The Practice Facilitator Role: 'The everything facilitator' within pre-registration nurse education in practice

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Abstract

Background

The importance of ensuring student nurses being well prepared to deliver healthcare in a constantly changing environment has been a policy priority. A new practice facilitator role was introduced in the early 2000s in response to specific national policy initiatives which aimed to enhance pre-registration nurse education. The literature demonstrated a few similar roles were introduced in the UK. Limited research has been undertaken in respect of these roles and none explored role development over time.

Aim

This study's aim was to explore the way the practice facilitator role evolved in a real-world context over time and its impact on pre-registration nurse education.

Methodology and methods

A pragmatic epistemological perspective informed the research which used a qualitative, multiple case study methodology (Yin, 2009). Study participants (n= 57) comprised key actors engaging with the practice facilitator role (9 practice facilitators, 3 Trust education leads, 3 HEI heads of department, 26 mentors and 16 link lecturers). Data was collected through one-to-one semi-structured interviews (n = 15) and focus groups (4 mentor and 3 link lecturer).

Data analysis

The data was analysed using Braun and Clarke's (2006) model of thematic analysis.

Results

Three major themes and an overarching theme were identified which broadly reflect the way the practice facilitator role evolved over time. Firstly, *in the frontline* describes a managerial focus centred on establishing systems to control access to and management of practice resources. Secondly, *everybody knows them and they know everybody* whereby practice facilitators have assumed a critical frontline decision-making role influencing student outcomes and at the same time displacing the link lecturer role. Thirdly, *de facto gatekeepers to the profession* where practice

facilitators have developed a close reciprocal relationship with mentors through whom they exercise a quality assurance function to ensure robust assessment of students' practice and transition to qualified status. These were encapsulated in an overarching theme *the everything facilitator*.

Discussion

Lipsky's (2010) concept of street-level bureaucrats provided an analytic framework to interpret the results where practice facilitators were found to possess the characteristics of street-level bureaucrats. Crucially, they were found to occupy a unique spatial location across, between and within the Trusts and HEI at frontline strategic and operational levels, conceptualised as interstitial spaces (Furnari, 2014). This allowed practice facilitators to have a significant impact on pre-registration nurse education. It is argued this is a development of Lipsky's street-level bureaucracy.

Conclusions

The results indicate that practice facilitators function at both strategic and frontline operational levels, working uniquely within the 'interstitial spaces' (Furnari, 2014) of pre-registration nurse education. Their current way of working is significantly expanded from the original policy intentions. Moreover, the development of the role has been accumulative rather than sequential. The implementation of policy initiatives and the way the role has evolved is explained by the application and development of Lipsky's (2010) street-level bureaucracy with occupying the interstitial spaces (Furnari, 2014).

Acknowledgements

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Abbreviations

List of abbreviations that are used throughout this thesis

Abbreviation	Abbreviation meaning
AA	Academic assessor
BLS	Basic life support
CFP	Common foundation programme
CRB	Criminal records bureau
CQC	Care Quality Commission
DBS	Disclosure and Barring Service
DoH	Department of Health
EL	Education lead
ELs	Education leads
ENB	English National Board
GNC	General Nursing Council
HEI	Higher education institution
HEIs	Higher education institutions
HOD	Head of department
HODs	Heads of department
ILT	Institute for Learning and Teaching
IRAS	Integrated Research Application System
LL	Link lecturer
LLs	Link lecturers
LP	Lecturer practitioner
LPs	Lecturer practitioners
JD	Job description
NHS	National Health Service
NMC	Nursing and Midwifery Council
NVQ	National vocational qualification
PA	Practice assessor
PAMs	Professions Allied to Medicine

PBL	Problem based learning
PF	Practice facilitator
PFs	Practice facilitators
PI	Principal investigator
PS	Practice supervisor
PK2	Project 2000
PL	Principal lecturer
RCN	Royal College of Nursing
RN	Registered nurse
SHA	Strategic Health Authority
SHAs	Strategic Health Authorities
SLAiP	Standards to support learning and development in practice
SOM	Sign off mentor
SOMs	Sign off mentors
SSSA	Standards for student supervision and assessment
UK	United Kingdom
UKCC	United Kingdom Central Council

Table of contents

List of Tables

List of Figures

Chapter 1: Study background and context: the evolving nature of practice education

1.1 Introduction

Nurse education in the United Kingdom (UK) has undergone a number of significant revisions in order to meet changing health and education requirements. The integration of schools of nursing into Universities as a result of *Project 2000: A new preparation for practice* (UKCC, 1986) heralded the recognition of nursing as an independent field of study akin to other areas of study in the Higher Education Institution (HEI) sector. Prior to this an apprenticeship nurse education model predominated. Nurse education programmes were primarily delivered in schools of nursing which had close links with the National Health Service (NHS) sector. Students' primarily gained the practice aspects of the programme in the practice setting and the theoretical aspects in the college of nursing. However, deficits were identified with students completing *Project 2000* (UKCC, 1986*),* particularly with their practice skills (Parker and Carlisle, 1996; Rushforth and Ireland, 1997).

In response to these deficits, the UK Government pushed for change in a policy document entitled *Making a Difference* (DoH, 1999). The United Kingdom Central Council, which was the professional regulatory body for nursing and midwifery at the time, responded to this in *Fitness for Practice* (UKCC, 1999). Both these documents included the need for new roles in practice, particularly regarding the liaison between healthcare service providers, the National Health Service (NHS) and Higher Education Institutions (HEIs).

This chapter introduces the study's focus, context, its rationale and overarching aim and provides an overview of this thesis. It examines a range of contexts. Firstly, the key developments in pre-registration nurse education in practice. A range of concerns and issues are identified that eventually helped inform the major changes introduced at the turn of this century. Secondly, the two key policies, *Making a Difference* (DoH, 1999) and *Fitness for Practice* (UKCC, 1999) are examined, including the rationale for introducing a new role of practice facilitator, the title of the role introduced in this study area. Thirdly, during the lifetime of this study, further developments affecting pre-registration nurse education in

practice were introduced, which built on the two key policies identified above and these will be further highlighted. Fourthly, the chapter explores the policy dimension of the study. It opens with a brief overview of the principal models of policy formation and implementation. Subsequently, it specifically focusses on Lipsky's (2010) model of street-level bureaucracy, which is used as an analytical framework to understand the outcomes of the present study. Finally, within these wider contexts of the study, the local context and the study origins will be explored.

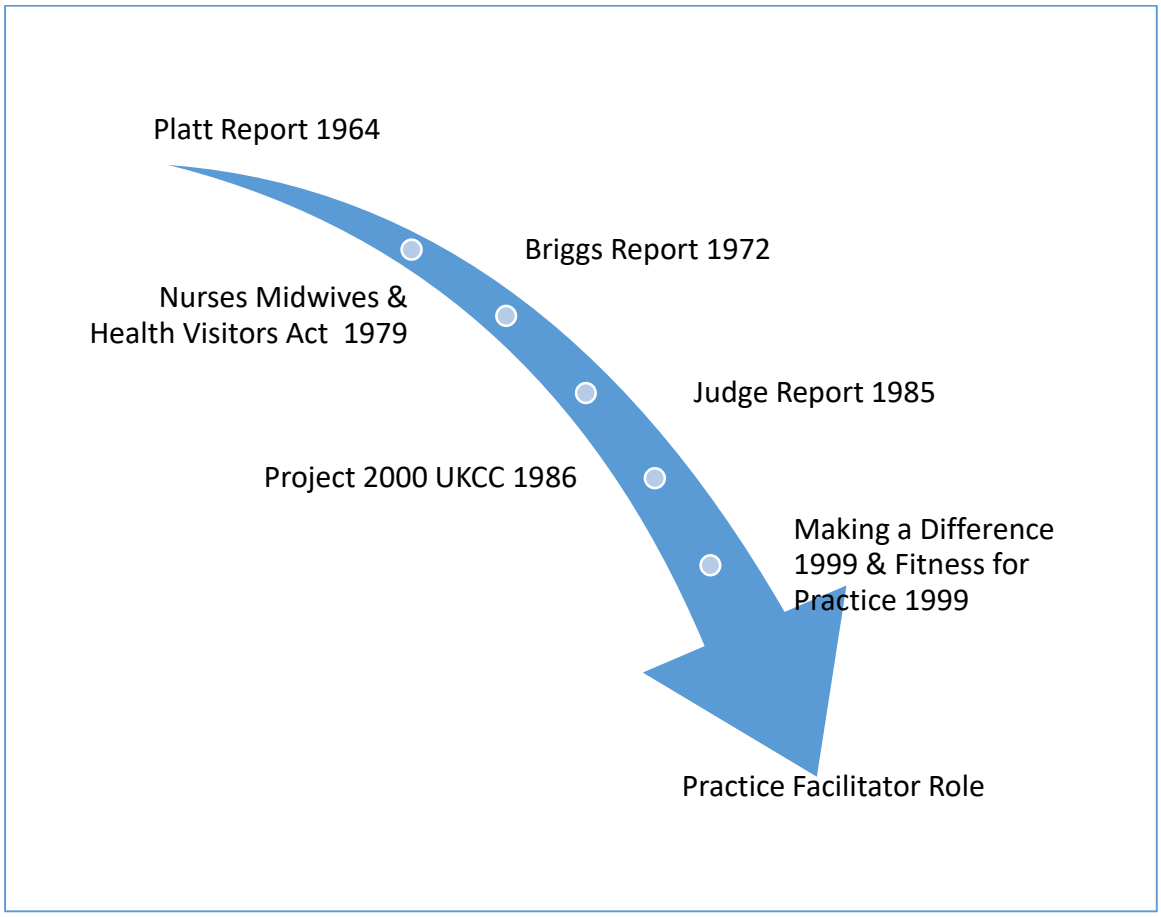
1.2 Study focus

Pre-registration nurse education in the UK incorporates the formal 50% academic teaching and 50% practice experience elements (UKCC, 1999; NMC, 2010b). The settings in which pre-registration nurse education takes place include the HEI where the 50% academic elements are taught and assessed by lecturers. Student nurses complete the 50% practice element in the practice setting, generally in NHS Trusts, where they gain a range of practice experiences, and, where they are assessed by mentors. For the purposes of this study, pre-registration nurse education in practice is used to represent the 50% element that takes place in the practice environment. Where the entire programme is being discussed, it is referred to as the pre-registration nurse education programme, or, programmes.

This study's aim was to explore the way the practice facilitator role evolved in a real-world context over time and its impact on pre-registration nurse education. Specifically, this thesis focuses on the implementation of the new role of practice facilitator in a large metropolitan area in the United Kingdom (UK). The title practice facilitator (PF) or practice facilitators (PFs) is used when referring to the role in this study. This new role arose as a direct result of recommendations made by the two aforementioned key policies which, to a large extent, represented an important re-direction in nurse education. The introduction of and deployment of practice facilitators were envisaged within these policies as having a pivotal impact on addressing major concerns about the pre-existing organisational tensions within the landscape of pre-registration nurse education and concomitant practice education. These concerns that had been building over time were within an increasingly complex system of healthcare delivery.

Figure 1.1 below provides a representation of the key policy drivers and timeline for the evolution of the practice facilitator role in the study area, the subject of this study. These aspects will be discussed in more detail in the following sections.

Figure 1.1 Representation of key policy and regulatory drivers and timeline evolution of the practice facilitator role



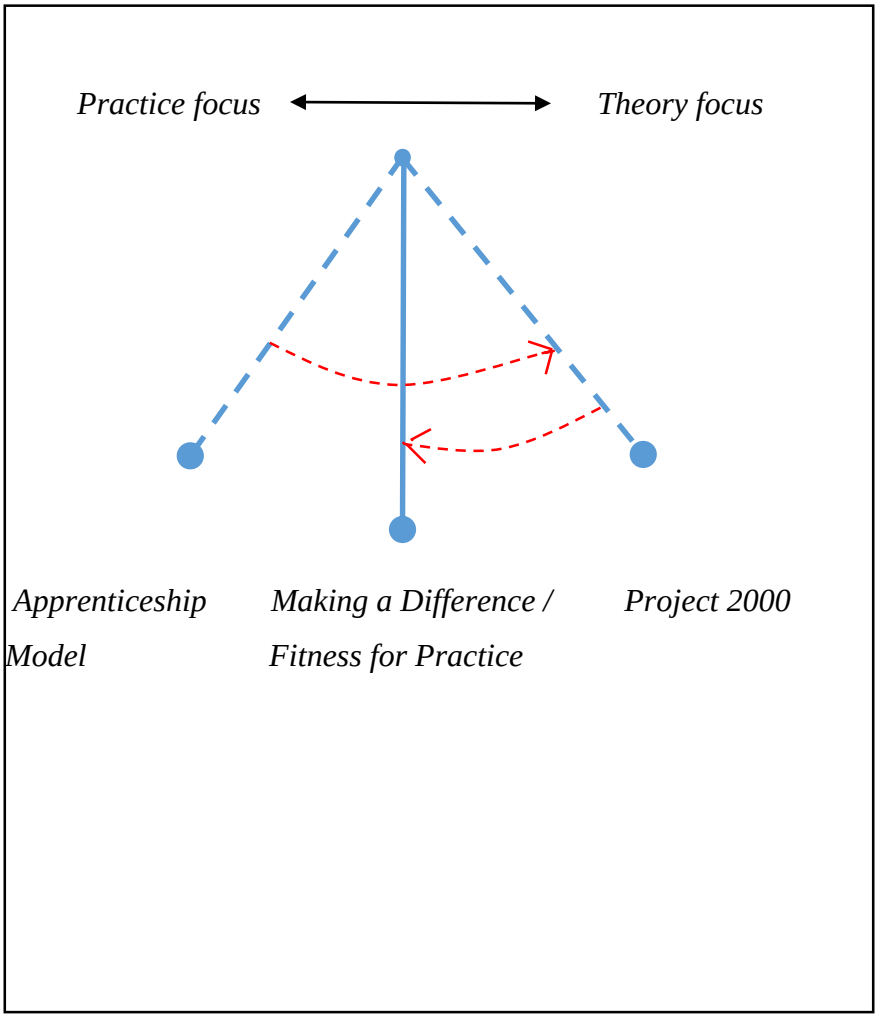
The initial studies (reviewed in chapter 2) carried out in relation to the new facilitator role revealed a variation in local interpretation and application of the role and a degree of role evolution. This raised some important questions for the present study about how the policy implementation aspects influenced the evolution and operationalisation of the new roles and how to explain their eventual role functioning within the area of study. Given that there have been no subsequent official policy statements regarding the role, the process by which they took the form they did in the study area is relevant in this study. To help understand this aspect, the application of Lipsky's (2010) seminal work on 'street-level bureaucracy' was

used to aid the analysis of the policy implementation aspects of the role of practice facilitator as well as providing insights into their actual functioning.

1.3 The context of nurse education prior to Making a Difference (1999) and Fitness for Practice (1999)

Historically, nurse education in the United Kingdom (UK) has undergone a number of significant changes in the preparation of student nurses for their role on qualification. These changes predominantly reflected an alternating emphasis in nurse training and education between practice requirements and theoretical underpinning respectively. These changes in nurse training can be represented in the form of a pendulum figure 1.2.

Figure 1.2 Theory-practice pendulum in nurse education



The traditional Nightingale approach was based on an apprenticeship model which strongly emphasised the practice dimension (Bentley, 1996; Ousey, 2011; Willis Commission, 2012). The General Nursing Council (GNC), which had been established under the nurses act in 1919, was the governing body for nurses as well as being responsible for nurse training and education (Rafferty *et al.*, 1996). The GNC maintained the register of nurses and was also responsible for deciding the rules of admission to this register (Ousey, 2011). In addition, alongside registered nurses, there were also Enrolled Nurses (referred to as pupil nurses when in training). Enrolled Nurses were not registered by the GNC and their training was just two years duration. The role of the Enrolled Nurse evolved from assistant nurses and were intended to have a more practice focus to support the registered nurse (Dingwell *et al.*, 1988).

Student nurses completed their apprenticeship training, primarily by caring for patients in the hospital setting and attending 'blocks' of theory in standalone schools of nursing that were attached to the hospital (Bentley, 1996; Barton, 1998; Camiah, 1998a; Willis Commission, 2012). This way of training meant there was a close working relationship between the hospital and their associated school of nursing. Underscoring the apprentice training and service link, student nurses were National Health Service (NHS) employees, receiving an NHS salary and thus formed an important part of the healthcare workforce (Bentley, 1996; Barton, 1998; Burke, 2006).

This association fostered both a practical and organisational relationship between service and students (Ousey, 2011). Employers, who were also the education providers where students gained their clinical experience, reinforced the NHS's sense of ownership of their students' whilst, at the same time, engendering students' identification with their employer and training authority (Burke, 2006).

Under the apprenticeship model, an emphasis was placed on students' acquiring required practical skills which meant limited time was devoted to theoretical input (Linsley *et al.*, 2008; Willis Commission, 2012). The extent of this emphasis was observed by Crotty (1993b) where a 1969 GNC syllabus only required a minimum of twenty-four weeks theoretical content of the one hundred- and forty-six-week programme. Furthermore, though students spent the majority of their training in practice, they were commonly seen as "*an extra pair of hands*" (Fulbrook *et al*., 2000, p. 351) with service needs taking precedence over their clinical development (Camiah, 1998a; Maslin-Prothero and Owen, 2001). Yet, despite

the amount of time students' spent in practice, only 1% to 2% of all ward activity was explicitly devoted to teaching students (Fitzpatrick *et al.*, 1993; Rafferty *et al.*, 1996). To use the pendulum analogy (figure 1.2) it could be said that the pendulum indicating the theory-practice balance of student nurse training was positioned firmly in favour of practice under the apprenticeship model.

However, the lack of emphasis on underpinning theoretical knowledge of nursing, likely compromised nurses understanding of the rationale for the care they were providing, so lessening their position as autonomous professionals in practice (Grindle and Dallat, 2000). This fostered a perception of nurses simply following routines and procedures instead of nursing practice being underpinned with a sound theoretical rationale (Glen, 2009). Indeed, this perception was such that nurses were seen as subservient to, and just an "*add on*" (Gillespie and McFetridge, 2006 p. 640) to the more important work of medical doctors' and thus merely carried out doctors instructions.

Nevertheless, given the extent of students' exposure to the practice setting, it would seem reasonable to expect that the apprenticeship model would have produced nurses that were clinically experienced on completion of training. However, the focus on service requirements taking precedence over student training needs meant, as newly qualified nurses, many felt ill equipped to cope with the demands of a changing healthcare system (Fulbrook *et al.*, 2000). Many students experienced high levels of stress and low morale whilst on placement. These circumstances resulted in a large number of students leaving the course (Bentley, 1996; Fulbrook *et al.*, 2000). Worrying attrition rates of 15%-20% with a further 30% failing to meet qualification requirements were reported in conjunction with many leaving the profession after qualification (Lindop, 1989; Ousey, 2011). Bearing in mind these factors, this researcher would conclude that the traditional, apprenticeship model was failing both the student, who had entered nurse training, and the NHS, who had utilised valuable resources to train the student, but in the end lost them from the workforce. Clearly, this raised questions as to whether this was a satisfactory or cost-effective way of delivering nurse training.

Students completing their training under the apprenticeship model were formally assessed via practical ward-based examinations and a final universal state written examination, overseen by the GNC (RCN Policy Unit, 2007; Roxburgh *et al.*, 2008). Whilst this brought the advantage of consistency to the apprenticeship model of training, this approach gave rise to

important tensions between nurse training and education. The primary concern of service managers was to adequately staff the wards, where there were often shortages of qualified nurses to provide care as well as support students. There was a reliance on students to learn "*on the job*" (Linsley *et al.*, 2008, p. 172) and to be part of the staff rota to provide nursing care (Bentley, 1996; Linsley *et al.*, 2008), therefore compromising the educational aspects of student's learning.

1.3.1 The move away from the apprenticeship model of nurse education

In addition to these concerns about the apprenticeship model of training, added tensions were predicted arising from demographic trends. Buchan (1999) stated that in the 1970s and 1980s, most UK nursing students were school-leavers. However, from a demographic perspective, it was anticipated the number of eighteen-year-old females, with five 'O' levels, who formed the majority of those traditionally recruited to enter nurse training, would fall by the mid-1990s (Bentley, 1996) resulting in a shortfall in staffing levels (Fulbrook *et al.*, 2000).

Keen to review student nurse training arrangements, to ensure that nurses were adequately prepared to assume responsibility on qualification, the Royal College of Nursing (RCN) convened a committee to consider nurse education (Bentley, 1996). The resulting Platt Report (RCN, 1964) made key recommendations that student nurses should be financially independent from service and training should be led by student educational needs. However, the Platt Report was not welcomed by the GNC who questioned the shift in emphasis from the vocational nature of nursing on which the apprenticeship model was based (Ousey, 2011). Neither did these recommendations gain support from nurse management level, whose overriding concern continued to be staffing the wards and not changing how students were trained, so the status quo continued (Bentley, 1996). No changes resulted from the Platt Report at this time.

Subsequently, the Briggs Report (Grindle and Dallat, 2000), published in 1972, continued to promote the need for nurses in training to be afforded student status and advocated that nursing should be a research-based profession (Ousey, 2011; Willis Commission, 2012). These were important proposals as their implementation would contribute to the professionalism of nursing and contribute towards making it an attractive career proposition.

Briggs (Grindle and Dallat, 2000), further recommended important changes in the way nursing was organised. These recommendations proved highly influential when the new suggested statutory framework came into effect some years later via the Nurses, Midwives and Health Visitors Act 1979. The GNC was replaced by a new statutory body, the United Kingdom Central Council (UKCC), with four national boards that had responsibility for professional standards and education at basic and post-basic levels. These changes were seen as providing the framework to reform the way nurses were educated as well as strengthening nursing as a profession (Bentley, 1996).

In the meantime, however, service reliance on students providing patient care, coupled with concerns regarding the cost implications of conferring student status, meant that students continued to be employees, thus perpetuating the apprenticeship model (Bentley, 1996). Furthermore, the teaching content continued to emphasise the medical/disease model where students focussed on nursing the sick, who were generally cared for in the hospital setting (Macleod Clark *et al.,* 1997b; Ousey, 2011).

Increasingly, the heavy weighting of the curriculum on a medical/disease model during training was becoming more out of step with the way nurses needed to be prepared. Even in hospitals, advances in technology and fast-paced changes in healthcare interventions were influencing how students were prepared. Driven by the reduction in junior doctors hours and as part of their expanding role, nurses were additionally undertaking procedures previously carried out by doctors (Aston *et al.*, 2000; Linsley *et al*., 2008). Healthcare provision was also contending with how care would be delivered to an increasing elderly population (Fulbrook *et al*., 2000). Furthermore, the focus of healthcare was moving out of hospital settings and into the community along with an increasing emphasis being placed on promoting and maintaining good health (Linsley *et al*., 2008).

1.3.2 *Project 2000*: Shifting the theory-practice pendulum in nurse education

These factors built up momentum and led to the Judge Report (RCN, 1985) which offered wide-ranging recommendations for the future education of nurses. Subsequently, the UKCC in its document *Project 2000: A New Preparation for Practice* (UKCC, 1986) adopted many of these recommendations which brought about a significant transformation in nurse education (Pope *et al.,* 2000). *Project 2000* represented wholesale change in pre-registration

nurse education as it was designed to produce a workforce that was envisaged to be better able to adapt to changes in healthcare versus the former apprenticeship model (UKCC, 1986; Fulbrook *et al.,* 2000).

Central to implementing *Project 2000* was that pre-registration nursing transferred from the schools of nursing to the Higher Education Institution (HEI) system (Linsley *et al.,* 2008). Significantly, this marked a radical step forward in establishing nursing as a profession, thus aligning it with other allied health professions (Barton, 1998). Additionally, this major break also shifted the emphasis to an educational, student learning needs approach, which replaced the former service-led, apprentice model. Indeed, changes in rhetoric were evident following the introduction of *Project 2000* with 'nurse education' replacing 'nurse training', signalling the increased theoretical emphasis of the programme (Kenny, 2004). However, as students were no longer NHS employees, there was an increased reliance on the goodwill of service staff to provide the resources required to support students in practice (Elkan and Robinson, 1995).

Project 2000 (UKCC, 1986) students attained a minimum diploma level award but with the advantage of joint professional and academic qualifications (Elkan and Robinson, 1995; Lewin, 2007; Findlow, 2012). This combination maintained the principle that nursing remained a practice-based profession (Murray and Williamson, 2009), preserving the importance of the student experience of learning in clinical practice. The curriculum aimed to produce a workforce of analytical 'knowledgeable doers' who would be effectively equipped to manage changing healthcare demands, whether provided in hospital or community settings (UKCC, 1986; Ousey, 2011).

With the implementation of *Project 2000* the intention was to introduce a single level of nurse and as a result, Enrolled Nurse training was gradually phased out in the 1990's. Existing Enrolled Nurses were given the opportunity to undertake a short conversion course to facilitate the existing standards to become Registered Nurses (Seccombe *et al.,* 1997). The *Project 2000* curriculum was delivered over three years, commencing with an 18-month common foundation programme (CFP) with progression for a further 18-months to one of four branches in either care of the adult, child, mentally handicapped or mentally ill (UKCC, 1986; Roxburgh *et al.,* 2008). During the CFP, consideration was given to socialising student nurses into practice with classroom-based teaching being linked to shorter placement

experiences, and, for the programme as a whole, a reorientation from hospital to community based healthcare (Elkan and Robinson, 1995; Bentley, 1996; Fulbrook *et al.,* 2000).

A further central element in implementing *Project 2000* was that students were no longer health authority employees but instead received a bursary (Bentley, 1996). The significance of this was that students became supernumerary to nursing staffing requirements so were no longer included on duty rotas (UKCC, 1986). This gave students the freedom to be more self-directed in their studies as they were no longer counted as part of the workforce. However, the original proposal for students to receive bursary support throughout the programme was revised due to the costs of student status and shortage of qualified nurses. Consequently, as part of the final arrangement, students were required to provide a 20% contribution in clinical practice (Ousey, 2011). Rather than this being seen as problematic, students found they benefited from their service contribution, particularly where there were longer placements (Elkan and Robinson, 1995; Barton, 1998). Granting students' supernumerary status resulted in health service staff changes where healthcare assistant posts were created to fill the void left by students who were no longer counted in the staffing establishment (Bentley, 1996). Although the principle of students' supernumerary status was generally supported by nurses (Elkan and Robinson, 1995) the major reforms brought about by *Project 2000* (UKCC, 1986) had knock-on implications for how student learning was supported in practice. The different components are examined in the following sections.

1.3.3 *Project 2000*: Shifting roles

Ward sister/charge nurse

From early on, the ward sister/charge nurse played a significant role in creating a positive learning environment (Pembrey, 1980; Jones, 1985; Andrews *et al.,* 2005a; Elcock *et al.,* 2007) and qualified staff in the placement were generally responsible for teaching students through delivering 'hands-on care' (Crotty, 1993a; Pollard *et al.,* 2007). Staff appointed at ward sister/charge nurse level were experienced clinical nurses but their role also incorporated additional management functions. Although their role contributed to the student learning experience, in practice, their role priority was the delivery of nursing care for patients in preference to teaching students. Coupled with this was the varying levels of commitment given by ward sisters/charge nurses to the teaching role (Ogier, 1981; Orton,

1981) with some discarding their commitment altogether which reduced the effectiveness of this role (Jones, 1985).

Nurse tutor and clinical teacher

Prior to *Project 2000*, support for students was also provided by two grades of teachers; the nurse tutor who focussed on formal theoretical teaching in the classroom and the clinical teacher who provided teaching in the clinical setting (Gerrish, 1992; Ioannides, 1999). The clinical teacher grade had originated in the 1960s to provide additional support for the ward sister/charge nurse involvement in teaching students in the clinical practice setting (Aston *et al.,* 2000; Collington *et al.,* 2012). The full-time clinical teacher worked 'hands-on' (Camiah, 1998b) with students in delivering patient care, wore a nurse uniform, had access to medical and nursing records (MacIntosh, 2015) and was also seen as a means for bridging the gap between theory and practice (Brennan and Hutt, 2001).

However, the role description for the clinical teacher was unclear. This resulted in some role overlap between the nurse tutor and clinical teacher grades, as found by Baillie (1994) where, depending on a range of local arrangements, the nurse tutor also had contact with practice areas. There were also variations in their responsibilities, both in and with the number of clinical areas covered, with some working in specific areas, whilst others worked with students across specialities (Ioannides, 1999). This lack of clarity compromised the effectiveness of the clinical teacher role. A more fundamental problem was the lack of time available and a lack of peer support from fellow teachers when undertaking teaching on the wards, revealing a lack of value of this aspect of the role (Jones, 1985). Eventually, ongoing problems with clarifying the role description and responding to conflicting educational and service needs contributed to the phasing out of this role (Jones, 1985; Gerrish, 1992; Aston *et al.,* 2000).

Project 2000 encouraged the removal of the nurse tutor and clinical teacher split and instead advocated there should be one level of teacher that included a presence in the practice setting (Gerrish, 1992; Ramage, 2004; UKCC, 1986). Subsequently, the clinical teacher role disappeared and a new nurse tutor role emerged with combined responsibility for classroom teaching, supporting student learning in practice and monitoring the quality of educational standards in placements (UKCC, 1986). The practice teaching component of this new role became generally known as the link lecturer (LL) (Aston *et al.,* 2000).

Nurse lecturer/Link lecturer

As discussed above, the clinical teacher role which had supported ward managers and students in practice under the apprenticeship model was phased out following the introduction of *Project 2000* (UKCC, 1986). In essence, the dedicated clinical teacher role, was subsumed into the nurse tutor role. Therefore, although based in the HEI, the nurse tutor role also incorporated a practice teaching component which became widely identified as the 'link lecturer' (LL) to describe their continuing link with practice (Aston *et al.,* 2000; Fisher, 2005). During this time, the nurse tutor role title was replaced with 'nurse lecturer' Clifford (1996) or 'university lecturer', to reflect the HEI academic system, and these role titles continue to date.

Mentors

The transfer of nurse education into the HEI (UKCC, 1986) heralded a change in the way students were supported in practice. Although the nurse tutor role had been incorporated into the university lecturers' remit, the LL aspect in the practice setting became mainly advisory (Clifford, 1993; Humphreys *et al.,* 2000; Murphy, 2000). These factors signalled a formal mentor role for registered nurses in supporting and assessing pre-registration student nurses in practice (Bray and Nettleton, 2007). Whilst nurses always had a professional obligation to support and teach students in clinical practice, it was not a specific role requirement (Nettleton and Bray, 2008).

1.3.4 *Project 2000*: Problems, issues and challenges that emerged

As *Project 2000* increased student education to diploma level (UKCC, 1986; Fulbrook *et al.,* 2000) a further recommendation was made that the qualification for teachers of nursing should be at degree level (UKCC, 1986). This ambition of raising academic standards was problematic for many nurse lecturers (Barton, 1998). Nevertheless, though often self-funded in terms of time and money, progress was made whereby in March 1990 only 33% of nurse teachers were graduates, but, by March 1993, 60% had attained graduate status with a further 38% studying for a degree (Bentley, 1996).

At the same time, whilst, many nurse lecturers undoubtedly experienced pressure in delivering the theoretical component of *Project 2000* at the higher academic level (UKCC, 1986; Aston *et al.,* 2000), their integration into higher education also required immersion into

a different cultural ethos (Ousey and Gallagher, 2010), and tensions emerged. Activities such as securing research grants, research and scholarly publications indicated effective performance in the HEI, but did not necessarily include working as LLs in the clinical practice environment (Barrett, 2007). Even so, in order to fulfil the LL aspect of the role, nurse lecturers were recommended to spend 20% of their time in practice (ENB, 1989; Ioannides, 1999) and so this was included in nurse lecturer employment contracts (Maslin-Prothero and Owen, 2001).

Although it appeared that the teaching and clinical elements of the nurse lecturer roles were amalgamated in one person, there were early indications that many nurse lecturers had difficulty in fulfilling the LL aspect of their role (Aston *et al.*, 2000; Clifford, 1993, 1996; Crotty, 1993a). Juggling the competing demands of teaching, administration and research, as well as increasing their own qualification's, contributed to the neglect of the LL aspect of the role (Luker *et al.,* 1995; Gillespie and McFetridge, 2006). Additionally, the lack of a clear purpose for the LL role and how it should be implemented was problematic (Clifford, 1993; Crotty, 1993a). It seems the long-standing problems of the lack of clarity of the former clinical teacher role, discussed earlier, had rolled forward into the LL role.

It would appear, even if nurse lecturers had spent 20% of their time in practice, it is difficult to envisage how this could have replaced the 'hands-on' dedicated presence of the former clinical teacher role. Although provoking considerable debate, no standardised role remit or model for providing support in practice emerged, which resulted in inconsistencies in the way it was delivered and managed in the UK (Crotty, 1993a; Goorapah, 1997; Maslin-Prothero and Owen, 2001). Generally, however, the LL role was a system for lecturers to provide academic support in the practice area. This system operated on the basis that clinical staff had a named LL in the HEI that they could contact for advice. Normally, the LL was the link for a number of clinical areas, but this varied between LLs, both in the number of areas allocated and the clinical speciality.

The LL aspect also differed from the former, dedicated clinical teacher remit in that it no longer included teaching students through 'hands-on' participation in patient care (Crotty, 1993a; Murphy, 2000) but instead offered guidance and support to staff and students in clinical placements (Clifford, 1993, 1995, 1996; Elkan and Robinson, 1995; Carnwell *et al.,* 2007; Pollard *et al.,* 2007; Kerridge, 2008).

Inevitably, lecturers were uncertain and confused about their role as well as losing their skills in clinical practice (Clifford, 1993, 1995; Elkan and Robinson, 1995). Indeed, many lecturers were found to have difficulty maintaining their clinical competence and credibility (Clifford, 1993, 1996; Crotty, 1993a; Owen, 1993; Luker *et al.*, 1995), again generating debate as to the level of competence or credibility that lecturers actually required (Goorapah, 1997; Murphy, 2000; Cave, 2005).

Against this background of increasing concern and with a view to informing policy, the ENB commissioned a UK wide, mixed methods study to examine 'the role of the teacher/lecturer in practice' (Day *et al.,* 1998). This study was carried out over an 18-month period in 1996-1997 (Day *et al.*, 1998; Aston *et al.,* 2000). However, it could be said the study was somewhat limited as it was confined to exploring the 20% time allocation recommended for the LL aspect of the role (ENB, 1989), rather than perhaps more broadly reviewing if the 20% time allocation was sufficient to meet practice-based learning support expectations in the first place.

The study identified the LL role title was the most commonly used approach in the UK, although overall, it concluded there was a lack of strategic management and lecturers were unprepared and unsupported in the role (Day *et al.,* 1998). Nevertheless, the fact that recommendations were made to address these deficiencies indicated support for the continuation of the role. These key recommendations, not surprisingly, included the need for strategic management, clarification of the purpose and objective of the LL role so that it was transparent to all stakeholders (Aston *et al.,* 2000). However, a definitive model or role remit was not provided. This may have been due to the special commission on education which was being conducted by the UKCC at the time which resulted in the *Fitness for Practice* report (UKCC, 1999) (discussed in section 1.4.2) and where the recommendations could be considered to inform future nurse education provision (Aston *et al.*, 2000; Roques, 1998).

Another issue to emerge following the introduction of *Project 2000* was the change in responsibility for registered nurses. Given the demise of the clinical teacher role and the inconsistency and uncertainty revealed above in relation to the 20% of the nurse lecturer's role in practice, the task of mentoring students in the clinical environment now lay solely with registered nurses'. Also, given the importance of the mentoring relationship with students, there was a lack of consensus on the exact nature and application of the role. In

particular, there was a lack of clarity regarding the extent to which an assessing function may have conflicted with supportive role functions (Hyde, 1988). Moreover, the speed with which *Project 2000* was implemented, prevented HEIs from preparing thoroughly and particularly in preparing mentors for their assessment responsibilities (Elkan and Robinson, 1995).

Further confusion resulted through the use of different terms such as mentor, assessor, supervisor and clinical facilitator, that were used interchangeably to describe the role (Pulsford *et al.,* 2002; Myall *et al.,* 2008). Nevertheless, the lack of an agreed understanding of the mentor role did not prevent its implementation (Morle, 1990) and the task of mentoring students now lay with nurses who had not been fully prepared for the role and had little guidance in how to perform as mentors (Elkan and Robinson, 1995; Andrews and Chilton, 2000).

Although the ENB had defined the mentor role as someone selected by the student to assist, befriend, guide, advise and counsel (ENB, 1989) their definition did not include a formal supervision or assessment remit of a student (Bray and Nettleton, 2007). Thus, implying the role of the mentor and assessor were separate.

Nevertheless, the introduction of mentorship imposed a role responsibility on registered nurses, that worked in practice, to support learning, supervise and assess students in the clinical environment (Neary, 2000; Myall *et al.,* 2008; Price *et al.,* 2011). Inevitably, this had implications for registered nurses in their day-to-day nursing care activities, as mentoring students had become a formal additional responsibility that increased their workload (Neary, 2000; Moseley and Davies, 2008).

Although some mentors absorbed the role as part of their job, others viewed the role as an additional responsibility, in which they had no choice (Andrews and Chilton, 2000) realities which invariably affected the mentor-student experience (Pulsford *et al.,* 2002). Additionally, there were concerns about low staffing levels and not having enough qualified staff to act as mentors which often meant staff were hard pressed to find time to teach and assess students (Elkan and Robinson, 1995). Nonetheless, the concept of mentorship in practice learning was now an integral part of supervising and assessing students in practice (ENB and DoH, 2001; Pollard *et al.,* 2007).

Lecturer practitioner

As discussed above, the loss of the clinical tutor role and the subsequent considerable reduction of LLs presence in clinical practice, a newly created lecturer practitioner (LP) role was developed in some areas (Burke, 1993; Rhead and Strange, 1996). Pioneered in the late 1980's, LPs were joint appointments between the HEI and the NHS, typically splitting their time equally between education and service (Shepherd *et al.,* 1999; Salvoni, 2001; Cave, 2005). The idea of combining teaching, clinical and managerial functions in the same person, working across education and health was seen as a way of fostering stronger relationships and of lessening the perceived theory-practice gap (Rhead and Strange, 1996; Barrett, 2007; Ousey and Gallagher, 2010). The development of the LP role, seems to indicate that another additional role to that of the formally recognised, though HEI based, LL role (ENB, 1989; Aston *et al.,* 2000; Fisher, 2005) was needed to address theory-practice gap concerns. However, similar to the lack of clarity surrounding the LL role as discussed above (section 1.3.4), the LP role also lacked clarity (Aston *et al.,* 2000; Williamson, 2004; Cave, 2005; Carnwell *et al.,* 2007; Ousey and Gallagher, 2010).

Additionally, expectations of what LPs should do were rarely made explicit along with Trust and HEI managers having different requirements of the post holder (Williamson, 2004). It seemed inevitable that LPs were likely to find working across complex education and health organisations challenging. Indeed, it was not unusual that LPs felt the tension of endeavouring to fulfil the expectations of both Trust and HEI managers, where each organisation may have expected 100% performance, with the result that the role was often seen as two full-time jobs rolled into one (Burke, 1993; Rhead and Strange, 1996; Maslin-Prothero and Owen, 2001; Williamson, 2004). Furthermore, although LPs operated at a senior level there was a lack of career structure (Carnwell *et al.,* 2007). Therefore, the LP role was unlikely to be an attractive prospect in the long term for applicants. Nevertheless, the LP role might have had some attraction as a stepping-stone test for those who might be considering a move into an academic career.

Whilst the LP was, in part, envisaged to bridge the theory-practice gap, they were frequently not teaching pre-registration students (Williamson and Webb, 2001; Williamson, 2004). Indeed, in a small ethnographic study of LPs, Lathlean (1992) found they did not see their role as bridging the theory-practice gap, rather they concentrated on their joint service/education role. Further, Brennan and Hutt (2001) in a descriptive paper noted LPs

tended to concentrate on specialist services such as accident and emergency, which often linked with specialist courses, rather than on general clinical areas where pre-registration students gained most of their practice experience (UKCC, 1986).

In addition, LPs only formed a small proportion of the population of nurse teachers (Cave, 2005). Therefore, although the LP structurally had 50% availability for service and 50% for the HEI, the lack of focus on pre-registration nurse education meant that it was unlikely to make a significant contribution to supporting student nurses.

1.3.5 Post *Project 2000*: Clinical skills deficits

Project 2000 (UKCC, 1986) had radically increased the academic status of nurse education in the UK. However, concerns were raised regarding the programme where the emphasis on theory was seen to be at the expense of practical skill development (Parker and Carlisle, 1996; Ousey, 2011). The curriculum content had increased emphasis on health promotion with a focus on teaching students from a wellness as opposed to an ill health model (Farrand *et al.,* 2006). This was particularly during the CFP, where increased time was focussed on theoretical studies, disproportionate to the time allocated to the acquisition of skills (Fulbrook *et al.,* 2000; Farrand *et al.,* 2006). Not surprisingly, poor practical skills resulted in some students feeling incompetent and undermined their confidence in practice (Macleod Clark *et al.,* 1997a).

There were also complaints from students that placement experiences did not link with theoretical input (Elkan and Robinson, 1995). Additionally, although students followed a wellness educational model (UKCC, 1986; Farrand *et al.,* 2006), the bulk of placement experiences were in hospital ward settings (Glen, 2009), where people were unwell, resulting in a mismatch between curriculum theory and clinical placement reality. Students also felt placement experiences were too short, which hampered the opportunity to develop their experience and confidence in clinical skills through repetitive practice (Dolan, 2003). Further, although in-line with one of the aims of *Project 2000*, placements also included community services, which again limited student experience in the acute setting where nurses had traditionally practiced and mastered clinical skills.

As a result, nurses, on qualification, without the breadth of clinical skills, lacked the confidence and experience to manage and implement care in clinical practice (Charnley, 1999; Evans, 2001; Last and Fulbrook, 2003). This lack of clinical experience was likely to have been more problematic as many newly qualified nurses chose to work in acute settings where people were ill, often with complex needs and who required complex management and interventions (Glen and Parker, 2003). Further, healthcare employers also raised concerns about newly qualified nurses clinical skills and confidence to work effectively in practice which did not meet their expectations (O'Connor *et al.*, 2001; Kenny, 2004).

Overall, it was felt, that since the transfer of student nurse education into the HEIs, the theory – practice pendulum had swung in favour of theoretical rather than practice-based learning (figure 1.2). Such was the public interest in how nurses were prepared, that the popular media captured these perceptions with headlines such as nurses were "*too posh to wash*" and "*too clever to care*" (Scott, 2004, p. 581), thus undermining confidence in the profession. It was in this context that, although the aims of *Project 2000* were largely met (Macleod Clark *et al.*, 1997a) there was recognition that the identified concerns needed to be addressed (Glen, 2009).

1.4 The policies underpinning implementation of the practice facilitator role

As an indication of its importance, the issue of nurse education was put on the public policy agenda by the newly elected Labour Government that came into power on 02 May 1997. This Government had a clear policy priority in modernising the NHS, including the development of its workforce. Thus, *Making a Difference* (DoH, 1999), discussed in section 1.4.1, was published in July 1999 which set out the direction of nursing, midwifery and health visiting in the delivery of healthcare in the NHS. This included recommendations for changes to pre-registration nurse education, including practice-based teaching. The academic and NHS requirements were communicated to the UKCC, which had statutory responsibility for nurse education standards, for consideration. The UKCC response was in the form of the policy *Fitness for Practice* (UKCC, 1999) which is discussed in section 1.4.2. Thus, these two policy documents which drew on the extensive critique of nurse education, that have been

discussed above, were central to a further significant re-structuring of nurse education with particular implications for practice education.

1.4.1 Making a Difference (1999)

Making a Difference (DoH, 1999) pronounced the Government's macro policy intentions where it "*set out its vision for the future of nursing in the NHS…with a strategy which builds on what has worked in the past*" (DOH, 1999, p. 6). The major contribution made by nurses, midwives and health visitors in the delivery of healthcare in the UK, was acknowledged. A major expansion of the nursing workforce was planned for the following three years where a target of 15,000 additional nurses were to be employed in order to meet and deliver future healthcare requirements. In 1999, nurses, midwives and health visitors were (and still are) the largest professional group in the NHS, comprising at that time 332,000 (247,240 qualified) (DOH, 1999) professionals that deliver healthcare 365 days a year and on a round the clock basis.

These NHS staff were seen to be crucial in the delivery of the Government's plan as detailed in *Making a Difference* (DoH, 1999). The Government's strategic intentions articulated support and recognition of the valuable contribution that the nursing workforce made to healthcare whilst stating their plans for the future of this workforce. Indeed, the nursing workforce remains the largest professional group in the NHS where in March 2019, 311,380 qualified nursing staff, including midwives and health visitors were employed (The Kings Fund, 2019). Despite the intervening years, the importance of nurses' contribution to the delivery of healthcare continues. Therefore, it is of vital importance that this workforce is well educated and well prepared to contribute positively to healthcare delivery.

Key areas were identified in *Making a Difference* (DoH, 1999), these being an increase in training places, strengthening pre-registration education and training arrangements including practice-based teaching. It was identified that training places for nurses had been reduced by 28% between 1992 and 1994, which had negatively affected healthcare delivery. 19,000 nursing and midwifery students commencing education programmes were planned for 1999, an increase of "*4,000 more than three years ago, before this Government came into office*" (DOH, 1999, p. 19). Further, an additional 6,000 training places were planned over the following three years. Supporting such increases in student numbers was likely to offer some

challenges. As students normally completed their pre-registration nursing programmes over a three-year period, this would have had a cumulative, year-on-year build-up of students on the programme. Although *Project 2000* (UKCC, 1986) was to be reviewed, there was no hint of changes being required to the length of pre-registration programmes. Further, as nurse education was based in the HEIs, the dependence on the NHS's goodwill in securing placements for increased student numbers (Elkan and Robinson, 1995) would likely be tested.

In the bid to strengthen pre-registration education, it was noted that evidence suggested that newly qualified nurses had a clinical skills deficit that detrimentally affected their delivery of healthcare (DOH, 1999). The Government, having raised their concern, wanted this issue to be addressed and stipulated that pre-registration education and training needed to have a "*stronger practical orientation*" (DoH, 1999, p.14). This included the provision of 50% of pre-registration programmes which were vital in preparing nurses being provided with good quality placements. The Government stipulated the requirement for professionals to be "*fit for purpose*" (DoH, 1999, p. 23) whose education was shared by universities and the NHS and underlined the Governments' view of each organisation having a role to play in nurse education.

Further, the integration of nursing into universities was primarily seen as a positive arrangement as nursing students were seen to have benefited from the University learning culture (DOH, 1999). With this Government support, any thoughts of nurse education returning to an apprenticeship system were removed. However, whilst the University and the NHS were required to work more closely together, the view was that the NHS, as a major funder and with responsibility for delivering healthcare, should take a stronger lead in ensuring education programmes met changing healthcare requirements.

A more flexible approach to nurse education and training was promoted. "*Higher quality and longer placements, and better teacher support, will help students to gain better practical skills*" (DoH, 1999, p. 23). The importance of where "*nurses are taught by those with practical and recent experience of nursing*" (DoH, 1999, p. 27) was stressed. Targets for boosting teacher support for students on placements were planned. Models, such as joint appointments between universities and the NHS, were suggested as ways of raising the importance of clinical healthcare in education programmes. The establishment of a "*Partners Council would bring together stakeholders including the regulatory and professional bodies,*

universities, patient representatives and the NHS" (DoH, 1999, p. 28). These key stakeholders were to influence pre and post registration education and learning. Stronger and more effective working relationships between the universities and the NHS underlined *Making a Difference* (DoH, 1999).

The expectation that new roles would be created to accommodate the new ways of working was revealed in the guidance provided. Roles developed "*based on a thorough needs assessment and consistent with Government policy to benefit patients and clients*" (DoH, 1999, p. 72). The autonomy and authority of the role, it was advised, should match role purpose and expectations. "*The role can be clearly located in the wider health-care team, complementing and working collaboratively with others*" (DoH, 1999, p. 72). The NHS was tasked to consider that new role titles should reflect "*the role*" and the work being undertaken (DoH, 1999, p. 72). Arrangements to monitor the contribution of new roles should be made, including adjustments to minimise risks and maximise benefits. Finally, these new roles should be properly supported through clinical supervision, leadership development and continuing professional development (DoH, 1999, p. 72, p. 73).

Within *Making a Difference* (DoH, 1999), the Government indicated the need for nurse education programmes to be revised in order that they were congruent with the Government's view of how the workforce should develop to meet changing needs. The UKCC had commenced a review of nurse education under Sir Leonard Peach, who had been appointed chair of a commission to review pre-registration nursing and midwifery education. In the light of the work of the commission, the Government proposed that outcomes for the end of each of the three years of pre-registration programmes in England be agreed in order that these were standardised. The Government stipulated three priorities to the commission to strengthen practice-based teaching as follows: "*Provide more flexible career pathways into and within nursing and midwifery education, increase the level of practical skills within the training programmes, deliver a nurse training system that is more responsive to the needs of the NHS*" (DoH, 1999, p. 24). The Government proposed the new model of nurse education should commence in a minimum of 10 sites in September 2000.

Making a Difference (DoH, 1999*)* was the key document against which national targets would be measured within a planned time frame. Local conferences and workshops provided the vehicle, from a Government perspective, where the NHS would build the objectives set

out in *Making a Difference* (DoH, 1999) into local capacity and capability planning. Regional nurse directors were tasked with working through established networks and health authority Trusts to support implementation. The importance of the nursing contribution in achieving the overall plans set out in *Making a Difference* (DoH, 1999) were seen as pivotal in delivering the objectives.

1.4.2 Fitness for Practice (1999)

The UKCC agreed in March 1998 to the establishment of a commission for education, which began work in June 1998 and reported to the UKCC in 1999. Sir Leonard Peach, who had previously been involved in approving *Project 2000* (UKCC, 1986) chaired the commission and commented that the *Project 2000* curriculum had been developed to address criticism of the previous programme of preparation for nurse education, so he had a particular interest in nurse education. The terms of reference for the commission were stated as "*to prepare a way forward for pre-registration nursing and midwifery that enables fitness for practice-based on health-care need*" (UKCC, 1999, p. 2), so incorporated the Government's *Making a Difference* (1999) policy intentions. The commission took the position that they would build on the strengths of the *Project 2000* curriculum whilst recognising and addressing its shortfalls. Fundamental to this review was that nurses and midwives were appropriately prepared to deliver healthcare across the range of healthcare settings in the UK. This revealed an increased emphasis on the practice elements of student nurse education, whilst retaining the positive aspects of the increased emphasis on theory resulting from the *Project 2000* programme. With this, the aim was to attain a balanced positioning of the theory-practice pendulum (figure 1.2).

The commission made 33 wide-ranging recommendations, incorporating objectives identified in *Making a Difference* (DoH, 1999) for consideration by the UKCC in future education preparation programmes for nurses and midwifes. An outcomes-based competency approach, integrating theory and practice, was viewed as producing nurses who would be fit for practice at the point of registration. HEIs and service were recommended to work in close collaboration to combine theory and practice with an emphasis on practice aspects and in particular practice skills. The need for service providers and HEIs to work together was crucial to integrate theory and practice in order to achieve "*knowledgeable doers*" (UKCC,

1999, p. 4). This echoed the ambition of *Project 2000* (UKCC, 1986) which had also set out to achieve "*knowledgeable doers*" (UKCC, 1986, p. 40).

Cognisance was taken in *Fitness for Practice* (UKCC, 1999) of education purchasing arrangements that appeared to have blurred responsibilities for student learning and support. A direct link was made between the number, purpose and quality of practice placements and nursing skill levels. The shortage of an adequate number of placements in the practice environment was seen to be detrimental to students' practice experience. Therefore, the increased pre-registration student targets set in *Making a Difference* (DoH, 1999) as discussed above, would increase the pressure on placement capacity, and so would be an important issue to address. Not surprisingly, the professional body called for "*closer collaboration between purchasers of education, HEIs and service providers to support teaching and learning in the context of practice*" (UKCC, 1999, p. 5). In any case, pre-registration nurse education priorities were refocused to ensure that practice was promoted as being as valid as theoretical learning in an academic institution. However, the organisation and supervision of practice placements was seen to be problematic and compounded by the pressurised workload of staff in practice placements, which had a detrimental effect on students developing their practice skills.

The outcomes-based competency approach was seen to have implications for the HEI and service providers. In conjunction with refocussing resources in the HEI from classroom to practice learning contexts, it was recommended that "*service providers would need to make an explicit resource commitment to supporting and assessing students in the practice context and funding staff development for mentor training*" (UKCC, 1999, p. 36). The assessment of students in practice was seen to be a collaborative, constructive arrangement between practice staff, academic staff and the student. However, the roles and responsibilities of academic and practice staff required urgent review to clarify each of their roles and responsibilities.

It was acknowledged, that the role of lecturers in teaching and assessing practice skills needed to be defined, and working with students in practice needed to be "*acknowledged as legitimate professional pursuits*" (UKCC, 1999, p. 48). However, no increase on the 20% LL time, recommended for practice was stipulated. Further, *Making a Difference* (DoH, 1999) articulated the need for HEIs to recognise the importance of practice-based learning as part of nursing and midwifery education and for this to be included in the assessment for academic

award. Practice staff also fulfilled a number of roles such as providing nursing care, teaching, managing, assessing and mentoring students in practice although being an expert in each was also seen as being unrealistic. It was recognised that no one individual could fulfil the full range of expertise required by students. Therefore, it was important for the HEI and service to work together to be best placed to offer students the full range of expertise required. It was recommended that dedicated time should be allocated, so that practice staff spent time in education, and lecturers in practice, to ensure that mentors would be competent and confident in teaching and mentoring roles, and that lecturers would be confident and competent in practice.

However, the report cites the English National Board for nursing which states "*it is essential that teachers not only have knowledge, teaching and academic credibility but also clinical creditability in respect of their capacity to teach the art and science of nursing*" (UKCC, 1999, p. 48). Particular reference was made to improve the involvement of HEIs and Trusts with the educational consortia and workforce planning processes. Educational consortia were responsible for organising the commissioning of pre-registration students with little consideration of the availability of clinical placements to support these students. HEIs, service providers and purchasers of education were urged to work together to take "*ownership of, and responsibility for, practice-based education*" (UKCC, 1999, p. 46). It was proposed that purchasers of education "*should be responsible for ensuring an adequate number of placements of an appropriate quality*" (UKCC, 1999, p. 46).

The importance of competent and confident teachers in the practice environment was seen as fundamental to student support. Whilst the UKCC was acknowledged as having revised its standards for the preparation of teachers of nursing, midwifery and health visiting (UKCC, 2000b) it was recommended these standards be updated and implemented. This was in recognition of the concerns around practice and education. The Institute for Learning and Teaching (ILT) had been established to accredit teacher education (Bucklow and Clark, 2000) and the UKCC standards were cross referenced with these. Facilitating lecturers and practice teachers through applying and achieving membership of the ILT would promote the status of these roles. Models, such as lecturer practitioner, were seen to have tremendous potential to support students in practice. However, it was advocated that the role needed to be better defined, funded jointly between service providers and at a suitable grade.

A proposal was made for "*the development of a partnership model whereby a named practitioner, supernumerary to the nursing team, had responsibility for organising the learning environment in practice areas*" (UKCC, 1999, p. 46). Recommendation 24 stipulated "*An accountable individual should be appointed by purchasers of education to liaise with the service providers and HEIs to support*:

- *The provision of sufficient suitable practice placements*.
- *Staff and students during placements*.
- *The development of standards and specified outcomes for placements.*
- *The delivery and effective monitoring of the contract to ensure that the contractual requirements are met*" (UKCC, 1999, p. 47).

These broad-ranging, top-down *Making a Difference* (DoH, 1999) and *Fitness for Practice* (UKCC, 1999) policies were key to informing the strategic intentions for the preparation of the future nurse workforce in the UK. Implementation of the recommendations was allocated across the various organisations involved in the regulation, commissioning and education of pre-registration nursing students. The organisational responsibility for recommendation 24, for the appointment of an accountable individual, was allocated to three organisations, these being purchasers of education, health services and HEIs.

1.5 Structural concerns addressed by Making a Difference (1999) and Fitness for Practice (1999)

A central concern in *Making a Difference* (1999) and *Fitness for Practice* (1999) was the consequence of the move of nurse education into the HEIs and that the gap between education and service was perceived to have widened. One element of this was the physical separation where Aston *et al.* (2000) acknowledged the problems of the geographical separation of education and practice provision. In addition, lecturers had restricted access to students in placements since becoming part of the HEIs and may not have had recent experience of clinical work which was coupled with the pressure to prioritise classroom teaching activities. This conflict in the lecturer's role was recognised by a number of authors (Baillie, 1994; Crotty, 1993a; Forrest *et al.*, 1996).

With lecturers spending little time in the practice environment, clinical staff viewed them as being out of touch with service provision and lacking clinical credibility (UKCC, 1999). In addition, Carlisle *et al*. (1997) found that even where nurse teachers attempted to incorporate clinical care to maintain clinical credibility, they met resistance from both their own colleagues and service managers. Crotty (1993a) highlighted the importance of LLs maintaining their clinical credibility but through theoretical rather than practice means. The UKCC report described that the lecturer role in practice usually focussed on liaison, negotiating placements, completing audits, providing support to students and mentors and at times, conducting assessments (UKCC, 1999). In conclusion, the idea that lecturers could be expert in the various aspects of their role, including lecturing, clinical practice and research, in retrospect can be perceived as naive.

The significant increase in student commissions in *Making a Difference* (1999) was particularly worrying as within this document they acknowledged there had been placement capacity shortfalls. In addition, others had reported there had been a substantial reduction in student numbers of 30% to 40% in some areas (Humphries, 1996; La Var, 1997) with the RCN report of 1994 which had estimated a 54% reduction on 1983 figures. Therefore, it was likely there was a limited number of placements operating with the reduced student numbers and a likely knock-on effect of limiting the availability of experienced mentors.

Additionally, two areas of concern were identified in *Making a Difference* (1999) in relation to clinical placements. Firstly, the quality was not always of a good standard and secondly, the capacity to accommodate students was not always available. *Making a Difference* (1999) identified that the provision of good quality clinical placements constituting 50% of pre-registration programmes was vital in preparing nurses. The importance placed on practice chimed with Kosowski (1995) who in a phenomenological study of nursing students found, as a practice-based profession, elements of pre-registration nurse education needed to be taught and explained in the practice environment. Following the introduction of *Project 2000* (UKCC,1986) sourcing a sufficient quantity of good quality placements was challenging (Elkan and Robinson, 1995). This may, in some part, be related to the increased reliance by the HEI on the goodwill of service to provide placements discussed in section 1.3.2 since the move of nurse education into the HEI.

Further concern was expressed about mentors being adequately prepared for their role and inconsistencies in the quality of mentorship were raised (UKCC, 1999). Some insight into these factors was provided by Neary (2000) who carried out a two phased, mixed methods study in Wales between 1991 and 1996. The studies aimed to examine the assessment of students' clinical competence, the support they received during their pre-registration programme and to establish the '*process and outcomes*' (Neary, 2000, p. 463) of the new mentor role. The findings indicated that many mentors were not conversant with educational terminology used in the *Project 2000* programme and had difficulty linking student learning objectives with clinical practice. This was of concern as these nurses were now responsible for assessing pre-registration students in clinical practice, a consequence of which was that students could receive an unjustified 'pass' in practice thus allowing the student to progress.

The UKCC (1999) held that the mentor role was pivotal, and that it required adequate preparation, quality support and appropriate feedback from the lecturers, and that these processes should be formalised. Unfortunately, the lack of LL availability compounded mentor vulnerability. Pulsford *et al.* (2002) in a survey of mentors found, although they felt supported by work colleagues, fewer felt they had sufficient support from the HEI. Aston *et al.* (2000) commented that the ad hoc availability of LLs at times left mentors to manage students on their own. Additionally, mentors' primary responsibilities were to patients, not students.

Both policies, as described, talked about current and new roles. Carnwell *et al*. (2007) in a three-phase mixed methods study undertaken in Wales (UK), explored the differences between mentors, LLs and LP roles that had responsibility for supporting pre-registration students to integrate theory and practice. The role of LP was included even though the role was not formally recognised by the professional body in student teaching and assessment (section 1.3.4). Nevertheless, they found the mentor, LL and LP each occupied different positions along the theory-practice continuum. Mentors, it was agreed, had a one-to-one relationship with the student, the LL role focus was on curriculum and supporting students from an academic perspective, whereas the LP was perceived as addressing student needs by incorporating and sharing their expert knowledge to make theory-practice links. Again, as discussed in section 1.3.4, the dissonance resulting from serving two masters was raised. There was also concern that LPs, even as experienced nurses, could become clinically deskilled due to spending less time in practice. This placed role holders in the unenviable

position of being forced into a career in education as they became deskilled in practice, but where they would also have needed to gain and maintain academic credibility.

