, particularly if having, or if they had just had their first baby.

'*The one looking after me, she was brilliant; she really was. Because I was a bit nervous … The student midwives were more sympathetic, more caring … they were more enthusiastic. They want to learn obviously, but I think they've got a different attitude.*' (Woman 3)

One new mother had experienced a long labour which had involved her having Pethidine for pain relief and syntocinon to aid contractions in labour. She described how the student's presence enhanced her experience. The following day, the student went to visit the woman on the ward, who stated that she felt really cared for by the student. The woman vocalised her disappointment that a student was not present on the postnatal ward as she had difficulties with breastfeeding the baby:

'*The students are the only ones that want to talk.*' (Woman 1)

5.17 The role of gossip

Women often talked to other women, sometimes comparing their experiences. This was witnessed during non-participant visits in hospital ward situations. Other evidence of this emerged from the telephone interviews. For example,
'*As we were all on my ward, we were saying the students were more caring. They hadn't got to do it day in and day out and got monotonous.*' (Woman 1)

5.18 Women's interpretation of the teaching process

Women conveyed how they interpreted the teaching and learning styles of the midwife mentor/student pairs:
'*… it was as if she [the student] knew what she was doing and just reporting back-saying "I've done that"*' (Woman 3)

Several women in this sample suggested that the use of abbreviations and midwifery terminology was distracting;
'*They used a lot of these technical terms that they're using on a daily basis but not necessarily that a lot of people would know about.*' (Woman 11)

One woman expressed that her antenatal visit was so quick that there was no time for any teaching. She concluded by saying that she felt it was vital for student midwives to do their training in real practice:

'… *especially if you're nervous about asking questions. You can listen to what the midwife says to the student*' (Woman 4).
Other women also described how they picked up information somewhat vicariously.

5.19 Perceptions of the mentoring relationship
A specific question regarding views of the mentorship relationship was not formally asked and yet most of the women alluded to the general feeling about how the pairs worked together:

' *… there was one pair … the qualified midwife and the student … they obviously got on very well anyway. She was talking all the time, explaining what was happening when they were dealing with me.*' (Woman 1)

5.20 General comments about having student midwives present
Some women expressed a neutral response to having student midwives involved in their maternity care. However, the majority were enthusiastic.

'*I think it's the best way for them to learn really. I've got no problem with it at all*'
(Woman 5)

'*I think they should have hands-on training … they'll have no bedside manner I suppose, they won't have any of that just sitting in a classroom.*' (Woman 13)

'*I think it's very important.. 'cos otherwise how would they learn? In other professions, like an apprentice, they are there when they are working. So I think they should be there.*' (Woman 1)

At the end of interviews with the women, it was common for them to express support for the project and the education and training of student midwives.

Summary of in-depth (pairs) section and views of women

Role modelling
- Students valued continuity of the named mentor
- Students selected out aspects of midwives' practice but struggled with conflicting practice
- For students to develop towards autonomous practice, mentors needed to assess students' abilities (formally and informally) *throughout* placements (not just at the beginning and end)

Learning and teaching styles
- Students needed more structured assistance to relate theory to the practice situations
- Management of the learning was variable depending on work load of the mentors and also schemes of care eg caseloading.

Assessment of practice
- The midwives used individual points of reference to guide the assessment of practice. This was not always articulated, potentially leading to misunderstandings
- Students valued regular (i.e. daily) feedback on their performance
- Positive comments were often made about the tripartite assessment process

Emotional support
- Midwife mentors often expended considerable effort in the mentoring process
- Mutual respect was an important quality in a successful working relationship

Women's views of their exposure to mentoring, student midwives and clinical education
- Some women stated that they found the students more caring and attentive than the midwives
- Women seemed not to mind if students spent longer doing, for example, antenatal or postnatal examinations, particularly if they were thorough.
- Women appeared to appreciate emotional support offered by student midwives
- The women seemed supportive of the student midwives having 'hands-on' training

CHAPTER 6   DISCUSSION

Introduction

The core of the discussion has been organised around the aims of the project. Within these aims, the central areas we have investigated are:

- the organisation of services offered which affect the women, the midwives and the students;
- the preparation offered to midwives for their teaching in practice role;
- the contemporary preparation offered to student midwives;
- the process of assessment occurring in England at this time;
- the support mechanisms in place for both midwives who mentor in a range of settings and for students who were studying on a variety of programmes (for example, diplomas and shortened or long degrees).

Evidence has been used from the variety of data sources to provide a composite picture of the management of the learning process across five sites in England. We will be referring to some key pieces of literature which informed the research topic and will draw together key issues from all data sources. The challenge has been to include the wealth of data from, for example, analysis of curriculum documents, the teachers and managers who showed varying levels of commitment to the development of ongoing knowledge and skills of the midwives and student midwives. Reliability and credibility have been established through cross-checking and comparing across all five case study sites and comparison across the methods of data collection and analysis.

6.1   Women receiving maternity care

When we think about the core skills and activities of a midwife, we may not include teaching skills in our description of the role of the midwife (Code of Practice, UKCC 1998). The data revealed that women are aware of and do remember teaching by the midwives to students, which occurred during episodes of their care. The women interviewed generally remembered and valued the student midwife as part of the team.

Aim 1 : To investigate the type of experience in practice settings

Complex organisational systems were occurring at the range of case study sites. What we have tried to discover from the information presented in all sites is: who was managing the learning process, at both a macro and micro level? This has been particularly important to help us tease apart the issues in areas where models of good practice were emerging or apparent. For example:

- where there was clarity in the system of mentorship;
- where there were resources allocated for roles based in practice e.g. learning environment co-ordinators and placement support midwives;
- transparent assessment processes; and
- preparation for and follow-up of clinical placements

6.1.1   Schemes of care

This research has shown that the educational activity in practice hinged, to a large extent, on the organisational structure and systems in place. The flexibility that is required to deliver a woman-centred service, with an holistic philosophy is a growing

challenge. Significant recommendations from reports such as Fitness for Practice (UKCC 1999), Making a Difference (DoH 1999) and the NHS Plan (DoH 2000) have had to be incorporated and merged with new developments in the Higher Education system. Student midwives have had to become involved in a huge variety of schemes of care in their allocated Trusts, including caseloads. For some students, this has marked a change in how care is structured for women and also how learning of knowledge and skills can be creatively delivered to students working in such diverse schemes.

6.1.2 Partnerships

Effective communication systems between the University and affiliated Trusts regarding clinical education were important. The case study data revealed that, for the institutions to run smoothly, much was dependent on two fundamental relationships. Firstly, the level of partnership between the University and affiliated Trusts and secondly, the quality of the ongoing relationship between midwife (mentor) and the allocated student. For the purposes of this report, these will be addressed separately.

