An Evaluation of Three Models of Practice Teaching in Health Visiting in NHS-East of England

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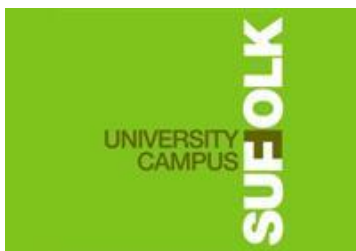**Deputy Dean: Teaching, Learning & Academic Partnerships**
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Executive Summary

The Health Visitor Implementation Plan (Department of Health, 2011), has created unprecedented demand for practice based learning placements for student health visitors. The regulators recent development of the practice teacher with due regard model (Nursing and Midwifery Council, 2011& 2008) has provided an opportunity to utilise the wider health visiting community in providing high quality practice-based learning while developing innovative solutions to expanding the health visiting workforce. This study set out to investigate and evaluate three models of practice based teaching and learning across the East of England region. The evaluation was comprised of two phases.

Phase 1 gathered quantitative and qualitative data from a practice portfolio audit (n34) and a survey of recently qualified health visitors (n39). Two key findings emerged:

1. **Irrespective of the practice teaching model, Practice Teachers rigorously manage their responsibilities** in relation to: provision of learning opportunities, monitoring of progression and assessment of fitness to practice 'sign off' thus conforming to the NMC Standards to support learning and assessment in practice (2008).
2. **Irrespective of practice teaching model, the vast majority of students felt able and or confident to undertake their role** in relation to the standards of proficiencies required of the Specialist Community Public Health Nurses-Health Visitor as determined by the regulator (NMC, 2004). Where there were disparities and students felt they lacked confidence this did not appear to relate specifically to the model of practice education but to a range of variables.

Phase 2 sought to describe in more depth student's experience of the practice education models in operation across the region. Data was collected from four focus groups (34 participants) from four participating Accredited Education Institutions. The findings revealed a number of key elements that provide a positive student learning experience;

* Proximity, continuity and reciprocal positive regard together with clinical expertise appears to be more important to students than whether the person is a PT or mentor.
* Practice based learning is deemed to be effective when it is structured, organised and progressive. A range of learning strategies were utilised and valued and time for discussion and reflection were highlighted as critical to learning. Clarity and consistency in relation to role and learning expectations and the requirements of practice assessment empower students to manage their learning.
* The practice environment can seriously challenge the learning experience of students, and where this results in a number of practice placement changes this is considered to be highly disruptive to learning and progression.

Recommendations

1. A re-examination of the culture and challenges that reside in practice placements and means to ensure optimal practice based learning that offer students a supportive clinical expert, working in close proximity.

2. A re-examination of the preparation of practice teachers and mentors, including practice teaching curricula and regulatory standards that give greater prominence to the affective aspects of practice learning considered fundamental to professional achievement.

3. The views of practice teachers and mentors are sought to gain further understanding of the mechanisms they employ to manage the opportunities and challenges of their role and establish 'best practice' benchmarks for practice educators.

1. INTRODUCTION

1.1. Background and Context

The Health Visitor Implementation Plan (Department of Health, 2011) indicates the UK Government's commitment to improving the health outcomes for children, families and their communities. It will be achieved by increasing the number of full time equivalent health visitors by 4200 by 2015, hence implementing an expanded, rejuvenated and strengthened health visiting service. This increase in the workforce will mean that approximately 50% of the profession may constitute newly qualified staff and can only be achieved through a significant increase in the numbers of student health visitors educated in the next three years. There is an awareness of the need to ensure that individuals emerge from this training well-prepared for their role as the beginning of a health visitor's career can be a challenging time and their early experience is pivotal in the development of their professional expertise (Watts, 2012).

The Specialist Community Public Health Nursing (SCPHN) Practice Teacher (PT) is an essential part of achieving this aim. They have a key role in teaching, supporting and assessing students throughout the fifty per cent of their programme that is located in the workplace as well as supporting newly qualified health visitors in the transition from student to confident practitioner.

1.2. Workplace Support for Students-The Role of the Practice Teacher

Potential support and learning opportunities for students in a primary health care working environment could involve a wide network of primary care disciplines including innovators and specialists from a range of health, social care and third sector organisations, as well as all members of the immediate practice team in which the student is located, e.g. GP, Nursery Nurse, and Health Visiting or School Nursing colleagues. However, within the SCPHN programme the regulator requires that all students have access to, the support of, and are assessed in practice by, a qualified practice teacher from the relevant field of practice.

'Students on NMC approved specialist community public health nursing programmes, leading to registration on the specialist community public health nurses' part of the register, must be supported and assessed by practice teachers' (NMC, 2008).

'It is expected that teachers in the practice field….will hold qualifications and experience relevant for the area of practice in which they are supporting students, as they will be required to contribute to summative assessments. "Appropriately qualified teachers" will be those who hold practice qualifications in the same area of practice as the qualification sought by the students they are supporting, and who meet the standards for teaching required by the NMC' (2004)

Practice teachers (PTs), sometimes referred to as Community Practice Teachers (CPTs) are registered Health Visitors with several years clinical experience who have done additional education to qualify as a clinical teacher. This qualification is recordable with the NMC and subject to triennial reveiw.

The central role that a PTs hold as practice-based teachers, assessors, clinical leaders, clinical expert and positive role model has led to some detailed debate about how best to utilise their expertise to ensure a future health visiting workforce that is fit for purpose. Ensuring that there are sufficient numbers of appropriately qualified and skilled practice teachers to develop and support newly qualified health visitors is critical to the successful realisation of an expanded and rejuvenated workforce. If sufficient capacity of good quality clinical learning environments is not achieved, then achieving the expanded and strengthened health visiting service is placed at significant risk.

1.3. Exploring Models of Practice Teaching in the East of England

Traditionally within the East of England, the practice teacher to student allocation has been on a one to one basis. However, those responsible for delivering the implementation plan within the region suggest that to successfully energise the profession of health visiting and to deliver the full service offer to children and their families, the whole health visiting resource should be engaged in developing its role in teaching and learning. They note that registered health visitors, who are not practice teachers, are still required to constantly update their practice and support practice based learning and preceptorship, as part of the professional code of conduct (Nursing and Midwifery Council, 2008). Therefore they are well positioned to engage more fully with the health visitor programme.

The regulators recent development of 'the practice teacher with due regard model' (Nursing and Midwifery Council, 2011& 2008), has provided an opportunity to utilise the wider health visiting community in providing high quality practice-based learning while developing innovative solutions to expanding the health visiting workforce. Whilst acknowledging the regulatory requirements for PT oversight of practice learning and assessment the standards also provide detailed guidance on 'the practice teacher with due regard model', whereby a practice teacher is permitted to oversee a SCPHN Mentor in supervising the SCPHN student. To ensure that practice learning and assessment is safe and meets the required standards, the practice teacher remains responsible for guiding and advising the process and is accountable for assessing performance and signing off the student, as fit to practice, at the end of the educational programme (NMC, 2008).

1.4. Rationale for the Project

In the East of England, determining the practice teacher with due regard to student ratio has been decided locally within the Approved Education Institutions (AEIs) practice governance arrangements, in line with the NMC guidance. Nevertheless the use of this model has created some speculation and a number of myths amongst the SCPHN-health visiting profession, particularly with regard to the practice teacher to student ratio, so much so that the NMC deemed it necessary to circulate a clarification document and subsequent guidance (Nursing and Midwifery Council, 2011). Though comparative evaluation of practice teaching models used in SCPHN-HV is somewhat limited there remains an unchallenged assumption that the 'best' model is the traditional one student with one practice teacher approach.   Currently, the use of several models of 'practice teaching' has enabled AEI's within the region to meet their responsibilities to train significant numbers of health visitor students, as part of the delivery of the Health Visitor Implementation Plan (Department of Health, 2011). The purpose of this project is to evaluate the models of practice teaching utilised in health visiting education across the region.

1.5. Preliminary Survey

In May 2012 a preliminary survey of practice teacher, mentor and student perceptions of the various practice teaching models operating in the East of England was undertaken (Mitcheson, 2012). Findings indicated that the range of practice models in operation was meeting the learning needs of students and the requirements of practice based learning (Nursing and Midwifery Council, 2011). The implementation of a variation of the model did not appear to increase student attrition, or negatively impact on student achievement, although it was clear that it was not without significant challenge for both practice teachers and mentors. The survey highlighted the need for further in depth study in order to more fully understand the different practice teaching models in operation and the student learning experience.

Subsequently the NHS East of England has received funding from Department of Health to carry out further evaluative study into emerging models of practice education to support the delivery of the national health visiting programme.

2. EVALUATION

2.1. Evaluation Aim

The aim of this evaluation is to compare key aspects of the students' work-based learning experience where different models of practice teaching are utilised. Key aspects of practice learning are deemed to be those required by the regulator. Therefore the 'fitness' of the three models of practice teaching utilised in the East of England will be examined in relation to their ability to meet the NMC standards for practice teaching and assessment (NMC, 2008). In addition this project presents an opportunity for a comparative analysis of selected aspects of the learning experience of students and recently qualified health visitors who have encountered differing methods of support in their practice based learning. Hence, the evaluation included the use of focus groups in four AEIs to explore the student's perspectives of support and learning in practice. A survey of recently qualified health visitors' views on their preparedness for their role was also undertaken.

2.2 Phase 1 Evaluation

The evaluation was carried out in two phases. Phase one was located in two AEIs in the East of England between October and December 2012. AEI 1. utilised a one to one or one to three model of practice teaching. AEI 2. utilised the peripatetic 'roving' model of practice teaching

2.3 One to One Model

Traditionally this has been the model of choice for preparation of SCPHN-health visitors and is detailed in the Standards for Learning and Assessment in Practice (NMC, 2008). One student is assigned one practice teacher for the duration of the programme.