It would seem that the expectation of fully fledged nurses meeting the Government's expectations were perhaps unfair to the nursing profession, as it was giving an impression, whether it be real or imaginary, that nurses were not fit for purpose (DoH, 1999). Nevertheless, a focus on apparent deficits, in this case clinical skills, to be included in pre-registration programmes may be welcomed.

The assertion that *Project 2000* (UKCC, 1986) new registrants lacked clinical skills was a widely held view (Charnley, 1999; Evans, 2001; O'Connor *et al.*, 2001; Last and Fulbrook, 2003; Glen, 2009). However, O'Connor *et al.* (2001) found that senior nurses had subjective, low expectations of the clinical performance of newly qualified nurses which might have contributed to this perception. When the expected competency and the actual competency of newly qualified nurses were measured using a validated tool, they were found to have consistently performed at a higher level of competency than senior nurses expected (O'Connor *et al.*, 2001). It is ironic, that this very point was raised in *Fitness for Practice* (UKCC, 1999), (section 1.4.2) where the following comment was included: -

> "*people tell me that newly qualified-staff don't have all the necessary skills on registration. How can it be expected that nurses coming out of training would? We don't expect this of doctors who go on to serve a house year.*"
>
> (UKCC, p. 43).

Despite the views above, Macleod Clark *et al*. (1997a) in a study of *Project 2000* (UKCC, 1986) students found that practical skills deficits were seen as initial deficit skills only and that a planned period of preceptorship was often only given lip-service.

The transition from student to newly qualified may be particularly stressful (Bick, 2000). Emphasis was placed on nurses being fully prepared for their role during the education programme. There was an expectation that nurses, on qualification hit the ground running. It could be argued, given the complexity of healthcare that this was unrealistic.

Kramer (1974) coined the term ‘reality shock’ to relay the physical and emotional responses when, having completed their nurse education programme, newly qualified nurses found they were not fully prepared for senior nurses’ expectations, in the reality of the workplace. To facilitate adjustment, a period of preceptorship had been recommended for all newly qualified nurses (UKCC, 1993). Alderman (1999) and Macleod Clark *et al.* (1997a) acknowledged that it was a long-held view that for the first few months in practice, newly qualified nurses needed support and guidance to adjust but this was difficult to achieve in the practice environment.

Making a Difference (1999) and *Fitness or Practice* (1999) represented a further major shift in nurse education. The new approach saw the theory practice pendulum (figure 1.2) swing back in the direction of a more practice focus. In conclusion, at the time, *Making a Difference* (1999) and *Fitness for Practice* (1999) were operating in tandem to address a wide range of issues. Key amongst them were the gap between service and education; new roles; impact of increasing student numbers; quality placements; issues with link lecturer and mentor roles; skills deficits and the realities of preceptorship.

1.6 Subsequent policy developments in relation to pre-registration nurse education

Nurse education continued to evolve following the two central policy foundations that were established as a result of *Making a Difference* (DoH, 1999) and *Fitness for Practice* (UKCC, 1999). These policy initiatives provided a developing contextual environment within which the newly established PF operated. These further policy developments will now be briefly reviewed.

Fitness for practice (UKCC, 1999) paralleled a number of *Making a Difference* (DoH, 1999) recommendations and resulted in the UKCC publishing new ‘Requirements for pre-registration nursing programmes’ (UKCC, 2000a) in order to address the *Project 2000* (UKCC, 1986) nurse education deficits (section 1.3.4; 1.3.5) and prepare nurses to meet current and future healthcare needs. Students completed a common foundation programme (CFP) for one year and two branch specific years in either adult, mental health, children’s or learning disability nursing. Importantly, all programmes were required to contain 4,600 hours

with an equal 50% theory, 50% practice split in CFP and branch and thus underlined the importance of practice learning and practice-based assessment in nurse education. The curriculum emphasis on stronger practice-centred learning, a greater emphasis on clinical placements and the achievement of clinical competencies at the point of registration took on board *Making a Difference* (1999) policy intentions.

Assessment of learning was based on the integration of theory and practice and focussed on competency outcomes. Whilst undertaking each placement, each student was allocated a registered nurse mentor (UKCC, 2000b) who was responsible for facilitating learning opportunities and assessing achievement of specific learning competency outcomes for each stage of the programme (UKCC, 2000a). This meant mentors, based in practice, now had the responsibility for the assessment of student achievement for 50% of their overall academic award, thus underlining the importance of practice in nurse education.

1.6.1 Move to the Nursing and Midwifery Council

The Nursing and Midwifery Council (NMC) replaced the UKCC in 2001 and became the current regulatory body for nurses and midwives in the UK. The NMC's role was to safeguard the public (NMC, 2018a). This was achieved by setting and regularly reviewing the standards of education and training required for admission to the register and via maintaining the register of nurses and midwives eligible to practice in the UK (NMC, 2001, 2018a).

The new Nursing and Midwifery Council (NMC) published revised 'Requirements for pre-registration nursing programmes' NMC (2002) but acknowledged no substantial changes had been made to the previous UKCC education programmes' requirements (UKCC, 2000a). The 50% practice requirement could vary in terms of the number, timing and length of the placement across HEI's in the UK which enabled programme and healthcare providers some flexibility in course planning to reflect local circumstances.

New standards for pre-registration nurse education were published in 2010 (NMC, 2010b). The four branches of nursing were re-named 'fields', whilst the 2,300 theory and 2,300 practice hour requirements remained unchanged. Importantly, all pre-registration nursing students were required to graduate at degree level or above, moving nursing to an all-graduate profession. These were the standards in force at the time this study was carried out.

It is of note that new standards for pre-registration nursing programmes were published since this study was carried out (NMC, 2018b, 2018d). However, the 50:50 theory and practice hours requirements remain the same, the four fields of nursing remain unchanged, 'mentors' (section 1.6.2) continue to assess the 50% practice component and students are required to graduate at a minimum of degree level.

Similar to the changes in pre-registration nurse education requirements following *Fitness for Practice* (UKCC, 1999) and *Making a Difference* (DoH, 1999) publications, teacher and mentor roles which were identified to support student learning in practice, have been subject to policy changes (NMC, 2008a; UKCC, 2000b). Mentorship, at the time of the data collection phase of this study, was provided by registered nurses who had undertaken additional NMC approved preparation in teaching and assessing students (NMC, 2008a).

1.6.2 New Nursing and Midwifery standards

During the period of this study (2010-2021) new standards for student supervision and assessment containing policy changes have subsequently been published (NMC, 2018c). From the practice perspective, a new role was created, the practice supervisor (PS) which includes all NMC registered nurses and midwives, or other registered health and social care professionals that support student learning in line with their scope of practice. The PS can contribute to student assessments to inform decisions for progression. All students are also required to be assigned a 'practice assessor' (PA) either for a placement or for a series of placements. They are responsible for assessing students in practice. Thus the 'mentor' assessment role continues to be key in students' progression to become registrants.

NMC standards at the time of this study (NMC, 2008a) endorsed that one way HEI lecturers could support practice-based learning was by having a LL role. Although the NMC standards did not specify the LL role remit, it was generally understood that LLs offered advice and support for mentors and students whilst promoting a quality learning environment. LLs normally linked with a number of placement areas where students gained practice experience and were assessed by the mentor, so providing the HEI link with practice.

The new NMC policy standards for student supervision and assessment (NMC, 2018c) also stipulate that students' must be assigned a different nominated academic assessor (AA) for

each part of the education programme. Furthermore, the nominated PA and AA are required to work in partnership to review and evaluate students and recommend progression for each part of the programme. The PA and AA are expected to raise and respond to concerns regarding student conduct, competence and achievement and to be supported when dealing with such situations. The new standards state that student supervision and assessment can be flexible on the proviso that the standards are complied with. Provision is made for additional roles although the NMC do not specify what these roles might be responsible for, nor their contribution to student assessment. A further requirement is that "*suitable systems, processes, resources and individuals are in place to ensure the safe and effective coordination of learning within practice environments*" (NMC, 2018b, p. 5).

The new standards (NMC, 2018c) for the supervision and assessment of students may be used from January 2019. However, after the 1 September 2020 only programmes approved against the new standards were able to accept new students.

Although almost twenty years have passed since the inception of the PF in the consortium and implementation of successive NMC standards for education, the role continued to evolve. This study seeks to explore how the PF role has evolved in the consortium and its impact on pre-registration nurse education.

1.7 Understanding the policy dimension

The starting point for this study was the establishment of two key policy statements from which the PF post emanated (appendix 1). It became evident from the literature reviewed in chapter 2 that different localities were implementing the posts with notably diverse remits. Moreover, it was also apparent from the principal investigator's direct knowledge of the role (see section 1.9) that it had evolved markedly from how it was initially conceived. This raised questions about how the policy establishing the PF role was implemented and evolved over time. It is important to note there were no further policy pronouncements regarding the PF role following *Making a Difference* (DoH, 1999) and *Fitness for Practice* (UKCC, 1999). The implication is that the way the role evolved was a result of 'bottom-up' influences rather than 'top-down' directives. These ideas led to the potential relevance of Michael Lipsky's (Lipsky, 2010) concept of street-level bureaucracy as an analytical lens through which the development of the PF role from a policy dimension can be understood. This perspective is

explored in this thesis. An overview of the key policy development and implementation theories are discussed below to provide the context in which to elaborate the idea of street-level bureaucracy.

1.7.1 Defining policy and its processes

Definitions of policy are difficult to pin down. Hill (2013, p. 15) cites "*the very British pragmatism of Cunningham*" (1963, p. 229) who said "*Policy is rather like the elephant – you recognise it when you see it but cannot easily define it.*" Policy gives a statement of intent of a course of action, often presented in written documents but can be implied or unwritten (Buse *et al.*, 2012). Policy affects a wide variety of fields, such as health and education, where policy made at central or local Government level is implemented through various organisations, groups or individuals.

Understanding power is fundamental to making and analysing policy, thus linking Government power and politics. Politics and policy are closely interrelated in that different political parties in the UK, based on their political stance, or worldview, if constitutionally elected, seek to implement their ideas based on their political ideologies, into outcomes expressed in the form of policies. In a democracy, people vote on a political party's manifesto, which gives weight or gravitas to the policies of prospective governing parties. This study centres on the effects of public policy in relation to implementing and operationalising the two policies, *Making a Difference* (DoH, 1999) and *Fitness for Practice* (UKCC, 1999).

The policy cycle starts with a problem, an issue or something that requires change. A simplified, systematic approach is described as the policy cycle where a problem is identified at the start of the process and once the problem is identified, it is then defined. Responses and solutions are then identified and the preferred policy option is selected. This is subsequently followed by implementation and evaluation of policy. Harold Laswell, a policy studies field founder (Diem and Young, 2015) did not consider these stages as real, rather that they provided a theoretical model to facilitate understanding of the various stages of the policy cycle, whilst acknowledging that the real-life application will be shaped by real world influences.

Buse *et al*. (2012) employ Walt and Gibson's (1994) policy analysis triangle, comprising of context, content and process where different actors, comprising of individuals, groups or organisations interact. This policy triangle can be employed to help analyse or understand a policy, or, it can be applied to plan a policy. Policy is applied in different contexts such as health or education (Hogwood and Gunn, 1984). Hill (2013) stipulates there are different kinds of policy where analysing or understanding a policy is analysis *of* policy and analysis *for* policy includes information which supports policy planning. Analysis of policy is a measure of outcomes, such as has the party achieved its goals, whereas analysis for policy is a prospective view that attempts to anticipate the effect of the policy on the perceived problem.

1.7.2 Where policy operates

Hudson and Lowe (2009) argue that the policy process operates in three layers, the macro-level, meso-level and micro-level. Macro-level policy analysis describes broad, worldwide parameters, such as globalisation, within which all policy is formed. The meso-level of a policy process sits between macro-level analysis and micro-level analysis and incorporates how policies originate, who is involved in putting them on the agenda and "*the institutional arrangements in which policy is defined and eventually implemented.*" (Hudson and Lowe, 2009, p. 11). It is at this level that the effects of policy can be seen in the real world.

Micro-level analysis describes how policy is implemented by individuals at the point of delivery, that is, at street-level (Hudson and Lowe, 2009). The role of individuals in the policy process is, to various extents, restricted and influenced by the institutions those individuals are delivering the policy in, described as the 'structure'. Structure can be social and/or political whereas agency refers to the individual. Agency describes how the individual within the organisational structure influences their personal interpretation of policy implementation. This power balance between structure and the agents gives freedom to decide at an individual level, so shaping policy implementation. Power is exercised through controlling resources and influencing people to achieve a preferred outcome (Buse *et al.*, 2012). However, resource deficiencies such as time and information affect and can prevent high standards of performance whilst agency is also important in terms of how much autonomy and influence actors exert outside the structure. This interaction takes place at a stage where policy is delivered.

1.7.3 Policy decision making

Decision making is central to the formation and implementation of policy. Theorists debate the rationalist versus the incremental approach. Rationalists consider all the options and their perceived consequences and then choose the approach with the best outcome. Those supporting the incremental model view decisions are best made through small adjustments on a successive basis with checks against progress in real life. Lindblom (1959) an influential incremental model theorist, described the process of decision making as 'muddling through' where decision makers test whether or not to pursue a course of action. A good policy is seen to be where the various interests of stakeholders is tested either for opposition or support. In this way, by taking incremental steps, the effects of action taken can be considered before the next step. This 'muddling through' approach facilitates adjustments being made in the policy process.

Etzioni (1967) offers a mixed-scanning model of decision making where a distinction is made between minor and major decisions. Essentially, policy makers undertake a broad scanning approach to the policy area. More detailed reviews of the initial policy selected from the broad scan are subsequently conducted which are considered as less important steps. The advantage of this approach is that it is thought to be more realistic than the detailed analysis of the options as employed in the rationalistic approach. Further, the broad scan taken in selecting the initial policy provides a more long-term view of possible implications of the policy, in contrast to the short-term 'muddling through' (Lindblom, 1959).

In the late 1990's, in the UK, an evidence-based approach was applied to policy and practice areas throughout public services (Packwood, 2002). The use of evidence was viewed as strengthening the understanding of an issue which had a positive impact on the policy cycle. Evidence can be used throughout the various stages from policy creation, its development, its implementation and to justify and defend policy (Campbell *et al.*, 2007). The UK Government mantras such as 'evidence-based policy' or 'what counts is what works' took the viewpoint that research findings could quickly influence policy decisions (Buse *et al.*, 2012). Dunsire (1978) advocated that pragmatic tactics were useful in turning policy into action. However, this shift towards evidence having a greater influence in policy decisions has its limitations. Evidence, which may not be easily available, is just one factor to be considered.

Other factors such as the actors' understanding of and their influence in the policy process, also has an impact on the evidence-based policy approach.

1.7.4 Policy implementation and analysis

Policy implementation is the process of turning policy expectations into practice (DeLeon, 1999; Buse *et al*., 2012). Prior to *Implementation,* Pressman and Wildavsky's (1973) highly influential book, implementation of policy was generally viewed as part of the policy process which essentially delivered the policy as intended. However, there was a realisation that policy content may be changed and modified between being formulated to being implemented. Anderson asserts that "*policy is made as it is being administered and administered as it is being made*" (Anderson, 1975, p. 98). This perspective is supported by Bergen and While (2005) who opine that policy implementation is based on the degree of vagueness of policy in the first place which subsequently enables interpretation and agent discretion in how policy is implemented.

Policy analysis facilitates exploration of what happens to policy once the initial course of action has been determined. The policy cycle from inception to delivery is a complex process normally involving a wide range of factors such as institutions, systems and people. Policy instigators and makers cannot assume their ideas will permeate to the delivery stage intact. Buse *et al.* (2012) observe that until relatively recently, the analysis of changes following policy decisions was a relatively neglected area. The idealised view of policy implementation, where policy, designed at a higher level being implemented through the various levels without changes being made is contrary to real life.

Two main models of analysis prevail in the field of policy implementation where policy is turned into action. Top-down theorists', such as Pressman and Wildavasky and Sabatier and Mazmanian assert that policy is implemented in a structured, compliant way, where policy designed at higher levels of the policy process is followed through to delivery (Hudson and Lowe, 2009; Conteh, 2011; Buse *et al.*, 2012). Bottom-up theorists', including Lipsky 1971, Berman 1978, 1980 and Hjern 1982, take the view those implementing policy will inevitably change how it is delivered (DeLeon, 1999). Top-down theorists view implementation as a mechanistic adherence to the prescribed policy, whereas the bottom-up school argue that human agency, at the point of delivery, defines the policy. That is, what is viewed by the end

user, the policy which has been delivered by the human agent, is the policy, as this is the final part, the outcome, of the policy process. Revision of the policy, by assessing the outcome, may lead to further adaptions of the policy in order to refine the policy and lead to the next cycle of the policy process.

The nature of the policy process and the influences by factors such as structure and agency, makes predicting an exact policy outcome evasive. The implementation of policy, turning policy into practice, may result in an implementation gap between the intention of the policy and the end result, or, what actually happens (Hudson and Lowe, 2009). Indeed, they opine that it is well-neigh impossible to predict the end result of policy with what was intended, would be the outcome. The non-linear nature of policy implementation, where cause and effect are unpredictable can lead to unintended consequences that is, the effect of the policy was not anticipated (Campbell *et al.*, 2007; Hudson and Lowe, 2009).

1.7.5 Lipsky and street-level bureaucrats

The personality of the agent influences both the shaping and the process of policy. Emotions, background, personal feelings and perceptions all influence and contribute to the individual actors' influence of the implementation of policy. Assessing the outcome of policy implementation may lead to further adaptations of the policy to refine the outcome and lead to the next cycle of the policy process. In the micro-level analysis, the human agent is driven by their natural ability to assess the situation and make decisions. Agents make, or should make, decisions through a rational process of considering all the options and selecting the best (Buse *et al.*, 2012; Hill, 2013). Making a rational choice is based on the understanding that the human agent will act in their own self-interest which may be driven by the need for approval by society, maximising status or utility to others.

Lipsky incorporated the idea of the critical role of individual agents of policy in his influential book *Street-level bureaucracy: Dilemmas of the individual in public services* (Lipsky, 1980). An expanded edition (Lipsky, 2010) contains an additional chapter where Lipsky reflects on significant policy developments that had occurred in the 30 years since the original publication. It is the Lipsky (2010) edition that is quoted in this study, except where other authors have used Lipsky's (1980) original book. Lipsky is considered to be "the founding father of the 'bottom-up' perspective" (Hill and Hupe, 2009) where his ideas in

policy implementation were developed by studying public service workers in North America in the 1970s. Lipsky's publication presented his findings where he had analysed the behaviour of frontline staff who worked at the point where public policy was delivered. He coined the term street-level bureaucrats to identify those frontline public service workers who held the key as to how policy was delivered. Hill (2013) notes that increasing attention was being given to the actions and decisions of these lower level actors operating at the micro level of the policy process and whose pattern of actions over time are the policy. Lipsky's central argument of the importance of these lower level actors, his street-level bureaucrats is stated as follows:-

> "*I argue that the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively become the public policies they carry out.*"
>
> (Lipsky, 2010, p. xiii).

Lipsky studied public service workers within Government organisations who interfaced directly with the public. Examples include seemingly unrelated roles such as judges, police officers, social workers and guidance counsellors, who exercised considerable discretion in their day-to-day work. It is important to note that, although these roles were different, they operate within similar organisational structures which he calls street-level bureaucracies. The organisational structure allowed Lipsky to analyse a small number of characteristics and identify operational similarities and differences. These street-level bureaucrats operated within constraints such as time, a limited amount of information, or resources. They exercised "*considerable discretion in determining the nature, amount, and quality of benefits and sanctions provided by their agencies*" (Lipsky, 2010, p. 13).

1.7.6 Practice facilitators as street-level bureaucrats

The street-level bureaucrat is the conduit by which a policy is delivered to the client, operating within an organisation, usually public, with the inevitable resource deficiencies. To reduce operational pressures in their day-to-day role, street-level bureaucrats developed strategies for managing their workload, employing any discretion and autonomy they may have had in their role to filter or interpret the policy delivered from 'on high' to the client. In this way, through the filter of the street-level bureaucrat's discretion, interpretation and

autonomy, what was delivered to the client, as this was the final stage of the process, was in fact the policy.

Lipsky's (1980) seminal work on street-level bureaucracy was seen to have value in making sense of how strategic policy was implemented in day-to-day practice in this study. In the context of this study, a new PF role created in the geographical area of this study as a result of *Fitness for Practice* (UKCC, 1999) and *Making a Difference* (DoH, 1999) was considered to meet the characteristics which Lipsky attributed to street-level bureaucrats. Therefore, Lipsky's street-level bureaucracy provided the perspective to explore the activities, behaviours and routines of these PFs and how they interpreted and used their discretion in the dilemmas they faced as the role was operationalised over time.

Lipsky's (2010) concept of street-level bureaucracy as a model for understanding policy implementation is advanced in this study as an explanatory framework to help understand how the new PF role evolved over time from the two key policy statements in *Making a Difference* and *Fitness for Practice* (DoH, 1999; UKCC, 1999). The extent to which the street-level bureaucracy model fits with the PF role will be evaluated in chapter 5.

1.8 Local policy expectations in the study area consortium

At that time NHS Trusts that provided local healthcare were clustered into educational consortia for the purposes of commissioning, organising and funding professional healthcare education and training, with the exception of medical staff. These educational consortia had the power to decide how these key policies were implemented. In the context of this study, the educational consortia, within which this research was undertaken, was located in a metropolitan area of a large city comprising of two Acute Trusts, one Mental Health Trust and four Community Health Care Trusts. One HEI provided pre-registration nurse education across the four fields of nursing for these Trusts. For the purposes of this study, this area will be referred to as 'the consortium' throughout this thesis.

In ‘the consortium’, the location of this study, a new PF role was created and prospective candidates were asked: -

> “*Can you help us ‘Make a Difference,’*
> *Do you want to ensure fitness to practice?”*

The full text of the advertisement for PFs can be found in appendix 1. As the role was advertised thus, the practice facilitator (PF) title is used throughout this thesis to refer to this role in the consortium.

The new posts were advertised in the consortium with the following remit:

> *Working in collaboration with [University], the Practice Facilitator is there to be a Trust based figurehead for Student Nurses and a support for Mentors in the management and care of students from a University and clinical perspective.*
>
> *Advertisement 2001 pg. 1*

At the time of this study there were nine PFs in post (section 3.4)

Five areas of responsibility for the PF role were identified in job descriptions: -

> *1. Ensure the provision of practice opportunities for pre-registration nursing students within the Trust.*
> *2. Establish systems for monitoring reviewing and reporting on the quality of the practice learning environment and the usage of placements.*
> *3. Instigate new developments and initiatives for promoting inter-professional learning opportunities for students in the practice setting.*
> *4. Provide support to mentors and maintain a ‘live’ register of current mentors.*
> *5. Promote and implement initiatives at developing and enhancing the quality of the students’ practice experience.*
>
> *Job Description 2003 pg. 2*

From the initiation of the PF role a key feature was: -

> *Identification of new placement areas and improving access to difficult areas. With the increase in student numbers, practical placement areas may become saturated with students within the first six months*
>
> *Job description 2001 B pg. 3*

From its initiation it was obvious the consortium was aware of the challenges of supporting students in the practice placement environment as they described it was: -

> *…difficult for service colleagues given the competing demands for their time. The purpose of the practice facilitator post is to address this issue [support for student nurses] by initially supporting placement colleagues in the management and support of student nurses within their environment whilst gaining an understanding of the key issues which have an effect on the provision of a positive practice experience. Utilising this information will allow the practice facilitator in collaboration with higher education and service colleagues to develop strategies in order to foster a cultural and behavioural change within the practice environment to student support and supervision.*
>
> *Job Description 01 pg.1*

1.9 Personal motivation for the study

Having worked as a registered nurse in the NHS for some twenty years, across a range of acute and mental health, I commenced employment in a newly created post in the Faculty of Health and Social Care at the HEI in the consortium in late 1999. This new post was part of the HEI arrangements to implement *Making a Difference* (DoH, 1999) and *Fitness for Practice* (UKCC, 1999) policies. The HEI provided pre-registration nurse education for adult, mental health, child and learning disability programmes.

This post had been introduced to co-ordinate and manage the practice experience element of pre-registration student nurse programmes for the HEI, in collaboration with Trusts in the

consortium. Subsequently, I was involved in discussions on how *Making a Difference* (DoH, 1999) and *Fitness for Practice* (UKCC, 1999) would be implemented in the consortium. These discussions involved the Dean, Heads of Departments (HODs), myself from the HEI and Trust based Education Leads from each of the Trusts in the consortium. These Trusts comprised of two Acute, one Mental Health and four Community Care Trusts which provided placements for pre-registration student nurses.

The over-riding priority at this time was focussed on the problem of providing sufficient placement capacity and managing the placement experience for an increasing pre-registration student population. At the time, securing quality placements was considered to be the HEI's responsibility, even though the Trusts 'owned' the placement resource. However, there was a sense of the Trusts not fully owning the need to provide adequate placements for the pre-registration student population. This stemmed, in part from the perception that students belonged to the HEI and, as such, there was no requirement to provide placements. For the Trusts' part, this was not deliberate, rather, it had stemmed from a disconnection and a lack of involvement in, and understanding of, complex HEI placement management processes. The number of students recruited to each cohort, and, the number of students within the cohort, completing Adult, Mental Health, Child or Learning Disability programmes varied. This caused changes in placement capacity requirements as students advanced through their pre-registration programme.

Furthermore, students required some practice experiences across Trusts, such as Adult programme students requiring placement experience in Community Care Trusts. Additionally, organising placement experiences was centralised in the HEI placement office, staffed by administrators, who arranged the required student placement experience in each Trust and at individual ward/service level. Placement capacity was generally managed on a historical basis where the ward manager/charge nurse had the authority to either accept or refuse HEI requests to place students. Overall, this resulted in an unpredictable system for managing placement capacity requirements, which it was felt needed to be addressed to support the predicted student population increase.

Whilst it was understandable that the Trusts' focus was on providing healthcare and not on arrangements for pre-registration nurse education, they nevertheless had a heavy reliance on the supply of students to join their workforce on qualification. It was out of discussions between

the HEI and the consortium Trusts to address how *Making a Difference* (DoH, 1999) and *Fitness for Practice* (UKCC, 1999) would be implemented that the PF post was created (appendix 1). Over time, the PFs' involvement in pre-registration nurse education not only became sustained, despite financial constraints, but also it expanded PFs remit in important ways. This led me to reflect on what is it about the PFs role that has enabled it to survive over time, if it's contribution to pre-registration nurse education was of value and its wider implications. This was the starting point for this study.

By the time of the initiation of this study I had changed role, but my interest in the PF role continued in wanting to understand its impact. My impression was that the role had expanded in a multitude of ways and seemed to permeate many aspects of the pre-registration landscape in the consortium. I was interested to see if issues identified in *Making a Difference* (DoH, 1999) and *Fitness for Practice* (UKCC, 1999) were being addressed by the PF role. I therefore wanted to explore how the role had developed over time and share the insights gained to benefit nurse education in practice.

1.10 Overview of the thesis

Following chapter 1, chapter 2 critically reviews the literature and considers Lipsky's (2010) influence on policy implementation in terms of the PF role. A rationale for this study is given, concluding with the research aim and questions that informed all subsequent stages of the research.

Chapter 3 provides an explanation of the research methods and the rationale for using a case study methodology. An explanation for the rationale for using a case study methodology draws upon the theoretical perspective of pragmatism. Data management, data analysis using thematic analysis, as well as how quality issues relating to the study was assured are provided.

In chapter 4, the results of the study are presented in the form of the key themes and sub-themes arising from data analysis. The chapter concludes with key messages from these results.

Chapter 5 discusses the study results in the way the PF role had evolved in a real-world context over time through the lens of Lipsky (2010) and its impact pre-registration nurse education.

The overall conclusions of the study are discussed in chapter 6. This chapter includes an evaluation of the research in respect of its aims and research questions and discussion of the contribution made to new knowledge. The strengths and limitations of the research are addressed. Recommendations are made for future research, UK policy makers, healthcare providers and education providers. The intentions for dissemination of the study and its results are outlined.

1.11 Chapter summary

This chapter has provided the background to pre-registration nurse education which led up to a major review of how nurses were prepared to meet the changing needs of the NHS, with particular reference to practice education. Two key policies, *Making a Difference* (DoH, 1999) and *Fitness for Practice* (UKCC, 1999), which led to the creation of new practice facilitator roles in the consortium were reviewed. A critical analysis summary of policy developments in relation to pre-registration nurse education was given and how the mentor and link lecturer roles had been impacted by changing policy directives. A review of the policy dimension was provided and the potential of Lipsky's (2010) model of street-level bureaucracy as an explanatory framework was proposed. The principal investigators' motivation for completing this study was given, which situated the researcher in the context of this study. Finally, the structure of the thesis was provided.

Chapter 2: Literature Review

2.1 Introduction

Chapter one provided the context of pre-registration nurse education in the UK, where key policy drivers *Making a Difference* (DoH, 1999) and *Fitness for Practice* (UKCC, 1999), led to the creation of the new practice facilitator posts at the consortium. Lipsky's (2010) street-level bureaucrats' policy implementation perspective was presented which has provided the theoretical lens through which the evolution of the practice facilitator role has been viewed in this study.

The purpose of this literature review was to provide an in-depth understanding of 'facilitator' roles that included a pre-registration remit, working across practice and academia, which had been created in the UK as a result of these policies. This focus was selected to enable the practice facilitator posts that had been created in the consortium to be reviewed in the context of similar facilitator posts emanating from the same policies in the UK.

The chapter begins with the literature review strategy, then explores the benefits of the selection of a narrative approach and methods. The description of searches includes examples as well as the inclusion and exclusion criteria. A summary table (2.3) of the primary literature found is provided as well as a discussion of excluded literature. The critical analysis of the facilitator role in the literature deals with quality and methodological diversity, consistency of findings, a discussion of conclusions and a summary of the key issues arising from the primary literature. A section on the challenges of conducting pre-registration nurse education in practice research follows, and includes a brief discussion of the impact of using Lipsky (2010) as the perspective through which to explore the practice facilitator role in the consortium. The chapter ends with the rationale for the current study, research aim, research questions and the chapter summary.

2.2 Literature review strategy

Literature reviews can have a variety of goals including theory development, theory evaluation, historical overview, survey of the state of knowledge on a particular topic or

problem identification (Baumeister and Leary, 1997). A key purpose for undertaking a literature review is to provide an understanding of the subject (Gray, 2014). Williamson and Whittaker (2020) identify that reviewing the literature is an integral and fundamental part of a research study. It allows the researcher to become familiar with what is already known in terms of the content and context of the subject and identify current research which exists in a particular subject.

The purpose of this thesis is to evaluate policy implementation therefore, theory development/evaluation were inappropriate goals. The historical contextualising account of pre-registration nurse education in practice was provided in chapter 1. The goal of this literature review is to identify and appraise early creations of facilitator roles in pre-registration nurse education as a result of the policies outlined in chapter 1 thereby allowing the gap in knowledge to emerge that this study aimed to address.

2.2.1 Literature review: selection of a narrative approach

The literature review needed to focus on systematically sourcing literature subsequent to 1999 when new 'facilitator' posts were introduced to support pre-registration nurse education in response to implementing *Making a Difference* (DoH, 1999) and/or *Fitness for Practice* (UKCC, 1999) policy initiatives until the end of 2012, the point at which data collection for the study could commence. As these policy documents pertain to the UK, the search was confined to UK related literature.

A variety of options were considered for this literature review which included a systematic review, integrative review and a traditional narrative review (Whittemore and Knafl, 2005; Howitt and Cramer, 2014; Ferrari, 2015; Bryman, 2016). Systematic reviews employ a rigorous, structured process designed to, and are particularly suited to reviews of randomised controlled trials (Bryman, 2016). Systematic reviews are considered to be at the top of the hierarchy for grading the quality of quantitative evidence (Moule, 2018). This approach was not pursued as the material for this study was not likely to be quantitative in nature.

Integrative reviews (Whittemore and Knafl, 2005) follow a rigorous approach, similar to systematic reviews, and are valuable for allowing a wide variety of literature including conceptual literature. This approach has been used in other studies exploring pre-registration

nurse education with a large evidence base (Almalkawi *et al.,* 2018) so serious consideration was given to this approach. However, as pre-registration nurse education facilitator roles were new, and, with a limited number of publications, the goal of the literature review was to explore and tell the stories of the early implementations of this role. Therefore, the integrative review approach was rejected.

In contrast to the above approaches, the traditional or narrative literature review "*critiques and summarises a body of literature and draws conclusions about the topic in question*" (Cronin *et al.,* 2008 p. 38). Ferrari (2015) provides an overview of the main differences between systematic reviews and narrative reviews and notes the latter is particularly useful for providing a rationale for future research and examining new types of interventions (for example, the introduction of facilitator roles). Narrative reviews are also recognised for their ability to provide a broad overview of a problem and its management (Green *et al.,* 2006). Further, Mays *et al.* (2005) valued narrative approaches as a way of summarising, explaining and interpreting evidence on a particular topic.

One of the greatest strengths of the narrative review is its ability to link studies to allow for reinterpretation and, or, interconnections to be identified (Baumeister and Leary, 1997) thus allowing gaps in knowledge to emerge. Additionally, the narrative review is a widely advocated approach to reviewing literature (Mays *et al.,* 2005; Howitt and Cramer, 2014; Bryman, 2016).

A narrative is "*an account of events, or more than one event, characterised by having some structure...and other story elements*" (Braun and Clarke, 2013, p. 333). As will be revealed in the next chapter, Braun and Clarke's (2006, 2013) thematic analysis approach was used for data analysis, thus, a narrative review helped provide congruence between the different elements of this study. The story of how the facilitator role was envisioned, developed and operationalised in practice was the narrative at the centre of this study, therefore, a traditional narrative review approach was chosen for use in this thesis.

Part of the attraction was that the narrative approach provided the researcher with the flexibility in "*what literature is reviewed and how it is reviewed*" (Howitt and Cramer, 2014 p. 138). However, a limitation of this flexibility may be the introduction of researcher bias in the selection of literature and how it is discussed although this can be mitigated by defining

the inclusion and exclusion criteria (Ferrari, 2015). Therefore, it was important to follow a clear, auditable approach to literature selection which will be presented next.

2.2.2 Narrative review methods

Green *et al*. (2006) and Baumeister and Leary (1997) advise that the use of a structure when conducting a literature review facilitates a clear and organised approach. Green *et al*. (2006) whilst stating there are no standardised requirements as to what should, or should not be included, nevertheless advised that the review should "*be well structured, synthesise the available evidence pertaining to the topic, and convey a clear message*" (Green *et al.,* 2006, p. 106).

In a systematic review of over 120 critical appraisal tools Katrak *et al.,* (2004) concluded there was no widely accepted generic tool. Therefore, the following structure was used in this review of the literature: author and year; type of publication; study type; length of time since post established; post title and number; role focus; methods, participants; sample number; geographical location; whether the role developed from *Making a Difference* (DoH, 1999) and/or *Fitness for Practice* (UKCC, 1999) and conclusion.

The synthesis of the literature included in the review has identified key concepts as advocated by Ferrari (2015). The methodological quality and diversity of the literature as advocated by Baumeister and Leary (1997) included methodological considerations, flaws in methods used, consistency of findings including response rates, explanations and evaluations of the conclusions reached. This allowed problems and gaps in knowledge to be identified.

2.2.3 Searches

The Cumulative Index to Nursing and Allied Health Literature (CINHAL), Medline and ERIC were utilised to access the literature. Reference lists of included studies were searched for other relevant studies and relevant nurse education journals (Nurse Education Today, Nurse Education in Practice and Journal of Advanced Nursing - Education section) were hand-searched from 1999 to 2012. Primary research was limited to sourcing facilitator posts with a pre-registration nurse education remit, which were created as a result of *Making a Difference* (DoH, 1999) and/or *Fitness for Practice* (UKCC, 1999). Sourcing of secondary references from

the literature extended the literature search and produced one additional study. After duplicates from the combined searches were removed, papers were screened by title and abstract, then the full texts of remaining papers were examined for eligibility. Subsequent extensive searches have been conducted but no other paper that met inclusion criteria were found.

The term ‘practice facilitator’ (PF) is used throughout this thesis as this is the title used to identify these posts, when they were first created in the consortium, which is the focus of this study. A number of job titles were found in the literature which included the word ‘facilitator’:

- practice facilitator
- clinical facilitator
- clinical placement development facilitator
- practice placement facilitator
- practice education facilitator
- clinical education facilitator
- clinical practice facilitator
- practice based learning facilitator

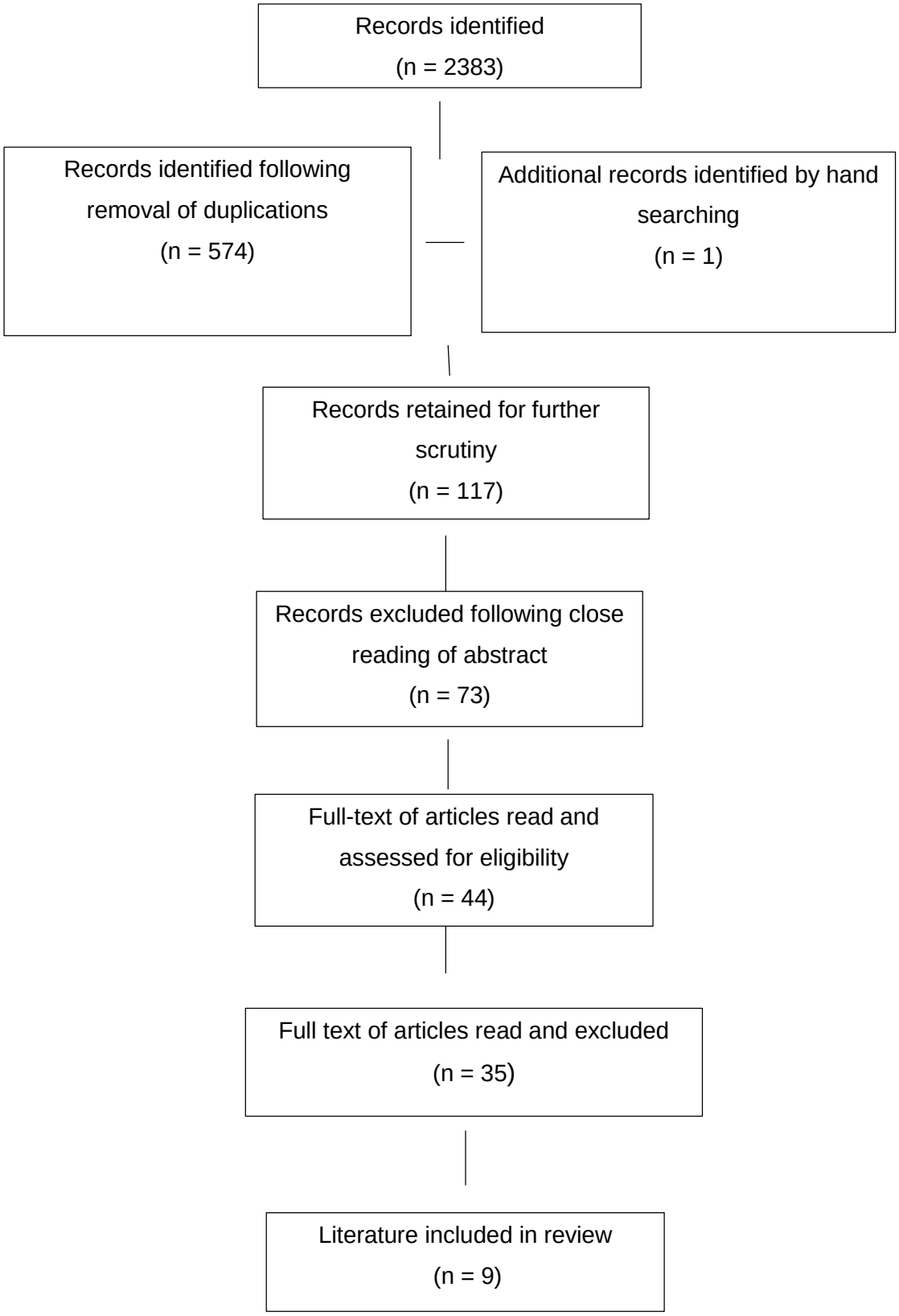
All of these job titles were used as search terms, alone and in combination. Additionally, each of these post titles and the associated phrases ‘and pre-registration student nurse’ ‘and mentor’ were entered as search terms. These combinations were used and employing Boolean logic which allows search terms to be combined or excluded. Initial searches were conducted up to and including 2012 at the point of data collection which represents the literature discussed within chapter 2. Inclusion and exclusion criteria used for the selection of literature is given in table 2.1.

Table 2.1 Inclusion and exclusion criteria for the literature search

Inclusion criteria	Exclusion criteria
Facilitator role	Non facilitator role
Primary research	Non research literature
Audit	Professional descriptions of new role
Systematic reviews	Reviews not systematically undertaken
UK based	Non UK
Role arising from *Making a Difference* (DoH, 1999)	Studies of posts created in response to *Making a Difference* (DoH, 1999) which were not 'facilitator' posts
Role arising from *Fitness for Practice* (UKCC, 1999)	Studies of posts created in response to *Fitness for Practice* (UKCC, 1999) which were not 'facilitator' posts
Pre-registration nurse education focus	Facilitator posts with only a post registration/patient care provision focus
English language	Non-English language
Publication year 1999-2012	Publication year beyond 2012

An example search using all of these terms together with the following initial terms of nurse or nurses or nursing; and UK or United Kingdom or Britain or England or Scotland or Northern Ireland; and pre-registration yielded 2,383 citations. Figure 2.1 shows the citations reviewed and selected.

Figure 2.1 Records identified through exemplar database search



Retrieved studies were read thoroughly and collated information is provided in table 2.3 and appendix 2. Author and year; type of publication; study type; length of time since post established; post title and number, role focus and conclusions are in table 2.3. Author and year; methods, participants, sample number; whether role developed from *Making a Difference* (DoH, 1999) and/or *Fitness for Practice* (UKCC, 1999), funding and geographical location are in appendix 2.

Additional relevant searches were conducted in response to the issues generated from the data analysis and continued until submission (table 2.2). Critical discussion of the results and the literature to contextualise this study can be found in chapter 5.

Table 2.2 Timeline of this study and literature searching

Study phase	**Search frame**
Study design and pre study data collection	1999-2012
Data analysis	1999-2015
Writing up	1999-2021

2.3 Critical analysis of the facilitator role in the literature

Overall, there was a dearth of literature on the facilitator role in the UK and these nine papers are summarised, as described above, in table 2.3 and appendix 2.

Table 2.3 Summary of literature where Making a Difference (DoH, 1999) and / or Fitness for Practice (UKCC, 1999) is referred to in the sourced literature and where new 'facilitator' posts were created which had a pre-registration remit

Author & Year	Type of publication	Study type	Length of post	Post title & Number	Role focus	Conclusions
Rowan and Barber (2000)	Professional journal article	Audit	Less than one year	Clinical Facilitator (CF) 12 post holders (11.5 WTE) (6 Trust sites)	Mostly operational in practice	• Most students felt more supported by CF and confident to practice • CF had regular contact with link tutor • CF offered a model to support teaching and learning in practice

Ellis and Hogard (2001)	Project report	Evaluation research		Clinical Facilitator (CF) 12 post holders (6 Trust sites)	Mostly operational in practice	18 recommendations Some focussed on student assessment eg OSCEs. The ones relevant to this study were: • CF role highly relevant to supporting practice • Consider different role focus for CF role (Four main headings for CF model of working proposed) • CF effect on clinical competence of students relatively undifferentiated • Clarify mentor/link tutor/ CF roles • CF should have full membership of curriculum planning, delivery and review groups • Consider who employs CF (college/Trust or joint appointment) • Mentor most important in practice and CF more important than link tutor role • Review link tutor role
Ellis and Hogard (2003)	Peer reviewed academic publication	Evaluation research		Clinical Facilitator (CF) 12 post holders	Mostly operational in practice	• Positive evaluation of CF role • CF effect on clinical competence of students not ascertained • CF role rated more positively than link tutor for student support

				(6 Trust sites)		• CF possible four level model of facilitation produced
Clarke *et al.* (2003)	Peer reviewed academic publication	Evaluation	Twelve months	Practice Placement Facilitator (PPF) 3 posts	Strategic and operational, managed in academia but working collaboratively with Trust	• Different groups of learners (other than pre-registration nurses) affect placement capacity • Placement staff derive benefit from PPF post • PPF role remit lacked clarity
Randle *et al.* (2005)	Professional journal article	Small study using mixed methods		Clinical Placement Development Facilitator (CPDF)	Some strategic but mostly operational in practice	• Role viewed positively • Role provided support for mentors and students • Effective in developing working relationships between Trust and HEI • Increased quantity of placements • CPDF role lacked clarity
Hyatt *et al.* (2008)	Professional journal article	Audit	Five years	Practice Facilitator (PFs) 9 post holders (8.00 WTE) (4 Trust sites)	Some strategic but mostly operational in practice	• Increase in mentor requests for PF support • PFs supporting mentors, particularly with student assessment • PFs increasing focus on providing mentor support

McArthur and Burns (2008)	Peer reviewed academic publication	Mixed methods evaluation	One year	Practice Education Facilitator (PEF) 100 posts in Scotland	Mostly operational in practice	• Role welcomed by participants • Some participants expected role to work with students • PEFs expected to work with mentors and other staff • Role and responsibilities being developed
Carlisle *et al*. (2008)	Project report	Impact evaluation / Mixed methods	Three years	Practice Education Facilitator (PEF) 100 posts in Scotland	Some strategic but mostly operational in practice	• Role well-received • Mentors valued accessible support and guidance in their role • PEFs ideally placed to expand ways to support mentors • Student evaluations of the quality of the learning environment valued to maintain and improve the clinical learning environment • PEFs were increasing placement capacity • Career pathways and professional development for role unclear
Carlisle *et al.* (2009)	Peer reviewed academic publication	Impact evaluation / Mixed methods	Three years	Practice Education Facilitator (PEF)	Mostly operational in practice	• PEF role widely accepted and seen as valuable

				100 posts in Scotland		• PEFs provide support and guidance for mentors when dealing with failing students • PEFs actively involved in student evaluation of placements • Further development of student evaluation of placements to be developed

Eight of the primary papers sourced refer directly to either *Making a Difference* (DoH, 1999) and/or *Fitness for Practice* (UKCC, 1999) and were about newly created 'facilitator' posts (appendix 2). One further study, McArthur and Burns (2008) has been included in the literature reviewed. The rationale for this is, although McArthur and Burns (2008) in their study on fifteen of the new practice education facilitator posts in Scotland do not make reference to *Fitness for Practice* (UKCC, 1999), the facilitator posts studied were part of the one hundred practice education facilitator posts that were the subject of Carlisle *et al.'s* (2008; 2009) impact evaluation.

Generally, of the literature that met the inclusion criteria, authors cited references for the background to the creation of the facilitator post from areas such as mentor, LL and placement quality perspectives rather than literature referring to similar role development elsewhere. This was not surprising given that this was a new role.

2.3.1 Excluded literature

A range of literature did not meet all the inclusion criteria as the roles described were not facilitator roles, focussed on newly qualified, post registration, did not emanate from the relevant policies, were journal articles, or, were outside the UK. Papers downloaded and read, and the key issues which caused papers to be excluded from the review, are presented in appendix 3.

As well as facilitator roles, practice educator roles were being initiated. Following on from *Making a Difference* (DoH, 1999) it was acknowledged that mentors would require support in their role which should include access to a lecturer and/or practice educator (ENB and DoH, 2001). The lecturer and practice educator role had "equal standing" (ENB and DoH, 2001 p. 12) with one teaching qualification recorded by the regulatory body for both roles. This was seen as a way for role holders to move between the lecturer and practice educator roles. Whilst the lecturer role was HEI focussed, the practice educator role focussed on student learning and mentor support and guidance in the practice setting (ENB and DoH, 2001). Generally, a fundamental difference was that the facilitator posts (table 2.3) were full time whereas the practice educator posts (Brennan and Hutt, 2001; Jowett and McMullan, 2007; Rowe, 2008) were often joint appointments risking the problems associated with the

lecturer/practitioner posts as discussed in chapter 1. Therefore, these roles were excluded from the review.

2.3.2 Quality and methodological diversity

There was variation in terms of authors explaining their underpinning methodology across the literature reviewed. Sourced literature included professional journal articles, peer reviewed academic publications and project reports (table 2.3). Quality varied widely from audits (Rowan and Barber, 2000; Hyatt *et al.,* 2008) to small scale studies/evaluation (Clarke *et al.,* 2003; Randle *et al.,* 2005; McArthur and Burns, 2008) and two multi-methods larger scale studies (Ellis and Hogard, 2001; Carlisle *et al.,* 2008). The two multi-methods larger scale studies (project reports) were partially reported in peer reviewed journals (Ellis and Hogard, 2003; Carlisle *et al.,* 2009).

Rowan and Barber (2000), an audit, lacked discussion on their methodological approach, instead provided brief information on the methods employed. This was likely due to the role being established in July 1999 and where the audit paper was accepted for publication in August 2000, so allowed little time for a substantive study requiring ethical approval. Nevertheless, this paper provided an early marker for the development of the facilitator role. Hyatt *et al.* (2008) was also a small-scale audit and used an author designed questionnaire. This was also published in a professional journal and did not provide information on having ethical approval, or, on their methodological considerations.

Randle *et al.* (2005) did not articulate their methodological considerations and just provided information on methods used to collect data. However, Randle *et al*. (2005) did receive ethical approval for their project which added some cogency to their findings. Clarke *et al*. (2003) did not provide information on their methodology, or indicate if ethical approval was gained for their study. Information was provided on the data collection methods which included interviews, focus groups, questionnaires and analysis of the audited placement capacity. Although calculating placement capacity was difficult to achieve, they collected data, over an 18-month period of

time commencing 6 months prior to the introduction of the new posts. However, it is considered good practice to receive ethical approval for all kinds research (Bryman, 2016).

McArthur and Burns (2008) paper on phase 1 of the evaluation of the Scottish posts, was only in relation to the 15 practice education facilitator post holders in NHS Tayside and Fife and does not refer to an underpinning methodology. A mixed methods approach which employed questionnaires and focus group interviews were used but the rationale for selecting these methods was not discussed. Other than a Likert scale questionnaire being distributed to a random sample of wards/clinical staff and mentors, details of the questionnaire were not provided which weakens understanding and contextualising of the subsequent analysis. McArthur and Burns (2008) did, however receive ethical approval.

In terms of their methodological approach, Carlisle *et al*. (2008) and Carlisle *et al*. (2009) used an impact evaluation design which was described as involving both quantitative and qualitative approaches. Carlisle *et al.* (2008) referred readers to the NHS Education for Scotland website to access the full methodological report including methods for the second phase of the study. This website was commended as an '*excellent resource'* Carlisle *et al.* (2008, p. 6) for practice education including information on the practice education facilitators. However, this on-line information availability was time limited as the methodological report was not accessible on the website.

Ellis and Hogard (2001) experienced substantial methodological challenges. During the first year of the project, tenders had been invited to undertake an evaluation, using an action research approach overseen by a steering group. In addition, a questionnaire was devised and data collected. Unfortunately, with the appointment of the research team this methodological approach and the preliminary data collected did not address the research aims. Therefore, although the initial tender specification stipulated an action research methodological approach, the researchers subsequently described the approach adopted was evaluation research. This approach was selected as it comprised of three main elements considered to be appropriate in evaluating the

project these being, "*outcome measurement, process description and analysis, and multiple stakeholder assessment*" (Ellis and Hogard, 2001, p. 30).

Methodologically, the two larger studies used an evaluation approach (Ellis and Hogard, 2001, 2003; Carlisle *et al.,* 2008; 2009). Ellis and Hogard (2001) underpinned their rationale for selecting an evaluation research approach by citing Bryman (2001). Typically, evaluative approaches to research seek to ascertain if the intervention has achieved anticipated goals in real-life context (Bryman, 2016). The impact evaluation research approach, selected by Carlisle *et al*. (2009) cited the impact evaluation textbook by Rossi *et al*. (2004) in their peer reviewed paper but this was not cited in their earlier report (Carlisle *et al.,* 2008). This approach provided the opportunity to evaluate the new role's impact in real-life. The methods and outcomes were similar between these two studies. Limitations of this approach may be a focus on the impact of the role with less exploration of underlying structure and context in which the role operated

None of the audits, project reports or formal studies found used a case study approach (Stake, 1995; Yin, 2009) which would have allowed for the exploration of context. Nor were there any that explored the role development over time or from an in-depth policy perspective.

This overview of each of the primary literature indicated a range of methodological shortcomings. In addition, sample sizes were generally small, participants drawn from a single location and response rates varied (appendix 2). Nevertheless, they do provide some useful insights which are discussed the following sections.

2.3.3 Consistency of findings

Across the literature, the role was implemented in diverse ways and developed in different ways from that originally envisaged, depending on locality and local priorities. The new facilitator posts were created across five clusters in the UK, those in the North West of England (Rowan and Barber, 2000; Ellis and Hogard, 2001; Ellis and Hogard, 2003), the midlands (Randle *et al.*, 2005) the North East of England (Clarke *et al*., 2003). Hyatt *et al.* (2008) study the practice facilitator role in

Wales and McArthur and Burns (2008), Carlisle *et al.* (2008), Carlisle *et al*. (2009) study the practice education facilitator role in Scotland. No literature was found researching or discussing this role in the South East of England.

The literature conveyed a sense of uncertainty about the permanency of the role and how it might work in practice. Aside from the role being newly created, this uncertainty was in some part related to the funding arrangements where posts were introduced for specific project times. Initially, Cheshire & Wirral received funding for 12 months (Rowan and Barber, 2000; Ellis and Hogard, 2001) although funding was subsequently extended for a further 6 months (Ellis and Hogard, 2003). Funding was agreed for the posts in Scotland for an initial period of three years (Carlisle *et al.,* 2008; McArthur and Burns, 2008). However, funding to evaluate these projects was also identified with resultant studies published to evaluate the implementation of these roles (Ellis and Hogard, 2001; Carlisle *et al.,* 2008).

A number of issues were explored that emerged from the literature. Not all issues were addressed in every paper. These included increasing placement capacity; mentor role and support; involvement in curriculum; dual responsibilities of the nurse lecturer; overlapping roles; clinical credibility and closing the theory-practice gap.

Increasing placement capacity

Given that one of the policy drivers for the role was to support an increase in placement capacity to accommodate increased student commissions, only three papers reported on placement capacity aspects of the role (Clarke *et al*., 2003; Randle *et al.*, 2005; Carlisle *et al*., 2008). Due to differing systems being used in HEIs and non-standardised methods of calculating placement capacity, it was deemed as an area which was "*notoriously difficult to establish robust data*" (Carlisle *et al.,* 2009, p. 715). In their study, Clarke *et al.* (2003) provided an overview of the approximate number of learners in each Trust providing different aspects of healthcare including primary and secondary healthcare. Clarke *et al.* (2003) found pre-registration student commissions used 70% to 80% of audited capacity. However, they found pre-registration students only accounted for 60% of learners in clinical areas, as other learners, such as medical students, enrolled nurses (completing conversion courses)

and those completing national vocational qualifications were also utilising the placement resource.

Carlisle *et al.* (2008) provided succinct data on this aspect of the practice education facilitator role. They report in the practice education facilitator study where 94% (n=79) of the practice education facilitators were likely to be involved in the identification of potential placements. Further, where 79% (n=66) responded, they were involved in auditing potential placements and where 87% (n=73) were involved with auditing current placements. They also found in their study that placement capacity was also affected by the number of qualified staff available 85% (n = 71). This result demonstrated that whilst mentors were the only staff approved by the UKCC to assess pre-registration students in practice, other qualified staff in practice played a crucial part in supporting students in the clinical learning environment.

Whilst Randle *et al.* (2005) articulated that the reason for developing the clinical placement development facilitator posts was to increase clinical placements, the methods selected did not calculate any quantitative data. Although the qualitative findings supported that the new role had shifted the ownership of placement capacity to the Trust, so that new areas had been opened, no data on the impact on placement capacity was provided. This was disappointing as it was one of the founding aims for the new role in this paper.

Mentor role and support

There was much discussion of the importance of the mentor role in teaching and assessing pre-registration nursing students in the practice learning environment but this could be limited by a number of factors. Of the 84 practice education facilitators who responded to the scoping survey by Carlisle *et al.* (2008) 86% (n=72) perceived that the availability of mentors affected placement capacity. Furthermore, Hyatt *et al.* (2008) wrote that 50% of the pre-registration academic award for student nurses was in the hands of mentors. Yet, the mentor had dual responsibilities, primarily the delivery of healthcare whilst additionally, teaching, supporting and assessing students in the clinical learning environment. Further, increased patient numbers, many of whom were acutely ill, resulted in the mentor having less time to support and assess pre-registration students in practice. Clarke *et al*. (2003) indicated

increased numbers of patients inevitably allowed less time for mentors and clinical staff to provide support for students in the practice environment.

Carlisle *et al.* (2009) found 41% (n=48) of mentors reported the demands of providing clinical care as a barrier to their mentorship role, and, 25% responded that the demands of clinical management was a further barrier to their mentorship role. The mentor role, it being in addition to the delivery of direct patient care created role conflict (Rowen and Barber, 2000; Ellis and Hogard, 2001; Ellis and Hogard, 2003; Clarke *et al.*, 2003). Increased student numbers resulting from *Making a Difference* (DoH, 1999) coupled with curriculum changes heralded by *Fitness for Practice* (UKCC, 1999) further contributed to mentor workload pressures. Staff participants expressed support for the new role as they anticipated mentors who experienced "*role strain from conflicting pressures*" McArthur and Burns (2008, p. 153) as issues to be addressed by the newly appointed practice education facilitators

McArthur and Burns (2008) asked staff whether mentor support had improved and found that someone to listen and talk with was seen to have value. Key stakeholders described support for the mentor as having improved since the appointment of the practice education facilitators and increased mentor confidence in managing students (Carlisle *et al*., 2009). Indeed, the practice education facilitators were aware of the importance of the mentor role from the beginning in the creation of positive student learning experiences (McArthur and Burns, 2008).

Support by the practice education facilitators was reported as being above average when a student was failing where 46% (n=32) of mentors responded that this was the case (Carlisle *et al*., 2009). Further, results from practice education facilitators revealed that 96% (n=81) had provided support for mentors with failing students (Carlisle *et al*., 2008). Mentors valued the guidance provided by the practice education facilitators as it increased their confidence in dealing with student problems (Carlisle *et al*., 2009). Rowan and Barber (2000) found the interaction between mentors and clinical facilitators had increased. McArthur and Burns (2008) promoted the importance of the role being available within the practice setting as an important feature which provided support for students and staff. Randle *et al*. (2005) found mentors also valued the clinical placement development facilitators support

through their regular contact and being able to discuss assessment documentation queries and valued access to a knowledgeable individual.

Hyatt *et al*. (2008) supported the view that the practice facilitators had a noticeable increase in mentors requesting support, particularly with difficult student assessments. They revealed mentors had increasingly sought support from the practice facilitator rather than from the link lecturer. Carlisle *et al*. (2009) found that 96% (n=32) of practice education facilitators had provided support for mentors to manage failing students. Further, a survey of mentors 46% (n=32) responded that the support offered by the practice education facilitator was above average (Carlisle *et al*., 2009). Support for mentors was viewed positively as it offered students the best opportunity to succeed (Carlisle *et al*., 2009). This was likely to have raised the confidence of the mentors as concerns about a student performance in practice would not inevitably lead to the student being failed.

Involvement with curriculum

The literature revealed the increased knowledge gained by facilitators of teaching and curriculum requirements. This was an important element as the design of the curriculum influenced how placement resources were used. The involvement of facilitators, who had knowledge of their Trust placement resources helped ensure best use of these resources. Rowan and Barber (2000) reported that the link lecturers ensured the clinical facilitators were involved in curricula activities. The clinical facilitators influence was evident during the design stage of student assessment documentation, where they promoted the inclusion of the needs of the placement environment. As the clinical facilitator role was involved in curricular design and briefing activities, they had become the on-site possessors of curricula information. Clarke *et al*. (2003) discussed that students had related that practice placement facilitators had briefed staff on curricula changes. The importance of the wider clinical team was recognised by the practice placement facilitators who were reported to have "*worked with clinical staff to ensure familiarity with curricula and awareness of the needs of students*" (Clarke *et al.*, 2003, p. 111).

McArthur and Burns (2008) related the practice education facilitators found curricula knowledge placed them in an advisory position as they found staff in clinical practice

most often referred to them to clarify the University objectives for students and how these could be met in practice. Carlisle *et al.* (2009) promoted "numerous examples" of the practice education facilitators who ensured the mentors understood the pre-registration programme and importantly the assessment process. In studying aspects of what mentors' viewed as most and least important in their role, Carlisle *et al.* (2008) provided a list of 11 items for the mentors to rate in order of importance. Whilst supervising students was placed as the most important aspect 59% (n=41) only 12% (n=8) of mentors responded that familiarising themselves with the students' programme of study/assessments was important in their role, placing this aspect of the role in 10th position. Whilst the sample was small, it provided an insight into the mentor's mind-set and raised concerns regarding their overall knowledge and comprehension of the importance of their contribution in assessing the 50% practice element of the pre-registration programme. These studies (McArthur and Burns, 2008; Carlisle *et al*, 2008) suggested that mentors could be clinically credible yet deficient in their understanding or interest in the overall pre-registration programme requirements.