- The University/Trust liaison and networks:

As Fraser et al (1998) asserted, for the preparation of midwives to be effective, there is a need for greater integration of theory and practice and the need for a more uniform approach to the provision of learning opportunities.

Across the five sites, many new midwifery roles were in operation, for example, research and development midwives and practice and development midwives. Placement support midwives were employed by one workforce confederation to primarily support the students in practice. The midwives in these posts who were approached for the purposes of this research, described the positive links they were achieving with both the Trusts and Higher Education Institutions.

The models the midwifery lecturers linked within, combined with the philosophy and vision of the Approved Midwife Teacher were key to effective linking processes with individual Trusts. In some Trusts, midwifery teachers were trying to work more with students to give the midwives 'time off' for the teaching role (See 4.2.3). There may however be a place for the link teachers complementing the role of the midwife mentors, forming more of a professional, team partnership. Forging clinical team links such as this could benefit all participants and ensure that basic teaching principles are entwined with high quality midwifery care. Tripartite assessments (involving the student midwife, her mentor and a link lecturer from the University) were in operation in some sites and proved popular for all involved.

- The quality of the ongoing professional relationship between the student midwife and midwife mentor:

Many students included in the in-depth (pairs) component of this project, demonstrated a commitment to developing a repertoire of skills and adapted to the individuality of and respected the demands placed on midwives, many of whom worked part-time.

Midwives demonstrated their loyalty to the women in their care and also to the students. The communication skills and, to some extent, the maturity of attitude which each mentor and student brought to their dyad relationship, was crucial for satisfaction of placement. Women's informal views of how this relationship affected the episodes of care were not formally asked for but women described how verbal and non-verbal interactions with the attending midwife and student affected their care.

As previously mentioned in the literature review, much of the knowledge gained by the student from the mentor in practice is learnt informally. Eraut (2000) defines this as personal knowledge, which may be explicit or tacit. Much transfer of knowledge from the mentor to student midwife appeared to be tacit and this is particularly evident in the diaries collected from the in-depth pairs.

6.1.3   The system of allocation

The systems were varied and depended on, for example, who held the information regarding trained mentors (managers in Trusts or allocation officers and lecturers in the Universities). Students were expected to access the information in different ways at some Trusts when changing placements. Many students stated they would welcome a much more streamlined system of allocation.

Students

Some students described the conflict and demands which stemmed from preparing for professional award *and* a professional qualification. Students therefore needed to plan their placements and allocation so they could manage their clinical learning within the remit of their studying needs and outside commitments (in particular, childcare or partners working within shift systems).

Having some choice in allocation of a mentor was vocalised by students in their focus groups. Even where the in-depth pairs did not seem that compatible in terms of personality and/or teaching and learning styles, there was general agreement that continuity of a mentor was more valuable than changing mentors. Students asserted that it would be helpful to meet their mentors prior to the allocation. In one site, the mentors arranged a coffee and team meeting but students often attended in their own time. This initial meeting is so important, being the cornerstone of the mentorship relationship that time should possibly be built into the clinical curriculum specifically for this purpose. Students in focus groups also suggested that time with and preparation of co-mentors would be useful.

Midwives

Across the data sources, role overload was found, particularly for more senior midwives who were managing clinical areas whilst simultaneously mentoring students. As found in the midwives' focus group interviews, many midwives welcomed the opportunity to support student midwives in clinical practice. Some senior midwives were also team leaders, managers or specialists in areas such as family planning or high dependency midwifery units. In many cases, this had a negative effect on students' learning. However, a few senior student midwives recruited to the in-depth data process, expressed the benefits of gaining insights into management issues.

Some midwives expressed how, even though they had the ENB 997 Certificate and updates, they needed a break between students. Supervisors of Midwives perhaps need to advocate for mentors, promoting greater recognition of the mentor role (i.e. teaching alongside all other midwifery duties) and press for individualising student allocation to the midwives so that the selection of mentors is appropriate to the students' needs and the circumstances of the midwife.

6.1.4 The placement system

All placements across the five sites were more than four weeks in length. At some sites, placements were long, particularly in community (See chart, section 3.4.5 with

demographics). Although many midwives expressed motivation to build in planned teaching and thorough assessment of students, the in-depth data from some midwife mentors revealed high levels of tiredness and fatigue. Many midwives in focus groups revealed a wish for some form of remuneration for mentoring.

Pressures of the training requirements were found to be difficult. Students reported in their group interviews that achieving the 14 competencies as well as all academic assignments, reflective papers and portfolios was stressful. Pressure on students in midwifery to obtain the clinical requirements to qualify, i.e. 40 normal births and 100 postnatal examinations, was vocalised and emphasised by students on shortened midwifery programmes. Students described how they needed to get their 'numbers' and competencies 'signed off'. There is perhaps a concern therefore with who is monitoring the overall auditing of student records and documentation as this has implications for client safety and clinical governance.

Night duty provided practical difficulties for students with complicated home arrangements but many students enjoyed the extra autonomy afforded to midwives when there were less distractions than on day duty.

Student involvement in caseloads in midwifery has been found to be very successful in some parts of the country (Lewis 2002). Some students invited to the in-depth data process did, however, remark on the unpredictability of the working hours. Combining academic studying and flexible shifts caused fatigue in some students. Other students found the travelling exhausting, particularly in rural areas.

In the Trusts, rotation of midwives usually occurred approximately every six months. Whilst the management staff suggested that frequent rotation of midwives was needed to maintain and update their skills (see section 4.1.1), the midwives stated that more time was needed to readjust to new settings prior to mentoring students. Observation notes from in-depth (pairs) data, give vivid examples of how resourceful the midwives had to be if they were performing more than one task at the same time in front of the women.

6.2   Aim 2: To investigate the preparation and role of mentors and students

6.2.1   Definition of the term mentor
There are now expectations that all midwives will teach as part of their role. (See section 2.6 for further detail)

6.2.2   Preparation of mentors
All mentors recruited to this research project stated that they had a minimum of one year to consolidate their own practice. The time suggested at one site was, in fact, eighteen months from qualification of a midwife to taking a student. In most sites, due to chronic short-staffing, this would not have been a practical option. In all sites, midwives in focus groups stated that it was important to the midwives that their mentoring role was defined. Whilst teaching in practice has been put forward as part of the role of the midwife (Code of Professional Conduct, NMC 2002), Dimond (2002) points out that the Nursing and Midwifery Council has failed to address the issue of clinical supervision. Most midwives had undertaken an ENB 997 (or 998) Teaching and Assessing in Clinical Practice course. During 2000 to 2002, this was offered in a variety of formats, including as an open learning module.

Local preparation sessions were offered at all sites. Some sites offered 2-day mentor/assessor days whilst others offered half day workshops. Some were run in Trust sites and others in the Universities. During the course of this research study, attendance by the midwives was generally poor. Many midwives often stated that they felt unable to attend due, partly, to excessive workload.