2.4 One to Three Model

The NMC (Nursing and Midwifery Council, 2011) issued guidance about the development of practice teaching models, one practice teacher to three students' each supported by a mentor, was considered an appropriate ratio.

2.5 Peripatetic 'Roving' Model

In this model a practice teacher has responsibility for six students within a defined geographical locality and each student is assigned a Mentor. The practice teacher has a reduced caseload in order to facilitate teaching, learning and assessment for students.
The model originally emerged as a solution to immediate workforce issues, such as the unexpected absence of a practice teacher. More recently it has been a planned model of practice based education to meet the increased demand for practice learning placements.

Table A - **Academic Education Institution & Related Practice Teacher Model**

Academic Education Institution	Practice Teacher Model
AEI 1	**1 to 1** **1 to 3**
AEI 2	**Peripatetic 'roving' model**

2.6 Phase One Objectives:

- Evaluate the potential strengths and risks in each model to comply with the NMC standards for practice learning and teaching hours.
- Evaluate the potential strengths and risks in each model to comply with the NMC standards regarding assessment.
- Explore and compare the range of practice experience offered to students in relation to NMC expectations within each model of practice teaching
- Analyse the retention, completion and outcome at award in both AEIs where different models of practice teaching operate.
- Survey recently qualified practitioners from both AEIs perspectives of preparedness for their role as Health Visitors.

2.7 Phase One Methods

Two methods were used to achieve the above objectives, the Portfolio Audit Tool and the Preparedness for Practice Questionnaire.

3 PORTFOLIO AUDIT

3.1 Audit Tool

The practice portfolios provide a record of student achievement against the standards of proficiency for SCPHN practice (NMC, 2004). It was therefore considered pertinent to audit a sample of practice portfolios to determine compliance with the NMC requirements of practice teaching. The audit tool was developed by mapping practice assessment portfolios with NMC standards for teaching and assessment (NMC, 2008). To this end the audit tool comprised evidence of the learning plan, practice teaching contacts, interim and final assessment of proficiency. It also provided details of any actions taken when students were having difficulty meeting the expectations of progression towards competency (see appendix 1).

The audited portfolios were randomly selected from the final portfolios submitted at both AEIs participating in phase 1. Initially each portfolio was read in entirety and then they were analysed to obtain the relevant information required to complete the audit tool.

Table B Sample of Portfolios Audited in each Practice Teaching Approach.

AEIs	Practice Teaching Model	Sample Number
AEI 1	**1.1 practice teacher model** **1.3**	**15**
AEI 2	**Peripatetic 'roving' practice teacher model ratio of 1:6**	**10** **11**
Total		**36**

3.2 Phase 1 Findings from Portfolio Audit

All practice portfolios indicated that the NMC standards for learning and assessment in practice have been adhered to as follows:

3.3 Learning Plans

All of the portfolios that were reviewed included a completed learning plan, which comprised of:

- A student self-assessment of their achievement against the proficiencies
- A learning agreement detailing the learning activities, proposed outcomes and timeframes required for achieving competence.

3.4 Practice Teaching/Contacts

The number of practice teacher and student contacts varied, from 4 to 12 for each student over the period of the final practice placement. The exact nature of the teaching ranged from; observations of practice, individual supervision, group clinical tutorials and action learning sets. In addition other learning opportunities were available to students provided by a wide range of health and social care professionals.

3.5 Assessment of Practice Proficiencies

Each student had an initial interview with their Practice Teacher and Mentor when their learning agreement was established, intermediate assessment/s to monitor and provide feedback on progression towards competency and a final assessment of competency with their Practice Teacher.

In all cases a practice teacher was responsible for final sign off. This was based upon the four principles defined by the (2004), that is, the complex and multifaceted nature of practice proficiency and the ways in which this may be assessed, and recorded, within the students' portfolios. It was evident that the portfolios provided a complex informational matrix that gave the reader a tangible insight into the underpinning rational/evidence for the PT's decision to sign off the student as having attained all standards for proficiency and therefore fitness for practice.

Irrespective of practice teaching model it was evident that practice teachers rigorously managed their responsibilities in relation to provision of learning opportunities, monitoring progression and particularly in assessment and clearly met or exceeded regulatory requirements. This would be anticipated in a one to one model but there was no evident dilution of this aspect of their role in the one to three or peripatetic 'roving' practice teacher models.

4. PREPAREDNESS FOR PRACTICE SURVEY

A number of studies were reviewed in considering a sound approach to evaluating newly qualified health visitors' feelings of 'confidence' to practice. These examined a number of concepts, e.g. student satisfaction (Chen & Le, 2012; Espeland & Indrehus, 2003) and clinical competence (Watson, Calman, Norman, Redfern, & Murrells, 2002). The survey prepared for this evaluation adapted the concept of 'self-reported preparedness' from Heslop McIntryre and Ives (2001), though the methodology used to prepare the questions was an amalgamation of Heslop (et al 2001) and Watson (et al 2002) -see appendix 2.

A small scale survey was conducted to determine recently qualified health visitors preparedness for practice. The survey was distributed via survey monkey to all students who successfully completed the SCPHN programme of preparation 2011-2012 at both AEIs participating in phase 1. Thirty nine participants responded, representing approximately 30% of the total cohort. The questionnaire responses were considered in total and also as subgroups representing each model of practice teaching. Analysis was also directed at key themes such as the areas where there were strong feelings of preparedness and the types of work the respondents felt less well prepared to tackle.

Table C Survey Sample Response by Practice Teacher Model

Practice Teacher Model	Survey Sample
1:1 one student placed with 1 practice teacher	20% of sample
1:2 one student with a student practice teacher and long arm practice teacher	10% of sample
1:3 three students each with a mentor and one practice teacher	25% of sample
Peripatetic 'roving' practice teacher model - students placed with a mentor and a practice teacher responsible for 6 students with a reduced caseload	45% of sample

Please identify which model of Practice Teacher support was provided for you:

1.1 to 1 Practice Teacher/Student working together

2.1 to 1 Student Practice Teacher - supervision (long arm) by Practi...

3.1 to 3 Practice Teacher / Student with mentor

4.Roving model - working with mentor - supervision by Practice Teac...
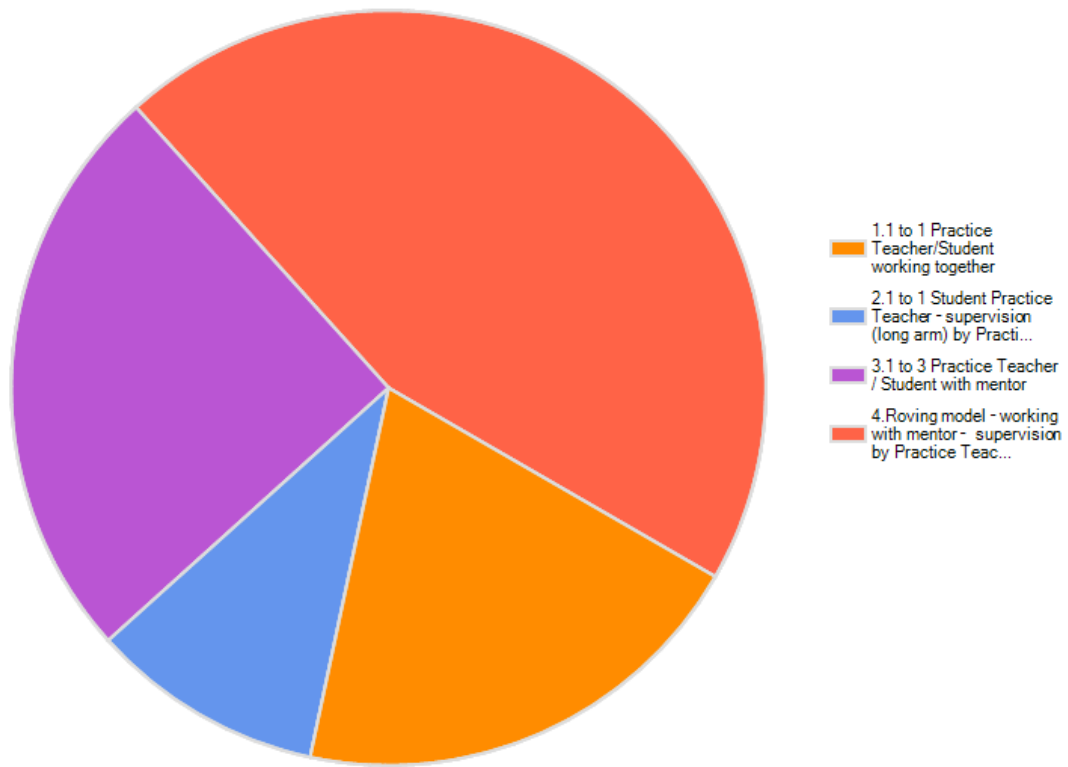
FIGURE 1 -

4.1 Findings from Survey Report

The majority of the randomly self-selected respondents, felt prepared for their role in relation to the NMC proficiency related questions in the survey. Over 90% of recently qualified SCPHN-HV's who participated in this survey agreed or strongly agreed that they felt prepared and able/confident to:

- collect and interpret data and information on the health and well-being needs of a defined population
- communicate data and information on the health, wellbeing and related needs of a defined population to colleagues and other
- develop and sustain relationships with individuals and groups with the aim of improving health and wellbeing
- identify individuals, families and groups who are at risk and in need of further support
- undertake screening of individuals and populations and respond appropriately to findings
- communicate with individuals, groups and communities to promote their health and well-being
- understand and can source the evidence base or research that underpins health visiting practice
- recognise the legal and ethical responsibilities of health visiting practice

In addition, 88% of participants felt confident to use leadership skills to deliver the Healthy Child Programme and work in partnership and communicate effectively within a multi-disciplinary multi-agency framework.

Generally, recently qualified SCPHN-HV reported feeling less confident (30.8%) to engage in work related to policy development e.g. via consultation, staff meetings, actions groups, special interest groups.