Dual responsibilities of the nurse lecturer

An important factor in nurse lecturers' lack of availability to provide support in the clinical learning environment was where they were based in universities which were often geographically separate from the NHS placement areas and which were unfamiliar to clinical learning environment staff (Carlisle *et al*., 2009). These factors combined, made it difficult for the lecturer to be able to respond at short notice to situations which may have arisen in practice. The support received from the lecturers in the clinical learning environment did not meet the requirements of staff in clinical placements (McArthur and Burns, 2008).

Clarke *et al*. (2003) observed the nurse lecturer were not viewed as academics in the University and not practice credible in the clinical learning environment. The perception of this clinical deficit was voiced on a regular basis with the result that the nurse lecturer role had little influence in practice (Rowan and Barber, 2000; Clarke *et al.*, 2003; McArthur and Burns, 2008). Being based and teaching in the University had deskilled the nurse lecturer in the eyes of their clinical colleagues in practice who now viewed the link lecturer as being an academic rather than a nurse. In their

study, McArthur and Burns (2008) found practice staff invested the new practice education facilitator role as addressing the nurse educator deficits who were perceived as being out of touch with practice and provided a reduced level of support in the clinical learning environment. Essentially, by 2009, the link lecturer role was no longer seen as clinically credible, practice-fit, or available to respond in a timely fashion to situations which arose in the clinical learning environment.

Rowan and Barber (2000) found the clinical facilitator was in regular contact with the link lecturer to relay information on students experiences in clinical placement. This enabled early identification of problems and allowed the link lecturer time to consider if any action was needed. The idea was conveyed that the facilitator was becoming a conduit for passing information from the clinical learning environment to the link lecturer who was separated from the clinical learning environment. The increased presence of the practice placement facilitator in the clinical learning environment was illuminated where students saw the role as their "*first port of call*" (Clarke *et al.*, 2003 p. 111). The acceptance of the role was viewed as having provided continuity of support in the clinical learning environment in contrast to that provided by the link lecturer (Clarke *et al.*, 2003). The clinical facilitator role was promoted as having a clearer understanding of the clinical environment, in contrast to the link lecturer, and, was promoted as having a better understanding of how students could achieve the skills requirement in the real world of practice (Rowan and Barber, 2000). Further, the role was seen as having enabled the link lecturer to relate to reality of practice (Rowan and Barber, 2000).

Loss of clinical tutor role

Ellis and Hogard (2001) advised that the loss of the clinical tutor role had left a deficit in practice as prior to *Project 2000* (UKCC, 1986), they had provided support for students in practice. The clinical tutor role had been phased out following the introduction of *Project 2000* (UKCC, 1986) where it was indicated that the University lecturers and clinical staff would work together to provide support. However, due to the day-to-day dual responsibilities of lecturer and clinical staff, good quality support in the practice learning environment was deemed to be suffering (Ellis and Hogard, 2001). Rowan and Barber (2000) also made this connection and compared the new clinical facilitator role to that of the clinical

teacher. The new facilitator role was based in the clinical care provider organisation, so was accessible, experienced, clinically credible and supernumerary. This provided the new facilitator role with the freedom to improve the quality of the clinical learning environment at local level. There was a sense that this additional support by the facilitator was now provided from inside the clinical learning organisations, within the clinical learning placement areas and within the practice settings (Ellis and Hogard, 2003; McArthur and Burns, 2008).

Rowan and Barber (2000) recognised that contact with ward staff on a daily basis built and strengthened the working relationship with clinical staff. This close working relationship was supported by Clarke *et al.* (2003) where the practice placement facilitators were working with clinical staff in areas such as the quality of patient care which also demonstrated their clinical credibility. Exposure to good quality care provision was crucial as this was where students worked in clinical placements and learned how to deliver care to real patients (Ellis and Hogard, 2001). Participants in Randle *et al.* (2005) disclosed they felt the deficit of support which should have been provided by the tutor had been filled by the clinical placement development facilitators.

Overlapping roles

The studies revealed concerns about the potential overlap of roles, which caused tension, particularly between the nurse lecturers and the facilitator roles. Clarke *et al.* (2003) revealed the practice placement facilitators were aware of this and were seeking to work with the link lecturers rather than the roles undermining each other. Despite the good intentions of working together, Clarke *et al*. (2003) found conflicting advice had been given by the University lecturer and facilitator roles. Indeed, advice given by the practice education facilitators was perceived to have been more in tune with the clinical learning environment (Carlisle *et al.,* 2009). However, Hyatt *et al*. (2008) articulated the new practice facilitator role was not created as a replacement for the link lecturer role.

Clinical credibility

Clinical credibility was important to the new facilitator role. The role holders needed to be secure in their standard of professional practice, as the role required them to

work with a range of staff including pre-registration students and newly qualified staff (Rowan and Barber, 2000; McArthur and Burns, 2008; Carlisle *et al.,* 2008; Hyatt *et al*., 2008; Carlisle *et al.,* 2009). Carlisle *et al.* (2008) found that 59% (n=46) practice education facilitators considered clinical credibility to be a strength in terms of the structure of their role. This result appears somewhat low given the emphasis placed on role holders needing to be clinically credible in order to be in a position to improve the quality of the learning environment.

Ellis and Hogard (2003, p. 19) advised the clinical facilitators were "*experienced, skilled and up to date nurses*". Similarly, "*experienced nurses*" were noted to be recruited into the practice education facilitator posts (McArthur and Burns, 2008, p. 149). Carlisle *et al.* (2008, p. 13) also confirmed the practice education facilitators were "*experienced clinical staff*". Clarke *et al.* (2003) confirmed each post holder had worked in the Trusts as a practitioner prior to being seconded to the new role. Rowan and Barber (2000) also identified the role specification required a competent clinically credible practitioner.

The need to be clinically credible was linked to the requirement that the new role would be spending the majority of their time in the clinical area. This placed the new facilitators in a position to work alongside and provide support for staff and students in the clinical areas. Positive outcomes were reported by Ellis and Hogard (2003) where of 144 students (n=71) strongly agreed and (n=64) agreed that working with the clinical facilitator had improved their skills and confidence.

Closing the theory-practice gap

Clinical facilitators viewed their role as having brought theory and practice together (Rowan and Barber, 2000; Ellis and Hogard, 2003; McArthur and Burns, 2008). Similarly, the ethos of the practice facilitator role was seen as one of collaboration between service and education providers (Hyatt *et al.,* 2008). Supporting students to link the theoretical content, taught in the University, with clinical practice was seen as key in bridging the theory-practice gap (Rowan and Barber, 2000). The issue of the post holders needing to be in possession of excellent communication skills suggested they were addressing sensitive issues between the service and education

providers and/or between the clinical facilitator and clinical staff (Ellis and Hogard, 2003).

In terms of the location of the facilitator role, the literature showed these new roles were in the main aligned with the NHS. The rationale for this decision was because the "*mechanisms for supporting learning in practice was held by the NHS*" (McArthur and Burns, 2008, p. 150). The contract of employment for the Scottish posts remained with the NHS boards (McArthur and Burns, 2008; Carlisle *et al.*, 2009). Similarly, Cheshire and Wirral confirmed the clinical facilitators were appointed to the NHS Trusts (Rowan and Barber, 2000; Ellis and Hogard, 2001; Ellis and Hogard, 2003). However, Clarke *et al.* (2003) stated the post holders were seconded to the University for the duration of the new posts but the practice placement facilitators maintained their Trust links. Surprisingly, only 29% (n=24) of practice education facilitators in Carlisle *et al.* (2009) considered being located on-site was a strength of their role. This was an unanticipated finding due to the strong focus of the role being based in the NHS but it is not elaborated upon.

2.3.4 Discussion of the conclusions reached

The literature revealed two models of facilitation where one predominantly focused on the facilitator working alongside the student to enhance students' clinical competence (Ellis and Hogard, 2001, 2003; Rowan and Barber, 2000). The second model was where the role primarily provided support for mentors to ensure a good quality student experience (Carlisle *et al.*, 2008, 2009; Clarke *et al.*, 2003; Randle *et al.*, 2005; Hyatt *et al.*, 2008; McArthur and Burns, 2008).

When considering the two models of facilitation, the literature gave a valuable insight. The model where the facilitator provided direct support to the student was reported as being expensive and therefore was unlikely to be sustainable without significant investment (Ellis and Hogard, 2001; 2003). This seemed to be an obvious finding as this model was designed to be in addition to the roles (mentor and team) that were already in place to support the student in practice. Further, in order to roll out this model, a sufficient quantity of facilitators would have required further funding and as their salary was at a senior level, and the posts supernumerary, this

model was unlikely to be affordable. Moreover, it was not established if the additional support provided by the new role had any effect on pre-registration student clinical skills (Ellis and Hogard, 2001; Ellis and Hogard, 2003). In contrast, the model of facilitation which focussed on providing support for the mentor was viewed as being effective (Clarke *et al.,* 2003; Randle *et al.,* 2005; Carlisle *et al.,* 2008; 2009; Hyatt *et al.,* 2008). This indicated that the role was likely to be viable when providing support for the teaching and assessment structure (mentors, LL) that was already in place.

Despite the differing models, the facilitator role incorporated some common aspects, a summary of which is presented (table 2.4). However, comprehensive analysis of the role content from the literature presents some limitations. For example, although three of the papers were based on the practice education facilitator role in Scotland (McArthur and Burns, 2008; Carlisle *et al.,* 2008; 2009) each paper, for differing reasons, may not have listed all aspects of the role focus.

Table 2.4 Summary of main aspects of facilitator role identified in literature

	Author	Address PK2 Deficits	Placement Provision Quantity / Quality	Mentor / Ward staff support	Student support	Link Lecturer / Tutor Support	Address Theory Practice Gap	Health Care Assistant / Preceptorship / Qualified Nurses Support
	Rowan and Barber (2000)	x	x	x	x	x	x	
	Ellis and Hogard (2001)	x	x	x	x	x	x	
	Ellis and Hogard (2003)	x	x	x	x	x	x	
	Clarke *et al*. (2003)	x	x	x	x	x	x	
	Randle *et al.* (2005)	x	x	x	x	x		
	Hyatt *et al.* (2008)			x				
	McArthur and Burns (2008)		x	x	x		x	x
	Carlisle *et al* (2008)	x	x	x	x	x	x	x
	Carlisle *et al.* (2009)	x	x	x	x	x	x	x

The new practice education facilitator role focus was interpreted primarily to provide support for mentors to secure high quality placement experiences for students (McArthur and Burns, 2008; Carlisle *et al.*, 2008; 2009). From their audit in Wales, Hyatt *et al.* (2008) revealed the new role provided support for mentors who had an increased responsibility for assessing students in the clinical placement, as a result of the implementation of *Fitness for Practice* (UKCC, 1999).

There was however, an expectation that the broad brief of the role would enable it to develop and evolve (Ellis and Hogard, 2003; Clarke *et al.*, 2003). This fluidity conveyed a sense of expectation that, whilst having a broad direction, the role

responsiveness to local circumstances was seen to be advantageous (McArthur and Burns, 2008; Carlisle *et al.,* 2008).

The new facilitators also had an expectation that their role would develop and change (Rowan and Barber, 2000). Aspects of this development was in response to meeting local requirements such as the provision of increased support for mentors (Rowan and Barber, 2000; Hyatt *et al*., 2008). However, there was an expectation that facilitators would also work in way which was unique to each of them (Clarke *et al.,* 2003). This suggested that early in the implementation of the role, even within the same organisation, facilitators were using their experience and preferences to develop individualised responses to managing the situations they encountered. The implementation of the role chimes with Lipsky's (2010) interpretation of policy at street-level that is responsive to local requirements. No studies looked at this over time.

2.3.5 Summary of key issues arising from the literature

Synthesis of the literature revealed the facilitator role was created as a way of responding to the professional regulator in *Fitness for Practice* (UKCC, 1999) and Government policy initiatives (DoH, 1999). From the regulatory perspective, the primary focus was to ensure pre-registration nurse education adequately prepared nurses to competently deliver high quality care in a changing healthcare environment. The prime focus of *Making a Difference* (DoH, 1999) in terms of pre-registration nurse education, was to increase pre-registration commissions to meet the predicted increase of the registered nurse workforce required to provide healthcare. These combined policies heightened the focus on the quality of the placement experience which would inevitably be under further increased pressure to support the increased pre-registration student commissions.

Primary research involving facilitator posts with a remit for supporting pre-registration student nurse education was limited. Only two of the papers were clearly research studies. As previously identified, there was no research into facilitator posts, created as a result of the key policy drivers in the South East of England, where the study reported in this thesis took place.

The first point to make is that there was a dearth of research on the facilitator roles arising from the key initial policy drivers. Furthermore, the research that had been undertaken were snapshots of the role, or, at most short-term follow ups of how the role had functioned. There were no studies that explored the role development over time.

Key stakeholders implemented various elements of the key policy drivers in a variety of ways. Amongst the differing factors in translating the requirements into action, the primary literature demonstrated five geographical areas in the UK where new facilitator roles with a pre-registration nurse education in practice focus were created. This role was created as part of key stakeholders' responses to implementing aspects of the two key policies. These related to support for the clinical learning environment, particularly in order to improve the quality of the practice learning experience for pre-registration students.

Primary literature indicated the emphasis and operation of the role varied where the role was moulded in response to local priorities. These priorities included placement resource management, support for students, links with the HEI and mentor support.

Further, the literature indicated that there was a tendency for the role to develop through the post holders' own interpretation of what the role needed to do locally and in conjunction with management influences. This feature offered tentative support to the bottom up theorists' perspective of policy implementation of whom Lipsky (2010) was a key proponent.

Generally, the literature demonstrated that there was an increased working relationship and support provided by the facilitator for the mentor role in teaching and assessing students in practice. In particular support was provided when the mentor had concerns about a student.

The literature found that one of the reasons that the mentor role at this time was problematic was that those performing mentorship responsibilities, had as their main priority delivering patient care. In the same way, the research reviewed identified a similar dual responsibility among HEI staff with LL responsibilities. It was observed

that increasingly HEI staff were prioritising classroom delivery at the expense of supporting students in the practice setting. In contrast, the new facilitator roles did not have similar competing priorities as it was a fulltime role.

A sense emerged from this literature that the facilitators, with their focus on the quality of the clinical learning environment: their access and ability to work with mentors, the clinical team, and students, were well positioned to contribute to a supportive practice learning environment. A further conclusion from the literature in terms of how the facilitator role appeared to be developing, was that due to their involvement in service and educational requirements, they were becoming increasingly knowledgeable of teaching and curricula elements of pre-registration nurse education programmes.

2.4 Challenges of conducting pre-registration nurse education in practice research

Pre-registration nurse education is delivered by academic institutions with the support of clinical organisations. Clinical placements constitute 50% of pre-registration nurse education programmes (NMC, 2002, 2010b, 2018b, 2018d) but pre-registration nurse education in practice research is a complex undertaking. Textbooks relating to nursing research tend to focus on the research process and have little to inform the researcher of the practicalities of research in the practice environment (Moule and Goodman, 2014; Holloway and Galvin, 2017). There has been some work to develop research guidelines for clinical staff to help structure the research process in practice (Cleary and Freeman, 2005). It is only recently that there have been calls by a group of Canadian academics for greater connectivity between academia and practice by proposing a nursing education research framework (Pepin *et al.,* 2017).

A prime challenge of pre-registration nurse education in practice research is that the education that occurs in practice, is delivered primarily in the NHS, where the focus is on patient care. This has implications for access, recruitment and participation. Further issues include ethical aspects, cultural conflicts and methods used. Additionally, workload pressures and staff shift patterns hindered information

gathering in a project where pre-registration nursing students completing service improvement projects in the clinical environment, (Baillie *et al*. 2014). Finally, there is the challenge of using Lipsky's (2010) policy perspective in this type of research.

Research involving an HEI and clinical practice requires ethical approval from both organisations (appendix 15, appendix 16, appendix, 17, appendix 18, appendix, 19) and insurance and indemnity (appendix, 20). As research in clinical practice involves the healthcare environment, ethical considerations include doing potential patient or staff participants no harm and where observing principals of respect for autonomy, non-maleficence, beneficence and justice are paramount (Holloway and Galvin, 2017; Stanley and McLaren, 2007). On a practical level this includes gaining access to and engagement of NHS staff or patients. Therefore, it is important to identify who are the gatekeepers, what level, and who do you need to gain access to do the research (Cleary and Freeman, 2005).

When nurse education moved into the HEIs (UKCC, 1986) there was an anti-academic culture within practice (Elkan and Robinson, 1995; Barton, 1998; Gillespie and McFetridge, 2006). This is despite the opportunity that nurse education being delivered in an HEI environment provides a platform for blending teaching and research to improve healthcare provision (Baillie *et al.*, 2014). They also stressed the importance of effective partnerships between the University and healthcare organisations.

In a critical review of clinical mentor research in the UK, Jinks (2007) discerned a range of issues in conducting and reporting these studies. Whilst research methods were well described, reported methodologies were not well articulated or absent. Sample sizes were small and response rates to questionnaires were difficult to ascertain as the total population present in mentor databases were identified as inaccurate. This affected the selection of participants and the subsequent reporting of exact response rates. Not all the studies reviewed had reported ethical approval (Jinks, 2007). This report brings into sharp focus the challenges of carrying out research into pre-registration nurse education in practice.

As described in chapter 1, Lipsky (2010) was a useful perspective to view the facilitator role in the real-world. Lipsky (2010) places value on those working in the frontline, where services are delivered. With this in mind, the context where the practice facilitators operated in this study as street-level bureaucrats was important. The literature revealed the facilitator role was created with a vision to carry out the policies. It also illuminated the variability of the new role in terms of its focus. Importantly, it confirmed the role was right at the heart of where policy was being translated at the point of delivery. The challenges then of using a Lipsky (2010) perspective meant any researcher, would need to gain access to the facilitators, that is, the street-level bureaucrats and the people that interact with them across organisations. Methods would need to be selected to be able to capture the development and nuances of the facilitator role over time.

In summary the challenges of conducting research in pre-registration nurse education in practice are varied. Details of these considerations in the context of this study are provided in chapter 3 section 3.7.1.

2.5 Rationale for the current research

There was a dearth of literature on the newly created facilitator role that had a pre-registration nurse education focus in their role remit. These new roles had been created in response to implementing aspects of *Making a Difference* (DoH, 1999) and *Fitness for Practice* (UKCC, 1999) policy initiatives. These wide ranging policy documents signalled changes affecting pre-registration nurse education in order to secure registered nurses that were in a position to provide good quality healthcare in a changing healthcare environment. An increased emphasis was placed on the importance of the practice aspects of pre-registration programmes in order to ensure nurses were fit for purpose on registration.

However, problems were identified with two key roles fundamental in teaching, assessing and providing support for pre-registration students in practice. The LL and mentor roles were deemed not to be providing the required level of support for the student in the practice environment. At the same time there was an increase in the

number of students being commissioned which placed increased pressure on these roles.

The literature revealed the practice facilitator was affecting the LL and mentor roles in how they were supporting pre-registration students in practice. However, no published literature on the facilitator role have been completed since 2009. This gap to explore the role development over time and how it has influenced other roles in pre-registration nurse education has been not studied.

The literature review suggested that the role was implemented in diverse ways (table 2.3) and was subject to change over time. This raised questions as to the policy implementation process of the practice facilitator role and warrants inclusion within this study. Therefore, this was the rationale for the research aim.

2.6 Research aim

This study's aim was to explore the way the practice facilitator role evolved in a real-world context over time and its impact on pre-registration nurse education.

2.7 Research questions

1. What was the rationale for the introduction of the role of practice facilitator?
2. How has the role of the practice facilitator changed over time?
3. How does the practice facilitator role function across a range of organisations?
4. How has the role of the practice facilitator impacted on pre-registration nurse education?
5. What effect has the role of the practice facilitator had on other key roles contributing to pre-registration nurse education?

2.8 Chapter summary

The literature review confirmed that two key policy initiatives, *Making a Difference* (DoH, 1999) and *Fitness for Practice* (UKCC, 1999) were influential in shaping the future education of pre-registration nurses across the UK to join the healthcare

workforce. Facilitator posts were developed in response to these policies in a number of locations with varying focus. None were located in the South East of England.

A comprehensive literature search was undertaken which revealed there was limited research undertaken on the facilitator role. Of the literature found, the role was implemented in diverse ways, depending on locality and local priorities. None explored role development over time. In the same way, there was some indication that the roles were developing in different ways from that originally envisaged. As a result of the review of the literature, an overall research aim and five research questions were formulated to explore these issues in greater depth. The next chapter discusses the methodological approach to provide answers to these questions.

Chapter 3: Case study approach: Epistemology, methodology and methods

3.1 Introduction

The previous chapter critically reviewed the published literature which informed the research aim and questions. This chapter discusses the philosophical considerations which underpin this study. The methodological rationale for selecting a case study design is presented. Selection of study participants and methods to address the research questions are critically explored. Data management, ethical considerations and safeguards for participants are discussed. The data analysis process is explained and finally, the chapter concludes with the actions taken to promote the rigour of this study.

3.2 Philosophical perspective

Early in the design of this study, it was crucial to consider how to explore the way the practice facilitator role evolved in a real-world context over time and its impact on pre-registration nurse education. Research design is based on fundamental ontological and epistemological beliefs, that is, the nature of social reality, and how the researcher can know this reality. These 'building blocks' of research are fundamental as they form the core beliefs of the researcher in the way they view the world and so influence the whole design of the research (Grix, 2010; Bryman, 2016).

The importance of this principal investigator's understanding of their own philosophical perspective (Grix, 2010; Bryman, 2016) led to further consideration of fundamental ontological questions (nature of reality, what exists, what units make it up and how these units interact) and epistemological questions (how do we know what we know).

Pragmatism was selected as an appropriate philosophical perspective to underpin this study as the main focus was on the research problem with a goal of yielding coherent, useful findings (Morgan, 2007). In its most basic sense, pragmatism is

about how, rather than what we think, and, that an idea or a proposition is true if it works satisfactorily (Menand, 1997).

Pragmatism began as a philosophical movement in America in the late 19th century with classical pragmatists such as Dewey, James and Pierce (Malachowski, 2010). William James (1842-1910) coined the term pragmatism but credited Charles Sanders Peirce (1839-1914) as having first introduced these philosophical ideas in an article published in 1878 entitled 'How to make your ideas clearer' (Menand, 1997; Warms and Schroeder, 1999). For Pierce, pragmatism was primarily a philosophy of meaning which have practical relevance and application in the real world. Having completed graduate work at Johns Hopkins University, where Charles Sanders Pierce was a lecturer (Menand, 1997), John Dewey (1859-1952) further developed pragmatism, thus fundamentally changed approaches to education where learning by doing and the development of practical skills were promoted (Dewey, 1916).

From an ontological perspective, pragmatists are concerned with the practical world and how people operate and respond in a particular environment. James (1997/1907) wrote "*the pragmatic method*" where he presented it as a method of addressing metaphysical ideas. Importantly, he maintained the significance of the 'practical consequences' of an idea being related to its effects or outcomes thus: -

> "*The pragmatic method in such cases is to try to interpret each notion by tracing its respective practical consequences. What difference would it practically make to anyone if this notion rather than that notion were true?*"
>
> (James, 1997/1907, p. 94).

Pragmatism holds with the truth of an idea, in that it matches with what is happening in reality, and where the notion that an idea or concept is related to its practical effects or outcomes (Johnson and Onwuegbuzie, 2004; Holloway and Galvin, 2017). Warms and Schroeder (1999) observed that pragmatism does not subscribe to any particular method in eliciting what is known whilst McCready (2010) explains it is a method of approaching philosophical issues. This approach is employed as to how

we acquire and use knowledge which supports testing ideas and how they function in reality. Pragmatism has a questioning approach where the view is that conclusions are rarely, if ever, final or absolute, as things change over time. Creswell (2009) viewed pragmatism as providing a focus on "what works." This approach aligned with the approach to policy, previously discussed in chapter 1, where "what counts is what works" (Buse *et al.,* 2012).Therefore, integral to pragmatism is gaining an understanding of the situation and what is happening in the real-world (Creswell, 2014).

In this study, the selection of a pragmatic approach enabled the role of the PF to be studied in the practical world. Additionally, Seale (2007) emphasised that pragmatists' test the reality of everyday life. Therefore, by studying the observable consequences of policy, "the truth" of how the PFs implemented policy "the consequence" could be explored. Indeed, for Warms and Schroeder (1999) pragmatism was where the outcomes of a course of action constitute its meaning. Understanding the consequences of actions are helpful in predicting real-life outcomes (Johnson and Onwuegbuzie, 2004). Moreover, the real-life outcomes of actions are consistent with Lipsky's (1980, 2010) idea of street-level bureaucracy where the combined actions of those implementing policy, in the context of the realities of day-to-day practice, and taking individual decisions become the policy reality.

Further, pragmatism was not constrained by specific methodological approaches (Patton, 2002; McCready, 2010). Rather, the focus was on selecting the methodology best suited to answering the research question/s and where multiple methods could be used to source data (Welford *et al.*, 2011). Therefore, a pragmatic methodological approach, using multiple sources of evidence to explore the real-life impact of the PFs on pre-registration nurse education provided a solid philosophical basis on which to address this study's research questions.

3.3 Methodology

Methodology pertains to the "*principles and ideas*" (Holloway and Galvin, 2017, p. 21) on which research methods and research strategies are based and link the

methods to the research question/s (Silverman, 2020). Therefore, it was an important consideration that the selected methodology was practicable to enable the research questions to be answered (Newell and Burnard, 2011; Bryman, 2016).

Various research designs can be used within the pragmatic paradigm. However, from a conceptual perspective, it was important that the study design would enable exploration of the initial concerns identified in the literature by the principal investigator on the evolution of the PFs role in the context of pre-registration nurse education with a view to providing new insights on this role as it operated in the real-world.

3.3.1 Consideration of methodological approaches

Whilst keeping the aforementioned considerations in mind, methodologies were considered in order to select a suitable study design to undertake this study. The literature review (chapter 2) revealed little was known about the new role, created as a result of the two key policies (DoH, 1999; UKCC, 1999) and which had resulted in the creation of the PF role in the study area (discussed in section 1.8). An approach which would enable exploring, rather than measuring what the PF did, or, was perceived to do, was considered to be appropriate. This resulted in the selection of a qualitative, case study approach (discussed in section 3.3.2) rather than a quantitative approach. Holloway and Galvin (2017) espouse that qualitative approaches are concerned with how people make sense of their world and how they experience it, thus a qualitative approach facilitated the exploration of the real-life context of PFs in this study. Of course case study research can include the collection and analysis of quantitative data (Yin, 2009; Bryman, 2016) though frequently, emphasis is given to qualitative data (Moule, 2018).

The central determinants for the methodological approach for this study were the research questions (Silverman, 2020). In this study, the research questions did not lend themselves to quantitative data collection and qualitative methods were consistent with the epistemological and methodological rationale for the study design. It was recognised that the research was in relation to a complex social context so alternative methodological approaches were considered. Although aspects of

organisational culture could potentially arise, this was not the primary focus of the study, which, for example ethnographic methodological approaches "*which seek to understand cultural phenomena*" (Gray, 2014, p. 438) would be concerned with. Due to the nature of this study it was unlikely that grounded theory approaches, where a key "*purpose is to construct theory grounded in data*" (Corbin and Strauss, 2015, p. 3), would be a primary outcome. In addition, this study utilised existing theory in street-level bureaucracy (Lipsky, 1980, 2010) as discussed in chapter 1 section 1.7.6 and chapter 2 section 2.4. Participants' experiences were indeed important for this study, but again a phenomenological approach, which aims to explore phenomena including peoples' "*lived experience*" (Holloway and Galvin, 2017, p. 219) would have been too narrowly orientated. This was because it would not encapsulate the scope of the research questions. Secondly, the context within which the PFs were required to operate was considered an important aspect to be explored.

Action research, which aims to bring about a change in practice, (Moule, 2018) was not considered a realistic option because this study involved partly looking back at how the PF role had evolved since its inception. The potential for introducing innovation, that is, practice innovations was not a realistic proposition as this study was largely exploratory and any innovations that might potentially follow would need to be the subject of future research. These considerations helped inform the chosen methodology which was the case study approach and which incorporated a strong emphasis on qualitative methods (Moule, 2018). The rationale for this selection is discussed in section 3.3.2 below.

3.3.2 Case study methodology and the PF role

The real-world context in which the practice facilitator (PF) role operated and what influenced it, was considered highly relevant (Silverman, 2020). This was especially so as the literature review had indicated local differences in the way the facilitator role was being interpreted and implemented. Therefore, it was important to select a research design that enabled the PF role to be studied in the context in which this role operated.

Case study is a well-established approach in research design and is particularly useful where the phenomena being studied is not reliant on quantitative data. Case study is being increasingly used, due to its suitability for healthcare studies due to the complexity of many healthcare issues and contexts (McGloin, 2008; Moule, 2018). As case study is particularly suited to holistic and in-depth analysis, it is more usually used in the qualitative research paradigm. Further, case study enables complex issues to be explored in-depth from different perspectives and importantly for this study in its real-life context (Crowe *et al.,* 2011; Moule and Goodman, 2014; Silverman, 2020).

Two writers are particularly influential in defining case study as a research methodology, namely Stake (1995) and Yin (2009). Stake (1995) describes three main types of case study these being the 'intrinsic' case study where a unique phenomenon is explored, 'instrumental', where a particular case is explored in order to learn about a phenomenon and finally, the 'collective' case study where multiple cases are studied to learn more about and to explore a phenomenon. In the collective case study approach, the individual cases can be examined either simultaneously or in sequence.

Having considered both of these authorities on case study design Yin's (2009) approach was selected as it provided a more structured framework and systematic approach in the study design. This design provided the steps to study the PF role in its real-life context. The strategies and steps offered in Yin (2009) case study approach also align with those of a pragmatic orientation (Yazan, 2015). Furthermore, Yin (2009) promotes case study as enabling the in-depth investigation of phenomenon in the context of the real-world, thus, meeting the aim of studying the PF role in a real-world context.

Yin (2009) describes four types of case study designs (figure 3.1). These consist of single case designs and multiple case designs. Each of these in turn can be 'holistic' that is, a focus on a single unit of analysis, or, 'embedded' where there are multiple units of analysis. A feature of each of these designs is where they incorporate study of the context of the case or cases and as indicated above, context was an important element in studying the PF role in the current research.

The case study design can be used in many situations contributing to our knowledge of individuals, groups and organisations (Yin, 2009). Case study methodology placed the principal investigator in a position to study the case/s in context which enhanced the study as it contextualised the real-world factors influencing the individual case. The real-world contextual factors in this study were particularly complex because the participant PFs work for, and interact with, a range of different organisations. This was an important consideration in understanding the way the PF role evolved over time.

Five components are identified by Yin (2009) as being particularly important in case study methodology. These are: -

1. A study's questions;
2. Its propositions, if any;
3. Its unit(s) of analysis;
4. The logic linking the data to the propositions; and
5. The criteria for interpreting the findings.

(Yin, 2009, p. 27).

In case study methodology, the use of propositions helps the researcher articulate their initial ideas (Miles and Huberman, 1994; Smith, 2008; Gray, 2014). Yin (2009) promotes the use of theoretical propositions in case studies where the propositions are formulated by linking the original ideas for the case study with the researcher's original instincts. Using this technique, the principal investigator formulated the following propositions to devise a framework to study the PF role in the consortium.

1. The rationale for the introduction of the PF role varied between stakeholders.

2. The role of the PF has changed and evolved over time and is affected by individual organisation priorities as well as Department of Health and professional body requirements.

3. Standardised processes increase the impact of the role across organisation/s.

4. Key stakeholders impact PF role development and role focus and its resultant impact on pre-registration nurse education.

5. The PF posts have had an impact on pre-registration nurse education.

Subsequently, further reflections on the propositions, together with the literature review, led to further iteration and refining of the study research questions. Case study design is suitable when information is being sought using 'how' and 'what' questions (Baxter and Jack, 2008; Yin, 2009; Crowe *et al.*, 2011; Gray, 2014). These considerations informed the articulation of the research questions to be addressed in this study as follows: -

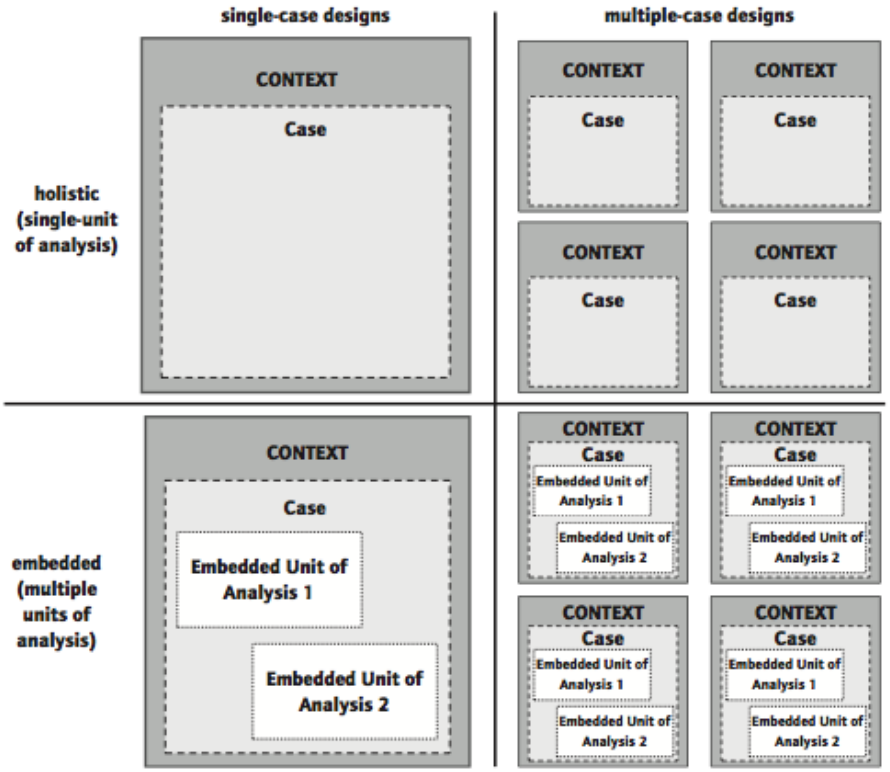
1. What was the rationale for the introduction of the role of practice facilitator?
2. How has the role of the practice facilitator changed over time?
3. How does the practice facilitator role function across a range of organisations?
4. How has the role of the practice facilitator impacted on pre-registration nurse education?
5. What effect has the role of the practice facilitator had on other key roles contributing to pre-registration nurse education?

Careful thought was required in order to define the 'case' to be studied. Although it may seem straightforward, defining the case, the unit of analysis to be studied, can be particularly challenging (Yin, 2009). According to Yin (2009) a case study is an empirical inquiry that investigates a contemporary phenomenon (the 'case') in-depth and within its real-world context. Although Yin recognises that defining the boundaries between the case and the context can be challenging, the case study approach is particularly promoted as suitable when the boundaries between the case and the context are not clear (Yin, 2009). It is also an important consideration that the research questions and the case need to be addressed together (Baxter and Jack, 2008; Bryman, 2016).

Yin (2009) outlines four basic designs for case study research. Each of the designs aim to analyse the contextual conditions in relation to the case. A clear understanding of what constitutes the case and the unit of analysis, and where they interface with

the wider context, contributes to a more robust case study design. The four types of case study designs Yin outlines are depicted in figure 3.1.

Figure 3.1 Basic types of designs for case studies (from Yin, 2009)

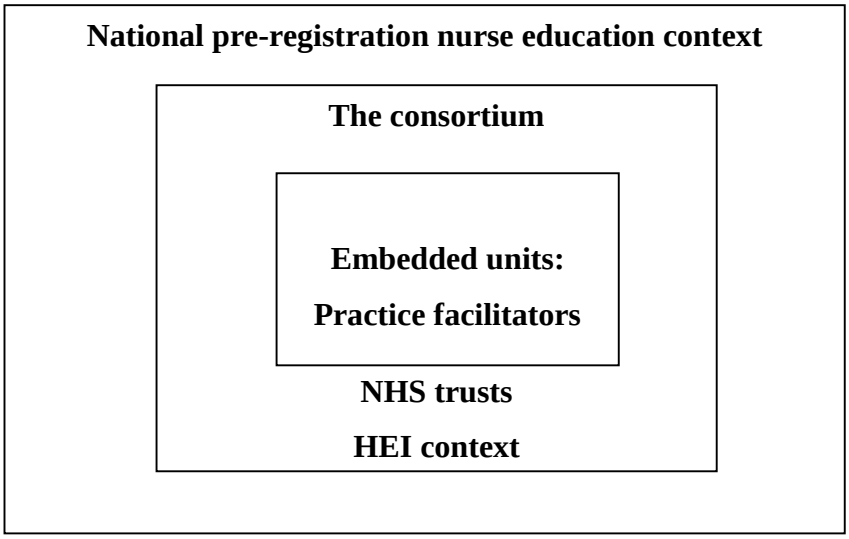


In this study, the design that has been adopted defines the case (i.e. the phenomenon being investigated) as the practice facilitator role. Within the case are embedded multiple units of analysis (figure 3.1, lower left quadrant). Each unit of analysis was each of the individual practice facilitators within the study consortium.

These all operated within the wider health and welfare context which directly impacted on the NHS Trusts, the HEI, pre-registration nurse education and associated professional frameworks (figure 3.2). In the specific context of exploring the evolving role and resultant impact of the PF in pre-registration nurse education, the embedded multiple units of analysis case study design therefore provided an appropriate framework (Yin, 2009).

A strength of embedded multiple units of analysis case study design is that it enables the researcher to analyse within each setting and across settings (Baxter and Jack, 2008; Yin, 2009). The selection of the case study approach therefore enabled the principal investigator in this study to study the impact of the PFs across a number of healthcare organisations and the HEI setting and in the real-world context in which they operated.

Figure 3.2 Practice facilitators as embedded case study units and relationship to study contexts (adapted from Yin, 2009).



A further advantage of using case study in this study was that the overall characteristics of real-life were maintained which included individuals, groups, organisations and managerial processes (Yin, 2009). Moreover, using embedded multiple units of analysis increased confidence in the results (Miles and Huberman, 1994). They expand further "*by looking at a range of similar and contrasting cases, we can understand single case findings, grounding it by specifying how and where and, if possible, why it carries on as it does*" (Miles and Huberman, 1994, p. 29) whilst building up an in-depth understanding of the context (Gray, 2014; Holloway and Galvin, 2017). This enabled the principal investigator to make comparisons across the units of analysis and reach "cross-case" conclusions (Yin, 2009; Gray, 2014). By examining multiple PFs in this study, comparisons and contrasts could be made to understand the role and how it functioned.

One of the challenges using case study, aside from defining the case, is that it can be too broad or too large and /or too complex for the researcher to manage. This can happen if the researcher has not defined the case and/or, where the researcher has not defined the objective. Therefore, it was important to decide what the case was and what the case was not (Baxter and Jack, 2008; Gray, 2014; Bryman, 2016; Holloway and Galvin, 2017). Each case should have pre-defined boundaries such as the group being studied, specific time-frame, geographical or organisation/s that are relevant to the study (Yin, 2009; Crowe *et al.*, 2011). Defining the PFs as the case to be studied in the consortium enabled these factors to be incorporated in the case study design for this study.

New policy initiatives and service developments could be explored using Yin's case study approach (Crowe *et al.*, 2011; Moule and Goodman, 2014) which enabled the exploration of the policy influence on the PF role in this study. Further, a case study approach enabled the participant/s views to be heard and which helped the researcher to view the participants' actions in the context of the research question/s (Baxter and Jack, 2008; Holloway and Galvin, 2017). Considering the range of elements of case study as discussed above, this approach was therefore eminently suitable for exploring the evolution of the PF role.

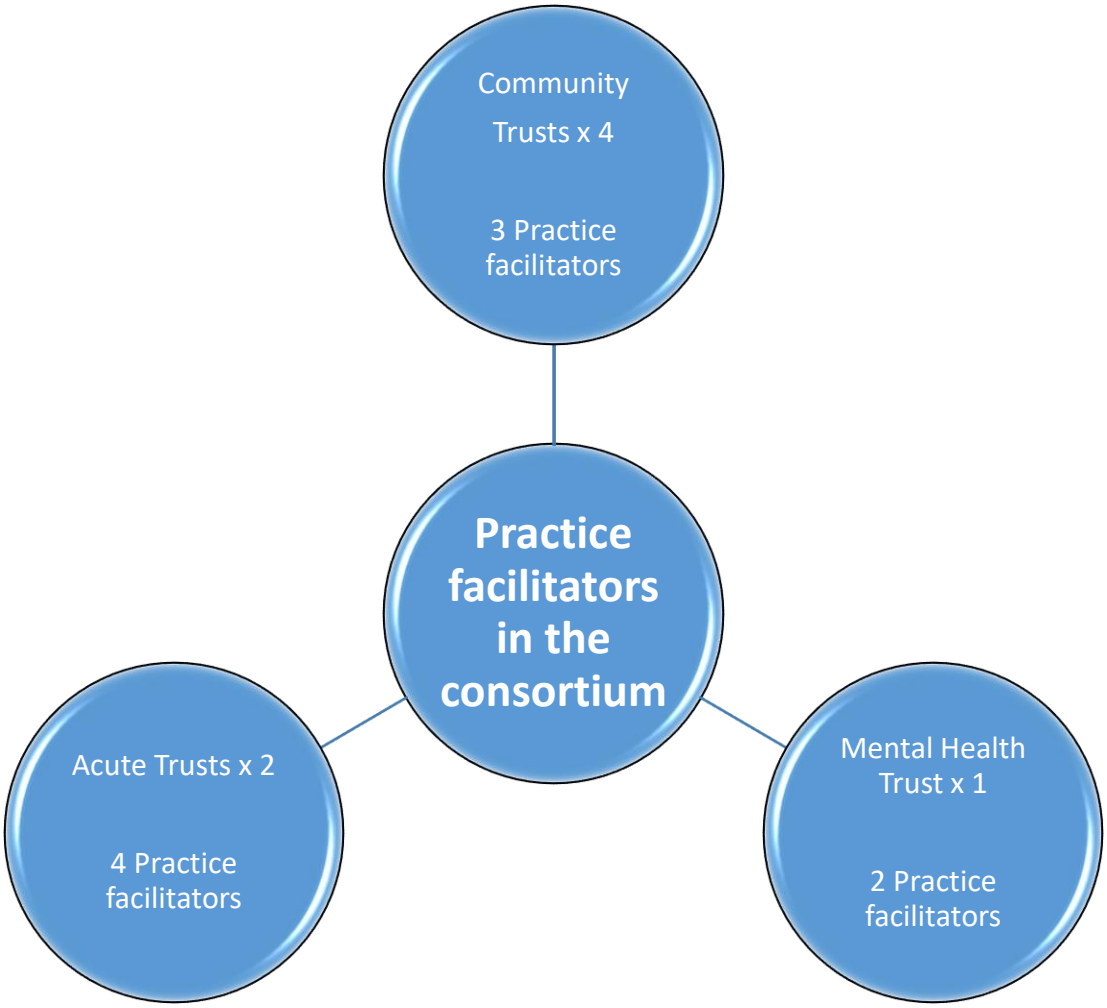
3.4 Study participants

There were five distinct groups of participants namely, practice facilitators (PFs), Education Leads (ELs), Heads of Department (HODs), Mentors and Link Lecturers (LLs). These participant groups represented the main frontline actors at strategic and operational levels both in the Trusts and HEI with responsibility for pre-registration nurse education (discussed in chapter 1).

Purposive sampling, or non-probability sampling, enabled the principal investigator to select study participants who were likely to be knowledgeable in relation to the area of investigation (Newell and Burnard, 2011; Moule and Goodman, 2014; Silverman, 2020). Participants were purposively selected from all nine of the existing PFs employed within the study consortium as they were in a position to provide information on their role. All nine were registered nurses. PFs who were in post and

based in the consortium were identified to take part in the study. These PFs were employed in the consortium constituting two Acute, one Mental Health and four Community Health Care Trusts respectively (figure 3.3). It should be noted that one PF covered two of the Community Health Trusts.

Figure 3.3 Location of consortium practice facilitators



Whilst the PFs were identified as central to this study, key individuals from both healthcare and education that influenced pre-registration nurse education were similarly purposively selected in order to collect data from their key perspectives. These participants were selected to include individuals whose responsibilities influenced pre-registration nurse education from strategic and operational perspectives. A brief explanation of these individuals' roles is provided below.

Education Leads

NHS Trust Education Leads (ELs) were employed in the NHS and had strategic responsibility for commissioning education and training in the Trust. Pre-registration nurse education was a key area of their portfolio and where the PF reported to the education lead on pre-registration nurse education issues. These ELs were based in the acute, mental health and community sectors.

Heads of Department

HEI Heads of Department (HODs) were employed in the HEI and lead at a strategic level adult, mental health & learning disability and child field pre-registration nurse education programmes.

Mentors

Mentors were employed in the NHS practice environment which included acute, mental health and community Trusts. They were operationally responsible for supervising and assessing pre-registration students in practice who were completing either adult, mental health, learning disability or child programmes.

Link Lecturers

Link lecturers (LLs) were employed in the HEI and taught, broadly speaking, academic elements of adult, mental health, learning disability and child pre-registration education programmes. They provided operational support for mentors and students in the practice environment.

3.5 Methods

Two data collection methods were employed comprising of one-to-one semi-structured interviews and focus groups (table 3.1). Semi-structured interviews are frequently used in qualitative research (Holloway and Galvin, 2017). Typically, the principal investigator has a series of questions to guide the interview but can vary the sequence of questions and can probe or ask further questions, depending on responses (Bryman, 2016). Focus groups are widely used to produce thoughts and opinions in areas such as policy, health and social care and can complement one-to one interviews (Holloway and Galvin, 2017).

Table 3.1 Summary of study participants and data collection method

Participant group	Number of participants	Method
Practice Facilitators	9	One-to-one semi structured interview
Trust based Education Leads	3	One-to-one semi structured interview
HEI Heads of Department	3	One-to-one semi structured interview
Mentors	26	Focus Groups x 4
Link Lecturers	16	Focus Groups x 3

The use of two methods contributed to achieving methodological rigour (Patton, 2002; Gray, 2014; Silverman, 2020) thus increased the robustness of the case study (Yin, 2009). Further, the use and triangulation of a variety of data sources reduced the likelihood of bias (Grix, 2004, 2010; Holloway and Galvin, 2017; Moule, 2018) and so contributed to the quality of this study (Tracy, 2010).

The one-to-one semi-structured interview method was selected as it facilitated in-depth discussion with the PFs, and the key role holders who had a strategic focus from the HEI and Trust perspectives on pre-registration nurse education (table 3.1). In addition, from a practical perspective, given that there were only small numbers of both ELs and HODs (table 3.1) individual interviews were an appropriate choice of method. Semi-structured interviews facilitated specific topics to be covered whilst enabling the interviewee flexibility in their reply (Bryman, 2012, 2016; Holloway and Galvin, 2017). The sample for the one-to-one interviews was purposively selected to include the PFs and participants who were in a position to have information on the role of the PF (Howitt and Cramer, 2014; Holloway and Galvin, 2017). These were identified as the ELs employed in the Trusts and HODs employed in the HEI (table 3.1). Interviews were planned to take place on a one-to-one, face-to-face basis in the participants place of work or, if it was more convenient for the participant, at the researchers place of work. One-to-one interviews were scheduled to take place for approximately 60 minutes.

As focus groups are suitable for exploring participants ideas and their differing views on a specific set of issues, focus groups were selected as a suitable method for

exploring mentor and LL experiences of the PF role (table 3.1) (Barbour and Kitzinger, 1999; Howitt and Cramer, 2014; Silverman, 2020).

This method lent itself to these two groups of participants because of their larger numbers as well as the potential methodological advantages. Focus groups facilitate gaining a wider insight into participants' opinions on a subject (Blaikie, 2010; Gray, 2014; Howitt and Cramer, 2014; Silverman, 2020). Mentor and LL roles were identified as staff who had an input into pre-registration nurse education where they had responsibility for teaching and assessing students in practice and the HEI respectively. These staff groups worked with the PFs, so it was important to elicit their views of the PF role.

Holloway and Galvin (2017) and Silverman (2020) advocate that focus groups can help participants articulate ideas and views they hold on a topic which can be generated through the interaction of the group and which other ways might not arise from individual interview responses.

Ideally, focus groups should contain between six to eight members (Bloor *et al.*, 2001; Silverman, 2020) or, as Barbour and Kitzinger (1999) and Howitt and Cramer, (2014) suggest, up to twelve, depending on the topic, is also acceptable. Nevertheless, even with careful planning, there may be occasions where participants have agreed to take part but may not be in a position to do so at the scheduled time for a variety of reasons. Therefore, the principal investigator aimed to achieve a minimum of six to a maximum of twelve participants for each focus group. In order to facilitate participant attendance, focus groups were held for mentors and arrangements made for these to take place in a central location to the participant's place of work. LL focus groups were arranged to take place in the HEI. Similar to the arrangements made for conducting the one-to-one interviews, focus groups were scheduled to take place for approximately 60 minutes as suggested by Holloway and Galvin (2017) in order to maintain participant engagement.

Holloway and Galvin (2017) opine that focus groups can complement and be used in conjunction with one-to-one interviews. A topic guide was prepared based on the literature presented in chapter 2, the propositions and the research questions in order

to gainfully use participants' time whilst maintaining focus on the research questions. Questions were structured in a logical order to facilitate the interviewing process for the principal investigator and participants (Patton, 2002; Holloway and Galvin, 2017).

The content of the topic guide was the same for the one-to-one semi-structured interviews (appendix 13) and focus groups (appendix 14). The one-to-one semi-structured interviews (appendix 13) and focus groups (appendix 14) were topic guides rather than a series of structured questions. In the case of individual one-to-one interviews, the topic guide was intended to elicit open and full responses by the individuals being interviewed. In the case of focus groups, the topic guides can best be considered a series of topics (Bryman, 2016) for discussion amongst participants. Using the topic guides did not preclude opening up new lines of enquiry that potentially emanated from either an individual participant or an idea arising from an interchange within a focus group discussion. The additional prompts in the topic guides (appendix 13, appendix 14) were not necessarily utilised, but were available to be drawn upon should they be required. It was possible that some topic areas could generate more discussion than others so the prompts were available should discussion wain. In both cases, although the facilitating style was different, the guides were intended to be reflective of the research questions (Bryman, 2016).

This facilitated maintaining a focus on the research questions for the different participants partaking in the one-to-one semi structured interviews and focus groups (table 3.1). In this way, the topic guide provided a cohesive framework to elicit and capture both individual participants' as well as group perspectives (Bryman, 2012, 2016; Holloway and Galvin, 2017). In addition, this approach was selected to bring together both strategic and operational perspectives across disparate HEI and Trust organisations. Therefore, taking this approach enabled a holistic understanding of the PFs to be contemporaneously ascertained from differing perspectives.

3.5.1 Accessing participants and invitations

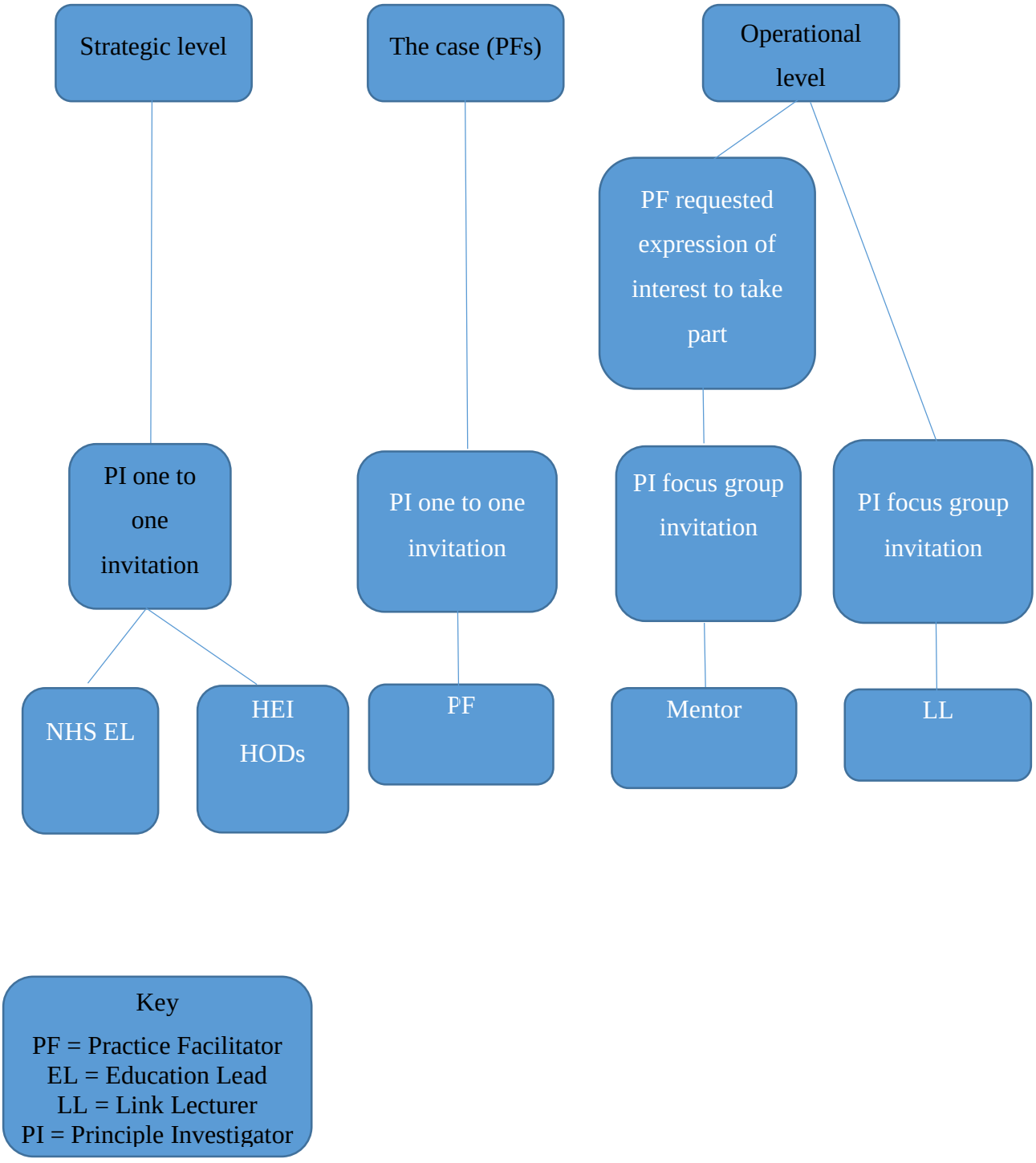
Following receipt of ethical approval (appendix 15) recruitment of potential participants was initiated by the principal investigator. All three of the HEI HODs

and all three Trust ELs, as well as all nine of the PFs were approached to participate in the study. The principal investigator worked with PFs and HODs on a regular basis and to a lesser extent, the Trust based ELs and so they had an awareness of this study through informal conversations. These potential participants that had been identified for the on-to-one semi-structured interviews were contacted via email with an attached letter of invitation to take part in this study (appendix 4) and included participant information for PFs (appendix 5), ELs (appendix 6) and HODs (appendix 7). Participants that agreed to take part were required to sign a consent form prior to commencing the one-to-one interview (appendix 10).

In terms of LL participants, the principal investigator worked in the same HEI location as LLs for the consortium study area and so had an awareness of this study through informal conversations. All LLs were contacted via email with an attached letter of invitation (appendix 4) and participant information for LLs (appendix 8) to request if they were willing to take part in this study. A schedule of dates and time of focus group meetings were circulated to those LLs that expressed an interest to participate. This facilitated potential participants the flexibility to choose a convenient date and time to attend. There were sufficient expressions of interest from LLs to accommodate the requisite number of participants to conduct three focus groups (table 3.1). Participants that agreed to take part were required to sign a consent form prior to commencing the focus groups (appendix 11).

In respect of recruiting mentors to the study a two stage process was used. This was because mentors worked in different NHS Trusts within the consortium. The first stage was, on behalf of the principal investigator, for the PFs, to send out an email invitation to mentors within their respective Trusts inviting expressions of interest to take part. Stage two was for the principal investigator to follow up the expressions of interest to take part with a formal invitation (appendix 4) and the study participant information (appendix 9). Prior to commencing the focus groups, mentors that had agreed to take part were required to sign a consent form (appendix 12). The process of participant invitation is summarised in figure 3.4 below.

Figure 3.4 Process for eliciting data from study participants



In conclusion, care was taken to make it clear to all potential participants that participation was voluntary. Recruitment was a phased process with participants invited by letter to participate. The principles of participant recruitment were adhered to as approved by the ethics committee (appendix, 15).

3.5.2 Linking research questions to data collection methods

Table 3.2 below summarises the link between each of the research questions, the related case study proposition, data sources and indicative interview questions or focus group topics.

Table 3.2 Linking research questions to propositions, data sources and methods

Research Question	**Proposition**	**Data Source**	**Indicative Interview Questions**
What was the rationale for the introduction of the role of the practice facilitator?	The rationale for the introduction of the role varied between stakeholders	One-to-one semi-structured interviews: PFs, Ed Leads, HODs Focus Groups: Link Lecturers Mentors	How long have you been in post? How long have you been in post / how long were you in the post of PF? (dates – historical perspective) Do you know when / or why the PF role came into being?
How has the role of the practice facilitator changed over time?	The role of the PF has changed and evolved over time and is affected by individual organisation priorities as well as department of health and professional body requirements	One-to-one semi-structured interviews: PFs, Ed Leads, HODs Focus Groups: Link Lecturers Mentors	Tell me about your / the PF role Tell me what your role entails / what does the role of the PF entail? Has the focus of your role / the PF role changed over time? If so, describe how you see it's changed over time / the years

			Are there elements of the PF role that have stayed the same?
How does the practice facilitator role function across a range of organisations?	Standardised job description/s and processes increase the impact of the role across organisation/s	One-to-one semi-structured interviews: PFs, Ed Leads, HODs Focus Groups: Link Lecturers Mentors	Tell me how you work / how your role works in your organisation / other organisations Tell me how the PF role works / works in your organisation / other organisations Given what you have told me about the way the PF role works do you think this is of benefit / problematic? Do you work with / communicate with / collaborate with other PF's in other Trusts and if so when / how often / what does this entail? Do you work with / communicate with / collaborate with anyone in the HEI and if so who / when / how often / what does this entail?
How has the role of the practice facilitator impacted on student nurse pre-registration education?	Key stakeholders impact PF role development and role focus and its resultant impact on pre-registration nurse education	One-to-one semi-structured interviews: PFs, Ed Leads, HODs Focus Groups:	Could you describe areas where you / the practice facilitator has influenced / impacted on pre-

		Link Lecturers Mentors	registration nurse education? What do you think the impact of the role of the practice facilitator is / has been on pre-registration nurse education?
What effect has the role of the practice facilitator had on other key roles contributing to pre-registration nurse education?	The PF posts have had an impact on pre-registration nurse education	One-to-one semi-structured interviews: PFs, Ed Leads, HODs Focus Groups: Link Lecturers Mentors	Who do you work with (does the PF work with) in relation to pre-registration nurse education? Has the PF role any effect on your role? Has the PF role had any effect on how you operate?

3.6 Data management

Bryman (2016) promotes the usefulness of digitally recording interviews which Moule and Goodman (2014) also support as recordings can be used to develop word for word transcripts. As such, all one-to-one semi-structured interviews and focus groups interviews were audio recorded using a digital recorder. All recordings were subsequently transcribed by the principal investigator which supported becoming familiar with the data corpus an important phase in Braun and Clarke's (2006, 2013) thematic analysis method (see section 3.8).

Confidential storage of data is a central consideration in the research process (McColl *et al.,* 2001; Gray, 2014). Therefore, arrangements were put in place where all research and personal data was stored in a secure and confidential manner whether as hard copy or electronically. Data was stored in a locked filing cabinet, to

which only the principal investigator had access and located in a locked office when not occupied.

The principal investigator assigned letters to identify the participant posts (PF, EL, HOD) that took part in the semi-structured interviews and each was allocated a unique number (table 4.1). Mentor and link lecturers were assigned letters (MFG and LLFG) to identify the staff focus groups (table 4.1). All participants' data was thus identified (table 4.1) before being made available to the research supervisors in order to maintain anonymity and confidentiality (Moule and Goodman, 2014). Information which might have identified a participant was not used in order to ensure participants anonymity and confidentiality (section 3.7).

To assure anonymity, the participant identification system was known only to the principal investigator and was stored separately from transcript data in a locked filing cabinet as advised by Bryman (2016) which was located in a locked office when not occupied. A password protected computer and an encrypted data stick was used for storing data and when writing the research. No data on results was published before the submission of the thesis. All data will be destroyed in a confidential manner five years following submission of the thesis.