Emphasis in the case study sites was placed on different aspects of teaching and assessing students. For example, at one site, the focus was primarily on aspects of new curriculum documents, whilst another site focused more on 'trouble-shooting' or using scenarios to, for example, help the midwives to deal with challenging students or situations. New preparation programmes have been in place since September 2001 but there is minimal standardisation. Individual variation in programme may be due, in part, to client population needs.

There needs to be wider debate around the need for protected time for attendance by midwives at update sessions. These were often cancelled due to low attendance. There may need to be increased incentives to attend the updates. Midwives are bringing ever higher levels of knowledge, practice and specialist skills into their Trusts. These skills are generally recognised and valued by colleagues and yet the art of mentoring and attendance at updates gives no added credibility for midwives. More attention may need to be paid to the midwives' evaluations of these sessions. Added incentives may be a free working lunch, financial reimbursement or perhaps a book token.

At most case study sites, a 'live' register of midwives eligible to mentor was available. However, the registers were maintained and managed in different ways and contained varied amounts of detail about the skills and teaching profiles of midwives. A possible recommendation is the development of a forum to discuss teaching practices and share ideas and information regarding mentoring. A formal peer review process would be complementary to traditional staff development for midwives. A practice education forum could generate exciting new ideas for clinical learning and create added incentives to mentor well.

As preparation to mentor students, some midwives needed to develop or enhance their clinical skills. Midwives in the focus groups talked about how they accessed the Trust workshops to update, for example, on child protection or HIV, but the seminars were always for the benefit of the women and not the students. The midwifery managers also showed a commitment to the midwives being updated and trained regularly.

6.2.3   Preparation for students
In the five Universities, all students entering the practice settings received documents to prepare them for their placements. Whilst some student handbooks offered a variety of promises that raised expectations for students, other statements were more realistic. The documents described the balance between skills learning in combination with academic learning and absorbing the more subtle intricacies of the midwifery culture. For some students, this did not dispel some of the myths of what being a student midwife meant. One student described the culture shock of being away from home for the first time. She was learning how to be independent - surviving as an adult, a health professional and also a student in the competitive University setting. Students in the focus groups described some lack of preparation for the reality of practice and described feeling exposed in practice settings. Some students on pre-registration shortened (18

month) programmes described the frustration of being unprepared for emergency obstetric emergencies despite being skilled nurses. The level of knowledge expected to prepare them prior to going into practice was not clear in the documentation. The students described an imbalance in their theoretical preparation and the need for an enhanced team approach to help them link theory and practice. Whilst some documents and student handbooks cited that students needed to perform within three broad domains, such as developing competence as a Foundation student, a Developing student and a Consolidating student, there was little advice as to how learning connects the theory and skills profile.

This is the relevance of the work of Benner (1984) and Eraut (1990, 1995) concerning application of knowledge and development of professional competence in different contexts. The midwifery students were expected to be self-directed learners, moving towards independence in their practice. It was expected, in many cases, that the level of supervision and mentor contact would reduce during final clinical placements. The data in fact showed that the students needed similar levels of supervision and support throughout their programme but the character of this support changed in the final stages. The students articulated that rising levels of responsibility meant that more pastoral guidance was needed from their midwife mentors. The lack of flexible learning agreements seemed to lead to mentors making assumptions about the level of independent activity senior students could manage. Throughout the data sources, students expressed the differing needs for support in developing as a competent professional, and the need to be 'fit for practice' but there is minimal formal recording of this aspect of clinical supervision.

Students also described how they needed their mentor to recognise their capabilities to guide them between the 'normal' and 'abnormal' spheres of midwifery. Mentors therefore need to implement strategies to help students to prioritise their learning needs, placing value on skills teaching.

In terms of academic support for the students, actual strategies for students to access support were rather vague. There were varied expectations of the levels of supervision required. There was also no formal information given as to who the students would see regularly in practice, for example, practice facilitators and teachers for one-to-one clinical tuition. The time and effort involved for students in finding a mentor was often under-estimated by personnel at the Universities and Trusts. Managing the tensions around supernumerary status also created concerns for students. There was a consistent lack of clarity emerging in the data as to how midwives and students would manage the constant adjustment required during placements. How this affected quality of learning and satisfaction within the mentorship relationship was most evident within the category 'shadowing/echoing' in the in-depth data source. This is an area which needs to be addressed by all personnel involved in facilitating clinical learning.

Expectations of working within a shift system or a caseload/team were not always realistic. When students spent time prior to placements meeting with their allocated mentors, there was less anxiety voiced and fewer misunderstandings. In many 'end of placement interviews' within the in-depth data, both the student midwives and midwives reflected on the mentoring style.

Although emphasis here has been placed on the pre-registration students, support is also required for post-registration midwives in preparing them to undertake their modules or programmes. Encouragement and support are needed to increase motivation to complete modules for continuing professional development. Midwives said that motivation was a factor in practising skills with clinical outcomes on the completion of the courses. Recommendations for re-skilling the workforce and developing a comprehensive Continuing Professional Development (CPD) strategy have been developed as part of a toolkit for NHS Workforce Development Confederations (RCM 2002).

6.2.4 The role of the student midwife

There are expectations by both midwifery educators and managers that the student midwife will be self-directed, analytical, reflective and professional. The student is working towards a professional qualification and must achieve all competencies prior to registration. The achievement of a set number of births, from witnessing to performing with minimal supervision is also a training requirement (ENB 1998). All student midwives have a responsibility, therefore, to complete the required amount of practice hours, complete all academic course work *and* show professional and personal development which meets the assessment criteria.

The academic curriculum documents often cited that the programme was supposed to be 'student-led' or 'learner-centred'. This creates pressure for the students to plan their time and to manage all aspects of their experience. It emerged from the in-depth data that there was a need for mentors to maintain a continual dialogue with the students to help them plan their learning needs.

Development of communication skills was an issue for some junior student midwives who, through in-depth data sources were found to be on a steep learning curve in absorbing the complex culture of midwifery. Students needed to feel prepared for the reality of performing clinical skills in practice and also skills of communicating professionally with women they were caring for. The need to develop assertiveness skills was mentioned in many focus groups and in the in-depth data (in particular, the students' audio-diaries).

Students at all levels found they were caring for women for prolonged periods of time and were often on their own (even early in the second year of a three year programme). In their audio-diaries, some more senior students revealed skills of self-assessment and were able to reflect constructively on both their practice and their learning. It would perhaps be appropriate for more junior students to have the opportunity to have structured clinical skills laboratory sessions in which the focus was purely on communicating with women and using terminology appropriately. In midwifery, there are often distractions which occur from, for example: toddlers; attitudes of partners; telephones and other interruptions.