However, within this sample there were 3 areas where there was less homogeneity between respondents. Participant responses indicated a lack of confidence or the requirement for further experience to enhance their development:

- SCPHN-HV's prepared in 1 to 1 model felt less able to engage in collaborative working with others to promote and protect the public's health and wellbeing (72%) compared with 90% in 1:3 and peripatetic 'roving' models who felt able.

FIGURE 2 - Q8 I have developed collaborative working with others to promote and protect the public's health and wellbeing
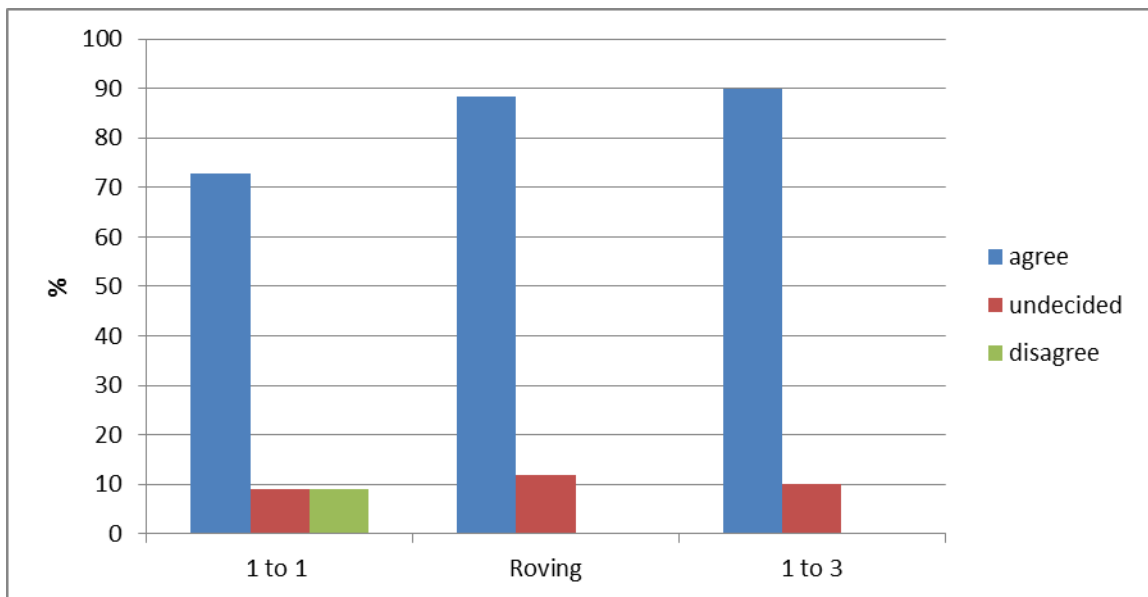
- SCPHN-HV's prepared with the 1:1 model and peripatetic 'roving' PT model felt most able to change practice (86% and 76.5 % respectively), those experiencing the 1.3 model felt least able (50%)

FIGURE 3 - Q15 I have changed/developed aspects of practice based on research evidence learned on or since my Health Visiting course
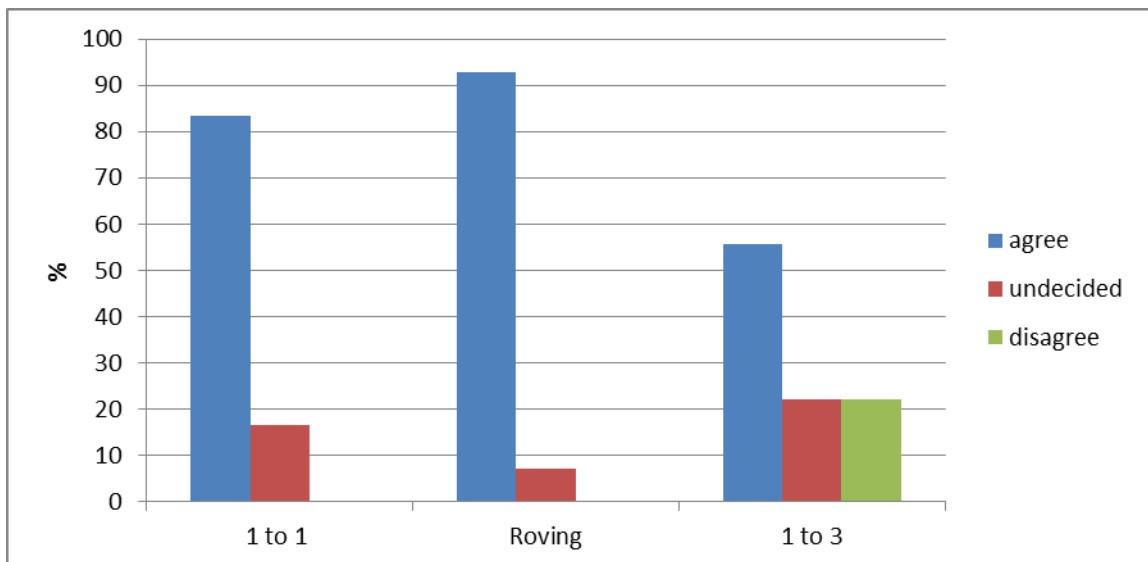
- SCPHN –HV's prepared with the 1:1 model felt most able to initiate the management of cases involving actual or potential abuse or violence where needed with confidence (58.4%). Of those prepared using the peripatetic roving practice teacher model 35.3% agreed they felt able.

FIGURE 4 - Q20 I am able to initiate the management of cases involving actual or potential abuse or violence where needed with confidence
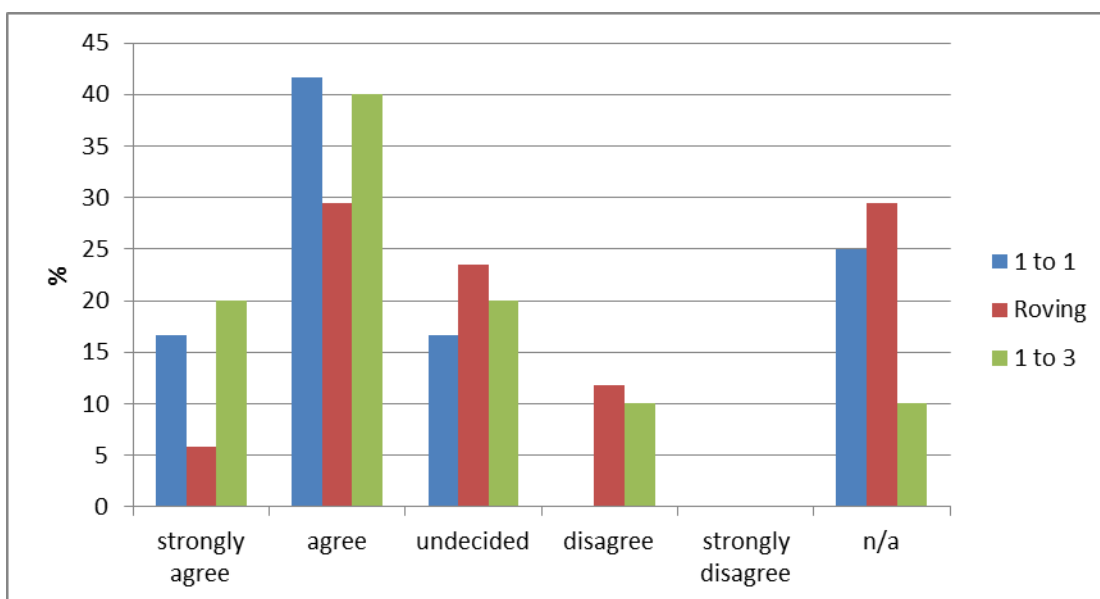
Interpretation of these findings must be treated with caution. The outcomes linked to specific practice education models must be viewed in light of qualitative comments that indicate a range of variables that could equally account for these differences. For example, confidence to manage cases involving actual or potential abuse was clearly related to the opportunities within the practice placement as a student and the differences in practice areas upon qualification.

'I felt quite well prepared due to working in a diverse area as a student, attending a lot of child protection meetings and witnessing a lot of situations that I could reflect upon.(peripatetic roving model)

I felt very unprepared, the area I am working in now is of very high deprivation and mainly progressive caseload with high CP. This was very different to my previous area of study which was mainly universal families (peripatetic roving model)

There are evident differences between caseloads which requires further increased learning when in practice in deprived areas. This can cause deficits to safeguarding practice but it is important to have experienced the so called norm.....if there is such a thing!!' (peripatetic roving model)

In summary, the practice education models adopted by the two universities in Phase 1 conform to the Standards to Support Learning and Assessment in Practice (NMC, 2008), and generally practitioners exiting from these programmes feel prepared for their role and are deemed fit for practice.

'I felt prepared because I have the support of a great team who I worked with as a student. Although my CPT long-armed 5 students and was clearly under a lot of pressure, she was excellent, committed and supportive, I also had an excellent mentor (peripatetic roving PT model)

I felt well prepared for my role. Working with my CPT gave me the help, support and advice I needed for the health visitor role. Her advice was consistent, reliable and supportive. She was an excellent role model'. (1:1 model)

Where there are differences, it would appear that there are a number of variables that may contribute to the preparedness of practitioners and the results therefore cannot be considered significant.

'I felt prepared for the day to day 'core' work, however we seem to be in an ever-changing world, which unfortunately is not being handled well. The main issue with this is lack of, or conflicting information, being fed to the workforce from above (1:3 model).

I had felt quite prepared for my role at first. However, moving to another area- county, I found this much harder than I had thought it would have been. Practices were so different (peripatetic 'roving' model).

My CPT helped prepare me well for practice however she was off sick for half my training so was on my own for a period of time so therefore received less support' (1:1 model).