3.7 Ethical considerations

The principal investigator was aware of and complied with the HEI Research Ethics Code and the Research Governance Framework for Health and Social Care. The principal investigator prepared the research ethics application and approval was granted for the study by the HEI research ethics committee (appendix 15).

The principal investigator subsequently contacted the research and development departments for the consortium Trusts where it was anticipated the research would be undertaken. The standard integrated research application system (IRAS: Registration number 120482) pro-forma was completed to register this study (appendix 16) and approval to conduct interviews in the consortium Trust premises was granted (appendices 17, 18, 19). Insurance and indemnity was provided by the HEI and

provided to the NHS research and development departments in order to meet potential legal liability (appendix 20).

Potential participants were sent an invitation letter (appendix 4) and a participant information sheet for the participant groups (appendix 5, appendix 6, appendix 7, appendix 8 and appendix 9). The participant information sheet explained the purpose of the research, confidentiality and consent, invited participants to take part or decline and the freedom to withdraw from the research study.

The principal investigator obtained the participants written consent before each one-to-one interview (appendix 10) or focus group (appendix 11, appendix 12) using the consent form which had been approved by the HEI research ethics committee (appendix 15) and subsequently approved by the NHS Trusts in the consortium where the study was being conducted. Participants were made aware they could withdraw their consent at any time up to the submission of the thesis.

The anonymity and privacy of participants in research should be respected (Bryman, 2012, 2016). Anonymity in research refers to ensuring non-identification by removing participants' names and information that identify the study site/s which also helps to maintain confidentiality (Tilley and Woodthorpe, 2011; Holloway and Galvin, 2017; Moule, 2018). The location of this study was identified as the consortium in order that the research site was not identified. Participants' privacy, confidentiality and anonymity was maintained throughout the research process. All participants' data was coded (table 4.1) before transcripts were made available to the study supervisors in order to maintain participants' anonymity and confidentiality.

Prior to commencing the one-to-one interviews and focus groups, the principal investigator discussed the researcher's role. This included discussing the information sheets and providing assurance that all personal information would be anonymised and confidential (Moule, 2018). The principal investigator discussed with participants that the role of the PF in relation to pre-registration nurse education was the focus of the study and was therefore not focussing on individual PFs.

As the principal investigator was a registered nurse, consideration was given to the possibility of a significant issue in relation to practice during the one-to-one or focus group interviews. As such, the principal investigator had professional responsibility to uphold professional standards and safeguard the public (NMC, 2008b, 2010a, 2015, 2018e). Information was included in the participant information sheets (appendices 5, 6, 7, 8, 9) that in the event of a significant issue in relation to practice becoming evident, the principal investigator would further discuss the issue with the participant/s in relation to organisational policies, procedures and NMC standards (NMC, 2008b, 2010a, 2015, 2018e).

Newell and Burnard (2011) and Silverman (2020) advise the researcher should be prepared to deal with situations where participants may become upset. Therefore, consideration was given in the event of a participant becoming upset during the one-to-one, or, focus group interviews. In such a circumstance the principal investigator planned to pause the interview and discuss the issue in a supportive manner and establish if the participant wished to stop, pause, or reconvene the interview at a mutually agreed time. If the participant wished to continue, the principal investigator planned on resuming the interview. If the participant wished to pause for a while, this would be facilitated as would reconvening at a mutually agreed time. This information was included in the participant information sheet/s. On completion of the interview, the principal investigator planned on discussing the experience with the participant/s to ensure appropriate support was accessed if required (Silverman, 2020). However, no instance of participants becoming upset occurred in either the one-to-one interviews or the focus groups.

3.7.1 Maintaining objectivity when conducting qualitative interviews

The principal investigator's position in the HEI and working in collaboration with the Trusts in the consortium (section 1.9) led to acknowledgement of, and consideration of this researcher's role status in order to promote the rigour of this study. Whilst it is important that researchers are objective in order that their research is non-biased (Holloway and Galvin, 2017) they nevertheless concede this is difficult to achieve. The significance and implications of both outsider and insider research positions is much discussed (Kanuha, 2000; Asselin, 2003; Kerstetter, 2012;

Hayfield and Huxley, 2015). Whilst outsider researchers are not members of the group under study (Breen, 2007; Braun and Clarke, 2013) insider researchers share some identity with the study group (Kanuha, 2000; Asselin, 2003; Braun and Clarke, 2013). Both perspectives are seen to have methodological advantages and disadvantages. One such disadvantage for the outsider is where the researcher may have difficulty accessing participants (Chawla-Duggan, 2007) but does not have preconceived ideas (Kerstetter, 2012) and so can remain neutral. However, it is also argued that outsiders may misunderstand the nuances of participant's experiences and so miss important aspects of the research (Hayfield and Huxley, 2015).

Some theorise that bias is unavoidable where the researcher has knowledge of the area being studied, so conducting qualitative research as an insider can be challenging (Asselin, 2003; Moule and Goodman, 2014). In relation to case study research, where the context is important, insider researchers have a fuller understanding of the contexts in which participants are situated. Therefore, this principal investigator, as an insider (section 1.9) had the advantage of having a shared understanding of the group culture (Newell and Burnard, 2011; Kerstetter, 2012; Holloway and Galvin, 2017). This was reflected in the interviews in this study as participants spoke openly as they presumed a shared understanding with the principal investigator of their role and work environment. There are two dimensions to this. Firstly, having been a practitioner within NHS Trusts and secondly, being employed as an academic in the HEI (section 1.9) the principal investigator had an understanding of the culture, processes and language of the respective organisations.

Whilst this was a potential benefit to the study, as the principal investigator had an insight into the role of the PF and pre-registration nurse education issues, the principal investigator maintained objectivity in the research process to minimise bias (Bryman, 2012) by "*turning off his or her own interpretative filters*" (Gray, 2014, p. 268). One means of achieving this was by attempting to step outside of the day-to-day professional relationship into a different role as "researcher". In doing so, it comes with an altered mind set for the researcher as well as a different way of relating to study participants from professional – professional to researcher – participant relationships.

Examples of this mind set were if responses to interview questions were different to those anticipated, the principal investigator was alert to the need and skill required to explore this. The principal investigator was also aware that there may be a risk of participants answering questions with information they may perceive the principal investigator wanted to hear. This risk was also managed by the principal investigator by providing the information contained in the participant information sheet, consent and the right to withdraw from the research process. Participants were advised they were free to choose not to participate and reassured that choosing not to participate would not affect their collegiate relationship with the principal investigator or the consortium.

3.8 Data analysis

When considering data analysis for this study, the principal investigator selected Braun and Clarke's (2006) six phase thematic analysis method to analyse the data. One reason for selecting Braun and Clarke (2006) was that it is not confined to a particular epistemological tradition, thus it was congruent with the pragmatic approach of this study. Braun and Clarke (2006) state that principal investigators, as well as applying their thematic method, still need to make their epistemological and other assumptions clear. Maguire and Delahunt (2017) endorse that the flexibility offered by Braun and Clarke (2006) means it can be used across diverse areas of work. This flexibility, combined with the structured approach meant it was a suitable approach for exploring the impact of the PF role on pre-registration nurse education in practice in the consortium.

A criticism levelled at researchers when analysing qualitative data is their failure to employ a standardised approach in the analysis of data (Miles and Huberman, 1994; Bryman, 2016). It follows that a non-standardised approach may be viewed as undermining the findings as they might be interpreted in different ways which may not withstand scrutiny and so the findings may be questionable. Since this problem was highlighted by Miles and Huberman in the late 1970's, it has been acknowledged that researchers have, in more recent years, addressed data analysis in a more systematic way (Vaismoradi *et al.*, 2016; Maguire and Delahunt, 2017). Now, various data analysis tools such as matrices and network displays are widely used in

qualitative data analysis (Miles and Huberman, 1994; Bree and Gallagher, 2016). Similarly, Madill and Gough (2008) point out that a number of different qualitative data analysis approaches have developed since the 1970s.

Yin (2009) considers that the analysis of case study evidence is under developed and is in fact one of the most challenging aspects of case studies. It is recognised that whilst one of the strengths of case study methodology is the diverse range of data, Yin suggests researchers face challenges when analysing the data (Yin, 2009). However, in order to address this aspect of data analysis, Yin suggests it is helpful to '*play*' Yin (2009, p. 162) with the data. This can be useful as data can be viewed in different ways such as putting information into different arrays or tabulating the frequency of events. For example, Braun and Clarke (2013) cite the example of Terry (2010), a former PhD student of Braun, who used some quantitative terms to elicit the prevalence of themes across the data corpus but emphasised this was "*to provide some indication of the strength or consistency of a theme*" (Terry, 2010, p.108) rather than an exercise to count the number of instances.

From an ontological perspective, the qualitative researchers' approach is that in relation to complex human activities, reality or truth cannot be readily measured. Therefore it requires an approach that is able to elicit not only behaviours, but also underlying meanings, beliefs and values of participants within social situations. This needs to be investigated in a flexible, intuitive manner which needs to be analysed in a logical, transparent and auditable way.

Braun and Clarke (2006) have provided a detailed systematic approach to undertaking thematic analysis as a data analysis approach used in qualitative research. This structured approach has been widely used in psychology and has been increasingly adopted by health and social care researchers, therefore offered a method for analysing data in this study (Kemp *et al.*, 2016; Nowell *et al.*, 2017). Qualitative methods, by providing a structured approach, are a valuable way for exploring the complexities of healthcare enabling rich insights into often complex areas (Smith and Firth, 2011). Whilst Bryman (2016) asserts that thematic analysis generally lacks agreed procedures and Smith and Firth (2011) caution that data can be separated from its origins, Howitt and Cramer counter these perspectives,

asserting that Braun and Clarke provide a '*fully fledged account of thematic analysis*' (Howitt and Cramer, 2014, p. 379). Furthermore, thematic analysis offers a '*typically inductive or "bottom up" approach in analysing data*' (Madill and Gough, 2008, p. 258). This enabled texts of similar meaning to be clustered through which the nature of the phenomenon could be obtained (Madill and Gough, 2008; Howitt and Cramer, 2014).

Braun and Clarke define thematic analysis as "*a method for identifying, analysing and reporting patterns within data*" (Braun and Clarke, 2006, p. 83). Thematic analysis is therefore a form of interpretative analysis whereby raw interactional data is made sense of by an iterative process of interpretation whereby patterns in the data build up to inform themes. The practical means by which this interpretation of the data is carried out is outlined provided in Braun and Clarke (2006) six phases of thematic analysis (see below). This is in relation to the research question where patterns in the data build up to themes. This is a further important aspect as this method enabled the principal investigator to capture important elements of the data in relation to the research questions on the PF role in this study.

Thematic analysis can be inductive or deductive. Inductive thematic analysis is a '*bottom up approach*' and is described as "*not shaped by existing theory*" (Braun and Clarke, 2013, p. 12). Theoretical, also termed deductive analysis, using a 'top down' approach is "*guided by existing theory*" (Braun and Clarke, 2013, p. 12). A topic guide for the semi-structured interviews with participants was used to gain participant perspectives in relation to the research questions (appendix 13, appendix 14). This was the material that was used for the 'bottom up' thematic analysis of the responses to generate the themes and sub-themes.

Braun and Clarke's (2006) thematic analysis has six phases, where the process starts with becoming familiar with the data, following which initial codes are generated and prospective themes are sought. The process continues where prospective themes are reviewed leading to defining and naming the themes. The final phase is producing the report. This study has used illustrative participant quotes that informed the themes and sub-themes. This structured approach to thematic analysis strengthened data analysis by making the steps taken transparent (Madill and Gough,

2008; Vaismoradi *et al.*, 2016). Braun and Clarke (2006) six phases provided an active and flexible way of identifying themes within the data corpus (the entire data) enabling the principal investigator to analyse data from the different sources in this study. The six phase approach provided a logical flow for data analysis, although in practice, this principal investigator found this to be an iterative process involving moving back and forth between the phases to 'refine and clarify' analysis. Braun and Clarke's six phases for thematic analysis are presented in table 3.3.

Table 3.3 Braun and Clarke's 6 phase guide to performing thematic analysis
(Summarised from Braun and Clarke, 2006)

Familiarising yourself with the data: Transcribing data, reading and re-reading the data, making notes of initial ideas
Generating initial codes: Interesting facets of the data are coded in a systematic way across the entire data set, bring together data relevant to each code
Searching for themes: Formulating codes into possible themes, collecting all data relevant to each possible candidate themes and sub-themes.
Reviewing themes: Check if the themes work relative to the coded extracts and the data corpus. Generate a thematic 'map' of the analysis
Defining and naming themes: Continue analysing each theme, relate the specifics to the overall story the analysis tells which generates clear names for each theme
Producing the report: The final opportunity for analysis. Select vivid, compelling extract examples which relate back to the research questions and literature to produce a report of the analysis

Braun and Clarke's six phase method of thematic analysis was applied to the current study in the following way:-

Phase 1 Familiarising yourself with the data

The principal investigator conducted all interviews which facilitated initial familiarity with the data. Data was collected through interactional means (in this study through individual interviews and focus group discussions). Recordings of all interviews were listened to. All individual interviews and focus group discussions

were transcribed verbatim by the principal investigator. The active iterative process of listening, transcribing and re-listening to the recordings facilitated in-depth familiarisation with the data. This proved to be a key advantage of self-transcribing. Transcripts were read in hard copy and notes made to reflect initial ideas. Reading through the data was via a process of active reading where the principal investigator began to try and make sense of meanings and patterns. This repeated, active reading took place in advance of the coding as recommended by Braun and Clarke (2006). Inevitably, the researcher comes to the analysis with prior knowledge and some analytical insights. Throughout this, it was important to act as a faithful witness to the accounts given in the data and be vigilant of the principal investigator's perspective (Nowell *et al.,* 2017).

Phase 2 Generating initial codes

All transcripts were re-read in hard copy and all statements of potential interest were highlighted. These statements and their identification source were entered onto an Excel spreadsheet. Initial short phrase codes were ascribed to the statements (appendix 21). In the coding process, it was necessary to keep revisiting the data in the transcripts and equal attention was given to each data item as recommended by Braun and Clarke (2006). Given the sheer amount of data generated, effective data management was vital. The raw data was entered onto an Excel spreadsheet as a data management tool. Repeated patterns were identified across the data set.

Phase 3 Searching for themes

Using codes and identified patterns potential themes were looked for within the results. Mindmaps were used as an additional means of identifying patterns. In order to minimise researcher bias and increase the trustworthiness of the results, the adequacy and appropriateness of the patterns and potential themes were subject to review by the study supervisors. Some codes were not treated with the same interpretive depth as others and this depended on their relevance to the research question. Some items that were coded referred to ordinary matters whereas others were of some significance to the themes. This process assisted further development and the formulation of candidate themes.

Phase 4 Reviewing the themes

The candidate themes were reviewed and sorted. This process involved integrating similar thematic ideas to inform a revised theme. Further interpretative analysis involved (returning to) re-engaging with the original codes to identify contradictions and corroborations within the data. Where there were closely related candidate themes that were strong enough to remain distinct, these were reconstituted as sub-themes. Through this iterative process the study's sub-themes, themes and overarching theme were finally arrived at. Through this process of formulating themes, returning repeatedly to the codes, patterns and candidate themes, it was eventually determined that further review did not contribute to any further development of the themes.

Phase 5 Defining and naming themes

Following on from the Mind mapping and identification of codes, patterns and candidate themes were considered in relation to each other and themselves. Consideration was given to the structure of sub-themes and themes. Finally, the study's sub-themes, themes and overarching theme were named to capture the nuances and meanings to reflect the data they represented. Efforts were made to give these names punchy immediacy to give readers a sense of what the theme was about.

Phase 6 Producing the report

The research undertaken is reported in this thesis. The collection and analysis of the data, using thematic analysis, informed the formulation of the key research themes. These are discussed in depth in chapter 5 against the wider context of Lipsky (2010) and published literature. This allowed a holistic picture of the case study subject, the PF, to emerge (figure 5.1) which enhanced understanding of the nature of the PF role, and wider significance of the PF in pre-registration nurse education in practice.

3.9 Promoting rigour: Tracy's (2010) key markers of quality

There are a proliferation of modes for evaluating the veracity, quality and rigour of qualitative research (Lincoln and Guba, 1985; Miles and Huberman, 1994; Rolfe, 2006; Yin, 2009; Gray, 2014; Moule and Goodman, 2014; Topping, 2015; Bryman, 2016; Holloway and Galvin, 2017; Silverman, 2020). The conventional criteria of

reliability validity and generalisation used in quantitative research is often cited as inappropriate for assessing qualitative research (Twycross and Shields, 2005; Braun and Clarke, 2006; Parahoo, 2006; Bryman, 2016). Perhaps the most frequently cited is that of Lincoln and Guba (1985) with their criteria of credibility, dependability, confirmability, transferability and authenticity (Treharne and Riggs, 2015).

This study utilises a set of criteria for addressing rigour developed by Tracy (2010) as a potential issue with Lincoln and Guba's (1985) criteria is that they are broad based, whereas Tracy's approach is more detailed. Further, (Halpin, 2015) provides an example of a research study where Tracy's approach has been applied successfully.

Tracy (2010) has formulated, what she refers to as the 'big-tent criteria' for judging qualitative research. She argues that different sets of criteria for evaluating qualitative research are often paradigm or qualitative community specific for example Creswell (2007). She also argues that there is a place for broadly stated, '*universal hallmarks*' (Tracy, 2010, p. 837) that can be applicable to all forms of qualitative research. This assertion aligns with Reicher (2000) who articulates that instead of using criteria for judging quality that are linked with ontological, epistemological and theoretical designs, it is important to judge the quality of research on its own terms. Tracy (2010) describes her "Eight "Big-Tent" criteria as creating "*a parsimonious set of universal criteria for qualitative quality that still attends to the complexity of the qualitative landscape*" (Tracy, 2010, p. 839). Tracy's (2010) eight criteria of qualitative quality are 'worthy topic', 'rich rigor', 'sincerity', 'credibility', 'resonance', 'significant contribution', 'ethics', and 'meaningful cohesion' and have the flexibility to be applied to a range of methodological practices. This understanding was, from this principal investigator's perspective, as providing good grounds for adopting Tracy's (2010) criteria for assuring the quality of this study and which are now explored.

'Worthy topic' The NHS registered nurse workforce is dependent on a continual supply of nurses who have completed pre-registration nurse education programmes that adequately prepare student nurses to join this workforce on registration. This was significant as it was essential that adequate resources were available to support

the student population and that students were provided with good quality theoretical and practical experiences throughout pre-registration programmes. Whilst the PF role in this study was created in response to *Making a Difference* (DoH, 1999) and *Fitness for Practice* (UKCC, 1999) policy drivers, 'problem issues' such as placement resource availability and deficits in LL and mentor roles identified at the time, continue to have current resonance. These were articulated by participants in the current research, presented in results chapter 4, and, subsequently discussed in chapter 5.

The literature review, chapter 2, identified that where PFs were introduced, studies on the role found it had made a positive contribution in differing aspects of pre-registration nurse education. However, no research had studied how the role had developed over time and its impact on pre-registration nurse education. This study explored the way the PFs role evolved in a real-world context over time and its impact on pre-registration nurse education.

A number of steps were taken to ensure ***'rich rigor'*** (Tracy, 2010). Careful consideration was given in identifying a sufficient sample (section 3.4, table 3.1) where participants were selected who were relevant to the research questions (Howitt and Cramer, 2014). In the current study, the sample was appropriate as purposeful sampling, consisting of PFs and key roles who worked with PFs, at strategic and operational levels in the HEI and Trusts were selected who could provide different perspectives and thus contribute to the provision of sufficient data for analysis. This analysis, discussed in chapter 5, provided answers to the research questions in chapter 6.

Braun and Clarke's thematic analysis is an influential and widely used approach to analyse data in qualitative research (Maguire and Delahunt, 2017). The rigour of Braun and Clarke (2006) six steps approach for conducting thematic analysis was systematically applied (section 3.8) and informed the themes which are presented in results in chapter 4.

Tracy (2010) conveys that ***'sincerity',*** an end goal of research, meant the principal investigator being 'earnest' and 'vulnerable' where they considered others, including

participants. This was achieved by considering each stage of interaction with participants including the preparation of questions for the interview process to ensure questions were neutral and not leading the participants (Howitt and Cramer, 2014). Data collection methods and questionnaire interview schedules were critically reviewed and discussed with supervisors. Prior consideration was given of action that would be taken in the event of participants becoming upset during the interviews (section 3.7). The possible effect of the principal investigator working with some participants (Howitt and Cramer, 2014) was considered (sections 3.7; 3.7.1). 'Sincerity' also required the principal investigator to, 'through 'self-reflexivity' be aware of and explore subjective 'inclinations'. All interviews were recorded and the process of analysing this data using Braun and Clarke (2006) was provided (section 3.8). Anonymised transcripts were discussed with the research supervisors in order to maintain objectivity.

'Credibility' was linked to trustworthiness where others can rely on the goodness of the research on which to make decisions (Tracy, 2010) so requiring '*the truth of the findings*' (Guba and Lincoln, 1989, p. 234). Using 'thick descriptions' was seen as one of the most important ways to achieve credibility (Tracy, 2010), connecting individuals to the issues and accurately relaying their reality (Patton, 2002). An element of credibility is 'multivocality' (Tracy, 2010) where the multiple and varied voices of participants were included in the report and analysis so providing the opportunity for differing opinions thus enhancing qualitative research. 'Thick descriptions' and 'multivocality' of the different participants were evidenced throughout the results in chapter 4 and in subsequent discussions in chapter 5.

A further element in achieving credibility was 'triangulation' (Tracy, 2010) where a number of data sources and methods (section 3.5) were used which allowed the principal investigator to address different research questions or aspects of the questions. This enabled the principal investigator to cross-check and triangulate results and were presented in chapter 4.

The ***'resonance'*** of good quality research relates to how it meaningfully chimes with, and affects those reading it (Tracy, 2010). Direct quotations using a variety of participant's own words evoke 'aesthetic merit' in this study which are presented in

chapter 4. This was seen as an important way of providing direct insight into and giving voice to participants' perspectives on the topic. Participants articulated their message in a way that was likely to engage readers so it was likely this facilitated the understanding of those readers who were not familiar with the topic area.

The participant's voice in this study contributed to ***'transferability'*** (Tracy, 2010) where readers could identify with the participants experiences and were presented throughout results chapter 4. An important element in 'transferability' was the extent to which the results could be taken up and implemented by others (Patton, 2002; Braun and Clarke, 2013). Detailed descriptions (Polit and Beck, 2010) on all aspects of this study were provided throughout which enables readers to evaluate if the research should be transferred to their situation.

Research needs to make a ***'significant contribution'*** (Tracy, 2010). This is demonstrated through the development of a diagrammatic representation of the PF role (figure 5.1) which brought clarity and new understanding of the role. Explanatory frameworks of the current operation of the PF role and the evolution of the role were presented (chapter 5) thus bringing new understandings of the PF role. The study contributions were evidenced (section 6.5) and recommendations from this study made for UK policy makers (section 6.7.1) UK healthcare providers (section 6.7.2) and UK pre-registration nurse education providers (section 6.7.3). Recommendations for future research were made (section 6.6) meeting 'heuristic significance' (Tracy, 2010) in supporting people exploring and learning for themselves.

'Ethical' research is a universal end goal in achieving quality (Tracy, 2010). Essentially, it is how research is morally conducted (Howitt and Cramer, 2014). In the current research, measures were taken where meeting procedural ethical requirements were given including ethical considerations (section 3.7) data management (section 3.6) and ethical approval (appendix 15).

Finally, ***'meaningful coherence'*** relates to how the interconnecting elements of the study achieve the research purpose and 'hangs together well' (Tracy, 2010). 'Meaningful coherence' was demonstrated throughout this study initially through

situating the research in chapter 1. Knowing the literature already available on the subject area (Bryman, 2016) was achieved in the literature review presented in chapter 2. Explanations for epistemological, methodological and methods selected were presented in chapter 3 guided by expert sources (Braun and Clarke, 2006; Yin, 2009). Results that related to the research questions were presented in chapter 4 subsequently illuminated and discussed in the context of the wider literature and presented in chapter 5 thus maintained the research foci (Tracy, 2010). Finally, the research questions were answered (section 6.3) and the study's contribution presented (section 6.5) recommendations for future research made (section 6.6) and recommendations from this study (section 6.7; 6.7.1; 6.7.2; 6.7.3) all of which support the achievement of 'meaningful coherence' (Tracy, 2010). Tracy's (2010) big tent criteria are returned to in section 6.4.4.

3.10 Chapter summary

This chapter has discussed the fundamental influence of pragmatism in this study. An explanation was given in pragmatisms congruence with Lipsky's (1980) policy implementation approach where 'what works' and what was delivered by street-level bureaucrats was the policy. The rationale for selecting a case study (Yin, 2009) research design was provided and linked to the rationale for purposeful sampling in selecting the study participants. Data collection methods and data analysis method (Braun and Clark, 2006) were discussed. Details of how ethical considerations were addressed are given. Finally, information of action taken during the research process in achieving good quality research was discussed. The results are presented in chapter 4.

Chapter 4: Results: the everything facilitator

4.1 Chapter introduction

The results of the study, presented in this chapter, provide a detailed insight into the evolving role of the practice facilitator within the study consortium. As outlined in chapter 3, the data collected was in the form of individual interview transcripts and focus group transcripts collected from the different categories of participants (table 3.1). Overall, the results reflected a cumulative development of the practice facilitator responsibilities and expanding remit in directions some way removed from the original conceptualisation and instigation of the role. To aid the reader, a system of abbreviations has been used to identify data sources (table 4.1). All of the data ascribed to participants is coded to preserve anonymity. The data analysis presented in this chapter adheres to the application of Braun and Clarke's (2006) approach to thematic analysis described in chapter 3 (section 3.8).

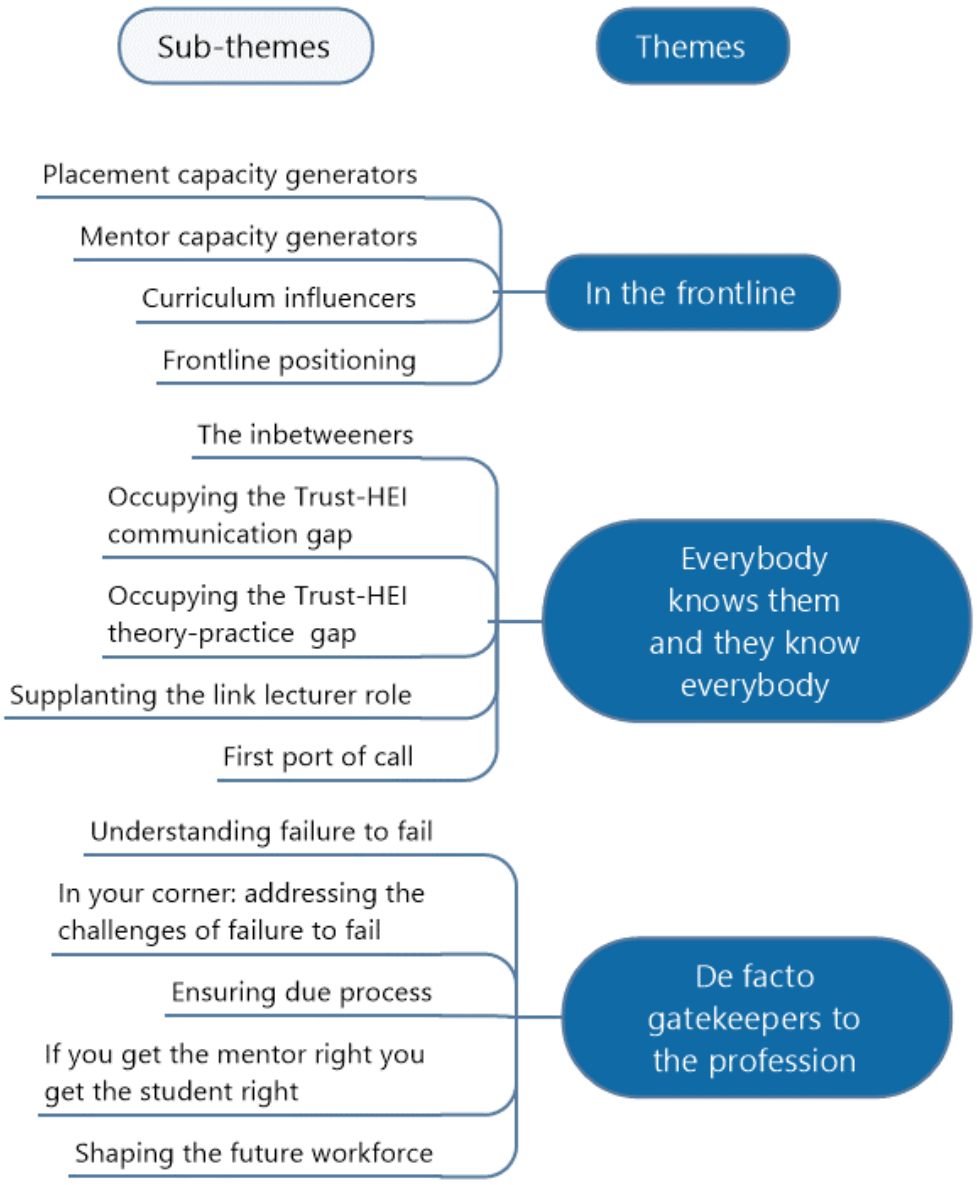
Table 4.1 Table of abbreviations and notations used to identify sources

Abbreviation	Abbreviation meaning	Data source notation
PF	Practice Facilitator	Individual number assigned to each individual interview participant, followed by transcript line, e.g. *PF1 100-110*
EL	NHS Trust Education Lead	Individual number assigned to each individual interview participant, followed by transcript line, e.g. *EL2 100-110*
HOD	HEI Head of Department	Individual number assigned to each individual interview participant, followed by transcript line, e.g. *HOD3 100-110*
LLFG	Link Lecturer focus group	Number of Focus Group, plus individual number of FG participant, e.g. *LLFG1, No. 2*
MFG	Mentor focus group	Number of Focus Group, plus individual number of FG participant, e.g. *MFG1, No. 3*

All participants (table 3.1) regardless of their strategic or operational positioning across the HEI and seven Trusts (figure 3.3) conveyed a clear message that practice facilitators (PFs) were influential fixers who were enmeshed in the fabric of pre-registration nurse education in practice across the consortium. Participants were eager to engage in this study and there was an overall positive regard for the practice facilitator (PF) role. Regardless of their own remit, the non-practice facilitator participants conveyed that PFs solved their problems around supporting pre-registration students in practice. A noticeable feature was that all of these participants knew their PFs and there was a sense of familiarity and regular contact.

The results are presented in the form of the three main themes, their related sub-themes and overarching theme that were identified as a result of the data analysis. The first theme, *in the frontline*, explores participants' perception of PFs positioning of being directly involved in activities that are fundamental to the operation of pre-registration nurse education in practice. Theme two, *everybody knows them and they know everybody*, shows the PFs actively engaging in different activities across the Trust and HEI where they have become well known. *De facto gatekeepers to the profession*, the third theme, revealed how the PFs shaped their role elements to enable them to ensure the quality of students, mentors and newly qualified nurses. The themes and sub-themes (figure 4.1) are presented in broad order of chronology, reflecting the phases of role accumulation over time. Each theme and related sub-themes are presented in turn and the chapter concludes with a discussion of the overarching theme *the everything facilitator* arising from the analysis of themes and sub-themes. The chapter ends with a brief summary of the chapter.

Figure 4.1 Mindmap representing sub-themes and themes



4.2 Theme one: In the frontline

4.2.1 Theme introduction

There is a general sense from participants of the front line, direct nature of the PFs presence across pre-registration nurse education in practice. The instrumental nature of the PF role in…*making sure there is capacity* [HOD2 190], was recognised by participants as one of the enduring fundamental responsibilities of the PFs. This

meant not just the number of placement areas but participants were cognisant of the need for appropriate and positive placement experiences.

> *…student nurse education is 50% in practice so…the creation of that positive learning environment and all of that is linked to the work of, is central to the work of the PFs*
>
> *[HOD2 671-674]*

A PF describes the ongoing nature of the interactions to deliver this as: -

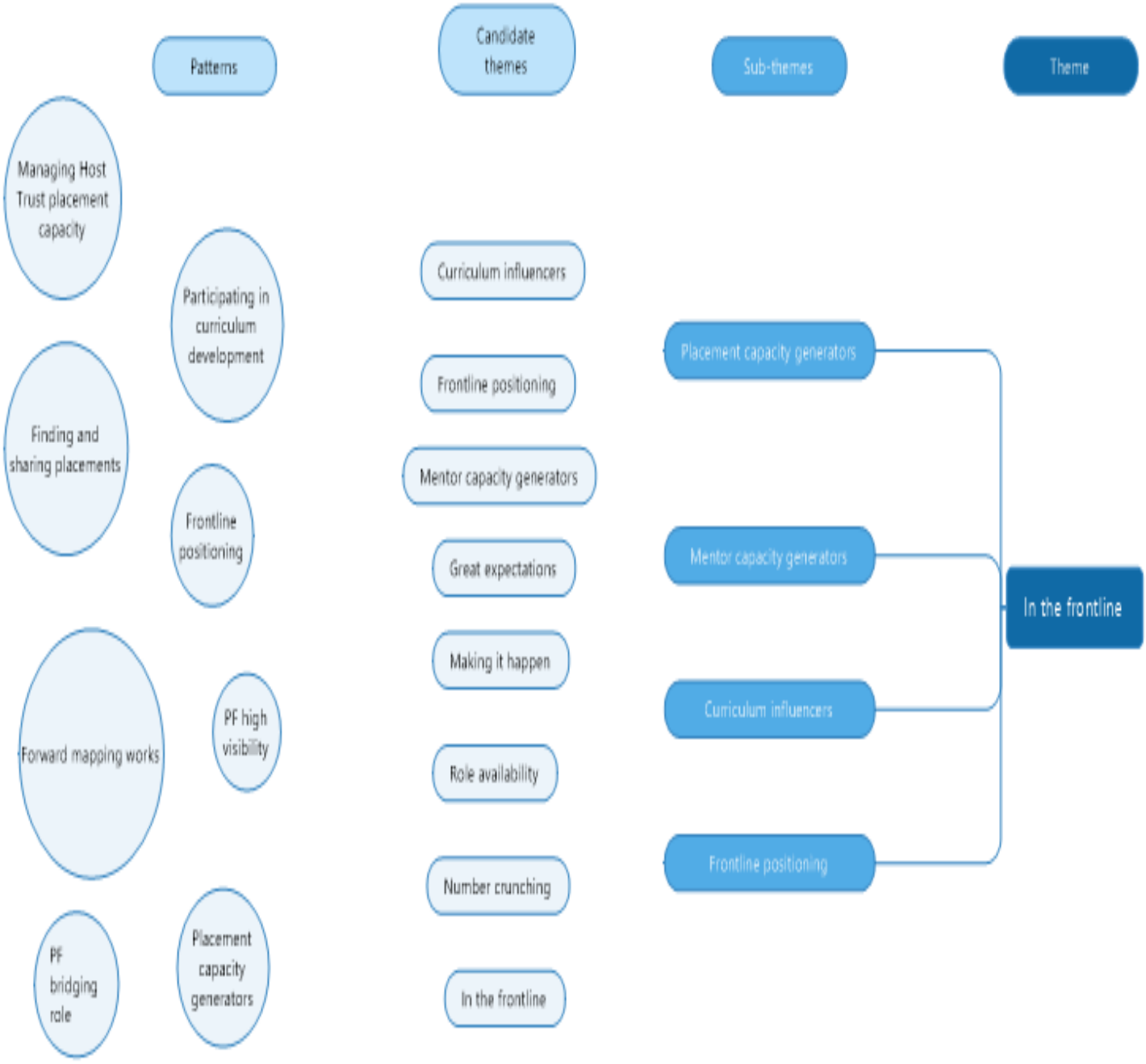
> *…there is that constant link between practice and University and quite a few of the things that we explore is usually around placements and capacity issues*
>
> *[PF8 458-560]*

PF's detailed knowledge of capacity has expanded into having a big influence in how curricula are designed as this had a big impact on capacity. A PF when talking about the PFs involvement with curriculum planning reported:-

> *…we were able to comment on the good points, the bad points of the curriculum and the placement plan and those views were obviously taken into account*
>
> *[PF2 118-121]*

This section illustrates how participants were part of the Trust and HEI management, so, were positioned to work effectively, viewing this as the…*need to be in the forefront of any changes* [PF7 458-459]. A Mindmap (figure 4.2) illustrates how the sub-themes and theme were developed from the patterns and candidate themes identified across the data set as advocated by Braun and Clarke (2006).

Figure 4.2 Mindmap representing theme 1: In the front line



The four sub-themes identified from the results reflect these main ‘fronts’ the PF became increasingly active and influential within, between and across Trusts and HEI. In this context, PFs were found to have a unique combination of organisational

authority and direct frontline positioning that enabled them to exert a powerful influence on the way pre-registration nurse education in practice is orchestrated.

4.2.2 Sub-theme i: Placement capacity generators

The provision of placements was recognised by participants as one of the fundamental responsibilities of PFs. However, this was a new role and new set of responsibilities and there was no pre-existing organisational model of how this might be accomplished effectively. One PF remarked: -

> *…I think before we actually came in post, the placing of students was not really monitored*
>
> *[PF7 164-165]*

Early on, a placement management process was developed by PFs described by participants as *'forward mapping'* which entailed: -

> *It means, it's a forward mapping exercise so we look at our capacity, it's a forecast of how many students you are going to be having on placement to see if there are any problems that are coming up so hopefully you can solve any problems particularly with the numbers of students on placements before they happen*
>
> *[PF2 81-85]*

This was so successful that a HOD said: -

> *I think the mapping is key I don't think we can do without that*
>
> *[HOD1 98]*

Essentially *'forward mapping'* involved the PFs scheduling the number of students per cohort for their Host Trust, including information such as the type of placement experience required for the stage of the programme as required by the curriculum, over a one year rolling time frame. The volume of available placements (obtained via auditing placement capacity) in each Host Trust was plotted in relation to students

requiring placement experience (appendix 22). This revealed the placement requirements versus placement availability although one education lead noted that: -

> *Placement mapping is a nightmare at times especially with the increasing numbers*
>
> *[EL2 115-116]*

At a strategic level there was regular ongoing communication between the PFs and the HEI to discuss Host Trust placement capacity including *forward mapping* and preventing crisis. Participants articulated: -

> *we have practice facilitators meetings once a month in the University where the University staff also attend and we discuss on a kind of a broader aspect any capacity issues or issues that might affect not just us within this Trust but also make an impact in our colleagues' organisations*
>
> *[PF3 64-70]*

> *This actually prevents getting to that crisis management thing of ending up with excess students and not knowing what to do with them*
>
> *[PF7 160-161]*

> *even more recently we had concerns about how we were going to manage student capacity in the next two to three years and again the University have responded to that and agreed rejigged course plans and that seems to have helped so we do get heard definitely*
>
> *[PF8 468-471]*

The PF participants described the various ways they used their discretion when maintaining placement capacity, saying: -

> *…we need to work very closely with placements around the mapping of students because again that if there is any change of service be it*

usually a closure of some particular area that has a huge impact on then where you put the students

[PF4 784-787]

…its two-way process I need the placements and support the students however if at any time they tell me they are finding it too much with the students they'd like the numbers decreased we negotiate them and I do and I listen to them and I've never had a problem with placing students in the community

[PF1 390-394]

This discretion particularly came to the fore managing the relatively high numbers of students who had been interrupted and needed to re-join the programme. The up-to-date accurate placement mapping management system provided the capacity data which allowed PFs to look at individual situations to enable the student to re-join the programme. This aspect was particularly valued by HEI management as students re-joined the programme more quickly: -

the practice facilitators are phenomenal…we get a lot of students that need to take interruption for a multitude of reasons and then they have to be fitted back in the programme…so we get students back a lot quicker than we would if we didn't have them

[HOD1 162-169]

…K [Principal Lecturer] would never dream of returning a student from interruption until she'd had a discussion with a [PF] about whether she could get somebody back in the Trust whether they've got capacity…

[HOD3 733-735]

if course plans overlap or if there has been quite a significant number of perhaps interruptions re-joiners so students who have not been able to stay on course on track and they've had to re-join the

course that will obviously add to capacity challenges and we have to look at individual student situations to try and accommodate them whilst not compromising the quality of the placement and the mentorship

[PF3 336-342]

Participants saw that PFs were key in identifying and interpreting how new areas within their Host Trusts that could be developed for placements so maximising use of available resources: -

identifying new areas for training areas for students

[HOD2 190-191]

Maximising capacity and its also maximising the experience the student gains because they are placements that often would not be suitable for full time placements but are very valuable for a student to spend maybe half a day or a day within that service

[PF7 656-659]

PFs were also seen to be sharing placements across the Host Trusts as discussed in one of the LLFG: -

No. 5*…I have known practice facilitators to communicate with each other in term of either identifying possible areas where students would be able to get those experiences which may not lie within their own Host Trust …*

No. 2*…in X we have developed a hub and spoke approach so the practice facilitator and the course team have worked to identify areas that the student might benefit from an experience whether it be a day or a week…*

[LLFG1 145-179]

This was reported to be particularly the case in regards to different specialist experiences and community practice: -

> *…they do some elements of moving students around to support each other and making sure there is enough placements…I think that the practice facilitator role is very good in terms of the way that it links with the University and they link across different Acute, Mental Health and the Community and they can support each other across those boundaries…*
>
> *[EL3 219-225]*

> *…the number of adult students on the curriculum is quite significant so to find the appropriate community placements within the limit of their course plan is challenging and is only successful with close collaboration with our community colleagues and requires a lot of forward planning*
>
> *[PF3 376-380]*

Managing the placement resource and, crucially, at a time of substantial increases in student nurse commissions, expanding the placement resource, was a central aspect of the role of the PFs and was the key focus of their attention in the initial inception of the posts. One EL described it as currently: -

> *The fundamental elements have stayed the same, so ensuring that the audits are carried out with the University, that's still the key role…if we have new areas we have to make sure they are audited, although that sort of sits with the University obviously the PFs facilitating this process*
>
> *[EL3 175-178]*

A PF described how they followed up any issues from educational audits.

> *If there are any areas we feel need clarity we will liaise back with the link lecturers. If the link lecturers raise any concerns during that*

audit then our responsibility within the Trust would be to address those concerns and to investigate and to put in action plans

[PF3 726-729]

A local approach to meet this requirement was developed but, as identified within the following sub-themes, it helped propel further evolvement of the role in unanticipated ways.

4.2.3 Sub-theme ii: Mentor capacity generators

Just as PFs were seen as instrumental in generating additional placement capacity, they were similarly seen as having a role in increasing and managing available mentor capacity. One of the PFs described in detail the complex nature of their efforts to maintain an accurate assessment of the true number of mentors available in practice, which they have at their fingertips.

Yes, placement forward mapping we look at numbers of mentors in each clinical area from a managerial perspective. Within each clinical area they will have a number of qualified staff perhaps wanting to go on the mentorship course we have to look to make sure that the clinical areas where we place students have sufficient mentors to cope with that capacity and demand so we liaise with education here and highlight to them if perhaps mentors have moved on from clinical areas or if there are any changes in circumstances where a mentor can no longer be a mentor for a period of time and where there was a gap if you like in that particular clinical area then we would liaise with education here in terms of highlighting that area does need to be given a course by a member of staff

[PF3 117-127]

…if a ward manager phoned us up and said when did my, a certain staff have a mentor update we've got it at hand

[PF6 569-570]

The PFs are seen by strategic leads as doing the hands-on number crunching, describing it as: -

> *they do a lot of number crunching in terms of not just mapping what students are coming through they are also so looking at what mentors are available within the areas they are placing them in because obviously we have a responsibility to take the students and we can't take the students without the mentors*
>
> *[EL3 362-366]*

One PF described the more sophisticated mapping formula they used to calculate the number of students that are allocated to mentors: -

> *We do have a formula for working out how many students a placement can take and that is basically based on where there are three mentors in a placement, they can take one student so where there is six they can take two and where there is nine they can take three and so on…that helps us with our mapping process*
>
> *[PF8 479-484]*

Additionally, another PF revealed they used the information they have on number of Host Trust students to calculate the future number of Host Trust mentors required: -

> *likewise the commissions of mentorship particularly recently we have identified and we have now set based on the number of students they would have we have worked out a way of determining what our numbers of mentors should be*
>
> *[PF2 532-535]*

However, one PF acknowledged: -

> *at the same time there will be members of staff who want to do that course anyway so there has to be balance but our primary input will*

be to make sure that there are enough mentors to meet capacity for commissioned numbers

[PF3 137-140]

4.2.4 Sub-theme iii: Curriculum influencers

While the PFs originally focussed on generating placement capacity and mentor capacity, it became clear that they needed to use this information, knowledge and understanding to feed into the curriculum development process. One PF described it as being; -

…essential because it is fifty percent of the curriculum and if the placement area can't accommodate and meet the requirements because of whatever issues then that's going to have a huge impact on the delivery of the programme so I think its absolutely essential

[PF3 203-306]

Participants from one of the LLFG acknowledged the PF role.

No. 2 *they are always involved in curriculum development which includes how practice will be set out and have the experience*

PI *Mmm*

No. 5 *I think one of the things that is apparent…is the need to involve them in looking at capacity*

No. 2 *We have had bottle necks in the programme in previous years*

[LLFG1 113-133]

One PF explained how curriculum plans had caused placement problems as indicated above and how they resolved it: -

[The University] have reviewed the placement plan for all of the curriculums and…if we kept the same placement plan there was a huge peak where all of those students would come out and then there would be a long period where normally the March intake would have been where there is no students on placement…The new plan…spreads those placements over the twelve month period instead of a six month period so our mapping has looked to see what effect that has on our numbers

[PF2 103-113]

As the PFs became more embedded in practice, a PF said…I have probably been at four maybe five different curriculums [PF2 850-852] the effect of which one HOD admitted was that it: -

…makes sure that what we do is practice-focussed…it would be great to have a really academic year course plan, you know into the University at the beginning, out in practice for the second half of the semester in once at the start of the semester two and out at the end, but actually that would create massive peaks and troughs in practice. They make sure they don't do any of that stuff

[HOD3 391-396]

PFs mapping had evolved to be seen as key by another HOD who said: -

…for us we have utilised the mapping as the first stage of writing any curriculum and from that everything falls out

[HOD1 136-141]

HOD 3 acknowledged the PFs acted proactively in that: -

They don't miss a chance to get together to discuss developments and changes within the University that impact on practice and they're really good at that

[HOD3 374-378]

There was an awareness by HEI participants of the PFs bridging role: -

> ***No. 4*** *I think the practice facilitators probably of all the people in the Trust have perhaps a better understanding of our curriculum…*
>
> *LLs Yeah*
>
> ***No. 2*** *I'd agree with that I think crucial as that bridge*
>
> *[LLFG2 558-564]*

As well as at the HEI, the local EL was aware that: -

> *they are part of your curriculum review boards and they very much need to be part of those ongoing because they are the people that sort of hear and see the most in term and have the deep understanding of the programme and the pathway that our undergraduate students are on*
>
> *[EL2 691-699]*

Finally, once the curriculum course plan was approved, PFs were then able to look at the roll out practicalities due to: -

> *…the curriculum mapping and the close working with the University we often know how many students are coming out quite far in advance and we actually prepare mapping so we can be quite clear on how many places we need and we can identify shortfalls away in advance with the mapping and we can start looking at new placements if we need them*
>
> *[PF7 155-160]*

4.2.5 Sub-theme iv: Frontline positioning

This sub-theme shows that the frontline positioning of PFs involved them in strategic and operational decisions both in and across organisations, that is, their own NHS Trust and the HEI. PFs were part of both the Trust and HEI decision-making systems. This was summarised by one EL and a HOD as: -

> *They essentially support the students but they also support mentors and they also ensure the quality of the placement in terms of the learning environment and they also link very closely with the University*
>
> *[EL3 29-31]*

> *…we are linking together…they work as a conduit between the two of us to actually help us work in partnership*
>
> *[HOD1 348-352]*

When asked about where, in their organisation, they feed issues and concerns, one PF clearly stated: - *Yes, the Director of Nursing* [PF3 578]. The benefits of this was described by an EL as: -

> *…its a good three-way conversation, if you like, and also S was there at that meeting as well, because she is the Director of Nursing so its around having everyone around the table*
>
> *[EL3 407-409]*

This chain of command was recognised within the HEI: -

> *The practice facilitator because they are answerable to the Director of Nursing therefore, they were quite near a senior position in terms of influencing*
>
> *[HOD2 183-184]*

Despite being a Trust employee, it was notable that the same HOD saw the PF as a member of their department.

I saw my practice facilitators as a member of my department open to attend departmental meetings

[HOD2 192-193]

This HOD went on to say that: -

Their link with the Principal Lecturers for the fields of nurse education absolutely fundamental, linked with the practice manager

[HOD2 342-343]

A number of participants acknowledged PF activities between practice and the HEI across a range of operational levels.

I liaise closely with LL, course directors…I would say I'm in contact sometimes daily

[PF3 57-63]

Obviously, they link with governance, with investigations, with incidents

[EL1 548-550]

I sit on the Fitness for Practice Panels, the Course Boards…

[PF4 389-392]

practice facilitators are involved in the decision-making for CRBs in terms of whether we get the students through

[HOD2 634-636]

Due to the wide range of contacts and high visibility within the Trust they became part of Trust governance and quality systems as one of the PFs proffered: -

…you can pick up a lot of issues by just walking around and speaking to the students or mentors

[PF2 612-614]

These included frontline issues in practice reported from a range of participants: -

> *a student on a ward at Y raised a concern about how patients were being treated which is absolutely what we want students to do, well we want anybody to do that you know. Perhaps, if more people had done it we wouldn't have seen all the Francis stuff [Francis (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry] around whistle blowing and no one telling anyone anything or anyone doing anything about it*
>
> *[EL1 514-518]*

> *from the perspective of anything that involves an impact on patient care a negative impact on patient care which has resulted in a CQC [Care Quality Commission] visit or removal of a student from placement*
>
> *[PF4 739-741]*

> *students reporting bad practice the things you've not thought about until it actually happened or just certain structures being in place to support students or support mentors or even reporting systems*
>
> *[PF7 780-783]*

> *students with special needs who may have to have special adjustment in practice so we've got the involvement of practice facilitators…before the student even enters the course*
>
> *[HOD2 637-639]*

Although PFs worked within their Host Trust, participants articulated they also met as a group and as two PFs described how they collaborated.

> *You know some Trusts [within the consortium] come up with different ideas that we may take on board or we have discussed something that we have rolled out across the region as well and that*

is ensuring equity and parity in that really, because for [University] some students will go to X, some students will go to mental health some students will go to primary care, when they are all coming back the idea is they are getting the same experiences, that they are being treated in the same way, the mentors are approaching them in the same manner in the same situation

[PF2 299-306]

we can share concerns and where there's a commonality highlighted and that can be addressed on a boarder level with the University sometimes challenges are organisation specific and that need to be dealt with in an organisation but some are more boarder issues that need to be resolved and need to have the input and support from all organisations

[PF3 453-459]

This was positively regarded by University staff: -

that helps in standardization of process, I think it helps in standardisation of message

[HOD3 687-688]

In contrast, while the LLs were fully conversant with how the PFs worked operationally, there was some chagrin regarding the ways their role had developed: -

No. 2 *…essentially to support mentors in assessing and managing students' progress but I think their role has evolved into a political sort of role that deals with a lot more things and I think actually that is taking away the focus of why they should be there. That's for another day*

PI *Could you elaborate a little…*

No. 2 *Yeah, I think mentors in practice have been taught via different routes, different curriculum, and with curriculum changes…*

PI *Mmm*

No. 3 *I suppose drawing back on the mentorship aspect, obviously the requirement to maintain the NMC register has refocused some elements back in ensuring that they have sufficient numbers of mentors*

[LLFG1 73-103]

PFs were very aware of their strategic role in implementing NMC guidance: -

with a view to give an idea of the link between the acute Trust and the community care services and certainly with the education standards, the NMC want students to try and get as much experience of primary care and how we link to primary care within their training

[PF2 224-227]

One PF reported NMC approval for this engagement intensity as: -

…we have a close working relationship with the HOD from the [University]…we were commended by the NMC for our partnership working…so I think if you didn't have that close relationship and working relationship with your HOD then you wouldn't be able to address some of the issues

[PF4 571-581]

Finally, over time PFs frontline positioning between and within both organisational environments has earned them the following accolade: -

> *… the bottom line, if they say no it doesn't happen, if they say yes, it does*
>
> *[HOD3 741-742]*

4.2.6 Theme one summary

This section has presented the results of PFs being *in the front line* where the initial focus for the role was to ensure and generate adequate placement and mentor capacity to support pre-registration students in practice. Mapping systems were developed which enabled effective proactive management of Host Trust placement and mentor capacity. One important consequence of this was that PFs had a direct influence on curriculum course design. Although PFs were based in their employing Trusts, they shared placement resources across the consortium which gave access to scarce placement resources.

PFs inter and intra-organisational working at both strategic and operational levels positioned them *in the frontline* of nurse education in practice between the Trusts and HEI. This included membership of HEI departments management structures and a range of committees which made decisions on students. Similarly, an aspect of their frontline presence in their Host Trust was revealed through their walking the patch on a regular basis, picking up placement and other issues including where patient care may have been compromised. This developed into the PFs becoming part of the Trust governance and quality systems.

Their shared ways of working and collaboration across the consortium enabled standardisation of processes with the HEI across the landscape of pre-registration nurse education in practice. This way of working, endorsed by the NMC has led, over time, to PFs using their discretion to become arbitrators of what happens in practice. The next theme builds on these understandings expressed by participants.

4.3 Theme two: Everybody knows them and they know everybody

4.3.1 Theme introduction

Being *in the frontline*, as discussed above, PFs were in close interaction with key personnel who were involved in nurse education in practice. This included both senior managers with an overall strategic role as well as those staff such as mentors and LLs, who were concerned with the day-to-day student practice experience, their learning and their assessment. This had placed them in a crucial position in respect of strategic decisions and decisions related to individual students. This theme revealed the nature of how the PFs operate where one PF expressed the following working arrangement: -

> *…they know if they don't hear from me there are no issues, if there are issues then I will highlight them and I will bring them to their attention*
>
> *[PF1 499-500]*

This led to the second main theme arising from the results: *everybody knows them and they know everybody* where participants related the PFs omnipresence within pre-registration nurse education in practice.

LLs talked about their working with PFs and how they valued this working relationship: -

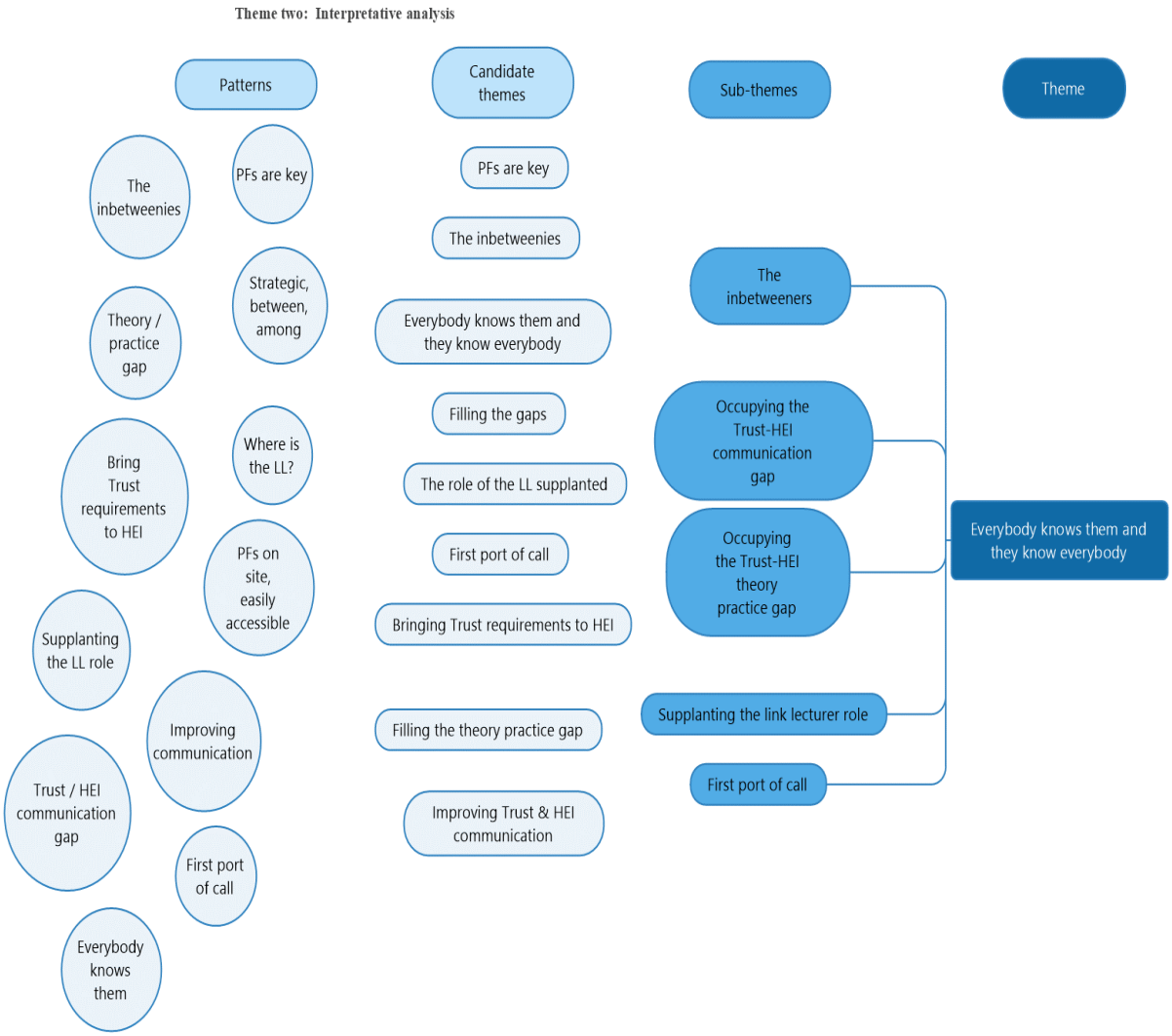
> ***No. 2*** *…luckily one of the other PFs stepped in I had no access to the live database for mentors…it was very stressful for me…I got no managerial leverage over them…when the PF is in place you have actually got somebody else if you like in partnership who can strong arm people*

No. 1 *…the more adverse the situation the better their relationship that the LL and the PF have… when there's a problem arising then they contact you, call you…*

[LLFG2 582-680]

A Mindmap (figure 4.3) illustrates how the sub-themes and theme were developed from the patterns and candidate themes identified across the dataset.

Figure 4.3 Mindmap representing theme 2: Everybody knows them and they know everybody



As part of theme two *everybody knows them and they know everybody*, participants talked about how the PFs operated within and between the Trust and HEI as *the inbetweeners*. Participants relayed how PFs were *filling the communication as well theory practice gaps* and supplanted the LL role, in many ways becoming the *first port of call*, for all.

4.3.2 Sub-theme i: The inbetweeners

Participants conveyed the positioning of the PFs as *the inbetweeners* who operated at strategic and operational levels in and between their respective NHS Trust and the HEI. PFs were therefore positioned to be part of, and involved in, key activities in the Trust and HEI where they linked and implemented the requirements of both organisations. This was particularly in regards to recruiting the right students and overseeing them in practice. As one HOD explained: -

> *There's somebody who can put the strategy into action and…the somebody who makes sure it happens, and they're there trouble shooting they're the sort of 'inbetweenie' if you like they make sure that all these things can be facilitated, they're there to understand the issues*
>
> *[HOD3 756-759]*

A range of participants were acutely aware of the strategic need for Trust involvement in student recruitment. One EL emphasised this was important from a Host Trust perspective*…because they are our future workforce [EL2 191-192]* and a HOD said *…that's really important cos they're making sure that we get the right students in nursing to nurse [HOD 3 875-876]*. This position was echoed within a LL focus group and also by a PF: -

> ***No. 1*** *Well I think it is because we are talking about Trust commissioned student places and so Trusts should have some input, some say in who joins us each September and they've got to manage students out in practice. We know sometimes there are management issues in the classroom but when you are out there students are*

interfacing with service users and patients you know it's a bigger concern if there are management issues out there so it's in the best of interests of our colleagues to be involved in the recruitment process

***PI** No. 3*

***No. 3** I support what has been said*

[LLFG1 336-346]

the emphasis for us is around making sure we get the right students, making sure we support them for that three years and at the end of that three years making sure we recruit them

[PF4 975-979]

The PFs themselves were strategically aware that academic requirements should not take precedence over the attributes that were seen to be required for nursing in practice. One PF stated that: -

…one of the things highlighted I think in the Willis commission report was about attrition and recruitment and making sure that we have the right candidate on the course to begin with and not just looking at the academic qualification we look at the other aspects in terms of their caring and compassion and those qualities…

[PF3 666-674]

The PFs described how they worked particularly closely with HEI colleagues to enhance the recruitment of appropriate individuals.