As we accessed sites across England, The Annual Public Health Reports from each area gave an indication of the cultural diversity of the clientele that the student midwives were exposed to. The degree students, particularly, were often entering higher education from other regions. Expectations from the Trusts and Universities are therefore high regarding how much a student midwife in her first year is expected to absorb.

One degree student (on her first community placement) who was recruited to the in-depth data process, certainly struggled during a home antenatal booking visit. According to the observation notes, the woman who was booked for hospital care, seemed unphased by the unusual order of questioning by the student midwife. But following feedback (and interruptions) from the mentor the student found her confidence reduced. The student subsequently recorded in her diary her anxieties about how she was going to change her approach to her 'communication' skills. (See section 5.1.10). If baseline discussions with mentors were more structured at the beginning of placements, there may be less nervous tension for students. Importantly, this student tension was often unknown by the midwife mentors. Students often described how they managed the tension as they needed to be seen to be coping.

The amount of supervision required from the mentors was a major concern for the students. Both mentors and students needed to be realistic about the actual level of clinical supervision and support that was required. For the more junior students, this often occurred in a vacuum. The in-depth data reveals that in one case 'the midwife would do the antenatal check to get it done more quickly'. Although the student initially justified this by expressing that this style was necessary for efficiency, it was evident from the data from women's interviews, that the women were happy for visits to take longer if student midwives were present.

As students stated in many focus groups, they were keen to be exposed to best practice and wanted to learn skills the 'right way' (See section 4.1.2). The students obviously need to avoid seeing caregivers cutting corners. The midwives stated in their focus groups that there was a constant 'lack of time' to complete tasks as they would like.

Students also expressed (in both in-depth sources and focus groups) that they found confusion in different practices draining (for example, 'having hands off or poised during second stage of labour'; how to 'fill in high dependency charts' and how to negotiate information-giving about pain relief in the first stage of labour). This confusion was compounded when students had alternative Trust placements as they were then confronted with more policies and procedures to contend with.

Tensions arose with regard to midwives demonstrating research-based versus experience-based practice. Students recruited to the in-depth data recorded that their lecturers had given information regarding, for example, pushing in the second stage of labour. There were instances in the data where students (particularly in their second and third years of degrees and diplomas) were acting as 'mediators' between the woman and the midwife mentor. How they dealt with this was dependent largely on their maturity, the quality of the relationship with the mentor and how the student managed with taking the 'lead role' in a variety of scenarios.

Complications arose for students if their main mentor was not available. This was due to sickness, study time (for midwives undertaking courses), midwives working part-time or sometimes because midwives were moved to other care areas at short notice, owing to lack of resourcing. Whilst some students in focus groups spoke of feeling lost or even cheated if this occurred, the in-depth data provided glimpses of how helpful it was in some circumstances, for the student to observe a range of midwives and their individual practices. One student used the example of seeing an epidural trolley being set up differently. It helped her to individualise her knowledge and make her own mind up as to how flexibility was a possibility. The selecting out of practice which is safe, evidence-

based and appropriate for *them* is an important concern. The process only really occurred from the second year onwards (for students on long programmes). Most students on shortened (18 month) programmes had prior experience of adapting their nursing knowledge and came with a broader perspective.

In view of the fact that, when qualified, midwives have an immense responsibility to provide quality care (for women and babies) and also to pass on their knowledge and craft to students and junior midwives, it should be acknowledged that a more inclusive policy is needed. As a child is supposed to need a 'village' of people to enable growth and development (and preparation for life) so perhaps should student midwives have a community (or cloak) of supportive midwives around them. All those who have the motivation to teach clinically need to connect in a complementary and creative way for enhancement of care for women and for the continuation of a strong and valuable profession.

6.2.5 Support for student midwives and their mentors

To describe how student midwives are supported in practice, we have drawn on all the data sources; the interviews, observations and diaries completed by the pairs of students and midwives, as well as the focus groups and the individual interviews with Approved Midwife Teachers, link-tutors and clinical staff. In terms of practical and academic support for pre-registration student midwives, the student handbooks and documentation at each site formed the 'shop window' for the support mechanisms that in theory were available for the students in the five sites.

From these data a model of support in practice evolved (see Diagram 1, presented below). This model places the student and their mentor in the context of the clinical setting and describes some of the complex relationships between the different levels of support that are either available or lacking for students in practice.

Key to Diagram 1:

The person in this model represents the student on their practice placement in the clinical areas.

The hands represent the different levels of support that the student receives *within* the mentoring relationship with their main mentor. Examples of this type of support (where it is available to the student), can be:
- Positive and supportive working relationships between student and mentor.
- Mentors who are trained and prepared to teach and assess students.
- Where students and their mentors are 'matched' according to personality, teaching style, age or other suitable variables.
- Where the mentor acknowledges the individual needs of students and the importance of emotional support.
- Mentors who offer continual feedback on performance and constructive criticism.
- Mentors who are motivated and *want* to mentor students

The safety net represents the context of support, which includes all other support mechanisms in place either in the clinical setting or by the academic establishment. Some examples of the type of support includes:
- Well-developed documentation, including assessment tools.

- The visibility and availability of link-tutors.
- An environment where teaching and learning is valued and encouraged by clinical management.
- Evidence of coherence of curriculum where theory links with practice.
- Evidence of teaching in the clinical area, for example clinical incidents, group tutorials and reflective sessions.
- Academic staff participating in tri-partite clinical assessment.
- Time built in for teaching and learning in practice.
- Co-mentoring structures.

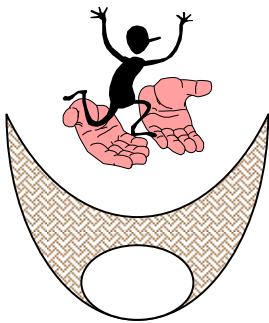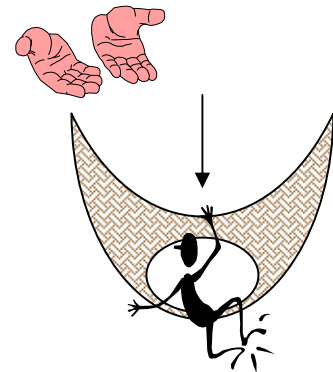Diagram 1 – Support Structures
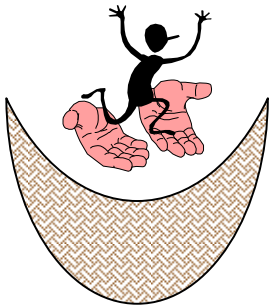
1. Supportive mentorship, supportive context (Clear structures and mechanisms in place to support students in practice).
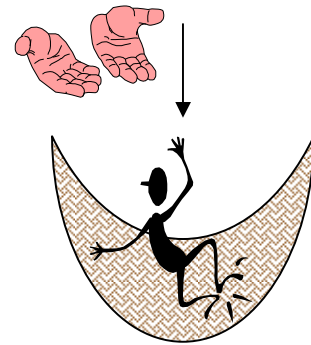
2. Poor/lacking mentorship, supportive context – acts as a safety net

3. Supportive mentorship, lacking context (lack of structures and mechanisms in

4. Poor/lacking mentorship, lacking context – student falls through the net.

Pope et al (2003)

In reference to Diagram 1 (Support structures), there was evidence of some students falling through the 'net' despite being in a seemingly supportive mentorship relationship and working within a system in which support in clinical practice was viewed positively. We had expected, at the outset of this research, that more support would come naturally from the mentorship relationship. There were possibly barriers to effective use of the mentor. As the mentor is expected to assess the student as well as to guide her through experiences in practice, the student may be reticent to go outside that relationship because ultimately the student must work with them on a daily basis and will be assessed often by both her mentor *and* a tutor.