5. PHASE 2: EVALUATIVE FOCUS GROUPS

Five AEIs were invited to participate in phase two of the evaluation; four were able to take part in the given time frame, from January to March 20th 2013. The four participating AEIs were:
AEI 1 utilised a 1 to 3 model of practice teaching in this phase.   AEI 2 utilised the peripatetic 'roving' model of practice teaching. AEI 3 utilised a variety of models from 1:1 to 1:8 student to practice teacher ratios. AEI 4 utilised a 1 to 1 model of practice teaching

The purpose of phase two of this evaluation was to undertake focus group interviews with current health visiting students and obtain detailed qualitative information about their experience of learning in practice. Each of the AEIs that offered the SCPHN-HV programme in the East of England region were invited to participate in order to provide as wide-ranging an input as possible. This enabled the views of students supported by newer and more traditional models of practice learning to be included also. As there were few exemplars of the one-to-one model of practice teaching in the East of England, an AEI in the North East of England where this is the exclusive model was invited and agreed to participate.

Table D: Number of Focus Group Participants in each AEI

Approved Education Institution	Focus Group Contributors
AEI 1	**8 Participants**
AEI 2	**9 Participants**
AEI 3	**8 Participants**
AEI 4	**9 Participants**
Total	**34 Participants**

5.1 Phase 2: Method

A schedule of questions was developed to facilitate the focus group discussions reflecting two key areas of interest to this evaluation:
Key Area 1 explored the models of practice teaching and support, and the students' evaluative comments on these.
Key Area 2 examined the students' experience of learning in practice and their views concerning what enabled or hindered effective learning in this milieu (see appendix 3).

Table C above indicates the number of student volunteers agreeing to contribute to this evaluation, with 34 students participating in total. The focus groups were located on the premises of each host AEI between January and March 2013 and took between 65 and 90 minutes each.

The group discussions were recorded as this provides the most effective way to capture and return to the very detailed accounts these group debates engender (Fern, 2001; Kamberelis & Dimitriadis, 2005). In addition to this, the facilitator(s) provided written notes of their observations and comments immediately following each group debate. The tapes were transcribed verbatim and a hermeneutic unit created in the qualitative data management software ATLAS.ti 6.2. This enabled a very detailed 'first pass' coding of the focus group transcripts and 381 codes were created in total. Those codes were then collated into 14 analytic files which clustered the coded data into families of meaning related to the aims of this evaluation (Miller & Glassner, 2011). This well recognised strategy enables large quantities of qualitative information to be categorised and compared so that the strongest themes emerging from the student evaluation can be distinguished (Gubrium & Holstein, 2009; Miles & Hubermann, 1994) -see appendix 4.

5.2 Exploring the Practice Education Model and Team

Students had a variety of differing practice education models within their practice placements, ranging from 1:1 to 1:8 students with a PT. All of the students in AEI 4 had a 1 to 1 model of practice teaching with the exception of one student who was allocated to a student PT. One student in AEI 1 and AEI 2 were also in 1 to 1 arrangements. Otherwise, the remaining students in AEI 1, 2, and 3 were in practice teaching models ranging from 1: 2 or more frequently 1:3, 1: 5 and 1:6. In these cases some of the students were aware that their PTs had reduced caseloads, and other were not, so it was not possible to ascertain from the focus group data the status of the PTs caseloads in all of those participating. Three students of the 34 indicated that their PT was responsible for 8 students. In one of these the student indicated that 4 of the 8 students were part-time and that her PT had a reduced caseload. It was not possible to identify the detail in the other two 1: 8 models.

Four themes emerged from an analysis of the evaluative comments collated from the student participants. It was evident from the similarity within these themes across the four AEIs that the model of practice teaching utilised was not the main factor that impacted on the students' workplace learning. The themes below illustrate the key influences on student perspectives of their learning in practice.

5.3 Theme 1: Relational Attributes

Proximity, Continuity and Positive Regard between Student and Lead Clinical Educator: Practice Teacher and/or Mentor

While there was no clear thematic preference regarding the model of practice teaching there was strong agreement across all of the student groups about the impact of the person the students' worked with on a daily basis. This individual assumed the lead responsibility for support, providing practice experience and day-to day facilitation of learning.

The relationship between the student and the Mentor or Practice Teacher was a key area of discussion for all of the students, and a key influence on the students' perspectives of their learning experience. Most of the students had predominantly positive relationships with their Practice Teachers and/or Mentors and appreciated how pivotal this was to their development as a Health Visitor

AEI 4 *'I think they need to be approachable, first and foremost, because if you've got somebody that you can approach with anything, how can you really learn constructively, and I think, you know, at times I've had that, I've had brilliant [..]*

Those students, who did not have this positive or consistent relationship, identified this as a significant disadvantage to their learning.

AEI 3 *'it's a tricky relationship between practice teacher and student health visitor, and if you don't get it right it can make your life miserable.'*

An important factor to note here is that it was not the role or status of this individual that was important in terms of their being a Practice Teacher or Mentor. The key factors associated with a positive student perception of practice learning were proximity, continuity and a reciprocal positive regard. Hence ideally this individual worked in close proximity with the student in an unfractured way and the student had daily and/or frequent contact with one or two individuals; but not more. Positive regard involved mutual respect from both parties.

AEI 4 *'she kept time aside to, you know, to go over things that we need to be doing, she was really helpful,'*

The students commented on and were appreciative of those PTs/Mentors that were knowledgeable and experienced in health visiting and were practiced educationalists. They appreciated the PT or Mentor who recognised the past experience of the student and valued the skills and expertise they already had.

AEI3 *'But she made it very clear from the beginning that I was also a professional and that I was coming into it already with communication skills and loads of other practical skills and life experience and that we would be learning from each other, and that's how she felt it should be.'*

AEI 4 *'she appreciates my experience from before but obviously is encouraging me to move away from my midwifery hat but accepts that I do have that and that's, you know, the skills that I've brought me.'*

There were a number of positive characteristics identified across the student groups that were associated with a positive learning relationship. These included PTs or Mentors who were friendly, warm and approachable. This was associated, by the students, with their feeling at ease both in terms of joining a new team and feeling a sense of belonging. Settling into a team and feeling relaxed enough to ask questions, acknowledge their uncertainties and reflect on their progress without feeling inadequate, was appreciated and considered a critical factor in their progression.

AEI3 *'I was just going to say that my experience in practice, like with my mentor she's been amazing, she's been the one who's taught me everything, who's empowered me, and she's like … she's like you were saying about your practice teacher … she's evidenced based, she's up to date on everything, and she's got that creativity, she encourages my skills in my previous roles and is open to us learning from each other as a team.'*

AEI 4 *'I think it's just like if, my least good experience, I just couldn't approach her, I just really couldn't approach her. It was just because of the inconsistence. I mean there were days when she was lovely, and it was alright, but still I think it's … I've been prodded and prodded that much now that I've got to the point where I'd rather not ask her, I'd rather ask someone else'.*

Having cognisance of the affective aspects of learning Health Visiting is probably related in some respects to the nature of the work which can be emotionally demanding but also because students in this field who are already qualified practitioners, are resuming the student role. This can be unsettling and a few students referred to worrying about becoming deskilled. There were also several students who identified that having their past experience and previous work roles 'valued' was important to them. It would appear from these student evaluations that the students demonstrate a level of dependence on the more experienced PT or Mentor to support them through their learning journey to proficiency. At the same time they are very aware of the power or authority that resides in the individual that signs off their ability to practice proficiency entry. It would appear to be a very skilled and nuanced relationship for the PT or Mentor to manage; the requirement to support and nurture students without encouraging a level of dependence that stifles progression.

5.4 Theme 2: Structured Systematic & Progressive Practice Experience

Whilst warmth, nurturing and approachability (positive regard) and a regular and unfractured contact (proximity and continuity) are important they appeared not to be sufficient to ensure a positive learning experience alone. Some students identified PTs and Mentors who they liked or who were friendly but who were not organised in terms of working experience or clinical teaching. There were also examples of PTs and Mentors who were business-like rather than warm, but very organised and systematic in their working practices and teaching. The latter appeared to be a key element of a sound learning experience for the students. Ideally, sound affective aspects of practice learning needed to be joined with a structured, systematic and progressive approach to providing and engaging students in effective practice based learning.

AEI 1 *'I think my practice teacher, she's a true teacher really because you feel she's always on the lookout for interesting things to tell you next time she sees you, so as soon as I sort of see her she'll say oh right, let's sit down, I went to this this case… if I wasn't there she will talk me through it…but I have the fortnightly supervision as well'*

Students recognised that PTs or Mentors provided access to experience and appropriate guidance and understood how best to benefit from this. Therefore, they identified that a knowledgeable and experienced health visitor with skilled clinical teaching abilities were important.

The characteristics of a structured, systematic and progressive practice experience included an organised approach to arranging the student's clinical experience. Students appreciated this as it allowed them to approach their tasks in a considered way and make an ongoing assessment of their own progress and learning. Prearranged regular time for discussion and reflection on practice was particularly appreciated here. Nevertheless, as is evident in theme four, students were realistic about their learning being to some extent governed by service needs and opportunistic depending on the socio-economic make-up of the caseload they were working in. The key factor here for students, was that in a busy and sometimes unpredictable workplace, the PT or mentor exercised management of their learning experience in the areas that they could control. For example, one student commented on how much she appreciated the half hour of quiet time given each day to discuss the work she was doing and plan what she would do next, no matter how busy they were.

AEI 4 *'Mine was positive really, she was very structured. She used to keep a track on the things I had to do and make sure that there was time set aside at least two or three times a week for me and her to go off somewhere and just sit and look'*

Many students commented on the challenges they faced managing the academic and practice learning and appreciated it when their supernumerary status was protected and they were not being required to repeat tasks in order to meet organisational requirements. Conversely those who were allocated work that was clearly about covering for absent colleagues recognised this was not helpful to their attaining proficiency.