I attend the recruitment meetings at University so when we looked at the different questions for the interviews, the different processes for the interviews, myself and other Trusts played a part in that

[PF2 723-726]

in the three years that I've been in post is in how we are now working towards developing values based questions, looking that the panels have been adequately prepared so that they are questioning the students in more depth rather than initially just going on placements and things

[PF4 280-284]

Although a PF criticised a recent HEI marketing campaign where: -

…there isn't much of an emphasis on the Trust where those University students are going to spend fifty percent of their placement

[PF4 792-799]

Over time the PFs were acknowledged to also be operationally involved in securing more and more Trust participants in recruitment as described by one of the PFs and a HOD: -

there's myself and then there's there is a lecturer from the University on the panel

[PF5 258-259]

the practice facilitators are the ones who have actually been instrumental in resourcing and being involved themselves…they are heavily involved in selection and recruitment activities and also organising for their managers to be involved

[HOD2 326-329]

PFs developed Trust staff involvement in recruitment from initially their own involvement as described to broadening it to involve mentors. One of the mentor focus groups discussed their involvement: -

No. 1 *…they have involved most of the mentors now with the recruitment process…*

PI *Ok, so that is a change in terms of the recruitment process of students…*

Several Mentors Yes …

No. 3 *Yes, definitely on the programme, but also towards the end of the programme we have a role to play in there as well whether the students have completed the training and if we are getting what we expected to get towards the end which of the previous which is obviously quality*

[MFG3 87-99]

Following on from recruitment, one HOD acknowledged the PFs conduit role in getting those recruited students into practice.

I don't think we'd manage that allocation of numbers into practice without them. I think they smooth the way and they are the conduit that allows us to put students in practice

[HOD3 97-99]

Another HOD spoke of an added benefit of the Host Trust recruitment approach. It meant students were linked and socialised to the location where they would complete the major part of their education in practice: -

…it was for making sure to bring all the students together so there was a network for the students and the students got a familiarisation with their Host Trust and they knew who the other students were they also knew who their education team was, and it really gave the students confidence in the organisation

[HOD1 225-229]

Looking after and overseeing students was a further aspect of PFs being perceived as *the inbetweeners* who were known by everyone as they were frequently in the

clinical areas. PFs provided an insight into the effect of being known by everyone as they were regularly*…out in the clinical area visiting the wards and that certainly has had a big impact [PF2 611-614]*. This led an EL to express confidence*…that the students out there are well looked after and the mentors are well supported [EL3 449-451]*.

A HOD expressed approval for PFs in the HEI as well as practice whereby: -

> *…some of them are supporting students in practice but also undertaking some teaching and supporting students at the University which is a good model*
>
> *[HOD2 109-111]*

PFs as *inbetweeners* were seen by participants to work in and between Trust and HEI where they supported student recruitment, student allocation and oversaw students and mentors in practice. Furthermore, PFs had input into University based teaching.

4.3.3 Sub-theme ii: Occupying the Trust-HEI communication gap

The way in which nurse education was delivered was recognised by participants as perpetuating a gap between the HEI and the placement providers. An EL described it as: -

> *the student does not want to see, for the student it is 50% practice and 50% in the University they don't want to see a gap in the middle do they, they want to see everyone is working together and following the same principles and processes*
>
> *[EL3 591-595]*

A HOD remarked about Trust HEI communication challenges in a time before the PF role.

> *the minute that these people came in post in my job…it meant that I didn't get all the problems day after day after day, millions of e-*

> *mails whinging and whining from ward sisters they cut out, their impact is to instantly decrease the problems coming from practice areas to the University…for all those ward sisters, suddenly they've got somebody to address their problems and issues to…that's local to them and has got a vested interest in sorting them out*
>
> *[HOD3 456-478]*

One of the PFs also acknowledged this gap.

> *There was a gap, I experienced it as a clinician and nurse mentor and that gap doesn't seem so wide anymore*
>
> *[PF8 742-743]*

Participants in a LL focus group strongly felt PFs were key in bridging this gap. Indeed, LLs expressed that their job was teaching and the primary focus of clinical staff job was caring for patients. The PFs were given a different status of understanding 'straddling' both the HEI and Trust worlds.

> ***No. 2*** *…it goes back to this divide doesn't it as was said because we came into the University and stopped being schools of nurses…it means that now there is that gap isn't there, of thinking them and us and clearly you know what we teach in the University has nothing to do with the real world and unless we can bridge that over and the practice facilitators are that link aren't they 'cause in a sense they straddle both so they understand the perspectives of both they understand the practice perspective…so by having that link over means it keeps us in touch with the practice areas…we couldn't possibly do the job we're doing 100% teaching etcetera and know all the people in practice, could we. We can't possibly do that even if you'd…had personal relationships so the practice facilitators are the people that actually in a sense are an extension of the University in a way into the Trust*

No. 4 *I would agree with that*

[LL2 399-426]

The PFs were seen by the mentors as the person to whom to refer student issues and not, as previously, burden their clinical managers.

No. 3 *I think their role here is, I mean the goal here is quality care and you know…*

PI *And you see somehow the practice facilitators having a key role in that*

No. 3 *Oh yes, definitely, because obviously I've known [PF] before…when I myself was a student and obviously go into that role both of us and then again becoming a mentor when you have issues with student nurses in those days there was a gap because you would either be liaising with the University or your ward manager to talk about your difficulties, or your supervisor… now you don't have to go to your manager or your supervisor whenever you have any issue with a student conduct any deficit or any issues, the first person you would really go to [PF] you know…so that makes it easy for us as nurse mentors as well*

No. 1 *I think taking that point actually, when they've identified the gaps that No. 3 was talking about I think the practice facilitators are the one who can go to the mentors*

[MFG3 346-373]

Other participants also reported improvements in communication facilitated by the PFs.

Their communication with the practice placement office is absolutely fundamental…they will be communicating a lot of changes in the

University to Directors and Assistant Directors out there…make sure that there is a connectivity to the University and practice

[HOD2 211-237]

No. 2 *…the practice facilitators are the people that actually in a sense are an extension of the University in a way into the Trust…so by having somebody there who is actually doing it and bringing the academia out into practice I think that really helps make that link*

No. 4 *I would agree with that*

[LL2 412-426]

A range of participants observed that the PFs occupied the communication gap at strategic and operational levels between the Trust and HEI.

I think what's been consistent what they're consistently excellent at in [Trusts] is the relationship with the University

[HOD3 367-369]

with everybody so busy these days it can be quite an issue where we can keep them up-to-date with what's happening in our Trusts and they keep us up-to-date

[PF7 681-683]

if you didn't have that close relationship and working relationship with your Head of Department then you wouldn't be able to address some of the issues

[PF4 579-581]

We, I, liaise closely with link lecturers, course directors and I suppose it's that interface between placement area and the University

[PF3 57-58]

Finally, the sense of how well the PFs were working across the Trust HEI communication gap is articulated as: -

> *this is where I believe we have moved, we have moved away from them and us and we have become almost a collaborative venture*
>
> *[HOD2 608-610]*

4.3.4 Sub-theme iii: Occupying the Trust-HEI theory-practice gap

In addition to occupying the Trust, HEI communication gap participants viewed *occupying the Trust-HEI theory-practice gap* as another aspect of the PF role.

> *key role if you like between the theory-practice gap for students undertaking pre-registration programmes*
>
> *[HOD1 15-16]*

> *we look at where there might be gaps in learning, you know the theory-practice gap and again we try to bridge that gap as much as we can*
>
> *[PF8 79-81]*

The ultimate goal of PFs occupying this gap was articulated by an EL and an HOD.

> *the role of the practice facilitator you know I think the primary purpose is to ensure that our cohort of students successfully complete their undergraduate programme get signed off in clinical practice and feel confident to undertake their role*
>
> *[EL2 241-244]*

> *It is really important that we are actually training students who are going to be fit for practice and purpose and also meeting the Trust priorities*
>
> *[HOD2 538-540]*

Two HODs talked about how the PFs had brought the Trust practice requirements into the HEI pre-registration programmes.

> *they've made us take notice of practice…I think they've made us take notice of the mandatory things that are necessary for the Trust induction and you know making sure that we do things like the BLS annually where that might fit in*
>
> *[HOD3 553-558]*

> *it's very much about ensuring that what we are teaching, the curriculum is actually meeting the needs of the Trusts, the workforce, future workforce, the dynamic of change where a student who can work flexibly with the reconfiguration of services in practice*
>
> *[HOD2 535-538]*

LLs discussed how PFs facilitated this in practice where they interpreted and utilised practice learning environments to bridge the theory-practice gap.

> ***No. 5*** *[PFs] essentially to look at capacity, to identify areas that are suitable to take students so to widen the learning experiences or opportunities available to students within the Trust to reflect the curriculum. Possibly to work hand and hand with the HEIs in developing, being instrumental in developing programmes and contributing to curriculum design*

> ***No. 6*** *I would support what has also been said in order to facilitate learners in bridging the theory practice gap and obviously trying to support students in trying to meet learning activities*
>
> *[LLFG1 60-70]*

This sentiment was echoed by a PF: -

> *the facilitator is there to ensure and to build on what has been provided in the HEI and make sure that the students are working to provide high quality evidenced based care*
>
> *[PF4 454-456]*

PFs described the myriad of approaches they used, working at operational levels, to address practice deficits that had not been previously dealt with in the HEI. PFs talked about how they used their discretion to tailor provision to meet Trust needs. Sometimes PFs delivered these in the Trust environment.

> *It's a requirement for all students prior to coming into the placement areas to complete an induction programme so C and I arrange that induction programme and we liaise closely back to the University to confirm who has not attended and so we monitor that very closely and to ensure that nobody comes in and has access to patients without having completed that induction*
>
> *[PF3 693-697]*

> *we pull students out of placement to do communication. The practicalities of that although learning in a classroom we teach them actually in practice about you know what communication skills, social skills, identification of illnesses and we do that after, when they've been exposed on the ward, they've been exposed to it, they come back and they are able to identify with it and so can actually put the theory and the practice and they can put it together so there's that*
>
> *[PF9 209-215]*

Sometimes, where PFs had flagged up clinical issue deficits these were subsequently integrated into University teaching.

We took this to the University and basically, we had a big influence on the fact that breakaway technique training is now introduced to all years of training, all years of students on the programme from first year through to third year

[PF8 601-604]

At other times, PFs organised Trust specialists to work with the University to ensure University practices were in keeping with Trust practice requirements.

So that then filtered up to J who then J had spoken to the University about it and our moving and handling coordinator here is going to be talking to the University about how we can help the students with their moving and handling techniques

[PF6 448-451]

Unfortunately, some issues, after much discussion, were required to be resolved in practice, without University support.

I have spoken to the University about the gap, particularly around medication management and the University state they do some learning activities for students but the emphasis really and the expectation is that students will learn this in practice

[PF8 105-108]

One of the HODs and a PF described learning materials that PFs designed to augment the curriculum specifically to meet practice requirements.

The practice facilitators also have been involved in designing learning packages for our students

[HOD2 306-307]

The type of things that we have done here in X is we have looked at developing some clinical workbooks for students that they can use in practice, they are not part of the formal assessment process

[PF8 81-83]

The PFs revealed, through their working relationships in practice, that they had up to date knowledge of practice changes and included HEI academic staff in Trust staff updating processes.

The injection strategy that we, I spoke about earlier we have actually got tutors coming in on that as well because they are keen to make sure that they are giving the right information to students

[PF8 578-581]

4.3.5 Sub-theme iv: Supplanting the link lecturer role

The impact of the PFs on the LL role provoked a rich vein of discussion in all participant groups and interviews. Overall, there was a general sense of dissatisfaction among participants with the LL role.

I think the link lecturers, their role is quite uncertain I think at the moment…I've always wondered what the link lecturer is actually going to do going to each of the wards, I don't know what the value is. If I could understand the value of a link lecturer arriving and saying how are you doing, is everything ok

[PF9 660-677]

Link lecturers traditionally perhaps have been very academically focused and rightly so and perhaps don't have that clinical, practical you know hands on experience

[PF3 770-780]

No. 3*…our link lecturer has been not, has been absent for quite a long time and then we briefly had another link lecturer but I don't think we have got her any more*

No. 1 *I didn't know that the Link Lecturer have been off for a while or even replaced*

[MFG4 311-318]

While a HOD acknowledged that*…link lecturers don't get out to the clinical areas as often as they want…[HOD1 388-391]* the link lecturers themselves acknowledged what they felt they lost in the move into higher education.

No. 4 *I think it's particularly when we moved, going back a bit further when we moved into the University and we were suddenly seen as a separate entity when we were part of [X] we were usually on site and we were seen very much as part of the staff really…suddenly oh you're the University and that is separate from us, we lost a lot of that, and I think we lost a lot of that goodwill, of exchanging things…*

No. 2 *Oh*

No. 1 *I would agree with all of that…*

[LLFG2 334-366]

The impact of the transfer to higher education was echoed by a PF who acknowledged the effect of distance thus: -

Once you got the sort of a bit of distance in between the hospitals and the Universities for the link lecturer to get out and respond to any incidents with students on placements, support mentors it was difficult

[PF7 25-30]

A HOD described how LL staff had to negotiate space on an ad hoc basis for their visits to see students but arrangements did not enable interaction with the mentor.

> *Lecturers go to see if any space in an office somewhere, a meeting room to see students, so therefore mentors were not actually interfacing with link lecturers*
>
> *[HOD2 694-699]*

Several of the LLs were aware of inherent conflicts in the LL and PF roles which they saw as overlapping.

> ***No. 3*** *I think there is an overlapping of the roles of link lecturers and practice facilitators There is always an overlap, so sometimes the practice facilitator might think that we undermine their role so there is a dichotomy there*
>
> ***PI*** *Mmm Ok*
>
> ***No. 5*** *I mean, I think it very much depends on the individual Trusts so then we have very large Trusts and people slightly differently operating as practice facilitators on different sites*
>
> *[LLFG1 346-360]*
>
> ***No. 1****…they are never clear to me…who is in charge of the student, is it the practice facilitator or the mentor*
>
> ***No. 3*** *It's a wider remit in as much as they are supposed to support…clinical problems if you found a particular ward that has [a problem]*
>
> ***No. 1*** *I hold the same view that the practice facilitator is the bridge between*

No. 3 *our role is being blurred…the setting of audits…we need the facilitator…[but they are]too senior to be there*

No. 1 *I don't think they take a leading role, they play a significant role*

[LLFG3 35-48]

there are some confusions around what the University link lecturer does and what the practice facilitator does because they don't it's, you know, we're on site so they'll call if there's a problem, we'll go over and talk with the mentor, talk with the student but I know that the University would prefer that we arrange for the link lecturer to come in and we all work together

[PF9 133-139]

The complexity of the LL role was compounded from the Trust perspective as explained by one of the ELs.

It's interesting because the link lecturer role are different with each University

[EL2 552-553]

Participants discussed the range of unsatisfactory solutions that were tried to resolve the LL problems, which included a review by the HEI.

There was a recognised review not just the link lecturer role but also look at link lecturer availability ensuring that there was link lecturer availability on every single Trust that the University has links with

[PF2 661-663]

An education lead also discussed another effort by the HEI to resolve the inadequacies of the LL role. However, it was seen to focus on what the role meant to the HEI rather than to practice: -

The Uni rejigged the link lecturer role and responsibility…to be assured that link lecturers are more consistent in the delivery of whatever that role means to the Uni

[EL1 843-846]

Another initiative was explained by a PF where: -

One of the things that was implemented…was the drop-in sessions with the visiting link lecturer so the students have an opportunity to visit a visiting link lecturer or the mentors if they wanted

[PF4 629-632]

However, an education lead's view was*…the drop-in sessions have been variable in success [EL1 230]*. Mentor participants unfavourably compared the drop-in sessions to the former link system.

No. 1 *In the past we used to have a link lecturer who was specifically for my ward and now they've stopped that and there is just one that comes into the Trust and we can come down to the education centre and discuss it…It is not really convenient to leave your ward to go and have that conversation and its not regular enough that they are here*

PI *How often are they here*

No. 4 *Once a month*

[MFG1 153-161]

Participants discussed that as the PF role evolved, the benefits of their being situated in practice and able to provide support similar to that expected of the LL, became more and more relevant. Unsurprisingly, it was felt that LLs may not be aware and may not get access to the 'politics' of individual placements and their staff. Being

accepted as part of the Trust team was seen by one of the PFs to be problematic for the HEI employed LLs as they were from another organisation.

> *I think its quite hard for people from another organisation to walk into a different organisation…once the courses moved out to University link lecturers could be going into teams that they had no idea about the politics within them areas they had no idea about the current working issues, the organisational issues*
>
> *[PF7 688-748]*

A HOD acknowledged that: -

> *Practice facilitators might know a lot more about that learning environment that I am going to visit they will be also involved in some of the changes that have taken place, so it is about using one another in order to enhance already the positive learning environment*
>
> *[HOD2 735-739]*

Another HOD mulled over the value of the PFs visibility in practice when compared with the LL.

> *because link lecturers don't get out in the way they did these are the only people that often they see for, you know they are the ones that are there every day they see them in the coffee room, they see them when they are walking between wards you know they are around, they are vis, a word I haven't used yet is visible, it's the visibility of somebody that they know*
>
> *[HOD1 424-429]*

Even LL participants acknowledged the benefit of the PFs based in practice: -

> ***No. 4** Because I don't think anybody sat down and worked out how we worked together but I know one of the difficulties being we are not getting out into practice perhaps as often as we used to. If there*

is an issue on the ward what I usually find happens is that the ward manager or the mentor will contact the practice facilitator and then they will let me know if there is an issue with a student on the ward. They may or may not contact me at the same time

PI *Is that a problem for you*

No. 4 *Not especially because the practice facilitator is on site they can go straight away to the ward, they can find out what is happening, they can come back and give me a much more detailed outline of what's going on*

PI *So is that something positive for you*

No. 4 *I think it is a positive thing because the thing is I'm not there and I was, originally, when I was based there it would have been a lot easier just to walk across and obviously I'm not based there now and if I'm here [on campus], I'm here to do something and so not in a position to just drop everything and go across to the ward*

[LLFG2 186-206]

However, another LL group, whilst they also acknowledged the advantage of the PF role in practice, one member expressed that at times they felt usurped.

No. 5 *I would say one of the things that I've known, is where students have run into difficulties or mentors have had challenges with individual students that they are the point of contact, outside of the link lecturer that will obviously support the student and support the mentor in that particular area or clinical area*

PI *Mmm*

No. 5 *So I don't see any difference in terms of that. In fact, they've become more, in X, they've become more of a co-ordinator to ensure*

link lecturing HEIs are aware of individual problems often in advance of even maybe interviews occurring…

***No. 2** I think that role is still there but actually my experience in Y is that sometimes they are doing that to the exclusion of the link lecturer and I think there is a sense that they are taking that role and asserting themselves on that role and often the link lecturer has to play catch up…*

[LLFG1 212-232]

PFs described how they negotiated with the HEI for a regular LL presence within their individual Trusts at the time of this study. This included providing accommodation for the LL.

The process has slightly changed over time currently the process is a link lecturer is here on both sites once a week at set times and days in the education department and in addition to that they are allocated specific placement areas so they go and visit students on those areas

[PF3 222-225]

I can only talk for X department but together we sat down we talked about the provision of the drop ins we discussed how often we felt they should be, what the benefit would be, how that person would visit their placement areas

[PF2 663-668]

A HOD discussed how the LLs used the PFs as a source of information and to monitor what was happening in practice.

the link lecturers know that they can go and talk to the practice facilitators about any issues, about any students and there is this role of feedback mechanism about what is going on

[HOD1 394-397]

Additionally, a PF relayed how they met the LL when they were in the Trust to keep in contact.

> *I do keep in regular touch and because we have link lecturers drop-in sessions every week here so we do meet up with them at that point*
>
> *[PF5 395-397]*

Mentor participants discussed how within their Trust PFs had proactively taken over mentor education from the LLs but engaged them in issues which required LL input. The mentors indicated that they were under the impression that the LL were reluctant to visit practice.

> ***No. 2*** *For me the PF is the one who has organised the link lecturer coming down so today, this morning they came down to the mid-point review of my pre-reg student and they were in the meeting with the PF but they only came down because it was under the PFs instructions to do so…the PF has organised an instruction day and has requested the attendance of the link lecturer and on the last couple of occasions that the PF has undertaken the mentorship update it has been in isolation…initially, the first ever mentorship update I did here the link lecturer was present but then hasn't been…*
>
> ***No. 3*** *I would agree. I have attended many mentorship updates that had the LL and the PF. They were no better than the ones with the PF. I consider the LL support as now extra to them*
>
> *[MFG4 324-340]*

Inherent in this discussion was that mentors were satisfied with the PF support and were not yearning for LL support.

One HOD looked positively on how the PFs worked in practice which had effectively led to the LL role being supplanted.

by actually providing this high level of support in practice might have influenced negatively the role of the link lecturer in the sense that as an area I don't have to worry so much because there is such good support from the practice facilitators

[HOD2 713-716]

Another HOD observed: -

I think that the link lecturers would have a much more difficult job without the practice facilitator there

[HOD1 401-402]

A PF concurred by saying…I think we've made their role workable [PF7 743].

Finally, having worked with the PFs for years a LL group admitted they truly valued the PFs contribution to practice education and supported the idea there should be more PFs.

No. 1 *If [PFs] weren't there, personally I think our jobs would become an absolute nightmare, they would become more clinical cos of the issues that would develop…we would probably start drifting our standards away from the academic to try and sort out the clinical and then the whole thing would just collapse like a pack of cards*

No. 3 *I support that. They are very, very valuable and the more we can use their services the experience of the students and the Mentor will be better*

No. 2 *I was just going to say I think there should be more if anything*

[LLFG2 903- 913]

4.3.6 Sub-theme v: First port of call

It is evident from the previous section that participants had a general understanding that the PF was viewed as the person to contact when pre-registration nurse education in practice issues were raised when students were on placements. One HOD reflecting on what happened before PFs were in post, spoke of the lack of support for students at that time but which was now available from the PFs.

> *…so there was nobody to do that and students got themselves into crisis and I think the fact that there is someone there stops that happening…The fact that there is somebody there and we use them as a link helps us and the student to be supported in that area*
>
> *[HOD1 131-155]*

One PF related their proactive approach in attending the areas where students were on placement rather than waiting to be contacted when issues arose.

> *if the students have issues and concerns they can contact me and I will go and see them in practice…likewise if the mentors have got issues and concerns I will go and see them and currently in H, I have four, five management students currently out on placement completing the primary care pathway course and I go and see them on a regular basis*
>
> *[PF1 105-110]*

Similarly, another PF related how they used their discretion to tackle a range of issues themselves and relayed their actions back to the HEI.

> *We could just say to the student you don't turn up late every single day, you've turned up late every single day Is there a problem, is there something and if it's just no its look don't do it again, come back, do an e-mail to the University so the University know that we are watching them or the mentor is watching them for being late, simple as that*
>
> *[PF9 650-654]*

> *if there's a student that the ward has said that is failing and I contact the link lecturer to go down there*
>
> *[PF6 692-693]*

Mentors discussed their perspective on the easy availability of the PF: -

> ***No. 2*** *There is always someone in the Trust who you know if there is a problem it's either the mentor or students can talk to…*
>
> ***PI*** *Do you think that's a positive thing…*
>
> ***No. 5*** *I think it is something positive because most of the time we may be busy on the ward and we need somebody to come and help…they are always around, anytime you call them we got M's mobile and we can call her on the mobile and even if she is at X hospital she gets back to us as soon as possible*
>
> ***No. 2*** *I think it is positive as well. It feels like there is an escalation process in place just in case things go wrong, or, you know we got a problem, there is always someone we can escalate this to before we reach and contact the University directly*
>
> *[MFG1 430-468]*

A PF reported that their mentors found them to be the conduit between themselves and the HEI.

> *mentors often say to me that if they need to talk to somebody its very difficult often to get hold of the University…we know who to talk to and I think it makes the mentors life a lot easier*
>
> *[PF6 132-138]*

With the PFs taking on a more active role in practice, much to the appreciation of senior staff in the Trust and HEI, who both spoke of issues being resolved early.

> *what we want to do is nip things in the bud, so a little issue could get to a big issue if someone didn't feel they could go…*
>
> *[EL1 242-244]*

> *we get very few complaints by students because these are nipped in the bud*
>
> *[HOD1 159-160]*

A range of participants described the PFs as the *first port of call* for issues that arose in practice.

> *if there is a student that has an issue they have a first port of call*
>
> *[HOD1 124-125]*

This message is also promoted by the LLs.

> ***No. 7*** *when we do our mentorship updates we do say the first port is the practice facilitator but equally it could be me so if they couldn't get in contact with the practice facilitator, then don't wait, contact me*
>
> ***PI*** *Mhh*

> ***No. 1*** *much of that proactivity remains and it works quite well and I can only speak from a Mental Health perspective but the practice facilitators provide that link…*
>
> *[LLFG1 303-321]*

Even PFs were aware of their evolved role as the first contact.

> *we are normally the first port of call that's raising the issues from a practice point of view then yeh and they do listen to you and things are taken on board and quite big changes have occurred that do make placements safer for everybody*
>
> *[PF7 784-787]*

> *And we follow the student from first year second year third year so we develop relationships with all of the mentors they come on our updates so we know everyone so our relationship with them they look to us for any issues and they will come to us first if there is an issue with a mentor or their own mentors or their own mentoring or any question they don't understand they will come to us, they won't go to the University*
>
> *[PF9 570-575]*

4.3.7 Theme two summary

Participants have made it plain how PFs have created a space where they are well-known and where they operate across pre-registration nurse education in practice. Using their discretion, PFs have targeted areas for their attention, including Trust involvement in student selection to secure suitable applicants that meet their Trust requirements. Participants revealed how PFs increased their involvement, over time, in overseeing students in practice. Operating in this created space, PFs participants revealed a range of activities where they occupied the Trust and HEI communication gap and theory-practice gaps, meshing theory and practice in the delivery of the curriculum to ensure students met practice requirements.

A strong message was given by participants of the LLs not being able to provide the type of support needed by mentors with student issues and often where a quick response was required. All participants revealed this need was, for the most part, met by the on-site PFs. They acknowledged that the PFs have supplanted the LL role and have become the *first port of call* for both Trust and HEI as well as students for all pre-registration issues which arose in practice.

4.4 Theme Three: De facto gatekeepers to the profession

4.4.1 Theme introduction

In this study, PFs had increasingly interpreted their role to incorporate a more qualitative perspective, particularly in terms of mentorship and supporting newly qualified nurses. Participants, during their discussions, repeatedly returned to their combined efforts in securing students who, on qualification, met NMC and Trust requirements. This vision was articulated by an EL thus: -

> *the purpose of us having undergraduate students is so that we have a workforce in the future…to develop people that have that share the values and vision of this organisation and the practice facilitators are essential to actually to help that to happen*
>
> *[EL2 312-315]*

A HOD viewed the PFs remit as: -

> *they make sure that that happens and that's a consistent standard that in terms of our processes ensure that the processes are right to ensure fitness for practice*
>
> *[HOD3 842-844]*

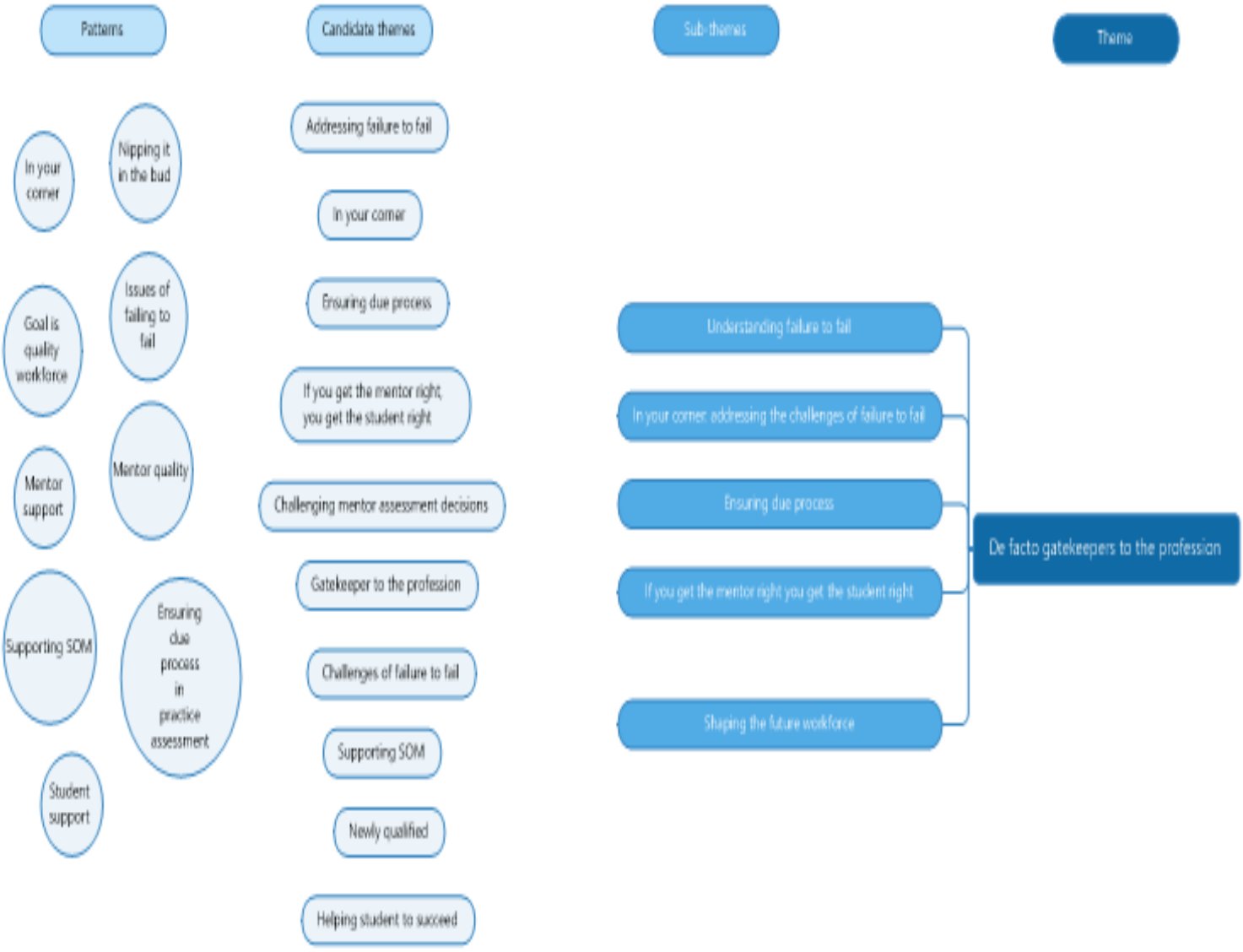
Although PFs had no formal role in the academic or practice assessment of students, participants conveyed how their presence had evolved and now permeated the landscape of pre-registration nurse education in practice across the consortium. From PFs *in the frontline* initial instrumental activities, where they established systems to

secure the quantitative resources required for practice experience, the role incorporated a more qualitative focus. This followed on from the fact that operating *in the frontline* positioned them to have regular, high frequency interactions with key personnel as participants explained in *everybody knows them and they know everybody*. Their increasing grip of ensuring the Trust gained newly qualified nurses that were *fit for purpose and fit for practice (UKCC, 1999)* was voiced by participants, encapsulated in *de facto gatekeepers to the profession* five associated sub-themes which will be discussed in this section.

In order to understand how the PF role evolved to become *de facto gatekeepers to the profession*, participants described how mentors struggled with underperforming students in *understanding failing to fail* and how, with the advent of the PFs being perceived to be *in your corner: addressing the challenges of failing to fail*. This included *ensuring due process* and the realisation that *if you get the mentor right you get the student right*. The final gatekeeper role described by participants is how PFs are *shaping the future workforce*.

A Mindmap (figure 4.4) illustrates how the sub-themes and theme were developed from the patterns and candidate themes identified across the dataset.

Figure 4.4 Mindmap representing theme 3: De facto gatekeepers to the profession



4.4.2 Sub-theme i: Understanding failure to fail

One PF described the effects of previously *failing to fail* on their workforce as*…we were ending up with nurses that were and are continuing to be incompetent…[PF9 39-41]*. PFs discussed how student assessment functioned in the early years of their role where one PF expressed their frustration with mentors not contacting them early enough.

> *one of the most frustrating things that I came across when I came into role was mentors would contact me regarding a student's performance and I would say to the mentor ok, that's fine, I can come out and see you how much longer has the student got on placement, oh they have got about two weeks which really doesn't leave you as a practice facilitator or the mentor to really do anything constructive for the student to help them get through their placement*
>
> *[PF8 633-640]*

A second PF recalled clinical staff, who had failed a student, expressing frustration with the University who did not provide support, yet, upheld the student's appeal.

> *there was a big issue when I came on into this role where…a good example where staff would say what's the point we contact the University we don't get no support we fail a student they go back to University, they appeal and it gets overturned basically because we're not using the correct process*
>
> *[PF7 720-725]*

A third agreed with the previous PF and in addition, related mentors' traumatic experiences of being pressured by students.

> *I've got a year's worth of mentors' responses to why they don't fail students and they range from being bullied by the student, being*

threatened by the student and they see it that the University will pass them anyway

[PF9 75-78]

This was also articulated in a mentor group.

No. 4 *I don't think some people realize really. You get the student come and they have been doing this for three years, either they are very good or they are not and they are just coasting through and people are just passing them, passing them, passing them and they come to your ward as management students and you are the one [SOM] who has to fail them and it shouldn't have got that far and it's not very nice*

No. 1 *It's a big responsibility the Sign Off Mentor especially when*

No. 2 *You hear life stories and things. When I've failed…I've been threatened you know they are going to come after me. I've had one that was going to go off and commit suicide and I'm running through the hospital looking for them*

[MFG1 784-798]

A HOD sums up many of the issues around why underperforming students were not being dealt with adequately in the early days of the PFs being in post.

One of the things we had a problem with was the Failure to Fail Duffy report and that and these practice facilitators almost have been around in the same era and one of the things we already knew was that mentors were not failing the students they were allowing students to go through because of the caring attitude that a nurse has but secondly because of the effort and energy to put into failure and also a lot of them didn't know how to go about failing

[HOD1 370-376]

The complexity and emotional toll on the mentor and their team of making a decision to fail and the frustration on how the student had been allowed to progress was related by an EL where: -

> *some of the cases have been really complex around allegations that have been made against particular wards, particular staff or the Mentor, Sign Off Mentor having angles of worry over a student and wondering how they've got through so many previous placements*
>
> *[EL1 102-107]*

Mentors additionally conveyed their concern that underperforming students could compromise patient care and the value of PF support.

> ***No. 1*** *I've been in a situation that somebody was being repeated and was actually quite dangerous with chemotherapy and things and I wasn't actually told that that member of staff was being repeated on placement but I think we should, I can understand wanting to protect the student but you've got to protect the patient first of all*
>
> ***No. 2*** *…if you think the person is not fit for practice, this can be quite emotional and it could be a very difficult decision so I think the practice facilitator is a very, very important role in supporting the mentors*
>
> *[MFG1 734-753]*

A PF recalled their own experience of being a mentor and commented: -

> *In my own clinical practice as a mentor we had no support when it came to a student that wasn't demonstrating the required competencies you know, it really did depend on the courage of the mentor really as to whether or not they would pass or fail that student*
>
> *[PF8 426-429]*

The LLs discussed these issues from their perspective.

> ***No. 2*** *…We are still finding, on the odd occasion, especially with mentors that are unsure of their own practice, then they get very wobbly about these things and they feel as a link lecturer I am going to come in and do this that and the other…I always start my link lecturer mentor thing I say I'm happy to fail any student but the reason we don't is because you guys don't give us the paperwork properly, you don't go through the right process. So when they realise, I'm actually on their side and then that you don't have that same sort of problem really. But then again is what I'm saying to you is over a period of seven years I've been doing that so they know me and they know that there have been students that failed and they've seen us being fair*
>
> ***PI*** *How does the practice facilitator feature in that…*
>
> ***No. 2*** *Because the practice facilitator I've always, I'm just thinking now as I'm talking we've always been together, doing it together and to uphold both the student which is my sort of remit but also uphold the mentor. It's quite difficult to do that when you've had them sitting in your car for twelve weeks…*
>
> ***No. 4*** *I think what is good is if there is a student who is failing hopefully most of the time what would happen is the ward manager or mentor would contact the practice facilitator who will go straight in and at the point will contact you and you can then look at the situation you can set objectives for the student to achieve and be seen to be doing as much as you possibly can to support the student and I think the difficulty is when they, they get to their last week and say I haven't had my mid-point interview. I haven't had my you know, and I've now been told, nobody said anything before…but I haven't found that as often*

No. 2 *No*

No. 4 *as it used to be because I think the practice facilitators are going in and nipping it in the bud you know*

[LLFG2 725-764]

4.4.3 Sub-theme ii: In your corner: addressing the challenges of failing to fail

Once in post, the concerted effort to tackle failure to fail over time was articulated by a PF: -

looking especially around failing to fail that's one of the biggies that we've really got down to, we've got that running really well now

[PF7 730-732]

PFs saw Duffy's (2003; 2006) seminal work as an influence on this aspect of their role. A PF also revealed they recognised the emotional toll experienced by mentors and that they stood by a mentor who had made a decision to fail.

I support the students as well but if you're looking at Duffy's failing to fail, it's not an easy task we don't like it, we're a caring profession we've been taught to care and we do care about our students, but I care about my mentors as well and I feel it's very important that they need to know that I'm there standing in their corner and I will back them when they need to fail a student if they do

[PF1 135-140]

The value of PF frontline availability along with the wide-ranging support for the practice environment was discussed within one of the mentor groups. Even an experienced sign-off mentor admitted she had never failed a student before and really valued not only the support for the assessment process but also the care.

> ***No. 1*** *…it's there for the students, there for the newly qualified nurses, newly qualified mentors, old hand mentors, mature students, anything to do with learning in the environment that we work in, the current PF is there for that support*
>
> ***No. 2*** *... as soon as there is an issue and you want to discuss something, she's there and she is very supportive…I do have a failing student at the present time and that is an element that I have never experienced as a mentor…it's been a bit of a rollercoaster for the last six weeks and to refer somebody at their sign-off, so knowing they've gone through maybe three years and they've got this far it has been really hard so to have the PF there and she has everyday checked in to see if I'm ok, if she can do anything more to support me, has read through my documentation and given me guidance on everything I've done, so, yeah, invaluable*
>
> *[MFG4 172-180]*

PFs were closely identified as best placed to deal with failure to fail.

> *that the Failure to Fail stuff sits very tightly with the practice facilitators because I think sometimes on their own a mentor might feel nervous of failing a student*
>
> *[EL3 318-320]*

Whilst continuing to manage placement and mentor capacity, as participants have previously described, PFs were already dealing with failure to fail issues. Being well positioned in their Trusts one PF spoke about how they had increasingly incorporated the quality of mentorship in their role stating*…obviously it has changed in terms of the NMC standards that came out in 2006, 2008 [PF8 176-177]*. Another PF agreed, saying*… I think the standards brought a definite difference in the approach to Mentorship…[PF7 202-203]*.

PFs took care of the mentors so they were not overloaded.

> *It's very much a negotiating obviously if I feel that the mentors are being pressurised to have too many students I have the ability to move them and to work with the Mentors to make sure that they aren't pressed to have too many students*
>
> *[PF1 176-179]*

Trust management was aware of the PFs increased focus on mentorship and its challenges as two ELs stated: -

> *…challenging learning environment…the introduction of the NMC sort of mentorship standards mentorship requirements…they worked together on to develop very clear sort of process and reporting mechanism…*
>
> *[EL2 419-423]*

> *It's about training, meeting the NMC guidance around mentor training. It certainly steps up a gear with the triennial review process and to actually manage that*
>
> *[EL1 55-57]*

The commitment to meeting the NMC standards is evident as posited by a PF: -

> *we want to make sure that our mentorship is meeting the standards, we want to make sure that our mentors are assessing the students in the right way*
>
> *[PF2 683-685]*

Another PF conveyed the amount of work undertaken to put the standards into action.

> *that has required a phenomenal undertaking to make sure that we meet the requirements of the NMC around mentorship and are*

compliant with the standards around mentorship, especially around the annual mentorship update that is required, that is still required to be delivered face to face and the triennial reviews, which according to the standards have to be delivered every three years, so the mentors and the facilitators would have a key role to ensure the organisation's compliance with that and working with it and maintaining that and in the preparation of staff

[PF4 603-610]

PFs promoted, despite the workload, they were the 'go to' person for mentors.

The practice facilitator's play that role in making sure if there are problems mentors have somewhere to go with it and feel confident to go with it and are able to say this is a problem with this student

[PF9 726-729]

A HOD reported that truly failing students are leaving the programme much earlier these days.

With the practice facilitators in place what I have noticed is because they are supporting the mentors we are getting failures in first year and second year so they are helping them to get to support students who are not going to achieve to be taken out of these programmes a lot earlier, because other ways students don't understand why they get to the very final placement and are failed

[HOD1 468-473]

Whilst it was acknowledged that PFs spent a lot of time focussing on supporting mentors and students to put standards in place one EL felt there was still more work to do.

One of the areas that they [PF] spend a lot of time doing is when people are in difficulties so when students have problems or students that aren't necessarily achieving the competencies and that takes

them a lot of time away from other things so, so we can strengthen people's sort of confidence in actually managing those because often often nothing really happens until its too late so there's more work to do around that I think as well

[EL2 194-199]

4.4.4 Sub-theme iii: Ensuring due process

As previously stated by participants the PFs were working actively to operationalise the new standards. Much of the work involved improving processes. One effect of PFs involvement was voiced by a HOD as: -

their impact is ensuring that due process is followed with student practice assessment

[HOD3 441-442]

A PF concurred and noticed this had been increasing with time.

Now because of the robust processes that I think that we have in place, there is more, we, I am seeing over the last, particularly over the last three years we are seeing more Mentors raise concerns about students and that is something that was not around a good few years ago

[PF8 429-433]

PFs involvement in ensuring due process was followed was seen by an EL as also addressing failure to fail issues thus securing students that were fit for practice.

> *When you've got the PF there supporting them…and the link lecturer or the University, they're there to make sure due process is followed but also that people feel confident enough that if there are issues with the student…they are able to actually follow the right process and those students if they are not fit for practice are passed through the system*
>
> *[EL3 324-329]*

One HOD talks of PFs participation in the specific aspects of supporting mentors to ensure due process and how it was seen to weed out underperforming students.

> *what has happened with the practice facilitators is that they have supported the mentors and have been there with them and have helped devise action plans, told them how and what you can do to manage a student to fail a student and as a result of those we have got many more students who have been put through a process to allow them to improve what they are doing either to achieve success or to leave the nursing profession which is what we want*
>
> *[HOD1 377-382]*

This intensive frontline positioning was confirmed by a PF.

> *We are happy to sit in interviews…as a support for the mentor, we are happy to sit down and go through action plans with the mentor…and go through the assessment process*
>
> *[PF2 620-630]*

PFs articulated this frontline support was for the mentor but was also to support the student.

Sometimes you do come across difficult situations where they need advice and support and if you do have a failing students then you helping them with action plans and making sure that you know that they are aware of the various aspects to associated with it and how best to improve the learning experience for the student

[PF5 41-45]

…it doesn't mean that they're bad students that they don't make good nurses but at that particular point in their career they need to get another opportunity to repeat their placement and a lot of them do turn it around in the same way as they would in an academic way turn it around

[PF4 695-698]

Similarly, an EL related the PF role as having helped students to succeed.

It's not about people thinking that's a, you know, dreadful person but this person has struggled here so how can we ensure that they get the appropriate support because it was difficult but they've met the requirements or they haven't met the requirements and they're going to repeat that placement area but to enable people to be successful as opposed to maybe some of our other systems didn't necessarily support people to get success

[EL2 639-644]

A PF described how their support had facilitated mentors understanding the curriculum to provide quality placements.

Mentors have felt that they're not supported in practice they've not fully understood curriculums…by us being there we're able to support them and to guide them providing a quality placement for all the students that are out with us

[PF1 249-254]

The importance of PFs understanding the curriculum and sharing this with students and mentors was underlined by a HOD.

> *Trusts benefit by having somebody who has a very clear understanding of the curriculum and that's not just for the students but that's for the mentors… and the practice facilitators because they are involved in our curriculum development really have that understanding…*
>
> *[HOD1 133-141]*

Mentors described how the PFs used their updates to keep mentors in tune with the University and NMC through direct discussion of practice assessment documents [green books].

> ***No. 3*** *…our current PF she has provided support, she has arranged mentor updates, she has been there for advice…guiding and advising, she's been easily accessible*
>
> ***No. 1*** *…information surrounding the student packs, any changes to their books, their green books, any NMC changes that we need to be aware of, always brought to our attention as soon as possible, either through the mentoring update or on the e-mail*
>
> ***No. 2*** *The mentoring updates have been very timely, they are significant, they are succinct and they give all the information that you require to maintain that mentorship, that theoretical knowledge that underpins your practice*
>
> *[MFG4 225-244]*

In addition, a PF advised that this included discussion on the process for assessing students.

> *we also know there are some issues about mentors completing the assessment process in the correct manner so that is something that is always picked up within our updates*
>
> *[PF2 295-297]*

A HOD agreed.

> *the practice facilitators were instrumental in ensuring that the mentors are familiar to how this assessment is going to be organised and managed in practice*
>
> *[HOD2 314-316]*

LLs discussed how, since the PFs were involved, they had noticed they were increasingly called early in compliance with and in support of assessment processes.

> ***No. 5*** *I see that occurring more frequently and the only driver I can see for that occurring is the practice facilitators to ensure the HEI, our link lecturers are involved at an early stage*
>
> ***PI*** *And that's where issues are being identified…*
>
> ***No. 5*** *They could be referred on a placement or it may not even be regarding a referral it may be to do with professional behaviour of a student, attitude, I see it more to do with identifying particular problem areas for students, or, in some cases where they have identified that Mentors are either unable to complete all the required assessment processes that the University gets involved, or that they ask the Link Lecturer to support a new Mentor or somebody who is obviously having some difficulties, so I'm not saying that's it's always worked really well but I have noticed a definite change in the last year or so in terms of the focus of the Link Lecturer and the*

practice facilitators wanting to engage more with the HEIs in the actual process of assessment out in the areas

No. 4 *I would support what No. 5 has just said*

[LLFG1 243- 263]

Other PFs confirmed that mentor behaviour had changed.

the mentors now know and are more in tune with escalating and escalating more quickly so they would either involve us from the education team or they would also involve the link lecturer

[PF4 172-174]

In the last two and a half years I have seen an increase in one, the number of mentors that actually call us for support and secondly, more timely contact from mentors when they require support

[PF8 640-643]

Mentors discussed how they had benefited.

No. 5 *[PF] is very helpful, it is because the time, the time factor. If they are there its ok for us to also be stressed 'cause we have to do our jobs. Immediately they come around, we are fine, no more stress we have to concentrate on our work whilst they will deal with the situation*

PI *So it removes stress from you so you can focus on what else is going on in the clinical environment*

No. 5 *Yeah*

No. 2 *I think it is positive as well…there is always someone you can escalate this to, there is always someone we can seek help and advice from*

> ***No. 1*** *I'd just like to add I think they are far more supportive, realistic and good listeners compared to the University…and they are there much more there for you where I think the University when there are big issues*
>
> *[MFG1 453-485]*

4.4.5 Sub-theme iv: If you get the mentor right, you get the student right

Participants placed a high value on the mentor role and recognised that the student experience was highly dependent on the mentor. A PF succinctly encapsulated the PFs perspective in supporting mentors as: -

> *…I would hope that mentors feel more supported and there is greater provision of information and education and advice for mentors who are the key people in practice who are responsible for the individual student in terms of their learning and assessment*
>
> *[PF3 388-391]*

One HOD understood how complex this support was in practice.

> *…practice facilitators have to go to the ward and sit with the mentor whilst they are undertaking an interview with a student to help them before an interview with the student, plan learning outcomes, plan action plans, help them to say things in the right way so that the student gets the feedback that is required because mentors aren't skilled, this is not something, that mentors on a six, forty hour taught mentorship course is not going to give you those skills. You only get those skills by working in an environment getting the student which challenges you to think how are you going to respond to that and the practice facilitators have got a huge wealth of experience over time about managing these and can go in and really, really, really help*

to underpin what the mentor is saying and support the mentor in achieving that

[HOD1 441-454]

Mentors saw the multifaceted nature of the PFs attentions where they provided support for mentors, staff and students.

No. 1 *They support the mentors as well they are always available when mentors are having problems with students, they come around. Then when students are having problems they come around to support the students as well. They sometimes arrange some studies for mentors so they support the mentors a lot and the staff at the same time*

No. 4 *I think it does help because it does help us a mentors to support the students better When we have problems with students, sometimes it's really hard as to what to do but you always know there's somebody there you can turn to who will then help you*

[MFG2 62-75]

As part of their remit dealing with failure to fail, described above, one PF revealed how they work with each other to standardise the quality of mentorship across the consortium.

I think if you look at the failure to fail research that was done one of the key parts of every single facilitators remit is to ensure that mentors are assessing the students in a consistent manner and that will go across the patch [the consortium] because we all talk to one another, we all meet together so we are obviously we are looking at issues around teaching and training to ensure consistency

[PF2 282-287]

A HOD positively rated PFs work towards *intra-mentor reliability* and valued the *mentor support groups so that the difficult questions can be raised [HOD3 781-782]*.

PFs revealed they gave sign-off mentors' special attention with their own support groups as their support needs were perceived to be greater given this was the final opportunity to pass or fail a student.

> *The sign-off mentors So, yeah, the other reason for the support group was that so I had regular contact with the sign-off mentors and we are constantly assessing their ability to do the role of the sign-off mentor*
>
> *[PF8 224-227]*

Mentors viewed the support they received from the PF and their peers as being very helpful particularly when dealing with underperforming students. The group seemed to provide a structured, safe environment to discuss assessment issues. They made known that PFs continued to extend their support for mentors on an individual basis throughout the assessment process.

> ***No. 3*** *…all the Sign Off Mentors will meet up…to discuss any issues regarding our third year students…and again highlighting to us the importance of documentation and if ever we have to fail a student which I haven't come across but you can see why it is very important you know to take this very seriously because at the end of the day you know you are passing somebody…who is not going to be a safe practitioner and to giving the quality care. It's not just about tick boxes*

> ***No. 1*** *…I was in the situation twice with a sign-off mentorship where I had to fail, two occasions two different students and it is quite difficult actually to reach that stage to make that decision because somebody goes on to…four and a half years of training and then you are deciding whether they are competent enough to be you know a*

staff nurse and I had to go, first of all the support group actually when we were discussing issues…and you could see that there are similar issues with other sign-off mentors also so that was something of reassurance that you are not the only one who is facing them issues…I have asked the practice facilitators to come and assess the student which they have done recently and they have gone into all sorts of things in what the decision I have made so that was a reassurance from my point of view because when it came to the crunch the student was saying that our standards were too high and things like that so the practice facilitators they confirmed no, the assessment standard we would expect that particular student to achieve at that particular stage of training so that support was inval, helpful

[MFG3 465-492]

One PF spoke of mentors in the chain of quality and mentor responsibility for student assessment decisions.

it's just again making sure that we are all working together to deliver high quality patient care by providing students that are of high quality and mentors that are assessing them are accountable for the quality that they are assessing against

[PF4 393-397]

The LLs were acutely aware of their limitations in dealing with poor mentorship.

***No. 1** I have a comment about that, their role is having a relationship with their mentors and the Trusts in that we can go in and we can guide and we can facilitate and we can advise mentors but we don't have a formal relationship we go in there as outsiders. Mentors, they can listen to our advice but there is no accountability in the way that there is with the practice facilitators and so when it comes to issues of standards and mentors failing in their role then there is somebody that has a formal relationship that can go in there on their own…*

somebody who is actually employed by the Trust to do that work but you know we as lecturing staff … we're strangers relative strangers so I think it's quite an important part of their role that they have that formal relationship already

No. 5 *…and possibly I think as you all pointed out I suppose the main aim of bringing in practice facilitators was to improve the learning environment*

[LLFG1 676-754]

A HOD was aware, where students were underperforming, that PFs were going back to previous mentors to review their assessment decisions.

they are reviewing systems and going back to mentors whereby with students have not done well just to check is there something that we could have done in order to, well basically it's about failing to fail

[HOD2 458-460]

Mentors acknowledged the work PFs were doing in reviewing mentor decisions.

> ***No. 1*** *Yes. They have recalled all the Mentors and they have been given the opportunity to explain where they have gone wrong what has been the impact with the student in their area and to re-look at the Mentorship standards and how they are Mentoring students. I think that has been taking place for at least the last twelve months probably more*
>
> ***No. 3*** *I think these issues came out I think us as Mentors and nurses became more aware with Sign off Mentor role came into effect or into force. The triennial reviews made thing more tight. Things were kind of fragmented and everybody practicing in isolation. But I think with the practice facilitators role they are drawing everything and audits of Mentors and identifying practices that were not up to the standard and to do something about it…*
>
> *[MFG3 392-404]*

More broadly an EL expressed how PFs activities contributed to quality.

> *It aids detection of poor practice and that's not solely from the student that's from the registered nurse who may or may not be fulfilling mentor requirements in the right way*
>
> *[EL1 52-55]*

A HOD and a PF summarise the substantial impact on students of the targeted mentor support provided by PFs.

> *if you get the mentor right, you get the support for the mentor right, then by default, the student gets a better experience*
>
> *[HOD1 78-80]*
>
> *…if the student has the right mentor and the right quality of mentorship and that the mentors themselves have the confidence to support students so that they are learning but also have the*

confidence to fail a student when a student is failing then we get it right

[PF4 541-545]

4.4.6 Sub-theme v: Shaping the future workforce

A strong sense prevailed that for each student the PFs were*…ensuring that a safe, effective competent and confidant practitioner enters on to the register [PF8 726-727]* as they*…are our future workforce [EL3 458].*

The link from recruitment right through to joining the Host Trust workforce is confirmed by a PF.

look to our workforce which is over 200 Graduates twice a year to see how many of them can we recruit into the positions we have and that's ongoing work…they are the commissions that are needed are required to meet our workforce requirements

[PF4 223-301]

PFs reflected on their knowledge of students, and commented on their unique position where they had an overview of students from being selected for the programme through to being a newly qualified employee.

you kind of feel that there is more of a beginning and end in sight, you know, that you are there at the beginning at the recruitment you are trying to make sure you've got this student of a high quality coming into the curriculum programme you want and then at the end you are having this nurse graduating and that you want to employ in your organisation and that is fit for purpose

[PF4 421-426]

We also have a relationship with the student which the mentors don't have we will be able to look at that and follow it through the three

years to see that's there an improvement and actually it's nice to see some nurses make the change, make the effort and they end up qualifying and they are good nurses

[PF9 729-732]

A HOD talked of PFs Host Trust recruitment activities.

where they [PFs] support students at the end of the programme and they prepare them to work in the Trust at the end of the time so again it is building up the Host Trust concept

[HOD1 240-242]

A PF expressed that: -

From a Trust perspective, if students are going to apply to our Trust for a job, our Director of Nursing is very keen that they are prepared for that because it is quite a strenuous and extensive experience to go through

[PF8 413-416]

PFs guided students in the intricacies of applying for a job which included the completion and submission of the application form.

well initially we'll guide them at how to actually apply for a job because it's all through online and through NHS jobs…then if any of them want any assistance with filling out their application form I always say to them I'm quite happy to read through their job you know why they want their job because sometimes if its their first go they sometimes will put the wrong things

[PF6 755-768]

PFs reported*…we get involved in their mock interview process towards the end of their training [PF8 407-408]*.

In addition, an EL advised the PF support encompassed: -

> *they do interview skills as well with the students and then obviously if they were successful and they got a post here they would then support them through that preceptorship process*
>
> *[EL3 676-678]*

A PF encapsulated their commitment to securing a workforce that imbued Host Trust values who were well supported as newly qualified nurses.

> *we make sure that we are developing safe practitioners that care about the job that they are doing, they are passionate about it and we know who they are because we recruit them, we train them, we look after them, then we employ them and then we mentor them and preceptor them and it goes on*
>
> *[PF9 777-781]*

This support was viewed by a PF as an important element in staff retention.

> *our preceptorship programmes have been really, really successful and I think of all the newly qualified staff that have come to community now, they are still there*
>
> *[PF7 947-949]*

An EL talked of PFs efforts within their Trust to identify lead mentors.

> *we're currently developing a strategy which the practice facilitators are leading where we would work with, with trying to identify a lead mentor in each of the clinical areas…*
>
> *[EL2 166-171]*

One EL spoke of how it felt to move from a process whereby nurses automatically completed a mentorship module and became mentors to a system which involved a selection process to identify mentors.

there is a really difficult balance I think for us to pull off here between mentors who clearly need to be fulfilling that role, they are appropriately selected and those mentors who are on a degree pathway…

[EL1 329-331]

This was described in more detail by another EL.

what do we need if we're going to develop people to be our future nurses - who needs to be mentoring those and what quality skills and attributes do they actually need to have and how do we then develop them further so you're looking at its more of a specialist role as opposed to just you know any band five will be expected to be an assessor in clinical practice of other people

[EL2 602-609]

PFs expressed satisfaction in how their role has evolved over time to have become the *de facto gatekeepers to the profession*.

I often walk around now… you know most of the staff and it's wonderful because you have seen them as first year students, second year students, third year students and then two three years down the line you see competent, confident staff nurses

[PF7 880-884]

The beauty of this job in a nutshell is that we recruit the students, we are a part of that process we teach the students we have a relationship with the student we know them all from first year, second year, third year, they come on the preceptorship programme which we run also, perhaps I should have said that earlier, we run the preceptor programme and then they are our mentors so the relationship we have with these nurses doesn't stop it's an ongoing thing from the first year 'till they retire

[PF9 748-755]

4.4.7 Theme three summary

Participants clearly expressed how PFs had incorporated an increased quality aspect to their role and had become de facto gatekeepers to the profession. In *understanding failure to fail*, a range of issues were discussed by participants which, in the past, had contributed to mentor's assessment decisions. In addressing challenges of failing to fail, PFs were revealed to have taken a central pivotal role in ensuring the standards for mentors (NMC, 2006, 2008a) were met. A key aspect of PFs support for mentors in addressing failure to fail was their responsive, frontline involvement, with tailored support for mentors which ensured due process in their assessment decisions.

Participants discussed and appreciated the PFs sign-off mentor support group as well as the accessible one-to-one support in getting the mentor right. This support was valued by participants and included their awareness that mentors were held to account by PFs for their previous assessment decisions where students were subsequently found to be underperforming.

In *shaping the future workforce*, the unique overview of PFs of the student's journey from recruitment to supporting students to secure first destination posts in the Host Trust was acknowledged by participants. Further revelations by participants confirmed how PFs continued to support these newly qualified staff through the preceptorship programme. In addition, PFs had expanded their quality remit to include selection processes for future mentors so had become *de facto gatekeepers to the profession*.

4.5 Overarching theme: The everything facilitator

Looking across the results has revealed three themes which illuminated the way in which the PFs role had developed. Three themes emerged namely *in the frontline, everybody knows them and they know everybody* and *de facto gatekeepers to the profession.*

In the frontline exposed how the PF role initially had a more operational focus. This focus comprised of a number of elements where, as *placement capacity generators,* PFs, used their discretion and focused on securing the quantitative elements of placement capacity required for pre-registration nurse education in practice. This aspect has continued as a significant role feature. This process was formalised across the consortium where a forward mapping of a placement capacity tool had been developed and which was managed by PFs and valued by participants. Another aspect was revealed where, as *mentor capacity generators* PFs, used their discretion to focus on building mentor capacity for the Host Trust student population which has continued as a significant role feature. Further, forward mapping included mentor information and allowed mentor requirements to be forecasted. Control and ongoing management of these two quantitative resources, essential for providing placement resources for pre-registration nurse education in practice helped reduce the consequences of uncertainty of placement resource availability. Indeed, this provided the platform for PFs to become *curriculum influencers* where PFs took on a more formative remit where they influenced curriculum design which was informed by placement capacity resources. Importantly, PFs influenced curriculum to be more practice focussed. The *frontline positioning* of PFs permeated pre-registration nurse education in practice where they were involved in mediating decision making at strategic and operational levels in their Host Trust and the HEI. Further, PFs became part of Trust and HEI governance systems.