Talking through events close to the time they occurred was not common. The pressures on the students often led them to use their families and peers for support. Few mentioned the student counselling service and the personal tutor was rarely used as a practical support contact.

Vulnerability sometimes increased for students as they became more senior and moved to a new identity. Whilst concepts such as 'independent learning' and self-directed learning are encouraged at the University, students needed a catalyst to aid them in translating this responsibility within the practice environment. What emerged through all data sources was that the students' need for support does not generally diminish over time. What is evident is that the nature and character of the support they require changes. For example, a student in the fourth year (recruited to the in-depth element of the project) had increased responsibility for her caseload in the community and was expected also to submit large pieces of academic work. A longer community placement meant that she was divorced from academic support but there was pressure to perform with reduced supervision whilst support in her practice increased. The pressure to perform independently in fact created stress and may have reduced learning for her.

There was a need for more pastoral support for both students and qualified midwives. Many of the placement support midwives who contributed to this project, worked part-time but appeared committed to the students' wellbeing and attempted also to support midwives who were mentoring. Support for the mentors came from different sources at the varying sites. The support also took different forms, for example, in some Trusts, the Supervisors of Midwives articulated a working knowledge of the issues which added to stress and subsequent burnout of midwives with a teaching role. To some extent, link tutors performed a supporting role. For students, however, it was suggested that this was hampered by tutors having limited knowledge of the issues, due to the underlying fact that they may have been involved with the assessment process.

The diary guide provided useful prompts regarding support offered in practice and revealed how the participants perceived support. The diary also portrayed the emotional work of mentoring in midwifery and the paucity of defined practical support networks. As Smith & Gray (2001) assert, emotional labour is minimally recognised and even reflective learning can become an emotional labour. The authors found that the process of storytelling helped participants reshape their lived experiences of caring. The structure of the diary used for the research in this study has positive potential to add to a student's or midwife's portfolio, as a creative learning and reflection tool.

6.2.6   Overview of Teaching and Learning in midwifery practice
As found by Bluff (2001), the main process of teaching in practice settings was found to occur through mentorship. Owing to individual variations, backgrounds and previous

teaching experience, the quality of mentorship varied. The in-depth data revealed the capacity for resourcefulness within many pairs of midwife mentors and students. We wanted to explore the steps the mentors were taking to promote active learning in practice and to examine how they attempted to plan the students' learning within the available resources.

Many factors influenced learning in the clinical settings (see section 4.1.8). Interestingly, for the majority of students recruited to the in-depth data, their prolific audio-diary output revealed that for them, everything was learning. The diary guide provided a springboard for them to relate what went well in their learning during that day or shift and what support they needed or accessed to assist their learning.

As one student stated, following an obstetric emergency, it was 'something you can't learn from a text book'. The importance of debriefing as soon as possible after each significant event needs to be relayed to the mentors. Many students demonstrated through their audio-diaries, that they were reflecting on and in practice.

Students described their need for structured learning sessions to help bridge the gap between theory and practice. In many cases, this need was not fed back to the midwives. This was compounded by the fact that the more senior midwives often had managerial tasks to complete over and above their teaching role. Much was dependent on individual teaching styles of the midwives rather than adapting to situations and facilitating learning in flexible and creative ways. Few books, key texts and teaching aids were readily available in the practice settings. There were also few resource rooms and a general lack of teaching/counselling rooms for assessments and sharing of issues concerning learning in private. Although students were actively encouraged to access databases such as the Cochrane database, to gain contemporary information, there was limited availability.

There were good examples of sound teaching and skills training within the data. The passing on of knowledge was valued by students as very relevant. The enthusiasm could be heard in the audio-diaries. However, some students found they were unable to respond as fully as they would have liked due, partially, to the pressure of academic work and deadlines alongside the practice experience. The situation was sometimes complicated by the student having such a heavy workload that they were not able to maximise the learning opportunities available to them. This created tension but stress management and time management sessions were not offered.

The individuality of differing learning styles of the students was often overlooked by the mentors and yet is key to planning learning experiences which are relevant. We wanted to understand what the mentors used as a basis for teaching and learning - in both ward and community settings. We were also interested in who primarily had responsibility for teaching clinical skills. Contrary expectations were sometimes found to exist between mentors and midwifery lecturers.

Recognition of the mentor role was not always evident, particularly as some mentors were also studying for extra qualifications. Having a student did affect their own professional development. In most cases, this was found to be positive. However, there was evidence that some midwives were potentially overloaded as they were managing their own learning and trying to create a learning 'package' for the student midwives.

As much clinical learning is based on experience with the mentor this creates added pressure for the named mentors. Few mentors demonstrated use of learning contracts to set learning goals. Midwives perhaps need more structured help and advice in devising formal and informal learning agreements for their allocated students.

Being a 'named mentor' is a significant responsibility for all midwives who mentor. The emerging findings are important in realising that managing the learning of modern student midwives means developing a mentorship system which is coherent and provides the safety nets not only for the students, but also for qualified midwifery staff (see Diagram 1 on page 95).

6.2.7   Assessment of practice

Students described the informal assessment midwives made of them at the outset of a placement. This was not standardised in any way or linked with specific outcomes or criteria. The in-depth data also revealed how some midwives assessed students using a system based on their own experience. This tacit component of midwives passing on skills and assessing them warrants further research.

Students on all programmes stated that they generally felt over-assessed in practice. Students also conveyed that where mentors were prepared for continuous assessment and were familiar with the documentation, the process was positive. The nature of the mentoring relationship was obviously crucial and needed to be as harmonious as possible with minimal misunderstandings during placements. Some students (particularly those on the shortened programme) stated in focus groups that there was little scope in the assessment documentation for identifying areas of strength in their practice. Some students came with a wealth of experience, which they felt was not recognised (for example, ward manager of a gynaecology ward).

This chapter has been a discussion of the main issues which emerged from the variety of data sources. The following chapter is a summary of recommendations for clinical midwifery education, which will be relevant for midwives, students, teachers and managers - and all who remain motivated to enhance clinical placements.