AEI 3 *'I think a negative from my practice and certainly in learning is because they're so short staffed, because they are so busy, sometimes you feel, because, you know, the girls will agree with this, [...] you quite often have questions to ask your mentor or student practice teacher, but there's nobody actually there to ask, of if there is someone there they're so busy you don't want to be, you know, a bother to them.'*

Another aspect of this progressive approach to learning involved arranging learning experience in a logical sequence, e.g. from less complex to more complex case-work. Those practice teachers/mentors who systematically structured the students learning to enable them to be aware of their direction of travel, monitor their own progress and be cognisant of their next set of learning goals were particular appreciated.

Unsurprisingly communication with PT and Mentor was an important element of 'keeping in touch' for the student meant having someone they could communicate easily with during the day, even if they were not working alongside each other; someone available to answer questions, offer supportive, texts. The most positive comments were directed toward PTs and mentors who continued this communication out of hours, perhaps texting the student to see how an exam had gone or on a Saturday morning to ask if they were OK after a tough week. Students perceived this as more evidence of positive regard; a PT or Mentor who cared about their learning and about them personally.

AEI 1 *'And so yeah, it's nice to have that discussion and I feel very supported and I feel like I can talk to her and there is nothing regarding the course that I can't say. It's good.'*

AEI 1 *' I would see my CPT once a fortnight, but I know that I f I had any issues or problems I could phone or email, she would definitely respond.'*

5.5 What is learned in the workplace and how this learning happens

Type of Learning

This was divided into several sections. Students described learning a range of different aspects of Health Visiting, such as core skills and other tangible aspects of the role such as record keeping and safeguarding.

A further subdivision was made to incorporate the professional attributes that students were learning, and included advocacy, anti-discriminatory practice, confidence, confidentiality, flexibility, leadership, listening skills and partnership working. Students also described learning less tangible aspects of Health Visiting, such as the reality of the job, and the varying styles of Health Visitors.

Perhaps most intriguing were the Insights into Health Visiting that students revealed during their discussions. These include aspects of Caseload Management, CPD, the Role of the HV, and the Value of Health Visiting, among others. Interestingly, the ways in which students portrayed their thoughts during their discussions, were evocative of a continuum between unconscious learning that had been assimilated and tangible learning of which they the students were conscious.

5.6 Theme 3: Facilitation of learning experience and assessment of practice

Several teaching and learning strategies were used widely by the practice teachers and mentors:

Observation was valued very highly by students across all four focus groups. Students found it useful to observe qualified Health Visitors (including their Mentor/ PT/ Other Team Members) to enable them to learn the role of being a HV, and to see them role modelling high level skills in practice.

However, students expressed a view that being in an observational role for too long subsequently led to a feeling of missed opportunities for learning and frustration that their PT/ Mentor had not guided them towards learning opportunities more swiftly. This was also associated with confidence issues as students commented that not being allowed to undertake tasks in practice must be a reflection of their abilities.

Discussion and Reflection was a significant means by which students learned, and discussions were with either Mentor or PT, or both. A key point of interest that came to the fore were that Students found that informal learning and teaching that happens in the car after visits was valued very highly.

Feedback was variable in terms of frequency, ranging from daily, where Students were based in the same office as their PT/Mentor, to more sporadic feedback based on when the PT was available. Students generally thought as highly of their Mentors as their PTs where they perceived them to be skilled and experienced and good teachers. Negative comments were associated with not being available or and having a negative attitude towards the student.

AEI 2*'So on the days that my mentor wasn't working I was expected to find groups to go to, children's centre, which was OK, but it's really difficult when you're still trying to find out what your role as a student is, the area and what's expected of you and what you need to know, and, you know, what would be really beneficial to go and visit and what you can actually leave 'til later. And so it would have been nice to have a little bit of guidance there. But now I know my role and I know what I can organise and it's a lot better.'*

Students commented on the different experiences that they were having in practice, which they felt were associated with the level of teaching experience of their PT/Mentor. Students were also conscious of the different experiences that they were having compared with their peers. Particularly when they were e given the freedom to undertake unsupervised visits. The exposure to different learning experiences, depending on their Practice Teacher's or Mentor's caseloads, and the differences between the localities in which they were based, were also raised.

Students had varying levels of insight into their own learning needs. Students demonstrating a proactive approach to learning tended to be those seeking to fulfil certain gaps in their experience or knowledge through making arrangements for particular activities that would be useful to them. Alternatively, some students allowed themselves to be guided by their Mentor/ PT towards suitable learning experiences. Most, but not all, students worked with HVs other than their PT or Mentor.

Frequency of Supervisions varied, although fortnightly was the most common timescale, one Student stated she had supervisions monthly.

What would students change students wanted **more time in practice** and less time spent on theory to enable **more continuity and more time to consolidate**. Students also highlighted the difficulties of **conflicts** between requirements to attend study days when this clashed with arrangements that they had made in practice. Interestingly, students stated they would find it helpful to have the opportunity to return to a period of observation later in the programme.

The students associated positive / good learning experiences with:	The students associated less good/negative learning experiences with:
A positive environment within their practice placement e.g. supportive, friendly, team, supportive Mentor/ PT, feeling able to ask questions of team members	**A negative environment for learning within the practice placement e.g. busy environment with a stressed team, a crowded office with lack of access to computers, dysfunctional poor relations in team**
An available and positive PT/Mentor, who is experienced at teaching and makes time for supervisions in which the Student is able to discuss and reflect on practice and feel that their learning in valued.	**An unapproachable and unavailable Practice Teacher** **Feeling that the PT does not respect the Student as a person or in terms of their previous experience**
Specific good learning related to particular experiences that Students had had in practice that they felt had been pivotal/ illuminating for them, e.g. a Student who observed her Mentor undertaking a home visit in which there were concerns about the children and how her Mentor had dealt with this	**Encountering lots of changes in the placement, such as staff changes, or relocating to different areas/ caseloads** **PT and Students feeling other work conflicted with the PT's time and ability to focus on their learning needs**
Workshops, action learning sets and opportunities to work with others in Practice were also viewed positively for Students.	**Students' feeling they did not have enough time in practice, that time in practice is interrupted with time spent in the University or having to study, and that the pace of learning in practice is hard, and that learning in practice is hard work and challenging.**

Practice Assessment

On the whole the practice assessment of student progression and proficiency was well managed in all models of practice teaching. Formative, intermediate and summative assessment by practice teacher and mentor was evident and this concurs with the findings of the phase 1 portfolio audit. Again students found the continuous, structured nature of the assessment process helpful and this was found to be enhanced by the provision of clear portfolio documentation.

AEI 1*'We have set supervision every fortnight but also in the day to day we have feedback because we discuss and reflect what's going on each day, so it's constant.'*

AEI 1*'it's been very positive and very adaptable, my CPT both trimesters has sat with me at the very beginning and we've blocked out a time for the whole trimester of when we're going to have supervision and what she expects me to bring to that as well as so that I can be prepared well in advance for what she wants.'*

Communication between practice teacher and mentor was considered key and where there was a lack of communication, clarity, and consistency this was perceived by students to bearing in mind the already stressful nature of the assessment process students deem this to be unnecessary and places them at a disadvantage with their peers.

AEI 2 *'So it was all based on what I'd got in the portfolio, the mentor had obviously verified and was happy with the content, but there was no independent assessment, observation as such from the practice teacher other than what was written in the portfolio, and that did surprise me.'*

AEI 1 *'My practice teacher I think has been really good at that side of things, I mean we do meet together with the mentor so I do feel that they're sort of communicating well.'*

AEI 3 *'When I was assessed I had to satisfy my mentor, my trainee practice teacher and my long-arm practice teacher, and unfortunately all three of them had very, very different views about the wording of a document and what was expected of me'.*

5.7 Theme 4: Challenges of the Practice Environment.

It was evident that a number of challenges within the practice environment were perceived to impact on the student experience. Specifically in some areas, low morale and significant workforce issues such as high levels of sickness, maternity leave and resignations required for some students multiple changes in locality and caseload and was perceived to make their practice learning more challenging.

AEI 4 *'[…] there was two on maternity leave and somebody on long term sick, she had to go into the areas where she was needed, which meant I had to follow her, so I've never had the same caseload […]'*

AEI 3 *'My practice experience has been a bit more challenging, its involved lots of moving of towns, working in different localities, which means I have to work out the different clinics on different days, different GP's ….by the end of the course I will have moved eight times. I'm finding it very very disruptive, I'm working with different people who have different expectations'*

Whilst students acknowledged the importance of the drive for increased health visitor numbers they questioned the quality of their learning experience when practice placements were limited. In some cases this impacted on time available for reflection, teaching and assessment. They were also acutely aware of the impact of the increased number of students' on not only physical resources 'there weren't even enough chairs for everyone to sit down', but also on other members of the team, particularly where they considered their employment was at the expense of others termination of employment (redundancy).

AEI 4 *'You could very easily as a nursery nurse look at the three student health visitors coming in and say, you know what you've taken our jobs really'*

Where the practice teacher or mentor had additional duties (for example lead for safeguarding or improvement programme) the students expressed their concern that the additional workload and responsibilities left insufficient time for some of the activities that would enhance their learning experience, or planned learning opportunities were cancelled at short notice because of other demands.

AEI 4 *'Well you know I just would rather had a CPT that wasn't the boss'*

AEI 2 *'There's a lot of demand on the practice teachers because they're the only band 7 …stuff like the cost improvement programme meetings and the child protection , the system one stuff so they are out of practice more'*

AEI 2 *'[…] because they were short staffed they'd booked quite a lot of six week checks and new births, so I said, I don't mind doing stuff to help you out, that's absolutely fine, but I need to also see the progressive side, because that's the side I'm lacking in […]'*

5.8 Phase 2 Summary

Themes 1 and 2 contributed to a learning experience in which the PT and/or Mentor and students devolved a relationship of mutual respect. The students appreciated PT and/or Mentors who were clinically expert and who acknowledged the students previous clinical experience and skills. The PT and/or Mentor was also an effective educator who planned a systematic and progressive learning experience that enabled students to monitor their own progress and feel secure that they were going to meet the demands of the course and achieve proficiency. The PT and/or Mentor managed this within the varieties of the opportunistic and unpredictable world of clinical practice and managed to both shape the learning experience to the needs of their individual student and provide a buffer to protect the student from the challenges of the practice environment. Students appeared to require the proximity and continuity of such a clinical expert with educational awareness whom they could contact frequently with questions and to obtain support. The important factor in this support did not appear to be the status of this individual, in terms of whether they were a PT or Mentor, but that they were appropriately expert and that there was an unfractured continuity and proximity of contact. Providing the individuals offering this support coordinated their communication effectively and were not conflicted in their counselling, this support could effectively be provided by 1 or 2 persons. More than this and communication appeared to be perceived by students as fractured.