Everybody knows them and they know everybody crystallised participants consistent perceptions that PFs were well known within and between the Trust and HEI. PFs were revealed to be operating fluidly, as *the inbetweeners*, in the pre-registration nurse education in practice landscape within and between the Trust and HEI. Moreover, it was evident that PFs exercised their discretion and autonomy in a range

of activities in both spheres. It appeared they had created their own sphere or space to work effectively. This included the PFs acting as the pivotal communication channel *occupying the Trust-HEI communication gap*, communicating with the relevant individuals at both operational and strategic levels. A key feature of *occupying the Trust-HEI theory-practice gap* was where PFs used their discretion to mediate and interpret the content of pre-registration curricula programmes that met Trust practice requirements and facilitated their delivery. In addition, PFs ensured students and academic staff were prepared and complied with required standards for delivering care in practice. The disconnection of the LL from practice placements areas had led to PFs *supplanting the link lecturer role* where PFs had developed routines to manage the consequences of issues that arose in practice. PFs had supplanted the LL role in practice due to their on-site, quick accessibility except where the LLs presence was required as part of a HEI procedure. Academics acknowledged the deficits in their LL role and appreciated PFs working to support students and mentors in practice. The ineffective LL role and the accessibility and availability of PFs revealed the PFs had become the *first port of call* for their Trust and HEI for all practice related pre-registration nurse education in practice issues. This high level of support in practice was greatly valued by Trust and HEI staff.

Over time, PFs role had evolved to a more qualitative focus as they became *de facto gatekeepers to the profession*. Participants in *understanding failure to fail*, described a range of challenges in managing underperforming students in the past. The professional and emotional toll experienced by mentors was highlighted in their attempts to manage underperforming students. *In your corner: addressing the challenges of failing to fail*, participants expressed strong sentiments for the range of tailored supportive activities for the mentors provided by the PFs. Mentors appreciated the PFs knowledge and direct timely guidance in student assessment. In *ensuring due process* PFs operationalised NMC mentor standards (NMC, 2008a) and ensured due process in student assessment. A range of tailored support for mentors in student assessment was provided by PFs in *if you get the mentor right, you get the student right*. PFs reviewed potential poor assessment decisions with those mentors that were involved. Further, PFs, used their discretion to provide locally responsive education and support mechanisms for mentors where they shared real-life student assessment situations. PFs had a unique position in the Trust as they oversaw

students from recruitment to becoming newly qualified thus *shaping the future workforce*. This extended into PFs providing preceptorship for newly qualified nurses who were subsequently available to be selected as future mentors.

These sub-themes and themes illuminated the overarching theme of the multiple aspects of the PF role that had evolved over time and encapsulated in their being *the everything facilitator*. Indeed, one of the practice facilitators aptly described their sense of their role as:-

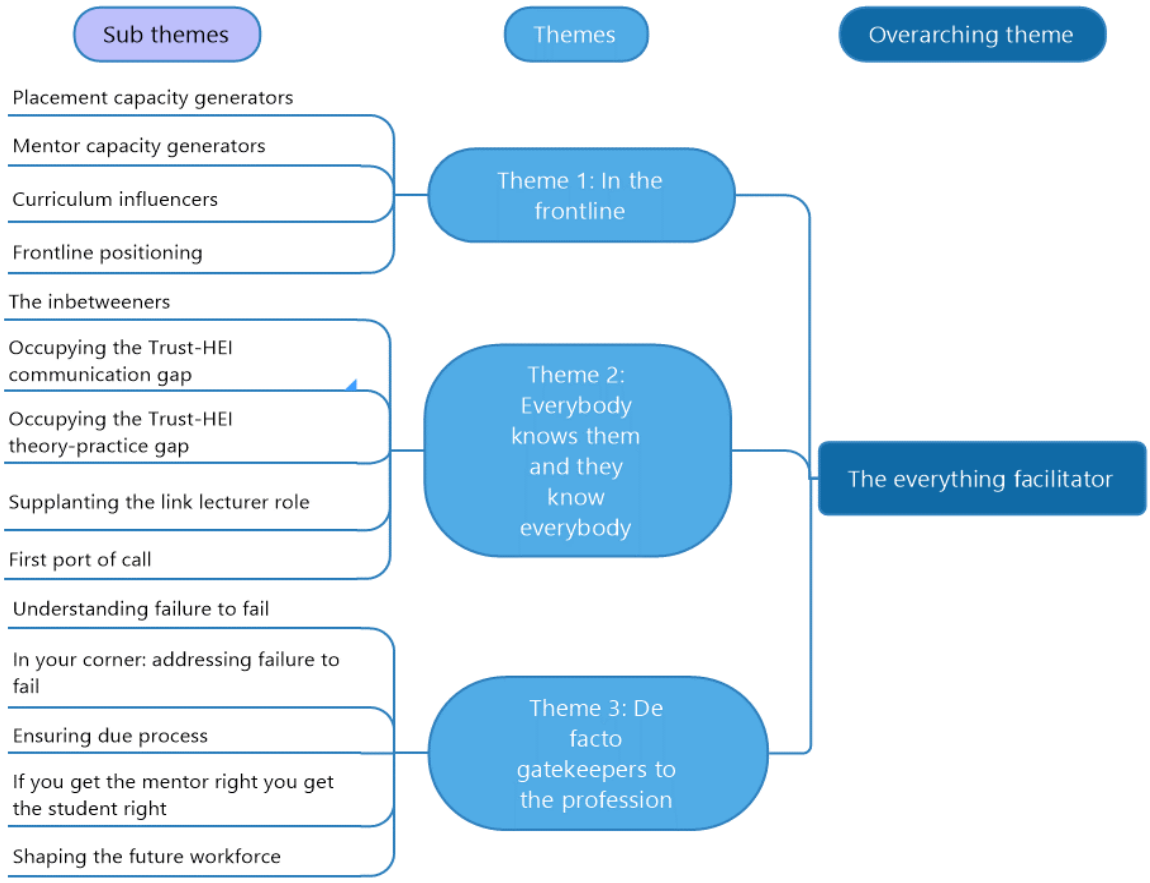
I think this role…you…you become the everything facilitator

[PF7 872-875]

The idea of the PF being …*the everything facilitator* is a re-current feature through the study results. It captured both the breadth as well as the depth of the evolving role within the landscape of pre-registration nurse education in practice over time. It appeared that the PFs were able to create a space for themselves to operate in as street-level bureaucrats across, between and within the Trusts and HEI at strategic and operational levels. This is a new conceptualisation of cross organisational working in this context and which will be discussed in detail in the next chapter. It is with this understanding, that…*the everything facilitator* was embodied as the overarching theme of this study.

A Mindmap (figure 4.5) illustrates how the sub-themes and themes developed to realise *the everything facilitator*.

Figure 4.5 Mindmap representing overarching theme: the everything facilitator



4.6 Chapter summary

In summary, this chapter explored and presented the results of the overarching theme, themes and sub-themes (figure 4.5) which showed the practice facilitator role was a well-known, well-established, knowledgeable and influential role. The evolutionary nature of the role over time was explored. The focus initially related to establishing systems for managing the quantitative elements of placement capacity to accumulate and incorporate qualitative elements of nurse education in practice in their role. There was a strong sense of the role being viewed as pro-active and one which was synonymous with influencing pre-registration nurse education in practice in the consortium. This proactive, influential nature of the role is conveyed where they were seen *the everything facilitator* (overarching theme) (figure 4.5) managing

and supporting key resources in their Trusts and working with the HEIs and, in the space between, translating pre-registration nurse education to produce a workforce which was fit for purpose and fit for practice. The results will be discussed in chapter 5 and will be critically evaluated with the literature.

Chapter 5: Discussion – the everything facilitator, street-level bureaucrats working in interstitial spaces

5.1 Chapter introduction

This extensive, in-depth case study (Yin, 2009) was the first exploration of the practice facilitator role in a real-world context and the way it evolved over time. Overall, study participants, from their different perspectives, articulated positive views of the practice facilitator role and provided grounds for considering the role as successful. This was largely because practice facilitators were pivotal in re-engaging the NHS service providers in a shared responsibility for pre-registration nurse education in practice as outlined in the foundation policy statements, *Making a Difference* (DoH, 1999) and *Fitness for Practice* (UKCC, 1999). This was a significant achievement given the setting of the Trusts and HEI being distinctly different organisations with different values, goals and ways of working, yet each responsible for delivering 50% of the curriculum.

Whilst the major impact of the practice facilitator centres on the pre-registration nurse education in practice component, the study results indicate that the practice facilitators also had a significant influence on the programme as a whole. As in section 1.2, where this is the case, the term 'pre-registration nurse education programme, or, programmes' will be used. Where pre-registration nurse education in practice is the sole element being discussed, the term 'pre-registration nurse education in practice' is used.

Lipsky's (2010) bottom-up approach to policy implementation, within organisations, proved to be crucial to understanding how the practice facilitator role functioned and evolved over time. Practice facilitators were found to exhibit the characteristic behaviours to deliver policy at a local level as outlined by Lipsky (2010). The results provided a crucial insight, namely that over time the practice facilitators, as street-level bureaucrats (Lipsky, 2010) occupied unique spaces across, between and within the Trusts and HEI at strategic and operational levels. The nature and significance of the spaces occupied by practice facilitators is discussed in detail (sections 5.2, 5.3.

5.4). It is argued that this analysis of the spaces occupied by practice facilitators, and the way they operated within them, represents a potentially important development of Lipsky's (2010) concept of street-level bureaucrats. In particular, how practice facilitators as street-level bureaucrats operate successfully, and influence policy implementation, not only at street-level within organisations, but also across and between organisations. Moreover, they operate at an additional dimension at both strategic and operational levels, across, between and within organisations.

In the organisational literature, working in the spaces between organisations has been referred to as "*interstitial spaces*" (Furnari, 2014, p. 439). These spaces are where individuals interact formally and informally to bring about change and develop new ways of practice and working (Furnari, 2014, 2016; Weinfunter and Seidl, 2019; Villani and Phillips, 2021). Whilst Furnari, (2014, 2016) perceived the spaces as informal and temporary, practice facilitators, as street-level bureaucrats were revealed to have created and occupied the spaces across, between and within the Trusts and HEI at strategic and operational levels on an ongoing basis. This was where they interacted both formally and informally to implement policy. In doing so, the interstitial spaces (Furnari, 2014, 2016; Weinfunter and Seidl, 2019; Villani and Phillips, 2021) enabled practice facilitators as street-level bureaucrats (Lipsky, 2010) to use their autonomy and discretion to mediate as well as implement policy at strategic and operational levels cross-organisations. These aspects are explored in section 5.3 and 5.4 and integrated throughout the chapter.

The quantity and quality of relevant research literature varied across topics and time. This included scant material in areas such as the involvement of Trusts in curriculum development and Trusts taking the lead in managing placement provision for pre-registration nurse education in practice students. In contrast, there were considerable bodies of research around the link lecturer and mentorship. Relevant literature found for chapter 2 to support the conduct of this study but which did not meet the inclusion criteria, has been incorporated in this chapter, where this literature related to the wider issues raised by participants. Literature searches of these issues were conducted and the time frames are broadly outlined in table 2.2. Where there was scant literature, editorial and expert opinion has been included where relevant.

Otherwise, only key papers are cited to contextualise and integrate the results of this study.

The first part of the chapter discusses the practice facilitators through the lens of Lipsky's (2010) street-level bureaucracy and the interpretation of their positioning in the interstitial spaces (Furnari, 2014, 2016; Weinfunter and Seidl 2019; Villani and Phillips, 2021). The spatial and operational parameters of these are contrasted, compared, contextualised and synthesised, culminating in a novel understanding of how street-level bureaucrats, can effectively operate across, between and within organisations as demonstrated by practice facilitators in this study. The synthesis generated three new purposes for street-level bureaucrats operating in interstitial spaces: firstly developing innovative resources; secondly developing solutions to uncertainties; and thirdly, supporting the development and embedding of routine practices. The later part of this chapter is structured around the three purposes, supported by the relevant literature and participants understandings of the practice facilitator role in a real-world context and the way the role evolved over time. Themes and sub-themes have been subsumed within this discussion and are highlighted in italics. The chapter ends with a discussion of the overarching theme of *the everything facilitator* identified in chapter 4. It explores how the idea of the street-level bureaucrat (Lipsky, 2010) working within the interstitial spaces (Furnari, 2014) helps understand the nature of *the everything facilitator* as well as the means by which the practice facilitators successfully operate within such spaces. This is followed by the impact of NMC (2018c) standards and chapter summary.

5.2 Practice facilitators through the lens of street-level bureaucracy (Lipsky, 2010)

From early on in this study, Lipsky's (2010) street-level bureaucracy model provided an increasingly relevant theoretical perspective in generating understandings around how the practice facilitator (PF) role developed in a real-world context and the way it evolved over time. It is important to note that practice facilitators (PFs) were able to create a space for themselves to operate in, as street-level bureaucrats across, between and within the Trusts and HEI at strategic and operational levels. Analysis

of this, it is argued, represents a new advancement of street-level bureaucracy within a real-world cross-organisational spatial context that will be further explored in the following sections. Before the discussion of these wider perspectives, street-level bureaucracy itself will be explored. This includes the use of Lipsky (2010) in key papers in the wider literature (section 5.2.1) and the limited number of studies in nursing (section 5.2.2).

5.2.1 Wider perspectives on street-level bureaucracy (Lipsky, 2010)

Lipsky (2010) argued, as discussed in chapter 1, that policy implementation was largely a bottom-up process within organisations, and, in practice, was determined by those who implemented the policies. Specifically, those who work at the frontline who Lipsky (2010) termed street-level bureaucrats. Lipsky's (2010) model has been used to explore a range of health and other public services research areas. For example, it is used in policy implementation in social work (Evans and Harris, 2004, 2006; Križ and Skivenes, 2014; Scourfield, 2015; Evans, 2011, 2016); public services (Virtanen *et al.*, 2018) and healthcare (Drinkwater *et al.*, 2013; Erasmus, 2014; Tummers and Bekkers, 2014). It was also used as a frame for a major literature review in public management, public policy and social work (Nothdurfter and Hermans, 2018).

Lipsky (2010) formulated from his research that, within an organisation, the street-level bureaucrat was able to use discretion, interpret policy at street-level as policy was delivered, operate autonomously and finally mediate between higher up policy and street level. Two key characteristics of street-level bureaucrats were that, firstly, they have the ability and freedom to select among various responses to complex situations encountered in practice. By this Lipsky (2010) was referring to the way street-level bureaucrats responded to clients in their frontline role as service providers. The operational location of PFs within the interstitial spaces as discussed below (section 5.3) illuminates the freedom, flexibility and fluidity to act in this way. The second characteristic of street-level bureaucrats was that they possessed a relatively high level of discretion in exercising how they respond. Lipsky (2010) summaries the discretion exercised by street-level bureaucrats:-

"*…the decisions of street level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively become the public policies they carry out*"

(Lipsky 2010, p. xii; 2010, p. xiii).

The way the PFs operated as street-level bureaucrats, reflected aspects of what Lipsky identified as the four purposes of street-level bureaucrats:

(1) *They ration resources.*
(2) *They control clients and reduce consequences of uncertainty*.
(3) *They husband worker resources.*
(4) *They manage the consequences of routine practice.*

(Lipsky, 2010, p. 86).

In a meta-ethnographic synthesis of studies on health policy implementation (Lipsky, 1980) in low-and middle-income countries, Erasmus (2014), explicated the factors, that in his view, affected street-level bureaucrats, noting the differences between socio-political context and work environment, personal beliefs and values. These factors influenced how the street-level bureaucrats operated in coping with the situation or, acting with logic either embedded in the situation, or, arising from their personal values and beliefs. Erasmus (2014) elicited subversive behaviours of street-level bureaucrats such as disregarding directions; breaching expectations as well as negative perceptions of clients affecting relationships. PFs in this study were aware of their socio-political context; Trusts and HEI work environments; their personal beliefs and values within which they worked as street-level bureaucrats.

A criticism levelled at Lipsky's (2010) model of street-level bureaucracy was that the theory pre-dates the growth of managerialism in public service organisations (see for example Howe, 1991). Organisational and professional power had shifted away from the frontline. Professional work was governed by service targets, detailed centralised objectives and operational protocols thus curtailed the degree of discretion frontline professionals had available to them. This potentially represented an important

criticism, particularly in respect of the hierarchical nature of the NHS. In contrast, however, Evans (2011), following a case study of social work practice in England, argued that the frontline professional had become the 'managerial unit'. Rather than automatically implementing top down managerial directives, street-level bureaucrats in this context retained a relatively high degree of discretion to make frontline decisions. In this study it is argued that the PF occupied an unusual position within and across the organisational structures, and this, arguably, as a means by which PFs retained a relatively high level of autonomy associated with Lipsky's (2010) original exposition of street-level bureaucrats.

Whereas Lipsky (2010) referred to street-level bureaucrats in the frontline of policy implementation as being at the bottom of the organisational hierarchy, Evans (2016) argued that those higher up the hierarchy, such as managers, also could operate as street-level bureaucrats. However, PFs in the current study were revealed to operate *in the frontline* at both levels as street-level bureaucrats. Further, these differing levels of operation were at both strategic and operational levels, within, between and across organisations. This represents a development and elaboration of the ideas first promulgated by Lipsky (2010) and expanded upon by Evans (2016). This previously discussed literature has predominantly been in social-work and community organisations. The influence of street-level bureaucrats on nursing has been comparatively less but is now explored in the following section.

5.2.2 Nurses as street-level bureaucrats (Lipsky, 2010)

In the nursing research literature, Lipsky (2010) has been used successfully as an interpretive framework to explore street-level bureaucrat activities within organisations. Hoyle (2011, 2014) used it in the context of front-line nursing staff's discretion in policy implementation in the acute hospital environment. Hughes and Condon (2016) employed it to explore how student and newly qualified health visitors functioned. Cuthill and Johnston (2019) used Lipsky (2010) in policy implementation of a new domestic abuse policy being implemented by health visitors. Brook *et al.* (2017) in a study of the integration of sexual health services after an educational intervention where it provided the lens through which to explore

nurse's discretion in integrating policy in practice. Johannessen *et al.* (2018) used Lipsky (2010) in the challenges experienced by healthcare professionals in user participation. Lipsky (2010) was used by Drinkwater *et al*. (2013) to explore healthcare professionals understanding of the reasons why patients, with long-term conditions, used unscheduled care. Bergen and While (2005) used Lipsky (1980) to reinterpret data from a longitudinal case study of case management in community nursing to elicit professional responses to policy. In summary these studies, similar to the PFs in this study, explored policy implementation in practice to gain a deeper understanding of how nurses interpret their work from Lipsky's street-level perspective (Lipsky, 1980, 2010).

Of the nursing papers sourced, some of the authors incorporated the notion of policy implementation in the frontline (Hoyle 2011, 2014; Hughes and Condon, 2016; Johannessen *et al.,* 2018; Cuthill and Johnston, 2019). Some authors incorporated a focus on the discretionary aspects of Lipsky's theory (Bergen and While, 2005; Hoyle, 2011, 2014; Hughes and Condon, 2016; Brook *et al*, 2017; Cuthill and Johnston, 2019). A number of studies identified a gap between policy ideals and the reality of delivering policy in real-life (Hoyle, 2011; Drinkwater *et al.,* 2013; Hughes and Condon, 2016; Johannessen *et al.,* 2018). However, unlike this study, none of the studies incorporated the unique mode of operation of PFs, where they operated across, between and within the Trusts and HEI at strategic and operational levels.

In respect of the complex frontline issues for which PFs in this study had assumed responsibility, they were required to make correspondingly complex judgements, often mediating between those performing the established roles within pre-registration nurse education in practice. This discretion in decision-making by PFs, as described by Lipsky (2010), arose both from their frontline roles and at the same time the authority they were imbued with because of their formal strategic management responsibilities and their relative seniority in the nursing hierarchy. The PFs were afforded a level of autonomy, as described by Lipsky (2010), in interpreting how policy was implemented *in the frontline*. Moreover, PFs had an unusual combination of strategic and frontline roles in contrast to descriptions in the research literature of other roles operating at street-level who directly interact with

the client (Cuthill and Johnston, 2019). They were also uniquely located in a particular organisational space which they occupied, across, between and within the Trusts and HEI (discussed in section 5.3, 5.4 and figure 5.1) which reinforced their discretionary powers.

Lipsky (2010) suggested that street-level bureaucrats may withhold information as a way of rationing services, or favouring some clients as they had privileged information so enabling them to have better access to resources. They used these devices to manipulate and manage their workload. In contrast, in this study, PFs were actually expanding their workload, in areas such as where they were *supplanting the link lecturer role*. This role expansion could be linked to their overall interest in, as nurses, to facilitate the selection and development of high-quality nurses as the product of pre-registration nurse education in practice. None of the nursing literature relayed the idea of withholding information, rather nurses were trying to provide good information (Johannessen *et al*., 2018).

In the sourced literature, nurses expressed a professional imperative in meeting the needs of their clients. For example, within Bergen and While (2005) nurses took on direct case management of patients in the community where their professional values influenced how they interpreted policy as street-level bureaucrats (Lipsky, 2010). In Hughes and Condon's (2016) study of health visitors, they had to mediate their professional values in the context of their work. Hoyle (2014) also found, where nurses had become ward managers, they retained a professional rather than a managerial focus. The results in chapter 4 suggested an underlying influence where professional values guided PFs in interpreting how, when, where and who was involved in implementing policy *in the frontline*.

Although street-level bureaucracy (Lipsky, 2010) is not utilised that frequently in the nursing education literature, the notion of physically operating in the spaces between education and service, both of which are responsible for pre-registration nurse education programmes, is frequently articulated. For example, the "uncoupling of education and practice following the move of nurse education into higher education" O' Driscoll *et al.,* (2010 p., 214) and theory-practice gap for newly qualified nurses

(Monaghan, 2015). Other authors have used spatial analogies in their nurse education in practice research including using such phrases as the "learning environment" (Mallik and Hunt, 2007; O' Driscoll *et al.*, 2010; Congdon *et al.*, 2013) being a "bridge" / providing a bridge (Price *et al.*, 2011; Maxwell *et al*., 2015) bridging the gap (Williamson *et al.*, 2010 or "plugging a hole" (Mallik and Hunt, 2007).

Cuthill and Johnston (2019) utilised street-level bureaucracy (Lipsky, 1980) as a way of exploring health visitors' implementation of reforms on domestic abuse policy in Scotland. They identified the impact of the space in which policy was implemented, in this case the intimate space of the family home, as an important consideration in implementing policy. They concluded, despite little attention in previous studies, that space and the use of discretion was crucial in shaping the actions of their health visitors as street-level bureaucrats (Lipsky, 1980). This was clearly reflected in this study by the understanding that PFs had created a unique space in which to implement policy *in the frontline*, across, between and within organisations at strategic and operational levels. This is explored in the next section 5.3.

5.3 Understanding interstitial spaces (Furnari, 2014) and street-level bureaucracy (Lipsky, 2010)

It was apparent from the results that participants described the PFs as working across, between and within the Trusts and HEI at strategic and operational levels. In physiology, the spaces between cells in the body are described as the interstitial spaces (Brooker, 2010). This serves as a useful analogy for the spatial location of the PFs within the organisational structure of pre-registration nurse education in practice. The articulation of interstitial spaces as virtual spaces (Furnari, 2014) between different organisations or fields has emerged in a range of literature. These include education (Mulcahy, 2011) conceptual institutional change (Furnari, 2014, 2016) innovation management (Yström and Agogué, 2020) social movement (DeJordy *et al.*, 2020) and technology transfer (Villani and Phillips, 2021).

Mulcahy (2011) generated her insights from a study of the implementation of problem-based learning (PBL) in a range of educational settings. She observed the inter-dependence of work-learning relations and locations, concluding that interstitial

spaces are where complex connections occur between the disparate worlds of work and learning. Mulcahy (2011) argued that activity in the interstitial spaces "*involved mutation and movement*" (Mulcahy, 2011, p. 210). Even though the editorial board (Whitchurch and Harvey, 2011) found Mulcahy's idea intriguing, no citations of this work was found.

Furnari (2014) in a seminal paper, postulated successful development of new ideas and innovations occurred in "interstitial spaces" where people from different fields came together such as in computer and coding clubs. Furnari (2014) provided three defining features of interstitial spaces where the first was "*they are made of social interactions between individuals positioned in different fields*" (Furnari, 2014, p. 443). Secondly, interstitial spaces are where there are "*micro-interactions that are occasional and informal*" (Furnari, 2014, p. 444). Thirdly, is that "*they identify cross-field interactions around some common activities to which individuals devote limited time*" (Furnari, 2014, p. 444). Later, Furnari (2016) in an opinion paper, continued to champion the idea that the interstitial spaces provide the opportunity for distinctive institutions to effect change as the practices from each "*can be combined in novel ways, eventually giving rise to new practices and institutions*" (Furnari, 2016, p. 552). Furnari (2016) further observed that an important factor was the dynamics between fields where, if actors were mutually dependant, the chances of institutional changes increased. On the other hand, if there was a power imbalance between organisations, then those with the power may work to maintain this power and so reduce the likelihood of institutional change.

An important factor in the interstitial spaces was the actors who functioned as '*catalysts*' (Furnari, 2014, p. 440) whose interactions over time bring about and embed the changes. Villani and Phillips (2021) in a study on technology transfer for specialists' organisation working with academic and industrial partners used Furnari (2014) definition of interstitial spaces as well as the importance of catalysts in bringing about change over time. Furnari (2014) perceived the interstitial spaces as informal and fluid where individuals from different fields interacted. However, Villani and Phillips (2021) envisaged the interstitial spaces as a separate location between formal organisations where the technology transfer specialists operated

within, temporarily, to connect the academic and industrial partners. Further, Villani and Phillips (2021) proposed that interstitial spaces are important in modern societies which provides a real useful place for work on developing innovative solutions to multi-party problems. In addition, similar to Furnari (2014) the interstitial spaces were perceived as facilitating new ideas and new practices.

The concepts within Lipsky (2010) and Furnari (2014) explore the people and places where changes happen in real-life. Lipsky's (2010) work was within public service organisations whereas Furnari (2014) offered a broader perspective where changes occur in the spaces between organisations particularly technological ones. Both identify key agents of change, street-level bureaucrats (Lipsky, 2010) or catalysts (Furnari, 2014). These change agents are fundamental in how changes to the current way of operating can be made. These changes, become the new practices (Funari, 2014) or, as in Lipsky's (2010) frontline street-level bureaucrats who use their autonomy and discretion to interpret how policy is delivered from a bottom-up perspective. In the end, the micro-interactions (Furnari, 2014) can become embedded, or, as in Lipsky's (2010) case, the routines street-level bureaucrats develop effectively become the policy. How the PFs in this study as street-level bureaucrats began to create their interstitial spaces through dealing with their initial challenges, placement and mentor capacity issues lead to them influencing curriculum and incorporating a strategic as well as an operational remit across, between and within the Trusts and HEI. This will be explored in the following section.

5.4 Exploring practice facilitators as street-level bureaucrats (Lipsky, 2010) working in interstitial spaces (Furnari, 2014)

The interstitial spaces (Furnari, 2014), where PFs as street-level bureaucrats (Lipsky, 2010) operated in this study, was revealed to be central to their success in the way their role had evolved in the real-world. Occupying the interstitial spaces (Furnari, 2014) placed PFs at street-level (Lipsky, 2010) in the crucial cross organisational location where they were *in the frontline* of strategic and operational activities in pre-registration nurse education in practice. Moreover, as street-level bureaucrats

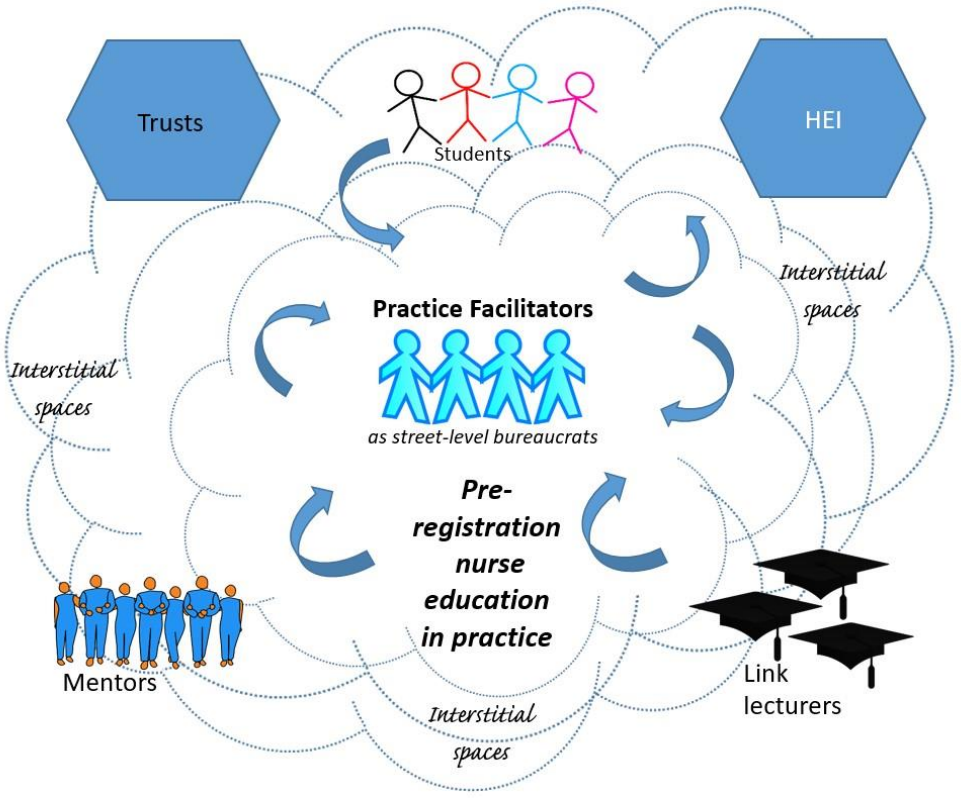
(Lipsky, 2010) PFs were afforded organisational authority, autonomy and discretionary powers, combined with operational decision-making capacities. With this broad remit it very quickly became clear that *everybody knows them and they know everybody*. The combination of operating as street-level bureaucrats (Lipsky, 2010) and occupying the interstitial spaces (Furnari, 2014) made them highly influential across the pre-registration nurse education programme landscape becoming *de facto gatekeepers to the profession* and ultimately *the everything facilitator*.

Lipsky's (2010) posits that actions effectively add up to agency behaviour was also reflected in Furnari's (2014) discussion where he regarded the "*interstitial spaces as micro-interactions settings where new practices can originate*" (Furnari, 2014, p. 241). In contrast, the understandings from this study indicated that interstitial spaces between organisations can be created on a permanent basis, can generate new practices but can also maintain and facilitate them on an ongoing basis. The permeance of the interstitial spaces in this study is linked to the idea that the Trusts and HEI have an ongoing working relationship with each other in the delivery of pre-registration nurse education programmes.

The integration of Lipsky's (2010) bottom-up policy implementation perspective and Furnari's (2014) interstitial spaces concept represents an advancement of the idea of street-level bureaucrats. This synthesis is a development of both Lipsky (2010) and Furnari (2014) as it highlights for street-level bureaucrats, the influence of the particularity of the spaces where the PFs operated. For Furnari (2014) street-level bureaucracy, highlights the use of discretion and autonomy to bring about interorganisational changes in the interstitial spaces. Further, whilst Lipsky (2010) street-level bureaucrats were low level workers, PFs in this study operated at strategic as well as at operational levels on an ongoing basis. This was in contrast to Furnari's (2014) concept of interstitial spaces being informal, short term and without a hierarchy. However, the ideas developed in the interstitial spaces can become embedded as in Furnari (2014) similar to the routines established by street-level bureaucrats (Lipsky, 2010) becoming the policy. The results of this synthesis of PFs

as street-level bureaucrats operating in the interstitial spaces of pre-registration nurse education in practice is represented diagrammatically in figure 5.1.

Figure 5.1 Diagrammatic representation of practice facilitators as street-level bureaucrats (Lipsky, 2010) working in interstitial spaces (Furnari, 2014) of pre-registration nurse education in practice.



With this synthesis, a new set of purposes for the street-level bureaucrat operating in the interstitial spaces was used. These were conceived to coalesce the purely operational conceptualising of Lipsky's (2010) purposes to incorporate Furnari's (2014) more strategic ideas of the interstitial spaces being the places where innovations and ideas can be created which can become embedded over time. These are developing innovative resources; developing solutions to uncertainties;

supporting the development and embedding of routine practices. A scope for each of these purposes is given in table 5.1.

Table 5.1 Purposes of street-level bureaucrats (Lipsky, 2010) working in interstitial spaces (Furnari, 2014).

Purposes of street-level bureaucrats (Lipsky, 2010) working in the interstitial spaces (Furnari, 2014)	**Scope**
Developing innovative resources	Physical means of help created to assist with policy implementation and deal with related problems
Developing solutions to uncertainty	Interventions created to deal with issues subject to doubt or questioned
Supporting the development and embedding of routine practices	Ways of working created to respond to policy and changes in policy to become the new cultural normal

How these purposes are underpinned and confirmed by the results of this study, in the context of the literature will be discussed in the following major sections.

5.5 Developing innovative resources, practice facilitator purpose as street-level bureaucrat (Lipsky, 2010) working in interstitial spaces Furnari, 2014)

5.5.1 Developing innovative resources, practice facilitator purpose as street-level bureaucrat (Lipsky, 2010) working in interstitial spaces (Furnari, 2014): introduction

The PFs in this study were placed into newly-created positions, operating in the interstitial spaces (Furnari, 2014) between the Trust and HEI, which initially emphasised the strategic and managerial requirements for ensuring that the practice education resources were available and appropriate. The unique positioning of the PFs, as street-level bureaucrats (Lipsky, 2010), enabled them to interpret and operationalise ongoing policy changes both at strategic and operational levels in pre-registration nurse education in practice. In contrast, facilitator roles in the primary

literature worked directly with placement areas (Rowan and Barber, 2000; Ellis and Hogard, 2001, 2003) or operated primarily at a strategic level (Clarke *et al.*, 2003; Randle *et al.*, 2005; Cameron *et al.*, 2006; Carlisle *et al.*, 2008, 2009; Hyatt *et al.*, 2008; McArthur and Burns, 2008).

Using their autonomous discretion to husband resources as street-level bureaucrats (Lipsky, 2010), PFs in this study, were able to innovate to expand placement capacity, the number of mentors and to influence curriculum *in the frontline*. This development of their role over time empowered them to adhere more strongly to the drivers within *Making a Difference* (1999) (section 1.4.1) and those found within *Fitness for Practice* (1999) (1.4.2). This was related to the need to develop skilled newly qualified nurses who were competent and confident without overwhelming mentors or the practice environment.

Over time PFs innovations extended to managing underperforming students. This was in sharp contrast to previous work which had shown substantial challenges for individual staff working across or between organisations. In an international systematic review of qualitative studies exploring inter-organisational working in healthcare shows there are problems (Karam *et al.*, 2018). Aspects included the differences between corporate culture, geographical difference, differences in processes and ways of communicating. This study found the way PFs operated have to some degree circumvented these problems from the frontline. Key messages from the results as to how PFs have achieved developing innovative resources are discussed in the next sections.

5.5.2 Forward mapping

The NMC requires approved educational institutions to have up to date information about placements including the live register of mentors maintained by the Trusts (NMC, 2010b, 2016b, 2018b). However, there are a number of limitations in monitoring placements (NMC, 2016b) which only provides capacity as a snapshot at the time of the audit. Therefore, this does not account for the impact of ongoing service changes on placement resource availability as found by others (Murray *et al.*,

2005; Carlisle *et al.*, 2008; Murray and Williamson, 2009; Leigh *et al.*, 2014a; Felton and Royal, 2015).

Securing adequate placement resources to deliver curricula in practice continues as a long standing problem across the sector (Chaffer, 1998; Bunce, 2002; Clarke *et al.*, 2003; Burns and Paterson, 2005; Ferguson and Day, 2005; Hutchings *et al.*, 2005; Murray *et al.*, 2005; Randle *et al.*, 2005; Magnusson *et al.*, 2007; Kenyon and Peckover, 2008; Murray and Williamson, 2009; Baglin and Rugg, 2010; Willis Commission, 2012; Leigh *et al.*, 2014a; Fotheringham *et al.*, 2015; Merrifield, 2016, 2017a, 2017b). Despite the policy demands for appropriate high-quality placements, there was a limited amount of literature on capacity planning, decision-making and placement management (Hutchings *et al.*, 2005; Murray and Williamson, 2009; Fotheringham *et al.*, 2015) to resolve this ongoing issue.

Participants emphasised the value of PFs central role in '*forward mapping'* (appendix 22), their first major innovation, successfully managing the essential practice experience element of pre-registration nurse education in practice. Essentially, this comprised live data on placement resource availability for each Trust, that facilitated the functioning of the Host Trust concept (sections 4.2.2, 4.4.6). This was used in conjunction with the live register of mentors maintained by the PFs. Used in combination, these provided the complex placement and mentor information that PFs required to place students, which prevented frontline placement capacity crises. These placement and mentor capacity management innovations have remained core features of the role. Thus, the PFs brought a new "*professional coherence*" as described by Ellis *et al.* (1999, p. 263) in a discussion of street-level bureaucracy in a social work context.

Jokelainen *et al.* (2011a) exploration of Finnish and British nurse mentors' views identified, in their focus groups, the importance of organisational strategies to support placement capacity building. Operating in the interstitial spaces (Furnari, 2014), PFs in this study had strategic and operational organisational overview of placement requirements from their *'forward mapping'* and could proactively calculate shortfalls between audited and actual capacity. Lacking such support,

Magnusson *et al.* (2007) and McClimens and Brewster (2017) found personal contact with practice areas helped to expand capacity for their programmes. PFs, as street-level bureaucrats (Lipsky, 2010) also used their regular personal contact with placement areas as an additional element in placement capacity management.

Whilst it would seem realistic to suggest that HEI or Trusts have systems to ensure students gain the necessary rounded placement experiences during their programme, little has been published on this aspect. The only paper found where a systematic approach for placement allocation, similar to the '*forward mapping'* entitled the 'Bulpitt framework', was reported in a narrative paper by Leigh *et al.* (2014b). However, although the 'Bulpitt framework' was used to identify placements for adult programme students (although they aimed to expand in other fields of nursing) the focus was on selecting placements that were suitable for students to achieve skills to meet NMC requirements rather than as a placement resource management system. McClimens *et al.* (2013) interviewed seventeen key stakeholders to explore expansion of placement capacity. Based on these results, they described a placement pathway tool they intended to use. No further publications were found reporting on this tool. McClimens and Brewster (2017) subsequently published a paper on a hub and spoke approach to placement management which had been implemented in a learning disability setting but did not reference or refer to the previous work.

5.5.3 Creating the Host Trust resource

In addition to '*forward mapping'* innovation the development of the Host Trust concept (section 4.2.2, 4.4.6) as a resource was their second innovation. Within this system, an agreed number of pre-registration student commissions were recruited to each Host Trust, where they primarily completed all practice elements of the programme. As the number of students was pre-determined, the placement resource requirement could be calculated, commensurate with curricula course plans, thus enabled proactive placement resource planning. This was original and distinct as although similar Host Trust placement systems such as base placements (Chaffer, 1999), learning communities (Thomas, 2002) Home Trust, or Home Base (Andrews *et al.*, 2005b) were used to place students, no other studies were found where pre-

agreed student commissions for each Host Trust proactively informed and underpinned placement resource management activities as found in this study. Additionally, this also promoted in the students a professional and organisational identity with the Host Trust.

Changing healthcare and professional programme policies increased the requirements for student experience in community and primary care (Kenyon and Peckover, 2008; Baglin and Rugg, 2010; Chowthi-Williams *et al.*, 2010; NMC, 2010b; Chowthi-Williams *et al.*, 2016) and caused increased pressure to provide placements in these settings (Kenyon and Peckover, 2008; Baglin and Rugg, 2010). Interpreting these changing policies, PFs as street-level bureaucrats (Lipsky, 2010) in the interstitial spaces (Furnari, 2014) used their discretion and autonomy, and evolved the concept of the Host Trust to include a circuit. Employing this Host Trust circuit innovation, PFs in this study were able to plan student rotations for one off placement experiences in other Trusts across the consortium, commensurate with curriculum requirements. PFs sharing rather than protecting Host Trust placement resources was evident thus facilitated the proactive management and rationing (Lipsky, 2010) of available resources across the consortium.

The Host Trust circuit approach proactively addressed a number of placement capacity issues. Dickson *et al.* (2015) in a critical review of current literature on undergraduate community placements, promoted the importance of this experience in preparing students for the future community workforce. However, the review was from a student perspective and not managing securing student placements. Several subsequent small studies have reported on the effectiveness of developing pre-registration nurse education in practice in the community setting (Gale *et al.*, 2016; Brindley and Carroll, 2018). They all report a positive impact on student knowledge, skills and experience. Whilst this literature presented a positive perspective on expanding placements into the community, there was no acknowledgement of issues such as scope of cases seen or, availability of mentors.

5.5.4 Knowing Host Trust mentor resource requirements

With programmes containing 50% practice within the Host Trust, planning an adequate number of mentors was a critical aspect of capacity management. The number of qualified mentors in a placement area was inextricably linked to managing placement capacity as outlined in sections (5.5.2, 5.5.3). PFs in this study, as part of '*forward mapping'* included taking account of the number of mentors using the 'live register' to ensure adequate resources were available to support students thus preventing mentor capacity problems. The innovative formula used by PFs to calculate mentor requirements was a local street-level interpretation as advocated by Lipsky (2010) of ensuring that that the number of students and mentors was well within the NMC standards which were applicable over that time (NMC, 2006, 2008a). In this way, student allocation to mentors were applied consistently across the Host Trust and helped prevent mentors becoming overwhelmed as identified in previous research (Veeramah, 2012).

Overall, there was limited literature on securing adequate mentor capacity to meet pre-registration requirements in practice. Jokelainen *et al.* (2011b) in a systematic review of mentoring students, in the context of clinical practice, found the demands on mentoring had increased through changing NMC (2008a) mentoring requirements at that time. The papers they found explored the experiences of mentors and students and many other aspects that influenced mentoring. It did not seem that they sourced any papers on mentor capacity building. They did however note that leadership and management were important factors in organising the student experience in clinical placements. From the studies they reviewed, the only references they make to capacity was around organising mentor availability prior to student placements but not specifically informing commissioning mentor education programmes.

Participants in this study strongly felt that the new NMC (2008a) standards had provided an increased focus for the PFs on the mentors. Using their discretion (Lipsky, 2010) PFs used the 'live register' of mentors to secure an adequate number of mentors at an operational level, but importantly, to predict future Host Trust commissions from a strategic perspective.

In a separate paper, Jokelainen *et al.* (2011a) identified that having enough mentor capacity was a factor in organisational capacity, how this could be achieved was not discussed. They concluded mentoring required integrated organisational, management, academic and clinical attributes although they advised this required organisational investment in financial and human resources. Indeed, these findings were reflected in the current study where PFs, working in the interstitial spaces (Furnari, 2014) had integrated the '*forward mapping'* and Host Trust live register of mentors as an integral part of maintaining the number of mentors required for the student population.

5.5.5 Availability of practice facilitator as street-level bureaucrat (Lipsky, 2010) in interstitial spaces (Furnari, 2014)

It was evident from the participant interviews that PFs, in this study, reported directly to the Director of Nursing which provided them with access to and input to the strategic level of management in the Trust. HODs, although from a different organisation, included PFs as part of their team. Indeed, Maxwell *et al.* (2015) in a study reviewing practice educator roles found, that in order to be effective, a regular presence in practice was needed. The strength of the PF role in the current study, was centred on the everyday reality of practice which was needed to bridge and have effective partnerships with the University.

Maxwell *et al's.* (2015) practice educator role was operationally focussed, which coupled with the division of their HEI and Trust commitments, limited its effectiveness in influencing and responding to policy changes. In addition, it appears this role did not have any strategic responsibilities in either the Trust or HEI. Similarly, but in a smaller process evaluation, Congdon *et al.* (2013) explored key stakeholders' perceptions of a new learning environment manager role which was operational in nature. These post holders worked closely with LLs, supported the learning environment and managed the live register of mentors. In contrast to the results of this study, where PFs, as street-level bureaucrats, had created and occupied the interstitial spaces, Maxwell *et al's.* (2015) conceptualised their new role to

support practice education as a bridge between the two organisations and again only at an operational level.

Unlike this present study, no apparent evidence of PF assimilation into HEI management and decision-making forums was found in earlier primary studies (Rowan and Barber, 2000; Ellis and Hogard, 2001, 2003; Clarke *et al.*, 2003; Randle *et al.*, 2005; Hyatt *et al.*, 2008; McArthur and Burns, 2008; Carlisle *et al.*, 2008, 2009). This may have been due to the fact that posts were newly established at the time of their data collection. In contrast, this study revealed a well-established level of integration and influence which PFs had achieved over time.

As PFs, in the current study were available full time in the interstitial spaces (Furnari, 2014), this facilitated the time for them to operate both vertically between frontline and senior management in both the Trust and the HEI, as well as horizontally across placements and frontline academic and practice staff. PFs operated in both cultures and were able to deal with inter-organisational issues as identified in Karam's *et al.* (2018) systematic review (section 5.5.1). Magnusson *et al.* (2007) in a multi-method study found clinical placement managers frequently set their own priorities in how they operated their role and recommended that clearer guidelines for the role should be developed. However, this study found it was the fluid nature of the PF role, operating within the interstitial space between these organisations (section 5.3; 5.4) which enabled role holders to be highly responsive to issues that needed to be addressed as they arose. A further key difference though between Magnusson *et al.* (2007) and this present study was that the former viewed the clinical placement mangers via a managerial lens. Indeed, Lipsky (2010, p.19) notes that managers aim to "restrict" the exercise of discretion, just as Magnusson *et al.* (2007) argued. The way PFs have crossed organisations to address issues from the frontline will be discussed in subsequent sections.

Participants in this study revealed other advantages of the PF role being full time, included their virtually exclusive focus on pre-registration nurse education in practice. Time availability meant role-holders could allocate time to plan and address issues over time, but crucially, allowed the flexibility to be available to respond at

short notice to any issues which arose. Primary studies on the new 'facilitator' role in the UK confirmed that separate funding was identified thus affording role holders full time status (Rowan and Barber, 2000; Ellis and Hogard, 2001; Clarke *et al.*, 2003; Hyatt *et al.*, 2008; McArthur and Burns, 2008; Carlisle *et al.*, 2008, 2009). This distinctive feature (Ellis and Hogard, 2003) enabled post-holders to fully concentrate on achieving their role remit (Wood *et al.*, 2011). In an action research project Kelly *et al.* (2002) supported the supernumerary status of clinical placement facilitators as being a major strength. Similarly, in a review of the literature, set within an Irish context, Lambert and Glacken (2005) promoted the importance of having access to education facilitators who had the time to concentrate only on clinical education and support.

Being Trust based placed PFs in this study where healthcare was delivered, placements provided and where mentors worked, taught and assessed students. PFs in this study had a visible presence as they were easily contactable and had the time to respond, often in person, to Trust staff and particularly with mentors in practice areas. As previously stated, visibility and presence have been found to be fundamental qualities in supporting students in practice and in linking with the HEI Mallik and Hunt (2007), Rowe (2008) and Maxwell *et al.* (2015). In addition, it was PFs visibility, presence and their key role in inter organisation communication, at strategic and operational levels which underpinned the unique way in which the role operated in the consortium. In this way, PFs in this study were in a position to interweave their communication to target activities in either organisation across the pre-registration nurse education in practice landscape. Thus, they were an innovative resource.

5.5.6 Practice facilitator purpose: developing innovative resources summary

Responding to the initial policy drivers (DoH, 1999; UKCC, 1999) the newly created PFs, as street-level bureaucrats (Lipsky, 2010) positioned themselves in the interstitial spaces (Furnari, 2014) to develop innovative resources for pre-registration nurse education in practice. Working *in the frontline* between the Trust and HEI, PFs

as street-level bureaucrats, used their discretion to interpret policy which lead to the development of systems i.e. '*forward mapping*' to secure and manage the essential pre-registration nurse education in practice learning resources, including placement and mentor capacity, to support student nurses in practice.

'Forward mapping' continued to be central to the effective management by PFs of the Host Trust placement resources. This frontline positioning at strategic and operational levels was revealed to enable role holders to speak with informed accurate knowledge of Trust resources as well as HEI placement requirements for students at each stage of their programmes. This underlined PFs value as knowledgeable and influential players who were able to contribute to realistic, practice responsive decision-making in the Trust and HEI.

Reflecting upon purpose one, developing innovative resources, the nature of the initiation of the PF role was apparent where the activities and the way the role operated as street-level bureaucrats (Lipsky, 2010) in the interstitial spaces (Furnari, 2014), subsequently had become embedded. Resources had been established to cater for providing adequate placement information in a timely manner. Maintaining the management of placement capacity had freed up time which enabled PFs to become an innovative resource themselves, allowing them to focus on other aspects of quality. These will be reflected in the discussion of purpose two, developing solutions to uncertainties and three, developing and embedding of routine practices as the role evolved over time.

5.6 Developing solutions to uncertainties, practice facilitator purpose as street-level bureaucrat (Lipsky, 2010) working in interstitial spaces (Furnari, 2014)

5.6.1 Developing solutions to uncertainties, practice facilitator purpose as street-level bureaucrat (Lipsky, 2010) working in interstitial spaces (Furnari, 2014): introduction

Many policy decisions are made in a state of uncertainty (Lipsky, 2010) and are open to interpretation when it comes to the point of implementing them in practice. PFs as street-level bureaucrats (Lipsky, 2010) operating in the interstitial spaces (Furnari, 2014) became central to their developing solutions to uncertainties that arose across the pre-registration nurse education in practice landscape. It was their successes in developing and maintaining innovative resources (section 5.5) as well as their positioning in the interstitial spaces, where they could operate at strategic or operational levels across, between and within the Trusts and HEI that underpinned the value placed on the PF role.

From this platform PFs were able to develop solutions to longstanding uncertainties, some that had proven to be intractable (Duffy, 2003, 2006; O'Driscoll *et al.*, 2010) but all of which had a detrimental impact on the quality of nurse education in practice. Key areas addressed by PFs included service involvement in curricula; Trust-HEI communication and theory-practice gaps; link lecturer deficits; failure to fail; and mentor support. These will be discussed in detail in the following sub-sections.

5.6.2 Curriculum design to meet practice and mentor resource uncertainties

A significant consequence of assuming the central responsibility for managing the nurse education in practice resources was that PFs in this study necessarily had assumed a key influence on curriculum development. As street-level bureaucrats (Lipsky, 2010) PFs operated in the interstitial spaces (Furnari, 2014) where they used their discretion and autonomy (Lipsky, 2010) and the organisational authority to influence curricula that met Trust needs.

Whilst the NMC has specific standards for all undergraduate nursing programmes, HEIs have relative autonomy (Lipsky, 2010) in how curricula are designed to comply with these standards (NMC, 2004, 2010b, 2018a, 2018b; Roxburgh *et al.*, 2008). This provided the opportunity to design local health partner responsive curricula (Roxburgh *et al.*, 2008; Felton and Royal, 2015; Chowthi-Williams *et al.*, 2016).

Curriculum change was and is a regular feature in the UK (Murray *et al.*, 2005; Roxburgh *et al.*, 2008; Mackintosh-Franklin, 2016; Armstrong *et al.*, 2017; Rutt, 2017) often in response to changing healthcare policies (Chowthi-Williams *et al.*, 2010, 2016; Chowthi-Williams, 2018). Much of this work has tended to focus on the HEI taking the lead, leaving practice participants to be included on an ad hoc basis (Fealy *et al*., 2000; Edwards, 2008; Felton and Royal, 2015; Chowthi-Williams *et al*., 2016; Rutt, 2017). However, no other published studies in the UK were found of the direct involvement of service providers in curriculum development committees.

In contrast, HEI, Trust and PF participants in this study occupying the interstitial spaces (Furnari, 2014) highlighted that PFs had over time a well-established, central and influential remit in curricula development activities collaborating with the HEI and ensuring healthcare requirements informed curricula design. It seems PFs contribution reflected the shift in emphasis of curricula changes having become more work and health service focussed rather than academically focussed as advocated by a range of authors (Melia, 2006; Allan *et al.*, 2008; Roxburgh *et al.*, 2008; Felton and Royal, 2015).

PFs in this study showed that semester course plans produced problematic ‘peaks and troughs’ patterns of students requiring practice experience, a feature also found by Magnusson *et al.* (2007) as students were on annual leave during the summer. This caused placement staff to view this pattern as having a ‘feast or famine’ effect on their resources (Murray and Williamson, 2009). To address this, PFs in this study as street-level bureaucrats (Lipsky, 2010) operating in the interstitial spaces (Furnari, 2014) revealed they aimed to design course plans that realised as steady a flow of students as was practicable throughout the calendar year. This example of PFs, as street-level bureaucrats in managing placement capacity exemplified their discretion in how they managed scarce resources (Taylor and Kelly, 2006; Lipsky, 2010).

Importantly, this study found the HEI accepted the primacy of securing guaranteed placement capacity and moulded the academic element of curricula to fit the placement availability model. This was despite HEI participants in this study expressing a preference to have course plans designed on a semester basis in

alignment with the academic year. Nevertheless, it resulted in an increased lecturer workload in the HEI as they work a calendar rather than an academic year. No other literature was found that discussed this issue for academics. In consequence, this study revealed a shift in the balance of power where PFs took the lead on shaping course plan designs where, despite the increased pressure on HEI resources, they adopted course plans that distributed students in practice throughout the calendar year that secured the viability of pre-registration nurse education programmes. This was a further indication that the theory practice pendulum (figure 1.2) had swung in favour of practice (DoH, 1999; UKCC, 1999).

Additionally, the results of the current study revealed the PFs critical exercise of discretion (Lipsky, 2010) to discern course plans that 'would work' and the autonomy (Lipsky, 2010) to reject problematic course plans influenced their willingness to subsequently implement agreed course plans in their Trust. Tummers and Bekkers (2012) expected that street-level bureaucrats that felt they did not have enough discretion, had a negative influence on their willingness to implement policy. This was not observed in this study where, on the contrary, the high degree of autonomy and discretion exercised by the PFs in the interstitial spaces (Furnari, 2014) had the effect of wholesale 'buy in' by PFs to ensure a successful roll-out of the curriculum in practice. The fact that PFs had the autonomy (Lipsky, 2010) to reject unsuitable course plans, meant that where they accepted a course plan, they implicitly were signed up to implementing it in practice.

Current local knowledge of placements has been identified as essential for effective capacity planning (Magnusson *et al.*, 2007; Leigh *et al.*, 2014a, 2014b), but ascertaining robust 'live' placement data has been found to be notoriously complex (Clarke *et al.*, 2003; Carlisle *et al.*, 2008; Leigh *et al.*, 2014a, 2014b). Whilst Leigh *et al.* (2014a; 2014b) in narrative papers identified the importance of a responsive curriculum in placement allocation, it was not explained how this worked in practice. Murray and Williamson (2009) in a qualitative study focussed on how decisions were made on placement capacity planning, again, did not consider the importance of controlling the flow of students into the practice environment at the curriculum planning stage. It seems, the crucial link between the course plan design, and its

impact on utilisation of 'live' practice resources at the planning stage did not happen. In contrast, participants revealed PFs in this study exercised the critical dimension of discretion (Lipsky, 2010) in making judgements and decisions by using 'live' '*forward mapping'* to approve or disapprove curriculum course plan designs from a nurse education in practice resource perspective.

Working in the interstitial spaces (Furnari, 2014) they also proactively collaborated with the HEI to select the most suitable course plan design. No other research was located that utilised 'live' placement data to inform curricula design even though designing curricula on the reality of available healthcare resources has been previously proposed (Hull *et al.*, 2001; Kramer, 2005). In addition, no published literature was found that evaluated the usefulness of a live mentor database although several have discussed how they used theirs (Walsh, 2011; McGuinness *et al.*, 2013; McGuinness *et al.*, 2016). Overall, this was a distinctive, innovative and valued outcome from this study as it provided a solution to these uncertainties.

Hutchings *et al.* (2005) found, at implementation, curricula changes needed to be managed at strategic and operational levels. Chowthi-Williams *et al.* (2016) in a qualitative UK case study, evaluated how curricula change should be managed and found differences in responses between strategic and operational levels on the implementation of a new curricula. In contrast, as street-level bureaucrats (Lipsky, 2010), PFs in this study had a distinct advantage where, working at both strategic and frontline operational levels, in the interstitial spaces (Furnari, 2014) had an in-depth knowledge of, and, responsibility for implementing new curricula in practice, thus avoiding this problem. Furthermore, the current study revealed PFs frontline position, as discussed in section 4.2, operating in the interstitial spaces (Furnari, 2014) across, between and within the Trusts and HEI as well as between the curriculum and Host Trust resources which ideally placed them to inform and influence what needed to be done to make the curriculum happen in practice. These developments offered proactive solutions to curriculum and Host Trust resource uncertainties.

5.6.3 Occupying Trust-HEI communication gaps

An important aspect revealed by participants in this study was the PFs as street-level bureaucrats (Lipsky, 2010) central role in effective communication between the Trusts and HEI. Participants reported PFs were occupying the gaps across, between and within the Trusts and HEI, working in the interstitial spaces (Furnari, 2014) within pre-registration nurse education in practice, communicating operationally, managerially and strategically. In their unique location, their status and positioning gave PFs direct access to both Trusts and HEI strategic levels of management where this study revealed their ability to influence decision-making processes as well as having access to information about strategic developments which might potentially affect pre-registration programme delivery. This was in contrast to a previously discussed study exploring an academic practice educator role that only worked operationally directly with students but without managerial or strategic responsibilities (Maxwell *et al.,* 2015).

In a large ethnographic case study, O'Driscoll *et al.* (2010) explored the responsibilities of different roles for supporting pre-registration students in practice. Data was gathered from a range of students, clinical and academic staff. One finding was that relationships between the University and clinical staff was at risk due to a lack of understanding of University regulations. A new practice development role had been introduced, but found it tended to concentrate on supporting mentors, dealing with underperforming students and paperwork. This left a significant gap, particularly in terms of communication between clinical practice and academia. Although this is a relatively older study, it was the only substantial study found in the literature exploring how nurse education in practice operated between clinical practice and academia. PFs in this study had incorporated and embedded communication across, between and within the Trusts and HEI as part of their role remit so fully *occupying the Trust-HEI communication gap*.

5.6.4 Occupying Trust-HEI theory-practice gaps

In addition to bridging an organisational communication gap, PFs in this study also contributed to minimising the more familiar theory-practice gap. Greenway *et al.* (2019) in a concept analysis of the widely used term 'theory-practice gap' in nursing, found it to be a poorly defined concept world-wide. They offered an emergent definition as *'the gap between the theoretical knowledge and the practical application of nursing, most often expressed as a negative entity, with adverse consequences* (Greenway *et al.*, 2019, p. 1). In their *frontline positioning*, PFs in the current study identified theory-practice deficits, and, operating in and between the Trusts and HEI (Furnari, 2014) addressed these deficits. Indeed, the vacuum following the decoupling of service and education in the early 2000s had frequently left students taking responsibility for their own learning without support (O'Driscoll *et al.*, 2010). The gap between theory and practice education is a long-documented dilemma (Hewison and Wildman, 1996; Aston *et al.*, 2000; Wilson, 2008; Chan *et al.*, 2011; Scully, 2011; Flood and Robinia, 2014; Wells and McLoughlin, 2014; Calleja *et al.*, 2016; Chapman, 2017; EL Hussein and Osuji, 2017).

Corlett *et al.* (2003) stressed the importance of collaboration between service and education to agree what students were taught. Scully (2011) promoted such collaborations as they ensured continuity and that rehearsing practice skills in controlled HEI facilities helped address the theory-practice gap. PFs in this study were revealed to be addressing the perceived gap in a variety of ways. Indeed, HEI participants viewed PFs as an extension of the HEI in the Trust who worked with the HEI to ensure service responsive requirements were included in students' preparation for practice experiences.

This need for integration of practical and academic content to prepare nurses that are clinically competent and confident is widely promoted (Felton and Royal, 2015; Fotheringham *et. al*., 2015; Monaghan, 2015; Rutt, 2017; EL Hussein and Osuji, 2017). In this study, Trust education personnel were included by PFs in teaching or to provide advice to the HEI and thus ensured current skills and practices were delivered using Trust protocols as part of students' preparation for practice in the

HEI. Inclusion of these changing requirements was seen by the HEI in this study as delivering a curriculum that was responsive to Trust and education practice requirements. This helped prevent the disconnect between clinical and practice aspects of pre-registration nurse education programmes (Flood and Robinia, 2014; Felton and Royal, 2015).

Furthermore, PFs in this study carried out a range of activities such as developing workbooks for students and delivering Trust induction which contributed to students meeting changing healthcare policy initiatives such as those in the wake of Francis (2013) Mid-Staffordshire public enquiry into poor care and the subsequent Government (Powell, 2013) and NMC (2013) responses. This revealed PFs as street-level bureaucrats, interpreting and finding means of implementing educational support, using local actors to translate Trust clinical care and values in student preparation for practice (Lipsky, 2010). This discretionary response to local circumstances ensured students met Trust practice requirements in order to be able to deliver care in the context of the local healthcare environment. These activities echoed Monaghan (2015) who in a critical analysis of the literature on the theory-practice gap for newly qualified nurses promoted the importance of HEI and practice working more closely together as a key area for bridging clinical skills deficits.