CHAPTER 7   CONCLUSIONS & RECOMMENDATIONS

Introduction

The research findings provide insights into the daily experiences, either vocalised or written, by the research participants. Evidence of what went well, in terms of teaching and learning for participants emerged, in particular, through the diaries. The qualitative research design has meant that the participants were invited to use their own language to describe their experiences, rather than being constrained by pre-formatted data collection instruments.

The investigation has uncovered some interesting views of how mentors were prepared and supported. The responsibilities for midwives who mentor to perform their role so that they create meaningful learning experiences for students are increasing. A concise definition of the mentor role and responsibilities needs to be re-stated. Re-appraisal of what clinical supervision of student midwives means will improve clarity and guide expectations from students and all involved in clinical teaching. The resources to support all aspects of clinical teaching must be mobilised. The potential for vibrant learning to occur in even simple situations and through basic interactions are immense.

Partnerships between NHS Trusts and Universities could be strengthened. For example, there is a need for more streamlined cascading of information, particularly where maternity units are being merged. It is important to include midwives who are core staff on night duty, also part-time midwives and all student midwives. Open meetings could be held at different times of the day and evening and would need to be advertised in a variety of formats, for example, notice boards and through electronic mail.

In the Universities, there is potential for a more creative approach to the provision of learning opportunities. Link tutors have to spend longer in clinical sites and therefore need to protect their clinical time. Where possible, lecturer practitioners could be involved. The building in of tri-partite assessments as shown by research participants, was beneficial for all concerned.

7.1   Managing the allocation of students to mentors

The allocation of students to midwives needs to be as individualised as possible. Co-mentors should be approached and, if resources allow, included in the allocation system. Midwifery managers should be sensitive to the fact that a midwife's circumstances may change to the extent that she may need a short break from mentoring students. Reasons cited in the data were; bereavements, getting married or having a run of more challenging students. Although student numbers have increased of late, it may be beneficial to pilot a scheme whereby a midwife mentors two students and then has a break from mentoring. This would obviously be dependent on human resources.

The research team recommend that a live register of practising mentors is updated and maintained by midwifery managers at each site with clinical placements. This information needs to be centralised with the University database. In some places this system is already occurring. Constant reviewing of the data means that, if the mentors' circumstances change, adjustments can be made prior to students commencing placements. There needs to also be recognition of students' outside commitments (for example, childcare and/or casual jobs to help boost student loans and bursaries). These

considerations are important to aid planning of the range of experiences in each midwifery placement.

A learning environment co-ordinator or placement support midwife who directs the student allocations and who works in partnership with the allocations officer at the University could facilitate the students' learning experience in practice. This would help to prevent students spending excessive time finding a mentor.

The clinical curriculum should include a meeting between the student and mentor *prior* to each placement. This needs to be built in to the curriculum so that the student feels welcomed and orientated to the clinical area. Expectations from both parties can be vocalised at this meeting and the student can begin to prepare for the specific placement. Details regarding placements could be posted on placement web sites.

The system of rotation of midwives could be designed to take into consideration the length of student placements to help reduce disruption to the mentorship relationship. There is a need for flexibility of students within the organisational system. The logistics of internal rotation onto nights needs to be considered, with student placements in mind.

Organised mentorship is also important for qualified midwives undertaking courses with clinical outcomes. Midwives identified that they needed support from mentors to obtain thorough feedback on their performance.

7.2   Practical planning for the placement

Protected time should be allocated for a meeting with the named mentor at the beginning of each clinical placement. This would aid the mapping of students' clinical development. A learning agreement could be drawn up at this meeting. Discussion of preferred teaching and learning styles should occur early in placements. The different realities of supernumerary status for students also needs to be identified early in each placement.

In a mentor/student relationship on long placements, particularly in the community, there needs to be recognition of the emotional work entailed for the mentors. This does not necessarily derive from personality issues but more from the emotional strain of constantly teaching, explaining and being watched by students. The pressure to provide quality supervision to students is sometimes increased by the exclusivity and intensity of the professional one-to-one relationship. Group or small team supervision is a possible way forward. The length of placements may need to be adjusted in some areas or co-mentors encouraged to share the mentoring role.

A clinical 'passport' could be devised and tested, which would include the broad summary statements of the student's performance. The mentor would have the opportunity to identify and record the levels of supervision and contact time given, on an individual basis. This could form the basis for any discussion with mentors occurring at the beginning of the next placement and could also assist students in planning of their own clinical skills repertoire and knowledge development.

7.3   Creating a positive ethos for mentors

Improved mentor preparation courses and updates are needed. The optimum time for consolidation of a midwifery programme and developing confidence to mentor students

may need further research. Preparation packs could perhaps be issued to midwives prior to attending mentor workshops. The material could include guidelines on effective mentoring of students on different programmes (for example, long and shortened midwifery programmes). The evidence highlighted that student midwives on the shortened (18 month) programmes, had different needs, for example, earlier theoretical and practical preparation for obstetric emergencies.

The Teaching in Clinical Practice (ENB 997) programme was replaced in September 2001, midway through this research project. New clinical teaching modules should be evaluated nationally. An investigation into the most effective module or programme delivery, for example, the suitability of open learning (or 'SLICE' distance learning modules) would be beneficial. Midwives' evaluations of courses in this format need to be considered. There is potential to re-evaluate the content and delivery of these current courses as clinical teaching is such an important skill for midwives. This area certainly warrants further research.

- Improved partnership is needed between Supervisors of Midwives, link tutors and possibly placement support midwives in developing updates. A more inclusive programme is needed, acknowledging the value and hard work of mentoring, which must be performed in parallel with all other daily duties and responsibilities. Peer groups (for peer support and exchange of ideas), led by a neutral facilitator could be set up.

Lively programmes could be developed to encourage rich discussion of issues connected with mentoring. This would also provide a forum to discuss positive changes to the learning environment and practical use of the student documents. There needs to be a refreshing team teaching philosophy, using the skills of the teachers and presenters but also knowledge of the mentors so that all sessions are relevant to them.

A web-site could be set up with on-line support for the mentors. This would need to be manned and financed. Alternatively, a CD-ROM could be designed with an interactive focus. The purpose would be for the mentors to link with the clinical teaching and learning modules at their own pace. This could encourage the mentors to return to the principles of teaching, for example, assessing a learner's prior knowledge and designing pragmatic and relevant practice learning outcomes for the students. The use of teaching aids could be revised. The mentors could also be given scenarios on-line to hone their skills in, for example, how to constructively criticise and praise a student and when to fail a student's practice in a fair and sympathetic way.