The teaching and learning strategies employed by Practice Teachers and Mentors varied. Most students found periods of 'observation' and practical experience critical to their learning particularly when this was well paced, organised, matched their learning needs at that time and accompanied by frequent supervision and time for reflection and discussion. With regard to the practice assessment process clarity and consistency with regard to expectations of practice teacher mentor and student was vital.

Finally, theme 4 provided an insight into the ways in which the current challenges within provider organisations with regard to workforce issues such as low morale, high levels of staff sickness and structural changes are impacting on the student learning experience. Again when practice teachers and mentors were able to buffer the students from the unpredictable and chaotic nature of the practice environment then students perceived their learning to be more optimal.

Summary and Recommendations

This investigation was established to evaluate the models of practice education for health visiting utilised in the East of England. The process commenced with a survey of practice teacher, mentor and student perceptions in May 2012. Included in this was an analysis of the attrition and completion data from all of the AEIs offering the SCPHN HV programme in the EoE. The preliminary survey indicated no variation in attrition or negative impact on student achievement associated with the implementation of varying models of practice teaching.

Phase one and two of the evaluation reported in this paper, commenced in October 2012. They focused on the SCPHN HV practice learning adherence to the regulators standards and fitness for practice, where varying models of practice teaching were in use. Key aspects of the student's experience of learning in practice and recently qualified health visitor's feedback on their 'preparedness for practice' were also explored. In each scenario the sample of participants included a sub group representing each of the three models of practice teaching of interest to this work. Combinations of quantitative and qualitative information were obtained which offered both rich and triangulated data and insights into some important characteristics of learning in the workplace. The following key findings emerged from this evaluation:

1. **Irrespective of the practice teaching model, Practice Teachers rigorously manage their responsibilities** in relation to: provision of learning opportunities, monitoring of progression and assessment of fitness to practice 'sign off' thus conforming to the NMC Standards to support learning and assessment in practice (2008).

2. **Irrespective of practice teaching model, the vast majority of students felt able and or confident to undertake their role** in relation to the standards of proficiencies required of the Specialist Community Public Health Nurses-Health Visitor as determined by the regulator (NMC, 2004). Where there were disparities and students felt they lacked confidence this did not appear to relate specifically to the model of practice education but to a range of variables.

3. Proximity, continuity and reciprocal positive regard together with clinical expertise appears to be more important to students than whether the person is a PT or mentor.

4. Practice based learning is deemed to be effective when it is structured, organised and progressive. A range of learning strategies were utilised and valued and time for discussion and reflection were highlighted as critical to learning. Clarity and consistency in relation to role and learning expectations and the requirements of practice assessment empower students to manage their learning.

5. The practice environment can seriously challenge the learning experience of students, and where this results in a number of practice placement changes this is considered to be highly disruptive to learning and progression.

Recommendations

A re-examination of the culture and challenges that reside in practice placements and means to ensure optimal practice based learning that offer students a supportive clinical expert, working in close proximity.

A re-examination of the preparation of practice teachers and mentors, including practice teaching curricula and regulatory standards that give greater prominence to the affective aspects of practice learning considered fundamental to professional achievement.

The views of practice teachers and mentors are sought to gain further understanding of the mechanisms they employ to manage the opportunities and challenges of their role and establish 'best practice' benchmarks for practice educators.

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Appendices

Appendix 1

1.   General Audit

Student Name / Number	Sample Number	Practice Learning Model eg 1:1, 1:3, etc	Practice Teacher Name	Mentor or other name

2.   Practice Portfolio demonstrates/includes the following:

NMC requirement				Comments
Learning Plan - Setting and monitoring achievement of realistic learning objectives in practice	Yes / Specify Number	No	Was Plan Reviewed	
Record of teaching and contact-by student and mentor/PT?	Yes / Specify	No	Type of Contacts	

Eg. observations of practice; supervision of practice; clinical tutorial	number of contacts			
Record of other contacts/meetings between student and eg, mentors, sign-off mentors, supervisors, personal tutors, the programme leader, other professionals	Yes / Specify Number	No	List Contacts	
Practice proficiency assessment – initial interview, intermediate assessment (how many), final assessment – with who?	Yes – all 3 evident and specify number of each	No	List who was involved in each assessment	
Any additional assessment eg: assessing total, skills, attitudes, behaviours, other	Yes	No	List additional assessment	
Evidence of the student's difficulty or lack of achievement and action to address this	Yes	No	Specify difficulty and action	
Confirm that students have met, or not met, the NMC standards of proficiency in practice for registration. Signing off achievement of proficiency at the end.	Yes	No	Indicate who was involved in sign-off	

3. Curriculum Audit to include:

NMC requirement	Evidence from course documents/curriculum/Exam Boards	Met	Unmet
Demonstrate NMC standards re hours in theory and practice			
Model of practice hours within curriculum meets NMC Standards.			
Outcome of theory and practice assessment from awards board			

Appendix 2

An evaluation of individuals' perceptions of preparedness to fulfil their Health Visiting role within 6 months of becoming a Registrant

Name: ……….. ………………………………………………….. Date: ……………………………… Name of Employer: ……………………………………………………….

Date of Registration: ……………………………………………. Length of time in practice post qualification: ……………………………………………………..

Search for health needs						
	Strongly agree	**Agree**	**Undecided**	**Disagree**	**Strongly disagree**	**Not applicable ***
I am confident about collecting and interpreting data and information on the health, wellbeing and related needs of a defined population						
I do not have difficulty in communicating data and information on the health, wellbeing and related needs of a defined population to colleagues and other agencies						
I have been able to develop and sustain relationships with groups with the aim of improving health and social wellbeing						
I have been able to develop and sustain relationships with individuals with the aim of improving health and social wellbeing						

I have identified individuals and families who are at risk and in need of further support						
	Strongly agree	**Agree**	**Undecided**	**Disagree**	**Strongly disagree**	**Not applicable ***
I have identified groups who are at risk and in need of further support						
I am able to undertake screening of individuals and populations and response appropriately to findings						

Stimulation of awareness of health needs						
	Strongly agree	**Agree**	**Undecided**	**Disagree**	**Strongly disagree**	**Not applicable ***
I am able to use appropriate teaching methods and materials for different audiences and plan and implement health teaching for clients and groups						
I have developed collaborative working with others to promote and protect the public's health and wellbeing						
I am able to communicate with individuals about promoting their health and wellbeing						

I am able to communicate with groups and communities about promoting their health and wellbeing						
	Strongly agree	**Agree**	**Undecided**	**Disagree**	**Strongly disagree**	**Not applicable ***
I have raised awareness about the actions that individuals can take to improve their health and social wellbeing						
I have raised awareness about the actions that groups and communities can take to improve their health and social wellbeing						
I have a good understanding of community resources in my locality and can support individuals, families and communities to use available services and information						

Influence on policies affecting health						
	Strongly agree	**Agree**	**Undecided**	**Disagree**	**Strongly Disagree**	**Not applicable ***
I have been able to work with clients and others to plan, implement and evaluate programmes and projects to improve health and wellbeing						

I have identified and evaluated service provision and support networks for individuals and families in my local area						
	Strongly agree	**Agree**	**Undecided**	**Disagree**	**Strongly Disagree**	**Not applicable ***
I have identified and evaluated service provision and support networks for groups and communities in my local area						
I have influenced policies affecting health						
I feel confident to engage in work related to policy development eg, via consultation, staff meetings, actions groups, special interest groups						
I understand and can source the evidence base or research that underpins my health visiting practice						
I have changed/developed an/some (delete as appropriate) aspects of practice based on research evidence learned on or since my Health Visiting course						
I have appraised policies and recommended changes to improve the health and wellbeing						

of clients and/or communities						

Facilitation of health-enhancing activities						
	Strongly agree	**Agree**	**Undecided**	**Disagree**	**Strongly disagree**	**Not Applicable ***
I recognise the legal and ethical responsibilities of Health Visiting practice						
I have no difficulty in using time and resources effectively and efficiently						
I feel confident about communicating effectively with clients about health enhancing actions						
I can work in partnership and communicate effectively within a multi-disciplinary/multi-agency framework to promote individual health and wellbeing						
I can work in partnership and communicate effectively within a multi-disciplinary/multi-agency framework to promote community health and wellbeing						

	Strongly agree	Agree	Undecided	Disagree	Strongly disagree	Not Applicable *
I am able to prevent, identify and minimise risk of interpersonal abuse or violence to children and other vulnerable people						
I am able to initiate the management of cases involving actual or potential abuse or violence where needed with confidence						
I am able to plan and deliver programmes to improve the health and wellbeing of individuals and groups						
I am able to evaluate programmes to improve the health and wellbeing of individuals and groups						
I am able to use leadership skills to develop a vision for improving health and wellbeing of individuals, groups and communities						
I am able to use management skills to develop a vision for improving health and wellbeing of individuals, groups and communities						

I have no difficulty in managing teams, individuals and resources ethically and effectively					

Please identify which model of Practice Teacher support provided for you:

1.   1 to 1 Practice Teacher/Student working together

2.   1 to 1 Student Practice Teacher – supervision (long arm) by Practice Teacher

3.   1 to 3 Practice Teacher / Student with mentor

4.   'Roving model' – working with mentor – long arm supervision of Practice Teacher

5.   Other – please specify:

Appendix 3

Focus Group Question Schedule

Introduction

The NHS in the East of England, who commission Health Visiting education, are evaluating different approaches and models of practice learning currently used across our region. They are doing this by having a focus group meeting with health visiting students in each University offering the health visiting programme. We are all aware of how busy the Health Visiting course is for you and very much appreciate your making the time to give us your views about your practice experience and learning.