5.6.5 Addressing link lecturer deficits

A key result in this study was the impact the PFs had on the LL role. In stark contrast to the relatively easy access to PFs, participants reported, in comparison, a perceptible lack of access to, availability and visibility of LLs within their link areas. The LLs had previously been seen as instrumental in bridging the theory-practice gap (section 1.3.3). Although the deficit in lecturer support for students in practice had been identified as an issue which needed to be addressed in *Fitness for Practice* (UKCC, 1999) it continued to be problematic (Turner, 2001; Clarke *et al.*, 2003; Ellis and Hogard, 2003; Carlisle *et al.*, 2008, 2009; McArthur and Burns, 2008; O'Driscoll *et al.*, 2010; MacIntosh, 2015).

All participants including the HEI LLs, were dissatisfied with the LL aspect of their role. LLs related that travelling to their link areas was time consuming and required planning, resulting in a lack of quick availability when issues arose in practice. Geographical separation following the move of schools of nursing into the HEI sector was long identified as having a detrimental effect on availability and the way support was provided by LLs (UKCC, 1999; Aston *et al.*, 2000; Barrett, 2007; Carlisle *et al.*, 2008, 2009). Lecturers in this study considered the move from the school of nursing into the HEI had created a separation where lecturers were no longer seen as part of the clinical team.

Participants acknowledged that as lecturers teaching commitments were prioritised, this reduced their availability for linking. Indeed, the LL role, although identified as the HEI role to support mentors and students in practice (NMC, 2008a), was subject to significant operational barriers. A three-phase mixed methods study, undertaken in Wales on roles supporting pre-registration students in practice, also found teaching demands were prioritised by lecturers (Carnwell *et al.*, 2007). This compromise of link commitments was also noted by Hunt *et al.* (2016a) in a grounded theory study with 31 nurses who had experience of failing a student. PFs in this present study suggested that lecturer teaching commitments and travelling times made it difficult for lecturers to attend their link area so, particularly for minor issues or issues which would take a short while to address, they would resolve them without LL involvement, again casting light on the PFs exercise of employing their autonomous discretion (Lipsky 2010) working in the interstitial spaces (Furnari, 2014).

MacIntosh (2015) in a qualitative study on the LL role across four Universities in Scotland, found link arrangements lacked consistency, were often unplanned and driven by local circumstances. It seemed, the revised but varying link arrangements to provide LL support in practice in this study, continued to be problematic irrespective of the model used. Some lecturers experienced difficulty in securing a suitable location to meet students in the link area. Indeed, in a critical evaluation of the clinical role of nurse lecturers, Barrett (2007) reported that some lecturers were made to feel unwelcome and even excluded in practice.

PFs in this study questioned the value of LL one-to-one student contact in the link area. This model of contact was viewed as an encumbrance which interrupted the team-student working dynamic, diverting the student from patient care and disrupting the working of the clinical environment. Grant *et al.* (2007) in a systematic review of the academic role in practice, found there was no LL model that met all requirements. Similarly, MacIntosh (2015) highlighted that students found link visits caused disruption, as they had to organise their shift to be available, so removed them from delivery of patient care.

Indeed, this study identified that the various models lecturers used for linking, their general lack of availability when needed, and, choosing how they operated their LL role, had resulted in mentors contacting the PFs in preference to the LL, again filling the gap identified by O'Driscoll *et al.* (2010). Further, PFs in this study filled the LL deficit identified by McIntosh (2015) and provided mentors with the support they needed (Hughes *et al.*, 2016; Hunt *et al.*, 2016a).

Thus, PFs had adopted a view that the LL role was not effective and were revealed to have used their autonomy and discretion (Lipsky, 2010) for *supplanting the LL role*. There was no indication in the results that they asked anyone for permission. Rather it was a *fait accompli* generated by the PFs themselves. Organisational priorities and the lack of regular interaction by LLs found in this study reinforced the idea, voiced by PFs, that LLs had become somewhat remote, distant outsiders, who were not party to, and were unfamiliar with Trust and the local day-to-day politics in their link areas. In reality, there were multiple instances of participants in this study rejecting any enduring value of the LL role.

5.6.6 Complementing link lecturer regulatory role

Even in situations in this study where the mentor and PF felt that LLs intervention or support was required, there were occasions where lecturers had been reluctant to attend. This reflected MacIntosh (2015) who found that due to inconsistencies in LL responsibilities, lecturers negotiated which activities they undertook. It seems that LLs unwillingness, in this study, to attend practice had become more entrenched over

time (even to the extent of the PF having to insist on their attendance for an underperforming student). Essentially, these behaviours culminated in LLs undermining their own role whilst bolstering the PF as predominant in the PF – mentor – LL relationship.

The interstitial nature (Furnari, 2014) of the PF role identified in this study enabled them to respond if mentors in this study expressed discontent about their fail decisions being overturned by the HEI. Similarly, Vinales (2015) proposed that if mentor decisions were not supported, this could leave mentors feeling undermined, not valued and questioning their ability. Hunt *et al.* (2016a) highlighted the point that mentors needed to feel secure about making a fail assessment decision. Where the HEI had overturned the fail decision, it was likely that this would have been due to a mentor not adhering to the practice assessment procedures. Maxwell *et al.* (2015) helped mentors and students to conduct the assessment and used practice assessment documents positively. This addressed the concern identified by others where a mentor fail decision was overturned by the HEI (Brown *et al*., 2012; Hughes, 2016; Hunt *et al.*, 2016a; Hunt, 2019).

Adhering to HEI assessment processes was important as students may appeal mentor decisions on process rather than competency grounds (Duffy, 2003; Vinales, 2015). This meant students could gain another attempt at placement.

In the event of an action plan being deemed necessary, PFs as street-level bureaucrats (Lipsky, 2010) in this study operating in the interstitial spaces (Furnari, 2014) contacted the LL so removing this problem from the mentor. Significantly, the results in this study suggested that the LL was only contacted in order to ensure compliance with regulatory (NMC, 2006; 2008a) HEI assessment processes rather than a requirement for their expertise in student assessment. Participants in this study strongly suggested that PFs were capable of fulfilling mentor/student support and assessment requirements without the intervention of the LL. This resonated with MacIntosh (2015) that LLs whilst responsible for linking with practice, acknowledged lack of role clarity due to duplication of their role with the practice

educators (PEs) they worked with, although some link lecturers liaised with the local PEs whereas others worked with them.

Additionally, PFs in this study operating in the interstitial spaces (Furnari, 2014) updated the LL on issues which arose in practice but continued to involve the LL when they considered the student issue to be more complex. However, the PFs did not hand over the matter to the LL but continued to be involved in agreeing to and supporting any subsequent action. Arguably, this illuminated the PFs' exercise of their awareness of cross organisational political sensitivities (Wells, 1997; Lipsky, 2010). Although the PFs had used their discretion (Lipsky, 2010) to deliver support in practice, in place of the LL, they seem to have recognised that for policy reasons (NMC, 2008) they needed to keep the LL informed of underperforming students.

5.6.7 Initially supporting mentors in addressing fail to fail

At the time of this study, participants reflected on how, previously mentors had not failed students when they should have. Participants identified this as a problem they had been grappling with, referring to Duffy's (2003; 2006) seminal work and recognised that it risked underperforming students progressing and entering the workforce. The exploration of reasons why mentors were failing to fail students included a lack of knowledge, experience, confidence, support, time, personal beliefs and values (Duffy, 2006). Hughes *et al.* (2016) in an international systematic integrative literature review on 'failure to fail' in nursing confirmed this phenomenon also exists outside the UK where the issue had been studied. However, they commented the literature was of mixed quality and concluded this complex problem required further research. North *et al.* (2019) in an integrative literature review agreed in that the quality and extent of existing evidence does not explain the phenomenon and also points out it does not account for the substantial number of mentors who are confidant in their assessment of students.

Participants in this study expressed that mentors who "*don't know how to go about failing"* felt isolated and nervous, and in the past, without support, had not always failed underperforming students. Mentor difficulty in managing, assessing and failing

underperforming nursing students was a widely recognised, ongoing phenomenon (UKCC, 1999; Duffy, 2003, 2006; Jervis and Tilki, 2011; Donaldson and Gray, 2012; Heaslip and Scammell, 2012; Black *et al.*, 2014; Hunt *et al.*, 2012, 2016a, 2016b; Moran and Banks, 2016; Bazian, 2016). Brown *et al.* (2012) in a non-experimental survey of 4,341 mentors in Scotland, realising a 41% response rate, found 18% of responding mentors had passed failing students whilst 58% had given students "the benefit of the doubt." Varying levels of uncertainty in student assessment processes were alluded to by mentors in this study. These included areas that had already been explored in the literature including factors such as mentors struggling to be clear of their concerns (Hunt *et al.*, 2016a) expected level of student performance (Lewallen and DeBrew, 2012) borderline competency (Cassidy *et al.*, 2017) understanding documentation (Scholes and Albarran, 2005; Seldomridge and Walsh, 2006; Andrews *et al.*, 2010; McIntosh *et al.*, 2014; Moran and Banks, 2016) how to write assessment documentation (Black, 2011) leading to mentors not being sure of what they needed to assess (Neary, 2000; Duffy, 2003; Elliott, 2016).

Whilst student performance was identified as a factor in mentor decision-making, it was seen as only the first step in their decision to fail. Mentors invariably experienced anxiety with underperforming students and sought support to give them security in their decision-making. More importantly, mentors were found to factor in if they could deal with anticipated challenges if they made a decision to fail. Hunt *et al.* (2016a) found the support provided by others was found to greatly affect whether the mentor went through with their decision to fail. Any mentor uncertainty in this study about who provided support was removed as PFs regularly reinforced the message to make contact with them as soon as they have any concern about a student.

Participants in this study certainly perceived PFs as central in successfully addressing failure to fail issues and to improve the quality of mentorship. NMC standards (NMC, 2006: 2008) introduced at the time of this study had enabled PFs as street-level bureaucrats (Lipsky, 2010) operating in the interstitial spaces (Furnari, 2014) to adopt this more qualitative remit where they focussed on providing mentor support,

particularly with managing underperforming students which is discussed in the following sub-sections.

5.6.8 Expanding tailored support for mentors

Despite mentors in this study meeting NMC (2008a) requirements, there was an overall lack of self-confidence in mentors, on their own, being able to comprehensively manage underperforming, problematic students and ultimately, being prepared to go through with a decision to fail. Black *et al.* (2014) suggested there was a gap between mentor preparation programme content and its application in practice. Vinales (2015) in an opinion paper also supported the idea that mentor preparation programmes did not fully meet the needs of mentors in practice.

Reinforcing their support commitment, PFs in this study, as street-level bureaucrats (Lipsky, 2010) operating in the interstitial spaces (Furnari, 2014) prioritised mentor contact, invariably responding immediately and usually in person. Mentors viewed PFs as sharing a common understanding where patient care and not the student was the priority in practice. Black *et al*. (2014) and Cassidy *et al.* (2017) also made the connection that mentors needed to make albeit difficult assessment decisions, to protect patients from harm. As conveyed in this study, this was an important consideration for the mentor as they had a personal investment in ensuring safe patient care was delivered as those patients' in the students' care could have been a member of the mentor's family. The shared PF and mentor affinity mirrored Hunt *et al.* (2016a) who found that a key assessment measure for mentors was the student's ability to care for '*my loved ones*'.

In the current study, whilst some mentors lacked experience, having never failed a student, even experienced sign-off mentors who had, still found the experience challenging. This resonated with Clark and Casey (2016) who understandably promoted the idea that new mentors needed support in applying theoretical knowledge in practice and where Black *et al.* (2014) found the need for support also extended to sign-off mentors when faced with failing a student. This resonated with Lipsky's (2010) view of street-level bureaucrats as mediators and conflict managers.

As identified by participants in this study, PFs early intervention provided mentors with tailored support which was central to ensuring due process in teaching and assessing students in practice. In a phenomenological study involving 22 mentors from Finland and 17 from the United Kingdom, (Jokelainen *et al.*, 2011a) underlined the importance of, and the need for, organisational investment in human and financial resources to promote good quality mentorship, but no specific role to achieve this was discussed. Further, Jokelainen *et al.* (2011b) in their systematic review of mentoring nursing students, promoted the development of a systematic approach to mentoring including managerial and organisational support. Similarly, Tuomikoski *et al.* (2020) in an updated systematic review acknowledged that organisational structures should afford sufficient support for mentors. Due to their organisational positioning, as street-level bureaucrats (Lipsky, 2010) operating in the interstitial spaces (Furnari, 2014), where participants revealed PFs in this study were at the heart of securing good quality mentorship through their support.

However, mentors have been reported to be reluctant to raise concerns (Haycock-Stuart *et al.*, 2016) so building their confidence was an important element in enabling them to seek support. In this study, PFs availability and willingness to support them bolstered mentor confidence. This was achieved by addressing their overall perceptible insecurities, particularly around managing underperforming students. This enabled and supported mentors to confidently manage and assess the often-entangled circumstances of underperforming students. Cassidy *et al.* (2017) also found confidence to be fundamental in mentor assessment of underperforming students. Andrews *et al.* (2010) found mentors could be overwhelmed with the complexity of student assessment, chiming with the results in this study where each student presented mentors with different circumstances which required differing support needs. PFs in the current research plugged the mentor support deficit and, where it really mattered, directly bolstering mentor assessment in the reality of practice. Further, PFs in this study by supporting and validating the way the mentor managed the student strengthened confidence and reduced any doubts about their competence as a mentor. Indeed, Hunt *et al.* (2016a) found mentors needed

reassurance that they were a '*good mentor*' underpinned with knowing that they had ensured everything had been in place to help the student succeed.

As well as adhering to HEI assessment processes, this study revealed that PFs rehearsed with mentors how to provide feedback to the student thus addressed concerns raised by Winterman *et al*. (2014) where many mentors had reported difficulty in this aspect of their role. Duffy (2013) stressed that constructive feedback was vital for underperforming students so they could address their deficits. Additionally, this support extended to the mentor/student meeting where PFs in this study 'sit in' during the meeting to build mentor confidence. This is an example of PFs developing and delivering policy at the point of delivery on how student assessment is carried out (Lipsky, 2010).

5.6.9 Building mentor confidence

Mentors in this study expressed that before the PFs, they had no support when managing an underperforming student and a decision to fail a student relied on the mentor's courage to do so. Black (2011) and Black *et al.* (2014) employed a hermeneutic study design to explore the experiences of 19 sign-off mentors, located in the southeast of England, who had failed students in their final placement. The lack of an effective formal support structure meant that sign-off mentors, whilst experiencing emotional turmoil and distress failing a student, in the main, had to draw and rely on their own reserves and personal courage to go through with the decision to fail. Similarly, Hunt *et al.* (2016a) found mentors generally needed a supportive network to enable them to go through with failing underperforming students, but, for the most part, had to rely on informal personal networks for support.

PFs in this study in their supporting of mentors acknowledged that nursing attracted people who perceived themselves to be of a caring, nurturing nature so failing a student was at odds with the mentor's core caring and nurturing values. The mentor conflict between going against their natural instincts and feeling they were uncaring when failing a student was well recognised as an important factor in mentor decision-

making (Scanlan *et al.*, 2001; Smith and Gray, 2001; Duffy, 2003, 2006; Luhanga *et al.*, 2008; Black *et al.*, 2014; Hunt *et al.*, 2016b). Mentors in this study revealed the unease they felt as they knew their decision to fail a student affected the students' future hope of becoming a nurse. Hunt *et al.* (2016b) found mentors were genuinely concerned for students that failed which exacted a personal cost to those mentors (Williamson and Webb, 2001; Black *et al.*, 2014).

In response to these uncertainties, high importance was given by PFs in the current study to provide emotional support to mentors. Markedly, mentors vividly expressed, even where the assessment process was followed, they still found it emotionally difficult when faced with the prospect of failing a student. It seems likely the assessment requirements (NMC, 2008a) fostered an 'up close and personal' mentor/student relationship. This personalised mentor/student bond was intensified when a student was underperforming, which had knock on practical and emotional consequences for both parties when the mentor was faced with failing the student. The emotional labour of mentoring students has long been known (Smith and Gray, 2001; O'Driscoll *et al.*, 2010; Cassidy *et al.*, 2017). In recognition of this aspect of mentorship, the results in this study show further expansion of mentor support, within the interstitial spaces (Furnari, 2014), where regular sign-off mentor support forums had been established by PFs. Sign-off mentors had been introduced as a requirement by the NMC (2008a). This represented PFs use of their discretion (Lipsky, 2010) in offering a solution to the emotional labour of mentoring students (Smith and Gray, 2001).

5.6.10 Supporting mentor to deal with students' challenging behaviours

However, not all of the emotion mentors in this study felt arose out of concern for students as some underperforming students in the current study applied pressure on their mentors to pass them by using varying behaviours. Emotionally extreme examples were related by mentor participants such as a student threatening to commit suicide which was anxiety provoking for the mentor. Participants also revealed occasions where underperforming students made allegations relating to

various aspects of their placement including the mentor, other team members or, relating the quality of patient care. Whilst these tactics placed the mentor and staff under pressure to respond to such allegations, mentors additionally wrestled with trying to balance their assessment decision with protecting patient care whilst risking a student backlash for themselves or the team. Similar pressure-inducing tactics by students have also been described by others (Hunt *et al.*, 2016b; Stephenson, 2016). Mentors balancing such tensions of their obligations to their students and providing patient care was a widely identified concern (Drennan, 2002; Ellis and Hogard, 2003; Myall *et al.*, 2008; Nettleton and Bray, 2008; Casey and Clark, 2011; Robinson *et al.*, 2012; Black *et al.*, 2014; Winterman *et al.*, 2014; Clark and Casey, 2016; Dobrowolska *et al.*, 2016; Chambers *et al.*, 2017; Rylance *et al.*, 2017).

This study found there was a strong sense that without the support of the PF, a mentor failing a student who may subsequently self-harm, felt vulnerable and struggled with the emotional and practical consequences of their fail decision. The significance of which is that, without the PF support, mentors might be tempted to take the less anxiety provoking option and fail to fail the student (Duffy, 2003, 2006, 2016; Black *et al.*, 2014). This could be particularly where underperforming students used coercive tactics to influence mentors to achieve a positive outcome in their assessment (Hunt *et al.*, 2016b).

In conclusion, PFs in this study were also revealed to have had a less personal relationship with students in comparison to that of the mentor. The discussion between the PF and mentor when issues arose around a student facilitated separation of the mentor/student emotional bond from the students' performance in practice. It also protected the mentor from any emotional tactics that the student may have employed to affect the mentors' decision in their favour. This resonated with Hunt *et al.* (2016a, 2016b) who identified the importance of those supporting mentors to keep the focus on the students' performance. This reflected PFs as street-level bureaucrats (Lipsky, 2010), in this study, operating in the interstitial spaces (Furnari, 2014) where they were able to dispassionately discuss the student performance with the mentor and support mentors through the process of making their assessment

decision. Thus, this solution revealed along with inculcating Trust values, discussed in the next section, reinforced PFs as *de facto gatekeepers to the profession*.

5.6.11 Inculcating Trust values

The policy push to attract and recruit applicants with the right values and behaviours (Willis, 2015) was promoted following the Francis report (Francis, 2013; Mazhindu *et al.*, 2016). Although responsible for recruiting and selecting students, HEIs found it challenging to select applicants with the right aptitudes and values (Callwood *et al.*, 2012, 2018, 2020; Gale *et al.*, 2016). Waugh *et al.* (2014) found there was a paucity of information on key skills or attributes that could be included in developing a personal specification for the selection of nurses. In a national study of selection processes for recruiting student nurses in Scotland, it was found there was a lack of substantive evidence on the interviewing process (Taylor *et al.*, 2014). Moreover, there was no definitive list of attributes as to what constituted selecting the right candidate (Taylor *et al*., 2014). Others had advocated values based recruitment (Callwood *et al.*, 2012). This was followed in an evaluation study that showed employing a multiple mini interviews approach to incorporate values based recruitment in student interviews was positively evaluated in the selection process (Callwood *et al.*, 2018).

PFs as street-level bureaucrats (Lipsky, 2010) understood these uncertainties and acknowledged that the recruitment interview to select students was crucially important in underpinning the Host Trust concept. Thus, participants from the HEI and Trusts were cognisant of the great importance of ensuring practice staff participated in recruiting and selecting potential students which was organised by the PFs using their discretion as street-level bureaucrats (Lipsky, 2010). As *the inbetweeners*, working across, between and within the Trusts and HEI (Furnari, 2014) enabled PFs to represent Trust care priorities and ethos as well as NMC quality requirements (NMC, 2008a 2010b, 2018b, 2018c) which facilitated values-based recruitment as advocated by Health Education England (2016). This gave Host Trust staff significant influence in selecting applicants. Miller and Bird (2014) in a narrative paper promoted the importance of values-based recruitment in securing a

caring workforce for the NHS. In addition, careful selection from service and academic perspectives could reduce attrition rates of up to 25% as reported from some pre-registration nurse education programmes (Willis, 2015). Furthermore, as part of values-based recruitment, PFs in this study saw service involvement in recruitment as informing prospective students of the reality of nursing in the real-world which better positioned students to make an informed decision to enter the profession, so *shaping the future workforce*.

5.6.12 Solutions in response to uncertainty summary

From the outset PFs quickly began operating as street-level bureaucrats (Lipsky, 2010) *in the frontline,* identifying a range of uncertainties arising in pre-registration nurse education in practice between the Trusts and HEI, but also their solutions discussed in this section. Forward mapping (5.5.2) and the Host Trust resource (5.5.3) live placement and mentor capacity information provided the platform for PFs to have an informed, influential input as *curriculum influencers*. By using their up-to-date practice resource information, PFs were enabled to develop solutions to secure curricula that were sustainable in practice. Positioning themselves to occupy the interstitial spaces (Furnari, 2014) across, between and within the Trusts and HEI, at strategic and operational levels ideally located PFs to address the longstanding uncertainties in Trusts HEI gaps (O' Driscoll *et al*., 2010; Felton and Royal, 2015; Maxwell *et al*., 2015; Monaghan, 2015; Rutt, 2017; Greenway *et al.*, 2019).

PFs using their discretion as street-level bureaucrats (Lipsky, 2010) and operating in the interstitial spaces (Furnari, 2014) moved onto grappling with the challenges of the deficits in the LL role, mentor support, and dealing with students. PFs incorporated Trust staff in the selection of students as a solution to securing students who inculcated Trust values and subsequently would have the potential to enter the workforce.

In summary, some of the uncertainties discussed here were resolved by the PFs, others were perceived to be more adequately addressed and some were ongoing. Actual

solutions the PFs developed around issues on fitness to practice will be discussed in the next section as they became embedded in practice.

5.7 Supporting the development and embedding of routine practices, practice facilitator purpose as street-level bureaucrat (Lipsky, 2010) working in interstitial spaces (Furnari, 2014)

5.7.1 Supporting the development and embedding of routine practices, practice facilitator as street-level bureaucrat (Lipsky, 2010) working in interstitial spaces (Furnari, 2014): introduction

PFs in this study were well known, visible and worked in close proximity at strategic and operational levels in the Trusts and HEI where *everybody knows them and they know everybody*. PFs as street-level bureaucrats took on a mediating role (Lipsky, 2010; Tummers and Bekkers, 2012) to find flexible and appropriate responses to mediate and embed routine practices at street level in the interstitial spaces (Furnari, 2014). The PF role evolved from ensuring *placement and mentor capacity*, *influencing curricula* and then encompassed a more qualitative supportive focus in their *frontline positioning*. Once *everybody knows them and they know everybody*, the role evolved further to address the fundamental professional challenges that arose. These included developing and embedding routine practices to deal with *understanding failure to fail*, and the challenges addressing that, including *ensuring due process*. Finally realising *if you get the mentor right you get the student right* leads to PFs becoming *de facto gatekeepers to the profession* thus positively *shaping the future workforce* and becoming *the everything facilitator*.

PFs embedded a range of routine practices across, between and within the Trusts and HEI. These included practice relevant curriculum; Trusts-HEI communication pathways; tailored mentor support; quality mentor assessment; mentor accountability; standards for quality mentorship; mediation of policy into practice; ongoing student support; support for transition to workforce; support for newly

qualified in the workforce and gatekeeping the profession. These are discussed in the following sub-sections.

5.7.2 Embedding practice relevant curriculum

The experience of PFs over time in this study led HEI participants to express the view that PFs operating in the interstitial spaces (Furnari, 2014) were recognised as the key staff in practice who understood curricula. They also acknowledged that PFs had embedded the routine practice where Trust staff viewed and used PFs as the 'go to' on-site resource who understood, advised and interpreted how the curriculum was delivered in practice.

This study found, once PFs approved a course plan design which they had helped develop, there was a real sense of ownership of, and commitment in implementing curricula in practice across the sector. Their autonomy (Lipsky, 2010) and positioning where they controlled access to resources (Taylor and Kelly, 2006) placed them *in the frontline* of making the policy work in practice.

Combining in-depth curricula knowledge whilst interpreting how practice resources were used, PFs in this study lead curricula dissemination in practice. Leadership was seen to be at the heart of managing curriculum change (Chowthi-Williams *et al.,* 2016) as it could be unsettling for those affected. However, although Chowthi-Williams *et al.* (2016) found curricula changes could be alarming due to fear of the unknown and loss of influence by the parties affected, such sentiments were not found in this study. Rather, there was a real sense that PFs in this study were easily accessible Trust experts for any curricula queries or issues that arose. No other primary studies were found that demonstrated engagement at this level of curricula involvement over the long-term.

5.7.3 Embedding Trust-HEI communication pathways

The theme of *the inbetweeners* related the way PFs occupied the work spaces across, between and within the Trusts and HEI organisational structures and processes

involved in pre-registration nurse education in practice. As discussed in section 5.3, Furnari (2014) identified this creative way of working between organisations as the interstitial spaces and where PFs very quickly acquired the status of *everybody knows them and they know everybody*. PFs involvement in recruitment and overseeing students in practice epitomised the role PFs performed as *the inbetweeners* in the interstitial spaces (Furnari, 2014), where they merged processes for the benefit of all involved.

Magnusson *et al.* (2007) had recommended that new roles to support practice learning needed a clear management structure to provide a clear role focus. It would seem that having one base and employer could avoid the pitfalls of similar education support roles such as joint appointments (Leahy-Warren and Tyrrell, 1998; Clarke *et al.*, 2003) (section 1.3.4) where role- holders had joint responsibilities to the HEI and Trust. Although they were acknowledged as being effective in bridging the gap between healthcare and HEI, having two organisations with two possible bases was often problematic as role-holders experienced problems in serving two masters which resulted in post-holders experiencing role conflict and strain (Clarke *et al.*, 2003; Lambert and Glacken, 2004, 2005; Rowe, 2008).

There were no other roles, found in the literature, that had this type of input where they communicated Trust requirements, whilst being part of the HEI infrastructure. Thus, PFs were able to embed routine practice communication pathways that promoted effective changes as discussed in the following sections.

5.7.4 Embedding tailored mentor support

Participants in this study identified that that PFs carried out a range of tailored activities in supporting mentors. This range of support reflected Hunt *et al.* (2016a) where they identified a variety of mentor support needs which included emotional, appraisal, instrumental and informational support. PFs in this study as street-level bureaucrats (Lipsky, 2010) working in the interstitial spaces (Furnari, 2014) viewed that providing the variety of support needs raised by mentors as key to their role so had long embedded this in their day-to-day working activities as did Maxwell's *et al.*

(2015) practice educators. However, Clark and Casey (2016) contended that the important role of mentors was not always recognised. Others have found that mentors were often not well-supported (Willis Commission, 2012; Kendall-Raynor, 2013; Black *et al.*, 2014; Clark and Casey, 2016; Hunt *et al.*, 2016a; RCN, 2016; Chambers *et al.*, 2017).

Bazian (2016) in their rapid evidence review of mentorship for the Royal College of Nursing mentorship project (RCN, 2016) revealed the importance of a conducive organisational context for supporting mentors. Subsequently, in their report, the RCN (2016) advocated that embedding organisational support was fundamental for mentors and promoted practice education posts as examples of good practice. PFs in this study working across, between and within the Trusts and HEI at strategic and operational levels addressed and fulfilled this recommendation and had long embedded it in their practice (Furnari, 2014).

Cassidy *et al*. (2017) also recognised the value of mentor support coming from an experienced educational and mentoring background, but who were external to the placement, with whom the mentor could discuss student progress. Clark and Casey (2016) advocated the need for support particularly where students were not meeting the required standard, although Elliott (2016) found the level of support needed varied between mentors but generally it was an area of 'significant deficit'. PFs in this study filled this deficit through their tailored support which included helping the mentor prior to the student interview, planning learning outcomes, action plans as well as how to articulate student performance concerns at the interview. Additionally, PFs reassured mentors their expectations were realistic if challenged by students that their standards were too high.

There was widespread discussion and recognition by participants in this study that PFs had become central in providing tailored support for mentors and for *addressing the challenges of failure to fail* issues. The early, direct, PF intervention supported mentors to make a definitive pass or fail assessment decision for that placement. This prevented mentors assigning underperforming students the worrying *'the benefit of the doubt'* outcome described by (Duffy, 2003, 2006, 2016; Luhanga *et al.*, 2008;

Mead *et al.*, 2011). The reluctance of mentors to fail students continues to be reported as a problem (Maxwell *et al.*, 2015; Haycock-Stuart *et al*., 2016; Cassidy *et al*., 2017; Burden *et al*., 2018; North *et al*., 2019; Devlin and Duggan, 2020).

Cassidy *et al.* (2017) found mentors were not deliberately failing to fail, rather, they were struggling to interpret practice learning outcomes. A key result, in this study, was that PFs as street-level bureaucrats (Lipsky, 2010) working in the interstitial spaces (Furnari, 2014) provided direct support for mentors when they had problematic or underperforming students. Much of their time was spent responding to, engaging with, and supporting mentors in managing these students. Congdon *et al.* (2013) and Maxwell *et al.* (2015) found that ongoing support for mentors underpinned the provision of high-quality practice learning experience for students.

Participants confirmed PFs, in this study, were contacted by mentors as soon as they had concerns about a student. This practice of being alerted early, whilst it identified underperforming students earlier in a placement, also had the important effect of PFs targeting early support for their mentors. Hunt *et al*. (2016a) and Luhanga *et al.* (2008) endorsed that unsatisfactory performance tended to be identified early during a student's placement. However, mentors were reluctant to contact anyone for support as they anticipated challenges to their concerns which made them feel vulnerable. Nevertheless, Winterman *et al.* (2014) considered it important for mentors themselves to seek early support in managing students who were failing to progress.

Mentors in this study valued the early opportunity to be able to talk through their concerns about a student during a one-to-one contact with the PF. This addressed a fundamental assessment problem where Hunt *et al.* (2016a) found mentors had often struggled to be clear on exactly what their concerns were and needed an expert to draw these out. Early discussion with the PF in this study tempered the mentor's viewpoint as differing perspectives were explored. This addressed the findings by Holland *et al.* (2010) and Bennett and McGowan (2014) where mentors recognised their inclination to make subjective assessment decisions where their first impressions of a student in practice influenced their subsequent assessment. In this

study, PFs tailored support helped mentors crystalise their concerns and was another aspect of the conflict mediation role of the street level bureaucrat (Lipsky 2010).

PFs support over time of the relationship between mentors and students through this tailored support for mentors promoted *shaping the future workforce*. Thus, PFs were interpreting how mentorship policy was translated and embedded *in the frontline* (Lipsky, 2010). The quality of mentor assessment, developed through this tailored support is discussed in the next sub-section.

5.7.5 Embedding quality mentor assessment

As PFs in this study were involved in all problematic assessments it brought standardisation and inter-mentor consistency to the mentor assessment process (NMC, 2008a). Moreover, HEI assessment processes were adhered to, so limiting the opportunity for students to successfully appeal mentor assessment decisions on process grounds. A recent systematic review of studies exploring nurses' sense of competence in mentoring nursing students found that they needed a supportive organisational structure to ensure a positive learning environment (Tuomikoski *et al.*, 2020). The support of a Practice Education Facilitator role, where it was available was also identified by (Hunt *et al.*, 2016a, 2016b) as being central to mentor decisions to go through with failing a student. In the event of mentors being concerned with student underperformance, PFs in this study continued to provide one-to-one support, thus further lessening the emotional impact on mentors as identified by Cassidy *et al.* (2017), O'Driscoll *et al.* (2010) as well as Smith and Gray (2001).

Overall, the PF actions helped the mentor cope with the burden of assessment as the onus was on the student to achieve the required standard in practice. In the event of the student not meeting the required standard, mentors had confidence that they had objectively reached a fail assessment decision and fulfilled their obligation to safeguard the quality of healthcare. Moreover, mentor concerns of the personal consequences for the student were mitigated by PFs in this study and thus guarded against mentor sentiments rather than the students' performance dictating the mentor

assessment decision. These factors placed PFs firmly in the *mentors' corner,* directly *addressing the challenges of failing to fail.*

PFs were perceived by participants as being *in your corner* for mentors and their *first port of call* during the assessment of students in practice. The on-site, immediate support provided, as well as one-to-one support and sign-off mentor forums were found to be most beneficial. Further, PFs provided practical and emotional support and supported mentors in addressing *failure to fail* thus *ensuring due process*. This pivotal role secured a chain of quality in mentor support which PFs, as street-level bureaucrats (Lipsky, 2010), working in the interstitial spaces (Furnari, 2014), standardised across practice.

An unintended consequence of PFs supporting mentors in improving the quality of their assessment, particularly with underperforming students was that it provided a 'Trust wide' viewpoint on individual assessment decisions. This instilled a robustness to the assessment process and thus increased inter-mentor reliability of assessment judgements (NMC, 2008a). This was the foundation for the PFs to develop and embed a more robust mentor accountability for their assessment decisions discussed in the next sub-section.

5.7.6 Embedding mentor accountability and quality mentorship

PFs positioning as senior Trust employees ideally situated them, as street-level bureaucrats (Lipsky, 2010) working in the interstitial spaces (Furnari, 2014) to work across, between and within the Trusts and HEI in *ensuring due process* in mentor assessment and accountability. This gave PFs the authority to promote early intervention and review previous mentor assessment decisions where underperforming students may have been allowed to progress.

This was in contrast to the LLs whose role focus was on providing support for mentors but without authority or a management remit to quality monitor or take action where assessment decisions were questionable. Similarly, mentors in the assessment chain, including sign-off mentors, had no formal remit to review or

challenge previous mentor assessment decisions. Black *et al.* (2014) clearly voiced sign-off mentors' sense of powerlessness and frustration where little action was taken to address a culture of mentors not failing underperforming students. This resulted in underachieving students being passed by mentors so progressing through the programme but leaving the difficult decision to be made by the sign-off mentor at the end of the students' programme.

This study found the impact of PF support at this juncture was crucial to avert the temptation for mentors to choose the easier and less problematic option to pass the student rather than expose themselves to the worry and risks of failing a student. Mentors needed support to manage both their feelings and the potential student response. PFs in the current research fulfilled this function mirroring Hunt *et al.* (2016a) description of a '*mentor's mentor*'. This provided the opportunity to devise action plans to support the student. If the student did not achieve the required standard, the direct PF involvement facilitated mentors to go through with a decision to fail the student.

Much of the focus in the literature was related to understanding mentor support needs when failing students in practice (Black *et al.*, 2014; Duffy, 2016, 2017; Hughes *et al.*, 2016; Hunt *et al.*, 2016a). However, there was a dearth of literature on how the problem of mentors who did not fail students that were underperforming was being addressed. Whilst the RCN (2016) posit that the accountability of the mentor role was undervalued, but unfortunately, they did not explore how accountability for poor assessment decisions could be achieved. No other study appeared to have identified monitoring the quality of mentor assessment decisions as part of the PF or other support nurse education in practice roles.

Although previous assessment decisions could not be altered, PFs in this study, by monitoring mentor assessments had the effect of previous mentor's decisions being explored or challenged so increasing mentors' awareness of their accountability (NMC, 2008a). A further consequence of this review process was that weak mentors were identified. Indeed, mentors in this study expressed a sense of relief and strong support that mentor accountability for their assessment decisions (NMC, 2008a) was

being addressed, underlining the message that the quality of mentorship and the assessment of students in practice really does matter. Cassidy *et al.* (2017) in their study explored the experiences of mentorship and advocated the value of collective accountability. However, they did not report whether or not, their participants had conversations with previous mentors who had passed a current underperforming student.

Finally, early detection was important as a second practice assessment failure resulted in overall failure to meet the programme requirements thus removing the student from the programme This prevented underperforming students progressing to their final placement culminating in problematic final assessment decisions as found by Black *et al.* (2014) and Hughes *et al*. (2016) in an integrative literature review. Therefore, this was an important finding, as serial *benefit of the doubt* underperforming students were prevented from progressing through the programme.

Quality mentorship was perceived by participants in this study to embed in practice the notion that *if you get the mentor right you get the student right* thus only allowing students that met practice requirements to progress. This chain of quality was developed over time by PFs through tailored mentor support, quality mentor assessment, mentor accountability and quality mentorship. PFs as street-level bureaucrats (Lipsky, 2010) working in the interstitial spaces (Furnari, 2014) were able to achieve this and their ability to embed current and emerging policy into practice is discussed in the next sub-section.

5.7.7 Embedding mediation of policy into practice

When new standards to improve mentorship were issued by the NMC (2008a) PFs in this study were revealed to have quickly taken ownership of how they would be implemented in practice. Implementing the new standards gave PFs an expanded quality focus where they used their discretion (Lipsky, 2010) to increase their influence *in the frontline* through enabling mentors to make assessment decisions that ensured the quality of students progressing through and completing pre-registration nurse education in practice elements.

Importantly, this revealed a shift in the PF role focus from an emphasis on setting up systems and managing the quantitative elements of *placement capacity generators* and *mentor capacity generators*, to also incorporating an increased emphasis on quality, including the implementation of policy into practice (NMC 2008a; Lipsky, 2010; Willis, 2015; NMC, 2018c). This was achieved primarily through supporting and securing good quality mentorship, fundamental to good quality student placement experiences. In Scotland, the central feature of the role of the practice education facilitators was realised to be supporting mentors (Carlisle *et al.*, 2008) and proved to have long-term benefit NHS Education for Scotland (2013).

Well-developed cross organisational systems were co-ordinated and delivered by PFs in the current study in the interstitial spaces (Furnari, 2014) to ensure mentors complied with regulatory requirements (NMC, 2008a). One of the regulatory requirements was for sign-off mentors 'to reflect, give feedback and keep records' (NMC, 2008a, p.34). A major aspect of this policy was mediated (Lipsky, 2010) by PFs in this study, where they established a sign-off mentor forum in each Trust which facilitated achieving this protected time (NMC, 2008a).

This was an important aspect as mentors designated as sign-off mentors provided a final formal verification that a student completing their last placement was fit to practice and to enter the professional register. This frequently placed an additional responsibility on these mentors particularly where students' performance was borderline. The sign-off mentor support forums in this study were referred to as having had the effect of raising the organisational importance of mentors as the protected time (NMC, 2008a) had been carved out from their clinical practice commitments. Bennett and McGowan (2014) conducted focus groups with mentors (n=35) in a qualitative study, found whilst mentors needed support in practice, allocation of protected time, away from '*work*' really helped in fulfilling their role. However, despite the protected time requirements for student assessment (NMC, 2008a), others have found this had proved difficult to achieve (Veeramah, 2012; Kendall-Raynor, 2013; Rooke, 2014; RCN, 2016). Nonetheless, Moran and Banks (2016) in a phenomenological study on the value of the mentor role, advocated that

time should be allocated in a structured way to achieve sign-off mentor protected time.

The sign-off mentor forum in this study operationalised NMC (2008a) requirements and brought together those sign-off mentors that had students allocated at the time on a Trust wide basis. It provided sign-off mentors with an additional support network at a critical stage where students were being assessed for the final time to establish if they met practice requirements for entry to the register, thus *ensuring due process*. Clark and Casey (2016) commented that even though there was a large volume of mentors in the workforce, little information was available on the value of mentors learning from each other or the benefits of peer support. Participants in this study used the forum to discuss current student assessments with their peers, discussing any queries or areas of clarification they may have. This support network was important as Black *et al.* (2014) found that failing a student in the final placement, particularly where the student had been passed by previous mentors, was stressful.

Moreover, group discussion fostered a sense of shared input and viewpoints which brought a sense of cohesion and robustness to the assessment process thus fostering *if you get the mentor right you get the student right*. In a two phase, grounded theory study in one health board in the UK found that mentors sought 'permission' for their assessment of borderline student performance but effective management of these students '*depended on the authorising effects of a wider community of assessors*' (Cassidy *et al.*, 2017, p. 2174). This study substantiated this finding, as although the sign-off mentor made the final assessment decision, the wider input of peer sign-off mentors helped to share the burden of the final assessment decision. In this way, peer support helped realise the sign-off mentors' common purpose of only passing those students that are fit to enter the register, thus maintained the chain of quality in *shaping the future workforce.*

5.7.8 Embedding on call support

HODs in this study used their discretion (Lipsky, 2010) as managers and supported the evolution of the PFs to become easily available to everyone else in the interstitial

spaces, across, between and within the Trusts and HEI (Furnari, 2014) i.e. the *first port of call.* Evans (2016) concluded that managers were street-level bureaucrats in their own way as they could block or facilitate how policy was implemented, or not, at their street-level. Senior staff from the Trusts and HEI benefited from being able to pass on pre-registration nurse education in practice issues strategically as well as operationally. Whilst Congdon *et al*. (2013) learning environment managers and Maxwell *et al.* (2015) practice educators also had the support of their managers but they only functioned at an operational level.

One of the issues in this study addressed by the PFs on call support being embedded in practice, was that they filled the vacuum left by the ongoing lack of timely LL availability. This had left mentors feeling unsupported and vulnerable as they had to decide, at the time, how to deal with student issues. As part of *supplanting the link lecturer role,* PFs took a proactive approach in providing support, advertised their accessibility and availability by regularly walking the Trust clinical areas. This enabled PFs to deal with issues even before the mentor sought help. This visibly demonstrated their willingness and ability to support mentors and students in practice. Over time, this consistent commitment instilled mentors, in the current study, with a sense of security and loyalty towards their PFs who had become the *first port of call.* Hunt *et al.* (2016a, 2016b) confirmed mentors valued the support provided by practice education facilitators where this role was available. Importantly, HODs in this study approved PFs support of mentors as it was challenging for LLs to provide the level and immediacy of support given by PFs.

Mentors in this study appreciated the immediate PF response, usually in person, making it possible for the PF and mentor to have a face-to-face discussion in the mentors practice environment. O'Driscoll *et al.* (2010) identified the need for a presence in practice that was responsive to pre-registration nurse education in practice needs. Lambert and Glacken (2005) in a literature review of clinical education facilitators found an important aspect of these roles was that students valued having someone that they could approach with issues and where staff were briefed. Others have reported that the new practice learning support roles were filling this deficit (Clarke *et al.*, 2003; Mallik and Hunt, 2007), and being the *first port of*

call for issues arising in practice. This was a very important result in relation to pre-registration nurse education in practice as it brought into question the future legitimacy of the traditional LL role.

The current study revealed that LLs also used the PFs as their *first port of call*. From the LLs perspective, pressure to respond to issues raised was alleviated as they had confidence that the PF would deal with issues quickly, feedback progress, filter the need for them to attend and prioritise issues requiring their further input or attention. Hunt *et al.* (2016a) in a national grounded theory study found that the practice education facilitator role, where it was available, was central in supporting mentors with problematic assessment decisions. However, it appears they did not explore the LL also using the PF for support, as found in the current study. O Driscoll *et al.* (2010) observed with the changing roles in clinical practice there was an increasing reliance on mentors who needed support, but there was a deficit in LL support. Therefore, they advocated mentor support should be provided by practice development/practice educator roles. Congdon *et al's.* (2013) shift in responsibility to the learning environment managers was supported by the University. They met regularly with mentors but this seems to be in the absence of LLs. They do not elaborate if there was an impact on the mentor, LL support relationship as seen in this study. Similarly, Maxwell *et al.'s* (2015) new practice educator roles also increased academic presence in placements providing support for mentors which they particularly appreciated. However, they were only available for 50% of their time in practice and whilst augmenting mentor and student support, the LL deficit remained. Importantly, such roles are not a requirement and therefore are not available nationally. However, no papers were sourced where LLs used such roles as their *first port of call*.

PFs had interpreted their role (Lipsky, 2010) to respond early to issues arising in pre-registration nurse education in practice. Operating in the interstitial spaces (Furnari, 2014), PFs were positioned to be on call and so were involved at an early stage. This enabled the PFs' expertise to be applied in the context of the practice environment. Thus, PFs were shown to be interpreting policy and regulations (Lipsky, 2010) to

identify responsive solutions including embedding student support as discussed in the next sub-section.

5.7.9 Embedding ongoing student support

This study confirmed having a Trust base and high frequency contact with practice settings placed PFs in this study, as street-level bureaucrats (Lipsky, 2010) occupying the interstitial spaces (Furnari, 2014). This positioned them *in the frontline* of pre-registration nurse education in practice. Visibility and presence were found to be fundamental qualities by Mallik and Hunt (2007), Rowe (2008) and Maxwell *et al.* (2015) in supporting students in practice and linking with the HEI. Maxwell *et al's.* (2015) study of a joint appointment practice educator role also found the regular presence, visibility and being easily contactable contributed to the success of that role. Being full time, PFs in this study, had the time to respond, usually in person, to Trust staff and particularly to mentors in practice areas in regards to student issues. This visibility of PFs included staff in the HEI where role holders were a well-known, familiar presence.

As Trust on-site managers, they collaborated with the HEI to ensure students were well-prepared for the practice environment. As role-holders they proactively managed and responded to changing policy and pre-registration nurse education agendas and the multitudinous issues that arose from everyday student practice experiences. PFs had developed embedded routines which were designed to reduce the consequences of uncertainty (Lipsky, 2010) for students. Students had viewed the facilitator role positively since its earliest inception (Rowan and Barber, 2000). Lambert and Glacken (2005), in a literature review of clinical education facilitators, found an important aspect of these roles was that students valued having someone that they could approach with issues and where staff were briefed. Other studies also found that students valued having someone in practice they could approach with issues (Lambert and Glacken, 2005; Price *et al.*, 2011; Congdon *et al.*, 2013; Maxwell *et al.*, 2015; Hamshire *et al.*, 2017). This PF availability to practice in this study was in contrast to that of the LL (discussed in section 5.6.5) and was also

evident where other new facilitator roles were filling the LL deficit (Clarke *et al.*, 2003; Mallik and Hunt, 2007).

In addition, PFs' early availability also helped mentors embed support for students. Duffy (2003, 2013), Vinales (2015) and Elliott (2016) promoted that early feedback by mentors of their concerns gave underperforming students the opportunity to improve in order to meet the required learning proficiencies. Maxwell *et al.* (2015) also found experienced practice educators were valued by practice staff as they recommended practice developments as well as providing opportunities for students to help them succeed. However, PFs in this study provided this support via the mentors in devising an action plan to help students succeed.

With this level of involvement, a further important outcome was that PFs were aware of 'at risk' students that had been identified as underperforming but had passed the assessment, and so maintained an oversight of these students in subsequent placements. This was in contrast to the identified mentor and LL roles that normally managed the student on a once off basis, which resulted in a lack of continuity and contextualising of the students' performance in further practice placements. Whilst mentors in Hunt *et al*. (2016a, 2016b) found mentors valued the support of practice education facilitators when failing a student but they did not talk about the practice educator continuing overseeing such students through their programme.

The PFs' overview of the student placement performance profile as described above reduced the likelihood of underperforming students being passed in placements. PFs involvement countered the lack of understanding around fitness to practice processes (Haycock-Stuart *et al.*, 2016) as well as a reluctance to fail a student (Duffy, 2003, 2006; Black, 2011; Burden *et al*., 2018). However, North *et al.* (2019) in an integrative literature review concluded that the issue may not be as widespread as previously thought as the majority of mentors were confidant in their assessment decisions.

All non PF participants conveyed the idea of PFs as their *first port of call* for any queries regarding pre-registration nurse education in practice issues. This was from

selecting students, supporting their progress on the programme, and onto their first destination post thus embedding ongoing student support in preparation for the transition to the workforce, discussed in the next section.

5.7.10 Embedding support for students' transition to the workforce

PFs as street-level bureaucrats (Lipsky, 2010) in this study had expanded their remit from the recruitment of students, overseeing them throughout their practice experience element of the programme to assisting the transition into their first jobs, principally within their Host Trust, as newly qualified nurses. This fostered a relationship between the PF, Host Trust and the student experience during their pre-registration nurse education in practice. Andrews *et al.* (2005a) in a three-phase multimethod survey in the UK found 'Home Trust' placements increased the likelihood of students applying for a first destination post. However, the survey only included students that had spent the majority of their practice in the 'Home Trust' and did not consider if practice staff, as in this study, were involved from the commencement of the programme made any difference. Literature tended to focus on students who had already completed pre-registration education programmes (Andrews *et al.*, 2005a; Foster, 2015) and the influence their placement experience had on where they choose to work on qualification (Baillie *et al.*, 2003). However, the importance of the student experience on placement and feeling supported (Baillie *et al.*, 2003; Wareing *et al.*, 2017) was found to lead students to develop an affinity with the Host Trust (Andrews *et al.*, 2005b) and so were more likely to apply for staff posts in a Trust where they felt supported (Wareing *et al.*, 2017).

PFs operating in the interstitial spaces (Furnari, 2014) prepared students to successfully navigate Trust recruitment processes to gain employment. This involved activities such as advice on completing application forms and mock interviews which the extended the Host Trust placement relationship. Familiarity with the Host Trust as a workplace eased the adjustment in taking on the responsibilities of being a newly registered nurse as identified by Halpin (2015). This process of familiarisation referred to as 'organisational knowing' by Terry *et al.* (2016) was an important factor

in the development and socialisation of new nurses in becoming proficient practitioners.

In an international scoping review on the transition of students to newly qualified nurse posts Aldosari *et. al.* (2021) indicated that many struggled to make the adaption, yet there was scant evidence to promote the usefulness of supported transition programmes. Nevertheless, the PF student relationship in this study continued as they transitioned to newly qualified nurses as discussed in the next sub-section.

5.7.11 Embedding support for newly qualified nurses in the workforce

PFs in the current study as street-level bureaucrats (Lipsky, 2010) working in the interstitial spaces (Furnari, 2014) within pre-registration nurse education in practice used their discretion to provide successful post-registration preceptor programmes. Participants perceived this facilitated students' transition as newly qualified nurses. The importance of a supported transition was widely supported in the literature. Brook *et al.* (2019) completed a systematic review on the characteristics of interventions to reduce attrition and improve retention of newly qualified nurses. Effective interventions appeared to be mentorship and preceptorship although there was acknowledgement that there were overlaps between these. Edwards *et al*. (2015), also in a systematic review on strategies to improve the transition from student to newly qualified, suggested it was the organisational focus, rather than the type of programme support that mattered. Holland *et al.* (2010) in an evaluative study design found that mentorship and a period of preceptorship were key in developing newly qualified nurses' confidence and skills. Whitehead *et al.* (2013) in a systematic literature review of preceptorship in the UK found such programmes assisted the recruitment and retention of newly qualified nurses.

Preceptorship was also promoted by NHS Health Education (2017) and was identified as it reduced stress by helping newly qualified nurses settle into their new role (Ross and Clifford, 2002; Halpin, 2015) and enabled moral support from peers (Odelius *et al.*, 2017). Stacey *et al.* (2020) found the use of resilience-based

supervision for a year with newly qualified nurses had a restorative/affiliative function. Indeed, preceptorship was beneficial irrespective of the type of support provided (Edwards *et al.,* 2015; Whitehead *et al.,* 2016) and importantly, contributed to the delivery of care at the required standard (Terry *et al.,* 2017). Moving into providing preceptorship programmes to support post-registration newly qualified staff saw PFs further embedding a gatekeeping to the profession role as discussed in the next sub-section.

5.7.12 Embedding gatekeeping to the profession

The policy drivers for the creation of the PF role in this study, aimed to secure nurses that met the Trust workforce requirements. PFs, as street-level bureaucrats (Lipsky, 2010) working in the interstitial spaces (Furnari, 2014) achieved this through a range of actions where they interpreted how policy was delivered. This began with the selection of students with the right attributes, who gained practice experience and mentor support in the Host Trust environment and culminated with being workforce ready on qualification.

PFs activities were perceived by participants as having well prepared student nurses to join the nursing workforce. They also approved of the PFs support in helping them to adjust to being newly qualified. This reflected Edwards *et al.* (2015) and Brook *et al.* (2019) and who both found that staff needed support on qualification, and, that this support needed to last for some time.

PFs in this study had instigated and were part of Trust processes to increase the quality of mentors where nurses who showed the potential to be good mentors were selected to complete an approved mentor education programme. By exercising their autonomous discretion (Lipsky, 2010) and operating at an influential level in the Trust, PFs were interpreting how mentors should be selected and were not following the previous Trust mantra that any nurse could and should teach.

Whether all nurses should be mentors, or whether nurses should elect or be selected to be mentors was a subject for debate (Andrews and Chilton, 2000; National

Nursing Research Unit, 2013; Clark and Casey, 2016; Moran and Banks, 2016). Irrespective of this debate, through selecting future mentors, PFs in the current study had become gatekeepers to the future mentor resource. In turn, these mentors were the gatekeepers who ensured that only students that met practice requirements progressed to registration and joined the workforce to support the next generation of nursing students, nurses and mentors.

As *de facto gatekeepers to the profession,* PFs through their various activities, selected, moulded and supported several generations of mentors. Along with this and the other routine practices embedded over time discussed above, the PFs as street-level bureaucrats (Lipsky, 2010) operating in the interstitial spaces (Furnari, 2014), had become *the everything facilitator* which is discussed in more detail in section 5.8. A summary of the development and embedding of routine practices is discussed in the following sub-section.

5.7.13 Supporting the development and embedding of routine practice summary

PFs operating as street-level bureaucrats (Lipsky, 2010) within the interstitial spaces (Furnari, 2014) between the different stakeholders where they were embedding routine practices in pre-registration nurse education in practice. An important finding in this study was the pivotal influence PFs had in contributing to and approving curricula designs that they ensured were successfully embedded in the Trusts. Their influence on how the curricula was successfully implemented came from their strategic as well as an operational overview of Host Trust placement resources combined with their detailed knowledge of practice and the curriculum.

Operating in the interstitial spaces (Furnari, 2014) within, between and across at both operational and strategic levels encapsulated how as *the inbetweeners* PFs interpreted their role at street-level, occupied the communication gaps, between the Trusts and HEI. They were able to take into account the needs of both and where *everybody knows them and they know everybody* came about.

The central importance of the mentor role was embedded into routine practice by PFs who, in response to mentor's concerns, provided tailored support by role modelling assessment and action planning in practice, building mentors' confidence and importantly holding mentors to account for their assessment decisions. Participants articulated the mantle taken up by PFs to tackle poor mentorship was fundamentally important. Part of *understanding failure to fail* was the idea that PFs were in the mentors' corner, helping them address the varying challenges including lack of support structures, the emotional price mentors paid and students' coercive behaviours. The most innovative practice embedded was PFs reviewing previous mentor assessment decisions where students had been passed but were subsequently found to be underperforming.

As street–level bureaucrats (Lipsky, 2010) operating in the interstitial spaces (Furnari, 2014) PFs embedded the routine practice of mediating policy priorities in relation to pre-registration nurse education in practice. For example, they took ownership of the implementation of the NMC (2008a) standards.

As the *first port of call,* PFs had embedded their availability of their on call support for mentors as well as LLs who valued this routine practice. This enabled early support for mentors with an underperforming student. This was viewed as a way to help students succeed.

PFs influenced and accompanied student nurses on their pre-registration nurse education journey guided by Trust values. As street-level bureaucrats (Lipsky, 2010) operating in the interstitial spaces (Furnari. 2014), PFs embedded routine practices that secured the future nursing workforce. This was from their involvement in initial selection, to providing support throughout the programme and as newly qualified, as well as to consideration as future mentors. Thus, the PFs evolved to become *the everything facilitator,* which is more fully discussed in the next section.

5.8 The everything facilitator as a street-level bureaucrat (Lipsky, 2010) operating in interstitial spaces (Furnari, 2014)

PFs in this study, were working across the four fields of nursing and, although based in different Trusts, shared the same challenges in devising systems (Durose, 2011; Lipsky, 2010) and processes to cope with uncertainties so they could interpret how the central policies were delivered in the consortium. PFs were able to discuss challenges and share good ideas, which had the advantage of being adopted across the consortium. They were able to develop innovative resources, solutions to uncertainties and embed these into routine practices, as discussed in previous sections (sections 5.5; 5.6; 5.7).

The advancement of Lipsky's (2010) street-level bureaucracy, through integration with Furnari's (2014) concept around the interstitial spaces (section 5.4) afforded a lens that gained deeper understandings of how the PFs operated at street-level from participants' perspective. This was particularly useful as these participants were drawn from the Trusts and HEI and with differing drivers and ethos, thus Lipsky (2010) with Furnari (2014) facilitated drawing together these different organisational perspectives. The very creation of the PF role (section 1.2; 1.8) had been as a result of policy initiatives where there was an expectation this new role would be involved in implementing policy across organisations. PFs had developed their role some way from the original vision of the founding policies. Using Lipsky's (2010) street-level bureaucracy policy implementation theory and Furnari's (2014) interstitial spaces, enabled greater insights as PFs responded to policy changes over time which had given role holders authority, autonomy and discretion in both strategic and frontline decision-making as street-level bureaucrats.

Participants in this study have overwhelmingly viewed the PF role positively in a real-world context and the way it evolved over time. A key insight was revealed which underpinned the positive view of the PFs, was that as street-level bureaucrats (Lipsky, 2010), they had a holistic overview of the pre-registration landscape as they operated across, between and within the Trusts and HEI interstitial spaces (Furnari,

2014). They had secured membership of and access to key Trust and HEI decision-making structures, and programme management processes which provided PFs with close and influential input to pre-registration nurse education in practice. This was a unique aspect as from this positioning they filled the leadership gap identified by O' Driscoll *et al*. (2010).

The three main themes drawn from the results of this study (chapter 4) are indicative of a broadly cumulative, policy responsive, acquisition of roles and responsibilities that, over time the PFs had accrued to become *the everything facilitator*. This has seen the role evolve from a largely operational and resource management role. Working *in the frontline*, as they acquired more responsibilities dealing with HEI and Trust gaps (O' Driscoll *et. al,*. 2010; Williamson *et al.,* 2010; Hunt *et al*., 2012) they occupied the interstitial spaces (Furnari, 2014) where they became so well known: *everybody knows them and they know everybody*. Over time, as they developed the role as street-level bureaucrats (Lipsky, 2010) in the interstitial spaces (Furnari, 2014) they were enabled to use their autonomy and discretion to mediate and interpret NMC policy initiatives (NMC, 2008a) thus incorporating a more qualitative perspective. By taking on this series of influential operational frontline decision-making roles they became *de facto gatekeepers to the profession*, particularly addressing the challenges of providing good quality mentorship (Jokelanian *et al*., 2011b; Tuomikoski *et al.,* (2020) so becoming *the everything facilitator*.

5.9 Impact of NMC (2018) standards

Subsequent to this study being completed new standards (NMC, 2018a) have become operational, see section 1.6.2 for details. While the roles of practice supervisor and practice assessor have been introduced, issues such as those that affected mentors including time to attend mentor preparation or updates remain. Neither has the prime role of the mentor as healthcare provider been acknowledged. Fundamentally, it appears the organisational lack of prioritising teaching and learning for pre-registration nurse education in practice has not been addressed in busy healthcare environments. These criticisms were echoed by Leigh and Roberts (2018). This

revealed, perhaps, the lack of value placed on the mentor role, despite its crucial importance in teaching and assessing the next generation of nurses.

In contrast to the mentor support operated by the PFs in this study, Clarke *et al.* (2018) in an editorial, advocated the use of a collaborative learning in practice model (CLiP), which was being developed in the South East of England to enhance the student learning experience. CLiP was a coaching and peer support model to support the practice of student nurses in clinical areas. This was as a replacement for the direct support of a mentor. A systematic review of CLiP (Williamson *et al.*, 2020c) funded by Health Education England, reviewed the international literature in the context of the new UK standards found no English language papers. Additionally, Williamson *et al.* (2020b) in a study involving 4 student focus and 2 staff focus groups found CLiP offered benefits. Students were exposed to the realities of practice from the beginning of placement, given greater responsibilities, and, had peer support. For clinical staff the burden of supervision was spread more widely. Both discussions concluded the CLiP model required further evaluation (Williamson *et al.*, 2020b, 2020c).

The results of this study demonstrated the likelihood the PFs, as street-level bureaucrats (Lipsky, 2010) operating in the interstitial spaces (Furnari, 2014) will be able to meet and interpret the requirements of the new standards (NMC, 2018c) and any new models of practice learning, such as CLiP, that may emerge in the future. This underlines the importance of the PF role, as *the everything facilitator*, providing structured and individual support for Trusts and HEI staff, across, between and within at strategic and operational levels of the pre-registration nurse education in practice landscape.