Recognition of the inherent tiredness affecting all levels of midwives is perhaps a new phenomenon. New incentives are required and remuneration for the mentoring role. If not financial this could be in the form of time back or in additional study days. A scheme of awarding academic credit for attendance at preparation and update sessions is a possibility. A commendation award could be offered annually to recognise and place value on excellence in mentoring. This would be supported by both the University and individual NHS Trust involved and has already been implemented at some institutions in England.

7.4 Preparation and assessment of students

The following could be provided to facilitate student preparation and assessment:
- Comprehensive placement preparation packs
- Access to a wider range of educational opportunities

- Increased profile of lecturers in clinical areas
- A commitment to the tri-partite assessment process
- Simulation and practising of skills in clinical skills laboratories.

Developing documents which are balanced and more realistic to the experience the student receives will prepare student midwives for a placement. Students need to know who to meet and what to read. For example scenarios of students' experiences on the current programme and how they dealt with new situations could be presented. Placement web sites would assist this. Key personnel need to be easily contactable, for example, link tutors, personal tutors and student counsellors. Local information, available in handbooks or attractive filofaxes, with, for example, location of launderettes, payphones, supermarkets, taxi firms and churches, mosques, synagogues would facilitate students' personal adaptation to a new university and the clinical sites.

A placement support midwife or lecturer-practitioner at each clinical site could be responsible for overseeing the *continuous* completion of student documentation. This would avoid the common panic to get activities 'signed off' at the end of a placement but would demand extra resourcing.

Women's perceptions of student midwives being involved in their maternity care, deserves higher priority. It was found that the teaching and learning activities impacted on women's views of their care.

7.5   Support
The term 'support' is currently ambiguous and opaque. More tangible support structures are needed throughout the maternity system. The challenges of mentoring in clinical midwifery practice need to be addressed. A lack of recognition of practical support by both midwives and the students they mentor leads to a lack of support structures. Safety nets for students and mentors need to be identified so that access to practical support is fair, equitable and transparent.

To aid a breakdown of the various types of support, this section has been sub-divided:
- Practical support for students
- Practical support for mentors
- Emotional support

7.5.1   Practical support for students
A buddy system could be set up for student midwives. This suggestion was put forward by students in individual interviews. In this system, which has been implemented in some places, a more senior student acts as a 'big sister' to the junior students. This might encourage open channels of communication, as the buddy would not be in an assessor role.

As many student midwives cited that they used their peers at the University for support, there needs to be an easy networking system for private contact. Students at some sites found that having the phone number of the link tutor was reassuring. The personal tutor role currently lacks definition. This area warrants further investigation as the pastoral role was not evident at all sites and yet could be helpful, particularly if the clinical site is some distance from the University. A student counselling service was available at all HEIs but

possibly needs to be more accessible for health care students and those working unsocial hours.

There is a need for provision of resource rooms in the NHS Trusts with other students and more facilities in them such as desks, so students can study if appropriate. Trusts could facilitate student access to email and web-based information.

7.5.2   Practical support for mentors
An increased profile of lecturers in the clinical areas and more transparent systems of support from the University would provide added structure to the 'safety net' (See Diagram 1, Support Structures on page 95). Honourary contracts need to be facilitated for lecturers. If lecturers regularly assisted in hands-on teaching, mentors may find this offered practical support. A variety of data sources exposed the need for more balancing out of student 'loads' on mentors.

Protected time within the working day would encourage mentors and students to debrief or simply give feedback to each other and openly discuss learning. Peer meetings could be set up with small groups of midwives, particularly for the midwives who are mentoring, to offer and receive practical support.

7.5.3   Emotional Support
There needs to be a return to the concept of caring in institutions. Many participants voiced the benefits of having a professional friend to talk to. For the majority of research participants recruited to the in-depth data process, the effect of completing the audio-diaries was powerful. Some midwives and students reflected on their practice in a way that was positive and meaningful for them. As they became accustomed to the dictaphone, they became more thoughtful about the details concerning not just their care of women and families but about their working relationship with each other. Using a teaching and learning diary which is guided, such as this, may provide a useful practice development tool for the future.

A large part of the role of the midwife is provision of support to the women. As Smith & Gray (2001) remind us, the emotional labour inherent within caring professions such as nursing and midwifery, needs to be recognised and codified. The sharing of experiences through diaries or storytelling could provide a challenging but progressive link between theory and practice. Midwives at all levels need to begin by looking after each other and reconnecting in ways which benefit care to women and babies.

Conclusion
The model of support (see diagram on page 95) illustrates the importance of having strong organisational structures as well as solid individual mentorship processes. The combination of these two spheres aids in maximising support.
What is unique about midwifery is that the relationship with the midwife and the woman being cared for, is special. Student midwives are moving through maternity units, developing knowledge and skills to become autonomous practitioners at the point of registration. Students are role modelling a number of midwives during their educational programmes. The organisation therefore needs to be sympathetic to the midwives' wellbeing (particularly where rapid changes and mergers are occurring). Protection and support of the midwife mentors and their students are pivotal, to ensure that clinical learning can be managed effectively. The evidence highlights the need for a commitment to investing positively in enhancing the whole learning environment.

It is the midwives who mentor students who are central to providing daily supervision, guidance, passing on practical knowledge and skills, thus participating in development of the students' clinical competence. Provision of quality mentorship and use of a transparent assessment process, are essential as the professional development of learners directly affects the quality of care of women and their families. The research findings point to the need to find ways to empower the mentors as the key to strengthening professional clinical education.

Structured, sustained support needs to built in, for all involved in clinical teaching but most importantly, the mentors. It is time to raise the profile of clinical teaching and re-evaluate the increasingly complex concept of mentorship. The role of the mentor needs to be more carefully defined and protected time given for the role. Both the formal and informal aspects of the role need to be examined at national and local level. In particular, the emotional work of mentoring needs more attention.

The mentors deserve better preparation, updating and support for their challenging and demanding role. The educational philosophy needs to be realistically interpreted in practice, with systematic support planned and built in, to maintain a positive learning environment. Investment in mentorship and valuing the mentors as a rich resource will enhance teaching and learning in midwifery practice in the long term.

Further research is now needed to explore:
- Midwives' views on different types of mentor preparation, for example, training packages, either on-line or in handbook form, with web-links.
- Investigation of the link lecturer and personal tutor role in midwifery
- A further exploration of women's views of student midwives and their perceptions of mentoring
- Current use and effectiveness of clinical skills laboratories-for students and qualified midwives
- Auditing of a 'good practice' tool.

Development of a 'good practice' tool

The above recommendations have been underpinned by research evidence from the three year research study, funded by the Hospital Saving Association Charitable Trust. To help mobilise some of the key recommendations, a 'good practice' tool is being developed by the research team (see Appendix 5 for an example of the tool).

The tool is not designed to be a directive but could be flexibly adapted for local clinical education needs. The tool draws together broad elements from the research recommendations for informing local provision. In this way, realities of resource needs can be piloted.