Student Question Schedule . (Please remind each student to say their name prior to speaking on the tape)

KEY AREA 1: Joining the practice education team
This area aims to explore
1. what type model of practice teaching is used and how the students join and then become part of a their practice placement
2. consider the culture within the community of practice, i.e. prevalent views and values, the espoused theories and practices and those in use
3. the students place and role within the team and how this supports learning if it does
4. the prevailing attitudes/opinions/practices related to education and learning.

Ask each student to indicate the practice teaching arrangement in their practice placement, e.g. student practice teacher and long arm, mentor and long arm, one to one working with their PT, other.
Ask each student to indicate how many students their PT oversees if they are in a long arm/roving model and ask them if they are aware of whether their PT has a case-load/reduced case-load/no case-load.

Transition question: think back to the first time you had contact with and went to your practice placement. Would someone like to tell us about their experience of this?

Prompts
Can you describe this first contact?
What were your first impressions of the placement?
What kind of team is it-Explore the type of placement, e.g. rural clinic, city clinic etc, small team, large interprofessional team?
Type of work/population served/main public health issues.

Encourage other group members to join in and offer their experience of above

Follow up question: Describe your experiences of learning in this practice placement now.
Are they friendly/welcoming/business-like/busy?
Key roles within the practice team, i.e. who the student sees most of, who they work most closely with.

How does the PT/mentor/long-arm model work in your placements, e.g. how often do you see/have contact with PT and what kind of contact, e.g. face to face, telephone, e mail, other?
What happens in these contacts, e.g. learning plans, discussion of placement experience, general support, practice assessment, other?
Ask students for some examples if these are not forthcoming and explore students perspective of their PT, e.g. do you have a close/constructive relationship, is the PT friendly or distant, is the PT knowledgeable, expert, a good role model?

Explore how learning is managed when student is not with PT, e.g. do you work alongside one mentor or with several different HVs. Who do you develop your learning plans with? Who provides day to day support? Who is the key person or people providing day to day clinical experience and ongoing clinical teaching for you in your placement?

Ask students for examples if the are not forthcoming-particularly looking for examples of who provides day to day support and how students are being offered experience, e.g. being sent to different teams/places, staying with one team, going out with other professionals such as social work, visiting the same families several times-and who organises this?
What methods of practice teaching they are experiencing, e.g. observing, doing under supervision, discussion and reflection etc-and who does this?
Again explore students' perspective of their mentor/student PT, e.g. describe your relationship with your mentor/student PT? Do you have a close/constructive relationship, is the mentor supportive, knowledgeable, expert, a good role model?

Who is involved in practice assessment and how is this carried out?

What is your opinion of the model of practice teaching used in your placements? What do you like or find useful for your learning about it? What if anything would you change?

KEY AREA 2: What is learned in the workplace and how this learning happens?
This area aims to explore
1. what students perceive they are learning in the workplace and what learning in the workplace is useful for
2. their strategies for learning in the workplace, i.e. what they do they to try to learn and how
3. their perceptions of their processes of work-based learning, i.e. how knowledge and action come together to become practice
4. Their views about what supports effective work-based learning
5. Their perceptions about what hinders or presents barriers to effective work-based learning

Key question: What do you learn in practice/what learning is practice useful for?
Prompts
Skills? Application of knowledge? Clinical context of knowledge? Values, beliefs, attitudes, caring, coping, prioritising, decision making?

Transition question: Think about some of the best learning you have had in practice over the first weeks of this programme. Would you like to share some descriptions of these?
Prompts
What was learned?
How did the learning opportunity come about?
What happened/who did what/said what/in what environment?
What happened after-any follow up action by you/ by others?
What made this such a positive experience i.e. an example of best learning?
Note: Invite several examples from the group-generate debate about what makes a good learning experience in practice.

Prompts
What was the role of the mentor/practice teacher and/or others in this 'good' learning?

Transition question: Now let us consider the opposite scenario; think about the least good/satisfying experience of learning in practice you have experienced over the first few weeks of this programme.
Prompts
What happened/who did what/said what/in what environment?

What happened after-any follow up action by you/ by others?
Why was this not a positive learning experience?
What were the major barriers to learning?

Note: Invite several examples from the group-generate debate about why learning does not happen, is hampered, and does not progress.

Final/round up question
Looking at your practice experience overall so far, what, if anything, would you change if you could?

Thanks again for your participation in this focus group; your views provide an important insight into your practice learning in health visiting. Your input will be combined with those of health visiting students in the other universities and from this we hope to identify some of the factors that support learning in practice best, and continue to improve the practice learning in the health visiting course.

Appendix 4

Focus Group First Pass Coding

Code-Filter: All

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HU: PT Project
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Caseload - Low Levels of Complexity
Caseload PT Size 250
Emotional Intelligence - Std Aware of Impact of Family
Emotionality Negative
Experience of Learning Approachability
Experience of Learning Barrier to Learning HVA Issue
Experience of Learning Challenging System One
Experience of Learning Confusing
Experience of Learning Continuity in Practice
Experience of Learning Effective Communication
Experience of Learning Enjoyable
Experience of Learning Establishing How
Experience of Learning Feedback
Experience of Learning Good
Experience of Learning Individual
Experience of Learning Making Sense
Experience of Learning Needs
Experience of Learning Neg Arranging Alternative Practice
Experience of Learning Neg Awful Experience
Experience of Learning Neg Being a Student Again
Experience of Learning Neg Being in Office
Experience of Learning Neg Being Observed
Experience of Learning Neg Clinical Supervision
Experience of Learning Neg Confidence
Experience of Learning Neg Continuity in Practice
Experience of Learning Neg Different Experiences
Experience of Learning Neg Exposure
Experience of Learning Neg Frustrating
Experience of Learning Neg Impact of SCPHN on Life
Experience of Learning Neg Insulting
Experience of Learning Neg Moving Clinics/ Caseloads
Experience of Learning Neg Observation Later
Experience of Learning Neg Opportunities
Experience of Learning Neg Pace
Experience of Learning Neg Prior Knowledge
Experience of Learning Neg PT-Student Relationship
Experience of Learning Neg PT Asking Questions
Experience of Learning Neg Staff Expectations
Experience of Learning Neg Tutor Drop-In
Experience of Learning Negative A Nightmare
Experience of Learning Negative Segmented
Experience of Learning Observation Luxury
Experience of Learning One Person's Way
Experience of Learning Overwhelming
Experience of Learning Personal Impact

Experience of Learning Pos Child Health Clinics
Experience of Learning Pos Exposure
Experience of Learning Pos Opportunities
Experience of Learning Pos Prior Knowledge
Experience of Learning Pos PT-Student relationship
Experience of Learning Pos Reflecting on Practice
Experience of Learning Positive Despite Changes
Experience of Learning Practice Challenging
Experience of Learning Practice Complexity Challenging
Experience of Learning Practice Expectations
Experience of Learning Practice Hard Work
Experience of Learning Practice Intense
Experience of Learning Practice Neg Formal Teaching
Experience of Learning Practice Neg Mentor-Student Differences
Experience of Learning Practice Negative Time
Experience of Learning Practice Peer Support
Experience of Learning Practice Pos Confidence
Experience of Learning Practice Positive
Experience of Learning Practice Questions
Experience of Learning Practice Supportive
Experience of Learning Practice Team
Experience of Learning Practice Tiring
Experience of Learning Std Recently Moved
Experience of Learning Theory and Practice Tiring
Experience of Learning Theory Challenging
Experience of Learning Theory Negative Time
Experience of Learning Theory Pos Tutor Drop-In
Experience of Learning Theory Positive
Exxperience of Learning Impact of Friendliness
L+T BLE Inappropriate Behaviour
L+T BLE Midwife's Attitude
L+T BLE NBV
L+T BLE Poor Communication
L+T BLE Presentation on Child Development
L+T Discussion and Reflection Unspecified
L+T Discussion and Reflection with Mentor
L+T Discussion and Reflection with PT
L+T Discussion and Reflection with PT and Tutor
L+T Discussion and Reflection with Student PT
L+T Feedback daily
L+T Feedback from PT Negative Contemporaneous
L+T Feedback from PT Positive
L+T Feedback from PT Positive Contemporaneous
L+T Feedback Student PT Negative
L+T GLE Most Useful Discussion/Reflection
L+T GLE Most Useful Incidents
L+T GLE Case Conference
L+T GLE Core Group
L+T GLE Development Checks
L+T GLE Good Team
L+T GLE Learning Breastfeeding from Mentor
L+T GLE Most Useful Experiencing
L+T GLE Most Useful Observation
L+T GLE Most Useful Range of Approaches
L+T GLE Most Useful Unexpected
L+T GLE Observing Mentor on Home Visit
L+T GLE Praise
L+T Importance of Practice Learn Job