A further possible use for the 'good practice' tool could be as a reference guide within the educational audit process. The aim would be for a model of good practice to be developed at each site, thus stimulating dialogue and collaboration between clinical and education staff. When auditing of a clinical area occurs, it will be important to consider the more subtle issues around quality mentorship which have emerged through the research project.

In conclusion, the 'good practice' tool provides an exciting area for further research (for example, action research studies) and enhances the potential to inform policy through current evidence. The data provide new evidence that steps need to be taken to develop a community of learning within a community of practice. The creative development of partnerships within the community of learning are central to empowering the mentors. The protection of our rich tapestry of midwifery knowledge is important. But more important is how we choose to pass on this body of skill and information in ways which are beneficial for all concerned.

Rule 33 (UKCC 1998)

Outcomes of programmes of education leading to admission to part 10 of the register

1.   The content of programmes of education shall be such as the UKCC may from time to time require.

2.   Programmes of education shall be designed to prepare the student to assume on registration the responsibilities and accountability for her practice as a midwife.

3.   Such programmes of education shall:

(a)   meet the requirements of the midwives directive

(b)   be provided at an approved educational institution

(c)   enable the student midwife to accept responsibility for her personal professional development and to apply her knowledge and skill in meeting the needs of individuals and of groups throughout the antenatal, intranatal and postnatal periods and shall include enabling the student to achieve the following outcomes:

(i)   the appreciation of the influence of social, political and cultural factors in relation to health care and advising on the promotion of health

(ii)   the recognition of common factors which contribute to, and those which adversely affect, the physical, emotional and social well-being of the mother and baby, and the taking of appropriate action

(iii)   the ability to assess, plan, implement and evaluate care within the sphere of practice of a midwife to meet the physical, emotional, social, spiritual and educational needs of the mother and baby and the family

(iv)   the ability to take action on her own responsibility, including the initiation of the action of other disciplines, and to seek assistance when required

(v)   the ability to interpret and undertake care prescribed by a registered medical practitioner

(vi)   the use of appropriate and effective communication skills with mothers and their families, with colleagues and with those in other disciplines

(vii)   the use of relevant literature and research to inform the practice of midwifery

(viii)   the ability to function effectively in a multi-professional team with an understanding of the role of all members of the team

(ix)   an understanding of the requirements of legislation relevant to the practice of midwifery

(x)   an understanding of the ethical issues relating to midwifery practice and the responsibilities which these impose on the midwife's professional practice

(xi)   the assignment of the midwife of appropriate duties to others and the supervision and the monitoring of such assigned duties.

Definition of a Midwife

A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service.

Activities of a Midwife

The activities of a midwife are defined in the European Union *Midwives Directive 80/155/EEC* Article 4 as follows:

"Member States shall ensure that midwives are at least entitled to take up and pursue the following activities:

• To provide sound family planning information and advice

• To diagnose pregnancies and monitor normal pregnancies; to carry out examinations necessary for the monitoring of the development of normal pregnancies

• To prescribe or advise on the examinations necessary for the earliest possible diagnosis of pregnancies at risk

• To provide a programme of parenthood preparation and a complete preparation for childbirth including advice on hygiene and nutrition

• To care for and assist the mother during labour and to monitor the condition of the foetus *in utero* by the appropriate clinical and technical means

• To conduct spontaneous deliveries including where required an episiotomy and in urgent cases a breech delivery

• To recognise the warning signs of abnormality in the mother or infant which necessitate referral to a doctor and to assist the latter where appropriate; to take the necessary emergency measures in the doctor's absence, in particular the manual removal of the placenta, possibly followed by a manual examination of the uterus

• To examine and care for the new-born infant; to take all initiatives which are necessary in case of need and to carry out where necessary immediate resuscitation

• To care for and monitor the progress of the mother in the post-natal period and to give all necessary advice to the mother on infant care to enable her to ensure the optimum progress of the new-born infant

• To carry out the treatment prescribed by a doctor

• To maintain all necessary records."

Advisory Standards for mentors and mentorship

Communication and working relationships enabling:
- The development of effective relationships based on mutual trust and respect
- An understanding of how students integrate into practice settings and assisting with this process
- The provision of on-going and constructive support for students.

Facilitation of learning in order to:
- Demonstrate sufficient knowledge of the student's programme to identify current learning needs
- Demonstrate strategies which will assist with the integration of learning from practice and educational settings
- Create and develop opportunities for students to identify and undertake experiences to meet their learning needs.

Assessment in order to:
- Demonstrate a good understanding of assessment and ability to assess
- Implement approved assessment procedures.

Role modelling in order to:
- Demonstrate effective relationships with patients and clients
- Contribute to the development of an environment in which effective practice is fostered, implemented, evaluated and disseminated
- Assess and manage clinical developments to ensure safe and effective care.

Creating an environment for learning in order to:
- Ensure effective learning experiences and the opportunity to achieve learning outcomes for students by contributing to the development and maintenance of a learning environment
- Implement strategies for quality assurance and quality audit.

Improving practice in order to:
- Contribute to the creation of an environment in which change can be initiated and supported

A knowledge base in order to:
- Identify, apply and disseminate research findings within the area of practice.

Course development which:
- Contributes to the development and/or review of courses.

Taken from 'Preparation of Mentors and Teachers: A New Framework of guidance 2001'

An example from the mentor 'good practice' tool

PLACEMENT AND ALLOCATION SYSTEMS

MODEL OF GOOD PRACTICE	CURRENT STATUS?	IMPLEMENTATION?
Managing the allocation of students to mentors		
Supervisors of Midwives work in partnership with placement support midwives (or equivalent clinical co-ordinator) and link tutors. They should have a working knowledge of the people in the work-force, the existing clinical teaching expertise and the learning needs of students.		
Links with University eg student profiles, from allocations office and personal tutors for matching midwives and students where possible.		
Equity of numbers of students placed with midwife mentors is monitored, to prevent overloading the midwives.		
Maintenance of a 'live' register of mentors from the clinical setting. Regular 'check-ins' with Supervisor / co-ordinator to update any significant changes in circumstances.		
Co-mentors are included in the named mentor / student partnership.		
Planning practicalities for the placement		
Protected time is given as part of the clinical curriculum, for a meeting with the named mentor at the beginning of each placement		
Student and mentor clarify expectations of each other, for both personal and professional development. Seeking positive ways to optimise the experience.		
Preferred teaching style of the mentor and student's learning styles are addressed.		
A learning agreement is drawn up.		
Student is given guidance as to how to prepare for the placement.		
Assessment strategies are planned and discussed.		

Key: Current status-refers to an evaluation or situational analysis to assess the individual (local) situation.
Implementation- refers to possibilities for mobilising the adapted recommendations and putting into action, for further testing

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