L+T Informal
L+T Learning Contract/ Action Plan
L+T Learning Style Learning by Doing
L+T Learning Style Like to Plan
L+T Learning Style Observing
L+T Observation
L+T Proactive
L+T PT Supervisions Fortnightly
L+T Spontaneous
L+T Student DNA Theory
L+T Student Insight
L+T Student Journal/Reflection
L+T Supervised Practice Unspecified
L+T Supervised Practice with Mentor
L+T Supervised Practice with PT
L+T Supervised Practice with Student PT
L+T Supervisions Monthly
L+T Universal to Progressive
L+T Unsupervised Practice
L+T Where? Car
L+T Working with Other HVs (No)
L+T Working with other HVs (Yes)
L+T Workshops in Practice Negative
L+T Workshops in Practice Positive
Learning Management Dialogue Negative
Learning Management Dialogue Positive
Learning Management Mentor
Learning Management Neg Mentor Allocation
Learning Management PT
Learning Management PT + Mentor
Locality Coastal
Locality Mixed
Locality Population Affluent
Locality Population Density - Dense
Locality Population Deprivation
Locality Population Social Divide
Locality Rural
Locality Rural Issues Bad Weather
Locality Rural Issues Clients' Transport
Locality Rural Issues Isolation
Locality Rural Issues Pavements
Locality Rural Issues Staff Getting Lost
Locality Rural Issues Telephone Signal
Locality Urban
Location of Team Health Centre
Location of Team Hospital
Location of Team Integrated School Health
Location of Team Primary School
Neg Practice Placement Stressed
Neg Practice Placement FC Childcare
Neg Practice Placement FC Daunting
Neg Practice Placement FC Meeting Cancelled
Neg Practice Placement FC Mentor Not There
Neg Practice Placement FC Mentor Unavailable
Neg Practice Placement FC Nervous
Neg Practice Placement FI Big Meeting
Neg Practice Placement FI Chaos
Neg Practice Placement FI Nobody

Neg Practice Placement FI Safeguarding
NMC Issues Minimum Hours Requirements
NMC Issues Sexually Inappropriate Behaviour
NMC Issues Sign Off
NMC Issues Unqualified Mentor
Placement Issues Locality Staff Changes
Placement Issues Mentors Changing Base
Placement Issues Moving Caseloads/ Clinics
Placement Issues Neg Leadership
Placement Issues Negative Access to Computers
Placement Issues Negative Changes
Placement Issues Negative Low Morale
Placement Issues Negative Organisation of Placement
Placement Issues Negative Paranoia
Placement Issues Negative Poor Team
Placement Issues Negative Pressure
Placement Issues Negative Pressure Barrier to Learning
Placement Issues Negative PT dual role
Placement Issues Negative PT/ Mentor off sick
Placement Issues Negative Space
Placement Issues Negative Staffing
Placement Issues Negative Student Numbers
Placement Issues Negative Team Leader Maternity Leave
Placement Issues Pos PT dual role
Placement Issues Positive Changes
Placement Issues Positive Good Team
Placement Issues Positive Happy Team
Placement Issues Positive Organisation of Placement
Placement Issues Skill Mix Team Dynamics
Pos Practice Placement FC Accommodating
Pos Practice Placement FC Already Knew PT
Pos Practice Placement FC Anticipations
Pos Practice Placement FC Expectations
Pos Practice Placement FC Letter
Pos Practice Placement FC Meet and Greet
Pos Practice Placement FC Paperwork Discussed
Pos Practice Placement FC Past Experience
Pos Practice Placement FC PT There
Pos Practice Placement FC PT/ Mentor Less Formal Approach
Pos Practice Placement FC Shown Around
Pos Practice Placement FC Supportive
Pos Practice Placement FC Telephone
Pos Practice Placement FC Worked in Trust Before
Pos Practice Placement FI Approachable
Pos Practice Placement FI Big
Pos Practice Placement FI Different Teams
Pos Practice Placement FI Friendly
Pos Practice Placement FI Mentor Nice
Pos Practice Placement FI Nurturing
Pos Practice Placement FI Organised
Pos Practice Placement FI Positive
Pos Practice Placement FI Welcoming
Pos Practice Placement Mentor there Day 1
Pos Practice Placement Orientation
Practice Assessment Discussion/ Reflection Unspecified
Practice Assessment Discussion/Reflection Mentor and PT
Practice Assessment Feedback Mentor and PT
Practice Assessment Neg Student Perspective Method

Practice Assessment Negative Being Observed
Practice Assessment Negative Inconsistency
Practice Assessment Negative Qualifications
Practice Assessment Pos PT Experience
Practice Assessment Spontaneous
Practice Assessment Student Perspective Child
Practice Assessment Student Perspective More Emphasis
Practice Assessment Student Perspective Supportive
Practice Assessment Student Perspective Time
Practice Assessment Trianglulated Negative
Practice Assessment Triangulated Positive
Practice Assessment Tripartite
Practice Education Model 1:1
Practice Education Model 1:2
Practice Education Model 1:3
Practice Education Model 1:5 Caseload Specified
Practice Education Model 1:6 Caseload Specified
Practice Education Model 1:6 Caseload Unspecified
Practice Education Model 1:8 Caseload Specified
Practice Education Model 1:8 Caseload Unspecified
Practice Education Model 2 Mentors
Practice Education Model Mentor and Long Arm
Practice Education Model Mentor, Student PT and Long Arm
Practice Education Model NK Caseload Specified
Practice Education Model PT as 1:1 and Long Arm
Practice Education Model Student PT and Long Arm
Practice Model Coporate
Practice Model GP Attached
Practice Placement Negative FC Childcare
Previous Experience Acute
Previous Experience Adult
Previous Experience Community Staff Nurse
Previous Experience District Nursing
Previous Experience Midwifery
Previous Experience New to Community
Previous Experience Paediatrics
Previous Experience Private
Previous Experience Special Needs
Public Health - Safeguarding
Public Health Breastfeeding
Public Health Drugs and Alcohol
Public Health Everything
Public Health Mental Health
Public Health Obesity
Public Health PND
Public Health Smoking
Public Health Teenage Pregnancy
Public Health Unemployment
Student Insight into Role Caseload Management
Student Insight into Role Challenging
Student Insight into Role CPD
Student Insight into Role Duration Visits
Student Insight into Role Evidence Base
Student Insight into Role Evolving
Student Insight into Role Neg Preceptorship
Student Insight into Role of HV
Student Insight into Role Responsibility
Student Insight into Role Skill Mix

Student Insight into Role Social Model
Student Insight into Role Social Worker
Student Insight into Role Trust
Student Insight into Role Value of HV
Student Insight into Service Reconfigurations
Student Insight Locality Juxtaposition
Student Insight Locality Practice Differs
Student Perspective Availability of Mentor Negative
Student Perspective Availability of PT Positive
Student Perspective Availability PT Negative
Student Perspective Caseload/ HCP Limitations
Student Perspective Computers
Student Perspective GLE Role Mentor/PT Support
Student Perspective GLE Role PT Respect
Student Perspective Long Arm Negative
Student Perspective Long Arm Positive
Student Perspective Mentor Neg New to Area
Student Perspective Mentor Neg Teaching Experience
Student Perspective Mentor Supportive
Student Perspective Mentor/ Std PT/ PT pressure
Student Perspective More Time for Reflection
Student Perspective Neg Flexibility
Student Perspective Neg Link Between Theory and Practice
Student Perspective Neg Mentor
Student Perspective Neg Mentor Academic
Student Perspective Neg Mentor as Student
Student Perspective Neg Mentor Chaotic
Student Perspective Neg Mentor Facilitating Learning
Student Perspective Neg Mentor Mentality
Student Perspective Neg Mentor Tone
Student Perspective Neg Mentor/PT Juggling
Student Perspective Neg More Consistency
Student Perspective Neg Onus on Student Making FC
Student Perspective Neg PT
Student Perspective Neg Supervision of PTs/ Mentors
Student Perspective Neg Tutors Limited Authority
Student Perspective Neg Two Mentors
Student Perspective Negative Learning from PT
Student Perspective Negative No Standardised Training
Student Perspective Negative PT Role Model
Student Perspective Negative Theory/Practice Balance
Student Perspective of Mentor Knowledgeable
Student Perspective Pos Mentor as Student
Student Perspective Pos Mentor Facilitating Learning
Student Perspective Pos Newly Qualified
Student Perspective Pos Onus on Student Making FC
Student Perspective Pos PT Academic
Student Perspective Pos PT as a Person
Student Perspective Pos PT as Student
Student Perspective Pos PT Facilitating Learning
Student Perspective Pos Student PT
Student Perspective Positive Theory/Practice Balance
Student Perspective Positive Two Mentors
Student Perspective Practice Learning PT/ Mentor Facilitator
Student Perspective PT Supportive
Student Perspective PT Teaching Experience
Student Perspective Theory Practice Conflicts
Student Perspective Theory Practice Gap

Student Perspective Will Not Take a HV Job
Student Perspective Would Like Competent PT
Stuent Perspective Pos PT Experienced
Supervision with PT Clinical
Team Size Growing
Team Size Large
Team Size Small
Type of Learning Alternative Practice
Type of Learning Antenatal
Type of Learning Application Theory
Type of Learning Baby Massage
Type of Learning Communication Skills
Type of Learning Domestic Abuse
Type of Learning Families with Complex Needs
Type of Learning Linking Theory and Practice
Type of Learning Multiagency
Type of Learning Needs Assessment
Type of Learning Nurse Prescribing
Type of Learning Observation Skills
Type of Learning Presentation Skills
Type of Learning Professional Attributes Advocacy
Type of Learning Professional Attributes Anti-discriminatory
Type of Learning Professional Attributes Confidence
Type of Learning Professional Attributes Confidentiality
Type of Learning Professional Attributes Flexibility
Type of Learning Professional Attributes Leadership
Type of Learning Professional Attributes Listening
Type of Learning Professional Attributes Partnership
Type of Learning Reality of the Job
Type of Learning Record Keeping
Type of Learning Safeguarding/ Child Protection
Type of Learning Skills
Type of Learning Special Needs
Type of Learning Style
Type of Learning Vulnerability
University + Placement Issues Neg Clear Guidelines
University + Placement Issues Discrimination
University + Placement Issues Neg Communication
University + Placement Issues Neg HV Implementation Plan
University + Placement Issues Neg Organisation
University + Placement Issues Tutor Involved
University Issues Negative Portfolio Requirements
University Issues Negative Student Numbers
University Issues Positive Portfolio Requirements
When Learning Does Not Happen - Repetition
When Learning Happens - All The Time