5.10 Chapter summary

This case study (Yin, 2009) provided the opportunity to explore the practice facilitator role in a real-world context and the way the role evolved over time. The wider perspectives of street-level bureaucracy (Lipsky, 2010) used throughout, and nurses, as street-level bureaucrats, were discussed. Subsequently, an exploration of

the idea of interstitial spaces (Furnari, 2014), where changes can happen between organisations, in the context of street-level bureaucracy (Lipsky, 2010) was developed. This led to the coalescing of Furnari's (2014) more strategic ideas of the interstitial spaces being the places where innovations and ideas can be created that can become embedded over time, and, the more operational purposes of Lipsky's (2010) street-level bureaucracy. This represented an advancement of Lipsky's (2010) work which generally focussed on working within a single organisation being extended to working in the spaces between conceptualised by Furnari's (2014). Further, in contrast to Lipsky's (2010) lower-level actors operating at operational levels, practice facilitators in this study operated at operational and strategic levels in these spaces. The results of this study were then discussed in the context of this advancement and the emergent purposes for practice facilitators as street-level bureaucrats (Lipsky, 2010) operating in the interstitial spaces (Furnari, 2014) and the literature. It was clear the emergent purposes were underpinned and confirmed by the themes and overarching theme in this study.

A key result was that practice facilitators had become successfully embedded over time in pre-registration nurse education programmes as *the everything facilitator*. Working at strategic and operational levels, as well as across, between and within the Trusts and HEI, gave the role a degree of autonomy and authority. Practice facilitators pro-actively lead on pre-registration nurse education in practice activities from a practice perspective, thus filling the leadership gap identified by O'Driscoll *et al.* (2010).

The first purpose for the practice facilitators as street-level bureaucrats (Lipsky, 2010) was to develop innovative resources to create physical means of help in implementing policy at street level within the interstitial spaces (Furnari, 2014). This purpose is supported by the first theme, *in the frontline*, generated from the results reflecting the earliest focus of the role. These resources comprised not only the availability of themselves in those spaces, but electronic means of identifying and tracing Host Trust placement and mentor resources. *In the frontline* outlined the evolution of the practice facilitator role from being operational and managerial *placement capacity* and *mentor capacity generators* to becoming *curriculum*

influencers and implementers as street-level bureaucrats (Lipsky, 2010) working in interstitial spaces (Furnari, 2014).

The second purpose for practice facilitators, with these resources in place, and where *everybody knows them and they know everybody* they were able to develop solutions to a range of uncertainties that were present in the pre-registration nurse education programme, across the consortium. These included the practice facilitators as *the inbetweeners* using 'live' data to inform curriculum designs that were viable in the Host Trusts, cross organisational communication *occupying Trust-HEI gaps* and ensuring students were prepared for practice as well as addressing LL deficits through *supplanting the link lecturer role*. Importantly, as *first port of call* practice facilitators were providing advice and support to enhance mentors functioning understanding and addressing their uncertainty in managing underperforming and failing students, whilst complying with assessment processes. Over time, they were able to address recruitment uncertainty and organised processes that inculcated Host Trust values from initial recruitment to the programme.

The third purpose for practice facilitators as street-level bureaucrats (Lipsky, 2010) operating in the interstitial spaces (Furnari, 2014) was to develop and embed routine practices. Over time, as *de facto gatekeepers to the profession,* a substantial range of quality practices were successfully implanted into the pre-registration nurse education in practice landscape. Having secured curriculum relevant to practice, practice facilitators took responsibility for successfully implementing it in practice and maintaining Trusts HEI communication pathways. The central importance of the mentor role was recognised by the practice facilitators in *if you get the mentor right, you get the student right*. By being *in your corner* for mentors, they were able to respond to mentor concerns and mentor assessment deficits *ensuring due process* through designing tailored support thus *addressing the challenges of failing to fail*. This included role modelling assessment due to their *understanding failure to fail,* and action planning in practice, building mentors confidence and importantly, for quality assurance, holding mentors to account for their assessment decisions. Their remit expanded in support of students, from their initial values-based recruitment, overseeing them in the practice elements of their programmes to assisting them to

transition into their first job, supporting them as newly qualified and choosing the best to be the mentors of the future thus *shaping the future workforce*.

It became apparent in the purposes, themes and sub-themes, of practice facilitators as street-level bureaucrats (Lipsky, 2010) working in interstitial spaces (Furnari, 2014) that the role expanded to become *the everything facilitator* positioned to implement at street-level new policy initiatives as seen in the above discussion. The next chapter will examine the extent to which the research questions have been answered and a summary of the new knowledge generated is provided. Dissemination of results, personal reflections as well as strengths and limitations, the usefulness of including case study (Yin, 2009) and Tracy's (2010) criteria for quality are provided. In addition, recommendations for future research, UK policy makers, UK healthcare providers and UK pre-registration nurse education programme providers are presented.

Chapter 6: Conclusion

6.1 Introduction

Overall, this study found that the practice facilitator role had an influential impact on pre-registration nurse education as it evolved, over time. In addition, the role was perceived positively by participants. These conclusions were from practice facilitators perceptions of themselves, as well as participants from strategic and operational levels across the Trusts and HEI. This outcome emanated from practice facilitators operating as street-level bureaucrats (Lipsky, 2010) where they had a frontline 'live overview' of all elements involving pre-registration nurse education in practice. This positioning enabled practice facilitators to take expeditious action as required. Crucial to the practice facilitators success was the location where they worked within the interstitial space (Furnari, 2014), where they were able to be part of either Trust or HEI organisations to mediate actions to deliver pre-registration nurse education in practice.

Practice facilitators, as street-level bureaucrats (Lipsky, 2010) had been given authority by strategic staff from the Trusts and HEI to take the initiative in interpreting and mediating how policies, as they were released, were implemented in practice. The interstitial spaces (Furnari, 2014) locale, along with their organisational authority afforded by strategic Trust and HEI staff enabled practice facilitators, as street-level bureaucrats (Lipsky, 2010) to operate with a high level of autonomy where they took the initiative in interpreting and mediating how policy was implemented in real-life.

The revelation of practice facilitators occupying the interstitial spaces was a development of Lipsky's (2010) street-level bureaucracy, which illuminated how the practice facilitators operated, but as important was the locale from where they operated which offered an important perspective on the way the role had evolved over time to become integral to pre-registration nurse education in practice. This is the first study that has clearly articulated the integration of interstitial spaces between organisations as described by Furnari (2014, 2016) with street-level bureaucracy (Lipsky, 2010) representing a novel application of Lipsky (2010). In contrast to

Furnari (2014) who postulated that the interstitial spaces occurred infrequently, whereas the practice facilitators, operating as street-level bureaucrats continually occupy these spaces. From these spaces, practice facilitators were positioned to operate *in the frontline*, where *everybody knows them and they know everybody* becoming *de facto gatekeepers to the profession*, culmination in becoming *the everything facilitator*.

A further important factor was that the practice facilitators were full time. This enabled role-holders to focus their full attention on their role which provided them with time availability, to respond to strategic or operational issues, even at short notice. Additionally, as practice facilitators constantly dealt with all elements related to pre-registration nurse education in practice, they had built up a wealth of knowledge and experience across the real-life delivery of pre-registration nurse education in practice.

Utilising a case study methodology (Yin, 2009) enabled the first in-depth exploration of the practice facilitator role in a real-life context over time and across organisations. It also facilitated being able to explore participants' perceptions and understanding of the context of the role from practice facilitators and non- practice facilitator participants.

The remaining sections of this chapter address the extent to which the research aim was achieved and the research questions were answered. The contribution this study has made to new knowledge about *the everything facilitator*, operating as a street-level bureaucrat (Lipsky, 2010) in the interstitial spaces (Furnari, 2014) is discussed. The research aim and research questions are explored in the context of the results. The strengths and limitations of this study are given before a summary of new knowledge gained. Recommendations are made for future research and for key stakeholders in policy, healthcare and pre-registration nurse education in practice. Reflections on the research process and personal learning as a researcher are also given. Finally, a dissemination strategy of the results is provided followed by the final conclusion.

6.2 Achieving the research aim

The research aim was stated in section 2.6 as:-

> *Explore the way the practice facilitator role evolved in a real-world context over time and its impact on pre-registration nurse education.*

This aim has been achieved and new knowledge generated that will potentially inform future pre-registration nurse education programmes and particularly pre-registration nurse education in practice. In addressing the research aim, the study, in using Lipsky (2010) as an analytical framework for understanding and interpreting the evolving role of practice facilitators (PFs), provides a theoretical development of the concept of street-level bureaucracy. It does so primarily by integrating the concept of street-level bureaucrats with the idea of PFs being located and operating within interstitial spaces (Furnari, 2014). In particular, whereas Lipsky (2010) identified street-level bureaucrats working at the frontline in a single organisation, this study encompasses the practice facilitator (PF) working across, between and within separate organisations and was able to do so effectively through being critically located in the interstitial spaces across, between and within organisations.

6.3 Answering the research questions

Five research questions (section 2.7), central to the research were formulated, informed by the literature review (chapter 2). Each will be explored in turn in light of the results and discussion chapter as well as key literature.

6.3.1 What was the rationale for the introduction of the role of practice facilitator?

Dissatisfaction with pre-registration nurse education in practice had long been articulated that nursing students had not been adequately prepared to enter the nursing workforce (UKCC, 1986; DoH, 1999; UKCC, 1999). Providing a sufficient

quantity of practice placements was challenging (Elkan and Robinson,1995; Magnusson *et al.*, 2007; Murray and Williamson, 2009; Leigh *et al.*, 2014a, 2014b) as well as poor standards of mentorship (Jokelainen *et al.*, 2011b; Hughes *et al.*, 2016; Tuomikoski *et al.*, 2020). The LL role, responsible for providing support for mentors and students was also problematic (Carnwell *et al.*, 2007; O' Driscoll *et al.*, 2010; MacIntosh, 2015; Hunt *et al.*, 2016a). Joint appointments, aiming to bringing theory and practice closer were also unsatisfactory (Williamson, 2004).

Making a Difference (DoH, 1999) set out a vision for the future of the nursing workforce in the UK. *Fitness for Practice* (UKCC, 1999) made recommendations to the professional regulator for nursing, (at that time the UKCC) so that future nurse education preparation programmes secured a well-prepared nursing workforce to deliver future healthcare. The rationale for the introduction of the PF role was to support the implementation of these two key policy initiatives. This led to the role having a pre-registration nurse education in practice focus to support implementation of these policies from Trust and HEI perspectives in the study consortium. A critical review of the primary literature (chapter 2) identified that similar new facilitator roles were created in a number of regions across the UK as a result of these two key policies. Some studies, were undertaken, largely following the inception of new facilitator roles, which focussed on aspects of the role or what were effectively 'snap-shots' of how they functioned. However, no studies have been published exploring how these roles evolved in a real-world context over time.

6.3.2 How has the role of the practice facilitator changed over time?

The PF role has changed substantially in a real-world context over time. Although the role arose in response to policy (DoH, 1999; UKCC, 1999) (section 1.4.1; 1.4.2) these had only made broad statements about how the role should operate. There has been no subsequent detailed policy guidance on this type of role. Subsequent NMC policy (NMC, 2006, 2008a, 2018c) focused on other roles in pre-registration nurse education. Secondly, PFs as street-level bureaucrats (Lipsky, 2010) demonstrated individual high levels of discretion operating in the interstitial spaces (Furnari, 2014). This can be perceived as acting as a propellant that enabled PFs to accumulate a

whole series of additional highly influential roles. These two factors together, illuminated how the role had evolved and developed into their current functioning. This enabled PFs to develop innovative resources (section 5.5), solutions to some longstanding uncertainties (section 5.6) and embed a number of developments into routine practice (section 5.7).

Thematic analysis (Braun and Clarke, 2006) of the results demonstrated that the PF role has evolved from being a newly created, somewhat nebulous role, to one which had become embedded in the provision of pre-registration nurse education programmes and particularly in pre-registration education in practice as far as the study consortium was concerned. The initial priority was concerned with placement capacity resource issues. Prior to the implementation of the role, systems to secure student placements were failing (DoH, 1999; Hutchings *et al.*, 2005; Murray and Williamson 2009). It was apparent that no central role was identified in the Trusts to oversee placement capacity, so the initial stated priority for the new PFs was to avert the predicted placement capacity crisis.

Whilst tasking role holders to collaborate with the HEI (UKCC, 1999), basing the role in practice was crucial as it immediately placed PFs at the centre of managing the Trust owned placement capacity resources. Whilst the initial priority was clear, it seemed nobody quite knew how the new role would operate, so it was left up to the PFs as street-level bureaucrats (Lipsky, 2010), working *in the frontline*, as to how they would address the impending placement capacity shortfall. The urgency of the placement and mentor capacity deficits, afforded the PFs the support of the Trusts and HEI to address this critical resource requirement. Instrumental and management systems were developed and implemented by PFs in conjunction with the HEI to secure ongoing adequate capacity for pre-registration nurse education in practice programmes.

Designing out problematic course plans (Magnusson *et al.*, 2007; Murray and Williamson, 2009) at the curriculum planning stage and overseeing the availability and use of ‘live’ placement resources underpinned the proactive management of the

quantitative elements necessary for effective placement capacity provision. This gave the role early impact and a substantial profile in the Trusts and HEI.

The ongoing provision of quality placement and securing mentorship capacity as identified by Jokelainen *et al.* (2011a), has remained central to the success of the role. Developing this capacity has afforded PFs greater recognition and influence in the Trusts and HEI such that it soon was the case that *everybody knows them and they know everybody*.

PFs continual activities managing and overseeing the practice resources placed the role in a pivotal position in the myriad of inter-organisational activities involving nurse education in practice. The spaces between the Trusts and HEI they created became where they worked together across, between and within which has been identified earlier in this thesis as the interstitial spaces (Funari, 2014). Over time, PFs, as street-level bureaucrats used relatively large levels of discretion (Lipsky, 2010), operating in the interstitial spaces (Furnari, 2014) to select how they addressed theory practice and communication deficits, identified by others (Stark *et al.*, 2000; Pulsford, 2002; Hogard *et al.*, 2005; Andrews *et al.*, 2006; Henderson *et al.*, 2006; Felton and Royal, 2015; Monaghan, 2015). This also incorporated providing support for issues arising in practice which developed and extended their role as they developed solutions and embedded routine practices where they were revealed to have become the *first port of call*.

Importantly, PFs were empowered by the Trusts and HEI strategic management to continue to operate in the interstitial spaces (Funari, 2014). This was based on their successful mediation of pre-registration nurse education programmes and pre-registration nurse education in practice issues, which they autonomously (Lipsky, 2010) resolved before they required senior management attention. Further expansion of the PF role encompassed an increased focus on the quality of nurse education in practice in response to policy changes (NMC, 2006, 2008a) and challenges in nurse education in practice. These included understanding the challenges of failing to fail (Duffy, 2003, 2006; Hughes *et al.*, 2016) and using their discretion (Lipsky, 2010) to tailor support for mentors managing underperforming students. PFs used their

autonomy as well as their discretion (Lipsky, 2010) to interpret (Lipsky, 2010) policies to provide good quality mentorship and student support thus *shaping the future workforce.* Combined with their support for newly qualified nurses and selecting future mentors made them *de facto gatekeepers to the profession*. Thus, over time PFs became *the everything facilitator.*

6.3.3 How does the practice facilitator role function across a range of organisations?

PFs in the current study, although based in their Host Trust, co-operated and, over time, had established a strong network both formal and informal in the interstitial spaces (Funari, 2014) across, between and within the Trusts and HEI. Operating within the interstitial spaces (Funari, 2014) as street-level bureaucrats (Lipsky, 2010) was crucial as it enabled access to and movement between strategic and operational levels in the Trusts and HEI involved in pre-registration nurse education programmes as well as pre-registration nurse education in practice activities. Their positioning in each Trust located PFs *in the frontline* so they had an awareness of any issues arising as well as the authority to locally resolve and/or implement proactive interventions that supported students and mentors.

Operating together PFs identified and brought together common issues which they had identified locally, or across the consortium or within the HEI. They were then able to use their authority and autonomy (Lipsky, 2010) to develop a single strategic approach all could use providing the leadership lacking in O' Driscoll *et al.*, (2010).

6.3.4 How has the role of the practice facilitator impacted on pre-registration nurse education?

The PF role had a profound impact on pre-registration nurse education within the consortium where they were *in the frontline* of interpreting how changing education and health policy was put into practice. From the creation of the role in 2001, role holders had demonstrated control of their work with the jurisdiction to focus on areas of priority. Operating as street–level bureaucrats (Lipsky, 2010), in the interstitial

spaces (Furnari, 2014) they decided policy priorities in relation to pre-registration nurse education across their varying cross-organisational work streams. This impact can be seen not only across, between and within organisational levels but also substantially at the individual level intervening to support mentors and students.

At the organisational level, the major impact of PFs related to the management of the practice placement resource, thus ensuring the viability of pre-registration programmes in practice. This has resulted in a system of placement management that facilitated better use of placement capacity, effective planning of student allocations through a mapping system devised by PFs in collaboration with the HEI and pre-empting any potential practice placement shortages. This had provided an effective response to managing the significant increase in student nurse commissions that occurred at the same time as the establishment of PFs (DoH, 1999). Over time, they were able to profoundly impact on curriculum design and content to be practice focussed.

At an individual level, PFs provided responsive interventions where there were concerns relating to student performance and assessment in practice. As in Maxwell *et al.* (2015) PFs tailored support had enhanced mentors' abilities and confidence to more objectively make difficult student assessment decisions. One outcome of this study was that underperforming students were identified earlier than previously and clear action plans put in place. Eventually, PFs involvement with students became more positive. They were able to accompany the Host Trust students, whose selection they influenced, on their journey through the programme. This PFs support for students continued to they becoming newly qualified and subsequently to be considered as future mentors. All of these processes they developed at individual and organisational level facilitated their becoming *de facto gatekeepers to the profession* and ultimately *the everything facilitator*.

6.3.5 What effect has the role of the practice facilitator had on other key roles contributing to pre-registration nurse education?

The PF was a newly created role. It was the only role in the consortium that was fully dedicated to the practice element of the pre-registration nurse education programmes. This was in contrast to other roles here, and across the UK, concerned with pre-registration which had additional remits (Mallik and Aylott, 2005; McIntosh *et al.*, 2014; Maxwell *et al.*, 2015). PFs operated as street-level bureaucrats (Lipsky, 2010) in the interstitial spaces (Funari, 2014) at strategic and operational levels in the Trust and HEI. In this unique location they held a level of authority, in, across and between these organisations that allowed them to respond flexibly compared to other key stakeholders. How the PFs affected other key roles in the consortium is explored in the following sub-sections.

Trust education leads

Trust ELs were very supportive of the PF role as it made the ELs more effective in their pre-registration remit and other aspects of their education role. Effectively supporting students in practice has long been discussed and identified (Mallik and Aylott, 2007; O' Driscoll *et al.*, 2010). ELs in the current study exuded confidence in their PFs where they articulated PFs were seen as managing all aspects of pre-registration nurse education in practice of which they were kept informed. ELs related that PFs contributed to Trust quality monitoring systems; recruiting the right students; forward mapping of placement and mentor capacity; quality placement and mentor experiences; managing underperforming students; and leading to the Trust gaining the desired workforce.

Moreover, they supported and had confidence in the PFs being part of HEI decision making processes where they represented and delivered Trusts' varying interests within the HEI. This freed ELs to work strategically with other aspects of their education in clinical practice responsibilities.

HEI heads of department

HEI HoDs related that PFs were seen as part of their HEI team and relied on them to articulate and deliver Trust requirements. PFs brought the real-life Trust into the HEI and were vital to the HEI delivering pre-registration nurse education in practice that met Trust requirements. They also interceded with day-to-day clinical practice issues that had previously been directed to HoDs. Importantly, HoDs recognised they were reliant on PFs, who had some management responsibilities within their Trusts and a great deal of influence to make pre-registration nurse education in practice work.

Mentors

Analysis of the results showed PFs also have a significant impact on mentors whose main responsibility was to their patients (Pulsford *et al.,* 2002; Ellis and Hogard, 2003; Andrews *et al.*, 2006; Myall *et al*., 2008; Black *et al*., 2014; Winterman *et al.,* 2014). Because of the support provided by the PFs, mentors were more likely to perform more consistently and with greater confidence when faced with difficult student practice assessments decisions. PFs held mentors who had previously passed an underperforming student accountable for their assessment by reviewing that decision directly with the mentor. With the introduction of the sign-off mentor role (NMC, 2008a) this had become particularly important because this was the final opportunity to decide on the students' performance in practice which, if passed, would lead to the student's entry onto the NMC register.

Link lecturer

A major outcome of this study was that PFs had, to all intents and purposes supplanted the link lecturer role in providing advice and tailored support for mentors supporting students in practice. This was related to the PFs visibility, availability, location and ability to respond swiftly to student related concerns in practice. This was in contrast to other published literature where the separation of Trusts from practice had resulted in LL difficulties in being available for mentor and students (Aston *et al.*, 2000; Williamson, 2004; Barrett, 2007; MacIntosh, 2015). As a result, PFs had become the *first port of call* for mentors and academic staff who had also acquiesced to this changed dynamic. Mentors clearly articulated they no longer

regarded the LL as the key source of support but instead deferred to and relied upon the PF.

Lecturers

Surprisingly, PFs also were revealed to have had an impact on lecturers within the HEI, where they included them in skills updates that met Trust practice requirements. In addition, PFs were able to obtain Trust expertise to teach in the HEI to ensure students were prepared and met Host Trust practice requirements.

Students

It has long been appreciated that supporting students in practice is multi-faceted (Aston *et al.,* 2000; Andrews *et al*., 2006; Williamson *et al.,* 2010). PFs were involved with students from initial recruiting those with Trust values; ensuring good quality placement and mentor resources; influencing curriculum design; occupying Trust-HEI theory-practice gaps; supporting mentors managing underperforming students; helping students succeed; overseeing the student during the programme; joining the workforce; and finally supporting them as newly qualified to becoming the future mentors.

Answering these research questions has revealed some of the new knowledge in relationship to the impact PFs had on key roles contributing to pre-registration nurse education in practice in this study. The new knowledge generated is fully explicated in the next section.

6.4 Strengths and limitations of this study

6.4.1 Overall strengths of this study

A strength of this study is that it uniquely explored the evolution and impact of the PF role over time. This enabled the principal investigator to explore the evolution of the role from its initial inception to its current wide ranging, omnipresent influence on pre-registration nurse education in the consortium. No other primary studies were

found that explored the impact of the PF role on pre-registration nurse education over time.

Another strength of this study is that the results resonated with a number of the 'big issues' concerning pre-registration nurse education such as mentor assessment (Brown *et al.*, 2012; Black *et al.*, 2014; Hunt *et al.*, 2016a, 2016b; Duffy, 2017) the LL role (MacIntosh, 2015) placement capacity provision (Leigh *et al.*, 2014a; Merrifield, 2017b) thus enabling new insights into these issues.

The purposeful selection of key participants, many of whom had been in post since the time of the initiation of the PF role, was a strength. Each of the non-PF participants contributed to pre-registration nurse education from either a Trust or HEI perspective, at strategic or operational levels. These participants along with the PFs themselves, provided differing real-world educational and healthcare perspectives on the PFs role impact on pre-registration nurse education. This was a strength as they were able to consider the evolution and impact of the PF role over time.

The methodological approach (Yin, 2009) selected for use in this study proved to be particularly beneficial as discussed in the next sub-section.

6.4.2 Usefulness of case study methodology (Yin, 2009)

A key strength of this study was the use of case study methodology (Yin, 2009) which enabled the embedded units of analysis (practice facilitators) working in the four fields of pre-registration nurse education to be explored in the real-life context in which the role operated. This is a widely used and credible methodology in health and social care. Since this study was designed a further two editions of Yin's case study methodology (Yin, 2014, 2018) have been published. In this study, using Yin's (2009) case study approach, enabled the in-depth exploration of PFs role from the experiences and views of a range of participants in the embedded case (figure 3.2). These participants were employed across the landscape of pre-registration nurse education, at strategic and operational levels in the Trusts and HEI (table 3.1). In keeping with Yin (2009) using one-to-one semi-structured interviews and focus

group interviews provided a richness of data from the different perspectives and experiences of the PF role, including role-holders themselves.

Case study has been promoted as a way of looking at cases and as a way of creating evidence in healthcare (McGloin, 2008). Particularly attractive for this case study (Yin, 2009) was that it incorporated the context in which the PFs operated. Therefore, Yin (2009) case study approach was eminently suitable as the boundaries between the Trusts and HEI responsibilities for leadership for student learning in practice were not clearly defined (O' Driscoll *et al.,* 2010). Additionally, but importantly, the case study proved useful in "*understanding a real-life phenomenon in depth*" (Yin, 2009 p., 18). These attributes aligned with the study's pragmatic philosophical underpinning (section 3.2), and policy implementation (section 1.7) perspectives where the policy delivered at street-level (Lipsky, 2010), was the policy.

Furthermore, analysis of semi-structured interviews and focus group interviews from this case study provided detailed participant accounts and perceptions of the PF role within a real-life context. This revealed the interdependence of the Trusts and HEI in the pre-registration nurse education landscape where PFs operated at strategic and operational levels. Importantly, PFs as street-level bureaucrats had created a unique space, the interstitial space (Funari, 2014) (figure 5.1) where they implemented policy changes over time and which is discussed in the next section.

6.4.3 Usefulness of Lipsky (2010) as a lens

Lipsky's (2010) bottom-up approach to interpreting policy at street-level has been applied as a means of uncovering the evolution and impact of the PF role over time. The results of this study resonate with Lipsky's (2010) street-level bureaucrats. The characteristics of the role of the PF appear to relate closely to the characteristics of Lipsky's (2010) street-level bureaucrats (section 5.2; 5.2.1).

Significantly, using the lens of Lipsky (2010) during the analysis phase revealed how the PFs, over time as street-level bureaucrats had carved out work spaces for themselves within which to operate in and between the Trusts and HEI. The specific

spatial location in which PFs were found to function, was identified as the interstitial spaces, a concept that has been to date most comprehensively elaborated on by Funari (2014). Ironically, this was the interpretative label which had emerged within the analysis (Braun and Clarke, 2006, 2013) of the results early on to describe the place where PFs were operating. Merging Furnari's (2014) concept as previously discussed in chapter 5, has allowed for the further advancement of Lipsky's (2010) bottom-up approach to be extended.

6.4.4 Tracey's (2010) quality criteria

The use of Tracy's (2010) quality criteria (section 3.9) proved helpful in contributing to the strength of this study. Each of the criteria highlighted in bold is discussed below and how they were met within this study.

This was a **worthy topic** as the literature revealed (chapter 1) some newly qualified nurses were not fit for purpose, fit for practice. How pre-registration nurse education in practice prepared nursing students to join the workforce was and is central to NHS providing good quality healthcare. Therefore, a study to e*xplore the role of the practice facilitator and its impact on pre-registration nurse education* was undertaken. The literature review (chapter 2) revealed little research had been completed on this type of role. In consequence of some newly qualified nurses not being adequately prepared for their role, the Government made recommendations for nurse education programmes to be revised to meet changing healthcare needs (DoH, 1999). In response, the nursing regulatory body issued the policy document *Fitness for practice, Fitness for purpose* (UKCC, 1999) which incorporated widespread changes for pre-registration programmes and including new roles. An outcome of this was the creation of a new PF role in the consortium.

Rich rigor was introduced into this study through the use of a pragmatic philosophical perspective (3.2). This underpinned the study's exploration of the PF role in a real-world context. This approach continued to hold these pragmatic principles throughout the thesis and complemented employing Lipsky (2010) street-level bureaucracy, which also focused on how policy was delivered in the real-world.

In addition, the widely used case study approach Yin (2009) enabled in-depth exploration of the PFs, across organisations, from strategic and operational levels and thus provided different perspectives in a real-life context. The highly structured framework (Yin, 2009) brought coherence to the study with the PFs as the embedded multiple units of analysis (figure 3.2), their locations (figure 3.3), participants from Trusts and HEI at strategic and operational levels (section 3.4) as well as the study questions (sections 2.7; 3.3.2).

To maintain **sincerity** throughout this study, consideration was afforded to maintaining objectivity throughout the study recognising the principal investigator positioning as an insider investigator (section 3.7.1). Participant invitation letter to take part in the study (appendix 4), participant information sheets (appendices 5-9) and semi-structured interview topic guides used for all participant groups are included in appendices (appendices 13-14). The strengths and limitation were considered and presented (section 6.4).

Credibility was maintained through the voices of participants being heard via careful reading of transcripts with excerpts selected to relay their input. Transcripts were subject to review by the study supervisors (section 3.8) to minimise researcher bias and increase the trustworthiness of the results. Care was taken to ensure quotes used were representative of all groups that took part. A recognised data analysis approach was used (Braun and Clarke, 2006) to generate the results (section 3.8).

Care has been taken to represent the qualitative narratives expressed in the results to meaningfully have **resonance** with the reader and convey insights to the results by careful naming of sub-themes, themes and the overarching theme. A new understanding of the PF role developed through critiquing and synthesising the results in the discussion chapter.

Significant contribution of new understandings of the PF role were developed where PFs, were revealed to operate as street-level bureaucrats (Lipsky, 2010). It was because they operated as street-level bureaucrats they had created and continued to

occupy the interstitial spaces (Funari, 2014) in the pre-registration nurse education in practice landscape (section 5.5; 5.6; 5.7).

Ethical approval for study was gained from the HEI and Trusts (section 3.7; appendix 15; appendices 16-19). Ethical principles were adhered to throughout the study. Insurance and indemnity for conducting the study on Trust premises was also approved (appendix 20). Participants' anonymity, privacy, confidentiality and data storage standards were adhered to (section 3.6). The principal investigator maintained objectivity during the interview process as well as preparation being made in the event of participant/s becoming upset (3.7; 3.7.1). Objectivity was also maintained in data analysis (section 3.8).

Meaningful coherence was attained as the aim of the research was achieved (section 6.2). The usefulness of case study methodology (section 6.4.2) allowed the explication of how the PFs operated successfully (chapter 4 and chapter 5). This brought a new understanding to the fore of how PF operated as street-level bureaucrats (Lipsky, 2010) and where they had created and occupied the interstitial spaces (Furnari, 2014) in pre-registration nurse education in practice landscape.

6.4.5 Limitations

There were some limitations of this study as it was conducted in one geographical location, thus potentially limiting the generalisability of this study. However, the consortium was a large area covering Acute, Mental Health and Community health services which to some extent ameliorates this geographical limitation (figure 3.3).

The recruitment strategy focussed on recruiting participants that had an input into pre-registration nurse education from Trusts and HEI at strategic and operational levels (chapter 3). Therefore, pre-registration nurse students', who may have been affected by the PF activities were not included. This means the student perspective have not been directly explored.

A further potential limitation of this study was that it was carried out by an 'insider' researcher. This aspect was carefully considered and arguments for and against were discussed (section 3.7.1). Nevertheless, being an insider was also advantageous as the principal investigator has an increased understanding (Kanuha, 2000) of how pre-registration was managed and delivered in health and education, enabling a more 'open dialogue' (Watson, 2016) and facilitating an in-depth understanding of the nuances of results. However, insider bias concerns were actively discussed with supervisors in order to explore any issues and maintain objectivity, as a researcher employing 'ethical self-consciousness' (Woods, 2006).

6.5 New knowledge gained

The aim of this study was to explore the way the PF role evolved in a real-world context over time and its impact on pre-registration nurse education in the consortium, using the lens of Lipsky's (2010) street-level bureaucracy policy implementation theory. This was a newly identified role arising from important policy statements in *Making a Difference* (DoH. 1999) and *Fitness for Practice* (UKCC, 1999), relating to meeting the workforce challenges confronting healthcare generally, and, pre-registration nurse education in practice in particular.

In researching the role by using a case study methodology (Yin, 2009) in one large metropolitan educational consortium area, a number of key contributions to understanding the role and how it impacts on pre-registration nurse education have been made. The new knowledge gained is outlined in the following sections.

6.5.1 Advancing street-level bureaucracy working across, between and within the Trusts and HEI

From a policy implementation perspective this study has shown several additional advancements to Lipskv's (2010) bottom-up policy implementation approach. Whilst Lipsky's (2010) street-level bureaucrats were low-level public service workers within a single organisation, PFs were found to work at both strategic and

operational levels. Thus, PFs had organisational authority and used their autonomy and discretion to influence how policy was delivered in a real-world context.

A further important advancement of Lipsky's (2010) street-level bureaucracy was the spaces where PFs operated across, between and within the Trusts and HEI. Furnari (2014) had described such spaces as 'interstitial spaces' where changes can happen and become embedded over time. PFs with their organisational authority and autonomy occupied the interstitial spaces between the Trusts and HEI. Utilising the sub-themes, themes and overarching theme, the purposes of each of these concepts were merged and integrated to generate a new set of purposes for street-level bureaucrats working in interstitial spaces (Furnari, 2014) between organisations (table 5.1). This new understanding was then used to guide the discussion of the literature (chapter 5).

6.5.2 Successes of the practice facilitator role working across, between and within the Trusts and HEI

The PF role has been shown through the results of this study to be highly effective in a real-world context over time. The role had evolved considerably from the way it was first conceived. PFs leadership positioning within both the Trusts and HEI was gained by their successful functioning. They had come to fill the long-known leadership void in pre-registration nurse education as identified by O'Driscoll *et al.*, (2010). They were ultimately found to be *de facto gatekeepers to the profession*.

From their position in pre-registration nurse education in practice they became an authoritative, influential voice of practice in academia. Over time, PFs developed a range of innovations including a live data management system for mapping placements and mentors. They then used this information to influence curriculum design and content to be more practice focussed.

The mentor support they devised was crucial to their success. By being on site, they were consistently available to mentors and students and over time, had developed a wide range of tailored support. This was critically the case in relation to situations

where students were experiencing difficulties in practice and supporting mentors in making challenging decisions in respect of practice assessment outcomes.

Importantly, as part of their efforts to maintain quality mentorship PFs were revealed to review mentor assessment decisions where students had subsequently been found to be underperforming. Mentor participants welcomed this innovation.

As their role developed PFs had filled the void left by LLs who were HEI based and limited in time availability. Thus, being readily available, PFs had largely taken over key aspects of the LL role. LLs themselves valued the support of the PFs as did HEI management.

6.6 Recommendations for future research

A number of areas warrant further research based on the results of this study.

6.6.1 Street-level bureaucracy (Lipsky, 2010) in the interstitial spaces (Furnari, 2014)

Explore the usefulness of this merged conceptualisation of how policy can be implemented between organisations at strategic and operational levels.

Confirm the purposes for street-level bureaucrats (Lipsky, 2010) working in the interstitial spaces (Furnari, 2014) through exploring other roles whose remit requires them to operate between organisations.

6.6.2 Practice facilitator role

Explore the other PF roles across the UK and their contribution to pre-registration nurse education. Suggested elements include role boundaries, permissions, authorities, exploration of mentor and student support and the interplay with the LL role.

6.6.3 Pre-registration student nurses

Explore the impact of the PF on the student experience in pre-registration nurse education.

Explore the quality of former students that are now employed in the healthcare environment that have been supported by the PF role.
Explore the impact on nursing students of PFs providing tailored mentor support, particularly in the assessment of underperforming students.

6.6.4 Practice facilitator mentor support

Explore the impact of the direct support provided for mentors in the assessment of underperforming students.

Explore the impact of PF support for mentors in tailoring support for underperforming students to help them succeed.

6.7 Key stakeholders' recommendations

Recommendations for UK policy makers, healthcare providers and pre-registration nurse education providers will be presented in this section.

6.7.1 Recommendations for UK policy makers

For all UK policy makers, when developing policies that generate new roles between organisations, consider the role holder as a street-level bureaucrat (Lipsky, 2010) operating in the interstitial spaces (Furnari, 2014). Embed features in the role that allow for working across, between and within organisations at strategic and operational levels with autonomy, discretion and authority.

For the NMC**,** formalise the PF role as demonstrated in this study as it has shown to be a particularly effective role from a practice perspective, to implement changes in pre-registration nurse education policy.

For the NMC, when considering pre-registration nurse education policy that generates new roles, consider the role holder as a street-level bureaucrat (Lipsky, 2010), operating in the interstitial spaces (Furnari, 2014). Embed features in the role that allow for working across, between and within organisations at strategic and operational levels with autonomy, discretion and authority.

6.7.2 Recommendations for UK healthcare providers

Develop clear boundaries for the various roles, between Trusts and HEIs, that support pre-registration nurse education, particularly in practice.

Evaluate the role features and scope of practice for each role and consider, for those working between Trusts and HEIs, to be street-level bureaucrats (Lipsky, 2010), operating in the interstitial spaces (Furnari, 2014). Embed features in the role that allow for working across, between and within organisations at strategic and operational levels with autonomy, discretion and authority.

When reviewing roles to support pre-registration nurse education, consider appointing PFs to lead and co-ordinate activities, particularly in regards to pre-registration nurse education in practice. Embed street-level bureaucracy (Lipsky, 2010) features that allow PFs to operate across, between and within Trusts and HEIs, at strategic and operational levels in the interstitial spaces (Furnari, 2014)

6.7.3 Recommendations for UK pre-registration nurse education providers

Develop clear boundaries for the various roles, between Trusts and HEIs, that support pre-registration nurse education, particularly in practice.

Evaluate the role features and scope of practice for each role and consider, for those working between Trusts and HEIs, to be street-level bureaucrats (Lipsky, 2010), operating in the interstitial spaces (Furnari, 2014). Embed features in the role that allow for working across, between and within organisations at strategic and operational levels with autonomy, discretion and authority.

When reviewing roles to support pre-registration nurse education, consider appointing PFs in the Trusts, to lead and co-ordinate activities, particularly in regards to pre-registration nurse education in practice. Embed street-level bureaucracy (Lipsky, 2010) features that allow them to operate across, between and within HEIs and Trusts, at strategic and operational levels in the interstitial spaces (Furnari, 2014)

6.8 Reflection of the role as researcher and personal learning

My role as a researcher in this study was embedded in a working lifetime of experiences as a registered nurse, and more laterally as an academic in a HEI. My interest in this study lay in exploring a research gap of professional relevance whilst improving my research ability.

Although I had started my research journey as a novice, I had a firm idea of the main research aim and questions that I wanted to answer. Consequently, this led me to explore methodologies which would be best suited to achieving this. Subsequently, this study was undertaken employing case study methodology. I was initially uncertain of selecting this approach as I had no previous experience of undertaking research. On reflection, I consider case study methodology to be the most suitable choice as it provided the framework to address my research aim and enabled me to answer my research questions. I have gained valuable experience in how to undertake qualitative research and thematic analysis. Although reading the literature on how to employ these processes and the reality of undertaking them was not a logical clear-cut process.

I now realise, when I first started this study, how unprepared I was for the journey ahead in terms of research knowledge. Completing this study process has been an invaluable learning experience for me. Extracts from my research journal which

facilitated my growth as a researcher is available in appendix 23. My experience in undertaking research in real-life has helped me grow in confidence, improved my skills as a researcher, my skills in critical analysis and in academic writing.

6.9 Dissemination strategy

It is my intention to disseminate the results of this study in order that they can add to current knowledge and understanding, be debated, inform and influence future pre-registration nurse education. Presentations of this study have taken place in the HEI. Plans to present this study to a wider HEI and healthcare audience working at strategic and operational levels are in progress. An event will be hosted for PFs to discuss the research results with role holders. Presentations at practice and education focussed conferences have been discussed and support has been secured from the employer's perspective. An article is in preparation for publication on PF role (Nurse Education Today).

6.10 Chapter and thesis summary

This first exploration of the way the practice facilitator role evolved in a real-world context over time and its impact on pre-registration nurse education employed an in-depth case study approach (Yin, 2009). Importantly, practice facilitatorss were required to work across distinctively different organisations, each responsible for delivering 50% of the pre-registration nurse education programme, but having different values, goals and ways of working. Using the lens of Lipsky's (2010) bottom-up approach to policy implementation within organisations gained important insights into the role. Thematic analysis (Braun and Clarke, 2006) revealed that the practice facilitators operated *in the frontline* where *everybody knows them and they know everybody* acting as *de facto gatekeepers to the profession* culminating in them becoming *the everything facilitator*.

From these results, it became apparent that practice facilitators as street-level bureaucrats (Lipsky, 2010) were able to successfully use their discretion to achieve a complex level of functioning, working in and occupying the spaces across, between

and within the Trusts and HEI at strategic and operational levels. Furnari's (2014) concept of working in the spaces between organisations which he termed 'interstitial spaces' has been used to further understand these results. Coalescing Furnari (2014) interstitial spaces with Lipsky's (2010) street-level bureaucracy in the light of these understandings, has provided the opportunity to advance street-level bureaucracy from within a single organisation to encompass working across, between and within organisations. This includes refining Lipsky's (2010) original purposes (section 5.2.1) incorporating Furnari's (2014) insights into the role catalysts play in interstitial spaces (table 5.1). The discussion in the previous chapter utilising these purposes to present the results in the context of the literature, underpins and confirms the usefulness of this advancement of Lipsky's (2010) bottom-up approach to policy implementation across, between and within organisations.

Finally, it is my sincere intention that this study will positively impact pre-registration nurse education, particularly in practice, thus contributing to good quality healthcare delivery, which affects each and every one on life's journey.

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Appendix 1 Practice facilitator post advertisement

PRACTICE FACILITATOR
'H' GRADE – FULL TIME/PART TIME JOB SHARE

Can you help us 'Make a Difference'

Do you want to ensure fitness to practice?

Apply to work as a Practice Facilitator to support the development of Student Nurses and Mentors.

There is one post available. Although based in PCT you will be working with partner Primary Care Trusts.

We are looking to recruit one Senior Nurse into this new post that has been funded by the

Working in collaboration with University, the Practice Facilitator is there to be a Trust based figurehead for Student Nurses and a support for Mentors in the management and care of students from a University and clinical perspective.

The posts are on a three year fixed term contract. For more information and informal visit please contact .

For an application form please contact:

Appendix 2 Summary of primary literature providing information on the methods, participants, sample numbers and posts funding/location resulting from *Making a Difference* (DoH, 1999) and *Fitness for Practice* (UKCC, 1999)

Author & Year	Methods, participants and sample number	Making a Difference (DoH, 1999)	Fitness for Practice (UKCC, 1999)	Funding / Location
Rowan & Barber (2000)	Questionnaire Student n=19 Questionnaire Ward Staff n=not stated Questionnaire College Tutors n=not stated Reflective Diary Clinical Facilitators n=6 Informal feedback Ward Staff n=not stated Informal feedback Students n=not stated Informal feedback Ward Managers n=not stated	X	X	Funding by Cheshire & Wirral Education & Training Consortium (Study explores 1 of these posts at East Cheshire NHS Trust)
Ellis & Hogard (2001)	Consortium questionnaire Service staff n=300 Response 60%(n=180) Students n=80 Response 38% (n=30) Tutors n=40 Response 38% (n=15) (Method found to be unsuitable. Data not analysed) Comparative analysis of outcomes of student assessment on clinical placement. Comparison between	X	X	Funding by Cheshire & Wirral Education & Training Consortium (Study by Chester College of Higher Education)

	students that had received clinical facilitation to those students that had not. **(Method found to be unsuitable. Data not analysed)** **Clinical facilitators** **Two in-depth individual interviews n=12** **Questionnaire n=13** **Higher education and service managers** **Interview n=5** **Questionnaire n=2** **Objective structured clinical examinations (OSCES) of** **Students n=50 Response 68% (n=34)** **(One student OSCE subsequently not included in results as did not meet inclusion criteria)** **Student** **Questionnaire n=not stated Response n=144** **Focus group** **Link tutors n=not stated (two focus groups)** **Questionnaire** **Link tutors n=16** **Consortium managers** **Interview n=not stated Response n=2** **Focus group** **Ward staff Group 1 n=6** **Ward staff Group 2 n=9**			

	Clinical staff **Questionnaire n=159 Response 26% (n=42)**			
Ellis & Hogard (2003)	**Comparison between students that had received clinical facilitation to those students that had not n=not stated** **(Method found to be unsuitable)** **Objective structured clinical examinations (OSCES) of** **Students n=57** **Of which** **Students who received clinical facilitation n=30 compared with** **Students who did not receive clinical facilitation n=27** **Clinical facilitators** **In-depth individual interviews n=12** **Focus groups n=12** **Questionnaire not stated** **Multiple stakeholders perspectives as follows;** **Clinical facilitators n=12 via** **Interviews not stated** **Focus groups not stated** **Questionnaire not stated** **University link tutors n=16 via** **Focus groups not stated** **Questionnaire not stated** **Ward staff n=150 via** **Focus groups not stated** **Questionnaire not stated** **Education managers n=7 via**	**X**	**X**	**Funding by Cheshire & Wirral Education & Training Consortium (though not stated in this study)**

	Interviews not stated **Questionnaire not stated** **Consortium managers n=2** **Interviews not stated** **Questionnaire not stated** **Students (who received clinical facilitation) n=600** **Focus group (one focus group) not stated** **Questionnaire not stated**			
Clarke *et al.* (2003)	**Total audited placement capacity to accommodate students calculated on a monthly basis across three Trusts over 18 month period including 6 months prior to introduction of PEF posts – Total audited capacity n = not stated** **Total number of pre-registration students present each month in each of the three Trusts calculated over 18 months n=not stated** **In a sample of clinical areas in each of the three Trusts maximum number of students present in any single week calculated n=not stated** **Questionnaire to all clinical areas, 2 occasions, to establish learner profile during two single weeks with a two month interval n=260** **Response on occasion one. 57% (n=149)** **Response on occasion two. 63% (n=163)**	**X**	**X**	**North East of England (3 Trusts)**

	In one of the three Trusts being studied staff working in 12 selected clinical areas received repeated questionnaires collecting data about all students passing through those areas during the study period as follows **Practitioners working directly with student nurses as mentors** **Four occasions** **Questionnaire 1. n=81 Response 43.2% (n=35)** **Questionnaire 2. n= 80 Response 35.0% (n=28)** **Questionnaire 3. n=72 Response 26.4% (n=19)** **Questionnaire 4. n=72 Response 29.2% (n=21)** **Ward managers** **Three occasions** **Questionnaire 1. n=13 Response 61.5% (n=8)** **Questionnaire 2. n=13 Response 46.2% (n=6)** **Questionnaire 3. n=13 Response 76.9% (n=10)** **Service managers** **Three occasions** **Questionnaire 1. n=7 Response 100% (n=7)** **Questionnaire 2. n=7 Response 57.1% (n=4)** **Questionnaire 3. n=7 Response 71.4% (n=5)** **Clinical liaison teachers** **Three occasions**			

	Questionnaire 1. n=9 Response 44.4% (n=4) **Questionnaire 2. n=7 Response 57.1% (n=4)** **Questionnaire 3. n=7 Response 71.4% (n=5)** **University placement office** **Four occasions** **Questionnaire 1. n=1 Response 100% (n=1)** **Questionnaire 2. n=1 Response 100% (n=1)** **Questionnaire 3. n=1 Response 100% (n=1)** **Questionnaire 4. n=1 Response 100% (n=1)** **Practice placement facilitators** **Six occasions** **Questionnaire 1. n=3 Response 100% (n=3)** **Questionnaire 2. n=3 Response 100% (n=3)** **Questionnaire 3. n=3 Response 100% (n=3)** **Questionnaire 4. n=3 Response 100% (n=3)** **Questionnaire 5. n=3 Response 100% (n=3)** **Questionnaire 6. n=3 Response (100%) n=3** **In one of the three Trusts where additional questionnaires had been collated all students from one Diploma in nursing studies cohort who had placements in the Trust invited to attend three focus groups.**			

	(Some students attended all 3 focus groups) **Nursing students n=20** **Focus group 1 n=14** **Focus group 2 n=5** **Focus group 3 n=13** **Information about evolving changes in role function focus groups** **Participants Practice placement facilitators n=3** **10 Focus groups held** **Clinical Liaison teacher focus group** **Focus group n=15 Attendance n=3** **Practice Placement Facilitator individual interviews** **Individual interviews n=3**			
Randal *et al.* (2005)	**One to One interviews** **Clinical placement development facilitators n=20** **Clinical placement development facilitators line Managers n=7** **Higher education Managers n=12** **Student representatives n=25** **Placement administrators n=7** **Questionnaire** **Mentors n=73** **Focus groups (5)** **Student representatives n = not stated**	**X**	**X**	**University of Nottingham, UK and Local National Health Service Queens Medical Centre, Nottingham**
Hyatt *et al.* (2008)	**Questionnaire Mentors n=45** **Response 100%**	**X**	**X**	**Funding via the National**

				Assembly for Wales
McArthur & Burns (2008)	**Ward managers / Clinical managers / Mentors (at commencement of practice education facilitator posts) Questionnaire n=150 Response 49% (n=73)** **Practice education facilitators. (Attend one of two focus groups upon commencement of posts) Focus groups n=15** **Practice education facilitators. (Attend one of two focus groups at twelve months into the project) Focus groups n=15** **Ward / clinical managers / mentors (Attend one of two focus groups at twelve months into the project) Focus groups n=15**			**Scottish Executive Health Department (Subsequently Scottish Government Health Directorates) NHS Education for Scotland, Higher Education Institutions and NHS Boards**
Carlisle *et al.* (2008)	**Practice education facilitators (Phase 1) Questionnaire n=118 Invitations Response 71% (n=84)** **First consensus conference Participants (key stakeholders including, PEFs, mentors, HEI representatives, clinical managers, students and PEF co-ordinators from all regions across Scotland) n=19** **Six case study sites (Phase 2) Student postal questionnaire Requests 148 Response 21% (n=31)**		**X**	**Scottish Executive Health Department (Subsequently Scottish Government Health Directorates) NHS Education for Scotland, Higher Education Institutions and NHS Boards**

	Mentor postal survey Requests 265 **Response 26% (n=69)** **Mentor face to face focus group n=31** **Telephone survey of key stakeholders, Request 105 (managers, students, mentors, registered nurses and midwives, representatives from HEIs 32% (n=34)** **Second consensus conference n=21**			
Carlisle *et al.* (2009)	**Practice education facilitators (Phase 1)** **Questionnaire 71% (n=84)** **First consensus conference Participants, (key stakeholders such as mentors, students, PEFs, managers) n=19** **Six case study sites (Phase 2)** **Pre and post registration student postal survey 21% (n=31)** **Mentor postal survey 26% (n=69)** **Mentor face to face focus group n=31** **Telephone survey of key stakeholders, including managers and mentors 32% (n=34)** **2nd consensus conference in case study sites n=21** **Participants (key stakeholders such as mentors, students, PEFs, managers)**		**X**	**Scottish Executive Health Department (Subsequently Scottish Government Health Directorates) NHS Scotland, NHS Education for Scotland, and NHS Boards and Higher Education Institutions**

Key N/S Not Stated

Appendix 3 Excluded literature

	Author(s)	Year	Post title	Summary of excluded papers
1	Andrews and Roberts	2003	Clinical Guide	Journal article
2	Andrews *et al.*	2006	No role identified	Students' perspectives of support in practice
3	Brennan and Hutt	2001	Clinical educator	Role focus – not a facilitator post
4	Burns and Paterson	2005	Personal tutor role	Role focus – not a facilitator post Journal article
5	Cameron *et al.*	2006	Practice education facilitators	Newly qualified
6	Carnwell *et al.*	2007	Lecturer Practitioner	Role focus – not a facilitator role
7	Dadge and Casey	2009	Clinical teacher	Journal article
8	Drennan	2002	Clinical placement co-ordinator	Role focus – not facilitator role Republic of Ireland
9	Edmond	2001	Clinical educators	Journal article
10	Gidman *et al.*	2011	No specific support role identified	Only student experiences reported
11	Jowett and McMullan	2007	Practice educator	Role focus – not a facilitator role
12	Kelly and Simpson	2001	Clinical practice facilitator	Role focus – newly qualified
13	Kelly *et al.*	2002	Clinical practice facilitator	Role focus – newly qualified

14	Lambert and Glacken	2004	Clinical support role/Clinical facilitator	Republic of Ireland – Journal article
15	Lambert and Glacken	2005	Clinical education facilitator	Republic of Ireland – Journal article
16	Lambert and Glacken	2006	Clinical education facilitators	Republic of Ireland. Post registration
17	Magnusson *et al.*	2007	Clinical placement manager	Not a new role Study look at placement capacity issues
18	Mallik and Aylott	2005	Practice educators/Clinical facilitator	UK and Australia. Clinical facilitator role Australia
19	Mallik and Hunt	2007	Practice educator	Role focus – not a facilitator role
20	McCormack and Slater	2006	Clinical education facilitator	Continual professional practice development Role focus – post registration
21	Milner *et al.*	2005	Clinical nurse educator	Role focus – not facilitator role Canadian study
22	Murray and Williamson	2009	Lead practice facilitator	No link to Making a Difference/Fitness for Practice
23	Myall *et al.*	2008	No role identified	British/Australian study
24	Nettleton and Bray	2008	No facilitation role identified	Views of mentorship generally
25	Robinson *et al.*	2012	Practice education facilitators	Focus on mentorship capacity Did not evaluate role
26	Rowe	2008	Practice educator	Journal article
27	Sanderson and Lee	2012	Clinical facilitator	Australia

28	Thomas	2002	Learning Community	Journal article
29	Turner	2001	Clinical placement support unit	Journal article
30	Walsh and Jones	2005	Clinical placement co-ordinator	Role focus – not a facilitator post Journal article
31	Widlake	2002	Practice facilitator	Role focus – newly qualified – Journal article
32	Wilkins and Ellis	2004	Clinical education facilitator	Journal article
33	Williamson and Webb	2001	Lecturer practitioner/ Clinical facilitator	Role focus - Post registration
34	Williamson *et al.*	2010	Placement development team	Baseline assessment before new Placement development team began
35	Wood *et al.*	2011	Clinical practice facilitator	No link to Making a Difference/Fitness for Practice – Journal article

Appendix 4 Invitation letter to take part in the research

London South Bank
University

Marie Horgan,
Work address

Tel No: XXXX
E-Mail: XXXX@lsbu.ac.uk

Date

Dear

Re: The Practice Facilitator Role: it's Impact on Pre-Registration Nurse Education.

I am writing to invite you to take part in a study that I am undertaking. As you may be aware, the role of practice facilitator was introduced in the late 1990s to support Pre-Registration nurse education. I am undertaking a PhD study into the impact this role has had on Pre-Registration nurse education in the XXXX health sector. I am a registered nurse and work in healthcare education as a lecturer at London South Bank University.

The study will include one-to-one interviews with practice facilitators, NHS Trust Education Leads and Higher Education Institution Heads of Departments. Mentors and Link Lecturers will be invited to take part in focus groups.

I have enclosed an information sheet which explains what being involved will mean for you. If you have any questions please do not hesitate to contact me or my

supervisors to discuss. My details and those of my supervisors are on the enclosed information sheet.

I will contact you in the near future to find out if you are interested in taking part in the study and discuss how we can take this forward.

Thank you for taking the time to read this letter.

Yours sincerely,
Marie Horgan.

Appendix 5 Participant information sheet Practice Facilitator

London South Bank University

Participant Information Sheet
Practice Facilitator

The Practice Facilitator Role: it's Impact on Pre-Registration Nurse Education.

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

Ask me, the researcher, if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

The aim of the research study is to explore the role of the Practice Facilitator and the impact this role has had on Pre-Registration nurse education over time.

You have been chosen to be invited to participate in this study as you currently hold the position / have held the position of Practice Facilitator in XXXX. In total approximately 36 people will be included in the study.

It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. No data on findings will be published before the submission of the thesis.

You are free to withdraw from the study, without giving a reason and not have your information included at any time up to the time of submission of the thesis. However, after that time, it would be impossible for the researcher to comply.

If you are willing to participate, the researcher will arrange to meet with you either in your Trust or at London South Bank University for one interview, lasting approximately one hour, at a mutually agreeable date and time. The study is planned to last five years but your involvement will be for one interview. During the interview, the researcher will explore with you the key elements of your post. For ease of later analysis, the researcher, will audio record the discussion as well as take notes.

It is not anticipated that you will be at any disadvantage or suffer any risk from this study. Should a participant become upset during the one to one interview, the researcher will pause the interview and discuss in a supportive manner if the participant wishes to stop, pause, or reconvene the interview at a mutually agreed time. If the participant wishes to continue, the researcher will resume the interview.

If the participant wishes to pause for a while this will be facilitated as will reconvening at a mutually agreed time.

When the interview has been completed the researcher will discuss the experience with the participant to ensure appropriate support is accessed if required.

Should a significant issue in relation to practice become evident during the interview, the researcher will discuss this further with you in relation to organisational policies, procedures and Nursing and Midwifery Council guidance.

It is unlikely that you will gain any personal benefit from participating in this research. However, the information you share with the researcher will contribute to the further understanding of the role of the Practice Facilitator and it's impact on Pre-Registration nurse education over time. Some individuals may gain some benefit from having the opportunity to discuss their role and how it has functioned with a receptive listener.

All information received from you will be handled in a confidential manner and stored in a locked filing cabinet and on a password protected computer in an environment which is locked when not occupied. An encrypted data stick will be used to store data. Only the researcher and supervisors will have direct access to the information. Any reference to you will be coded and you will not be identifiable from information included in the thesis. Information will be held for five years following submission of the thesis and then destroyed in a confidential manner.

This study is designed to fulfil the requirements for a PhD at London South Bank University. It has been reviewed and ethically approved by the London South Bank University Research Ethics Committee. National Health Service (NHS) Research Governance approval has also been obtained.

If you have a concern about any aspect of this study, you should ask to speak with the researcher and I will do my best to answer your questions.

My contact details are;

Marie Horgan

Work address

Telephone number: XXXX
E-mail address: XXXX@lsbu.ac.uk

If you wish any further information regarding this study or have any complaints about the way you have been dealt with during the study or other concerns you can contact the Academic Supervisors for this study as follows:

Professor Director of studies
Telephone number: XXXX E-mail: XXXX@lsbu.ac.uk
or
Dr. XXXX

Telephone number: XXXX E-mail: XXXX@lsbu.ac.uk

Finally, if you remain unhappy and wish to complain formally, you can contact the Chair of the University Research Ethics Committee. Details can be obtained from the university website: http://www.lsbu.ac.uk/rbdo/external/index.shtml

Appendix 6 Participant information sheet Education Lead

London South Bank
University

Participant Information Sheet
Education Lead

The Practice Facilitator Role: it's Impact on Pre-Registration Nurse Education.

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

Ask me, the researcher, if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

The aim of the research study is to explore the role of the Practice Facilitator and the impact this role has had on Pre-Registration nurse education over time.

You have been chosen to be invited to participate in this study as you currently hold the position / have held the position of Education Lead XXXX. In total approximately 36 people will be included in the study.

It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. No data on findings will be published before the submission of the thesis.

You are free to withdraw from the study, without giving a reason and not have your information included at any time up to the time of submission of the thesis. However, after that time, it would be impossible for the researcher to comply.

If you are willing to participate, the researcher will arrange to meet with you either in your Trust or at London South Bank University for one interview, lasting approximately one hour, at a mutually agreeable date and time. This study is planned to last five years but your involvement will be for one interview. During the interview, the researcher will explore with you the key elements of the Practice Facilitator post. For ease of later analysis, the researcher will audio record the discussion as well as take notes.

It is not anticipated that you will be at any disadvantage or suffer any risk from this study. Should a participant become upset during the one to one interview, the researcher will pause the interview and discuss in a supportive manner if the participant wishes to stop, pause, or reconvene the interview at a mutually agreed time. If the participant wishes to continue, the researcher will resume the interview. If the participant wishes to pause for a while this will be facilitated as will reconvening at a mutually agreed time.

When the interview has been completed the researcher will discuss the experience with the participant to ensure appropriate support is accessed if required.

Should a significant issue in relation to practice become evident during the interview, the researcher will discuss this further with you in relation to organisational policies, procedures and Nursing and Midwifery Council guidance.

It is unlikely that you will gain any personal benefit from participating in this research. However, the information you share with the researcher will contribute to the further understanding of the role of the Practice Facilitator and it's impact on Pre-Registration nurse education over time.

All information received from you will be handled in a confidential manner and stored in a locked filing cabinet and on a password protected computer in an environment which is locked when not occupied. An encrypted data stick will be used to store data. Only the researcher and supervisors will have direct access to the information. Any reference to you will be coded and you will not be identifiable from information included in the thesis. This information will be held for five years following submission of the thesis and then destroyed in a confidential manner.

This study is designed to fulfil the requirements for a PhD at London South Bank University. It has been reviewed and ethically approved by the London South Bank University Research Ethics Committee. National Health Service (NHS) Research Governance approval has also been obtained.

If you have a concern about any aspect of this study, you should ask to speak with the researcher and I will do my best to answer your questions.

My contact details are;

Marie Horgan

Work address

Telephone number: XXXX
E-mail address: XXXX@lsbu.ac.uk

If you wish any further information regarding this study or have any complaints about the way you have been dealt with during the study or other concerns you can contact the Academic Supervisors for this study as follows:

Professor Director of studies
Telephone number: XXXX E-mail: XXXX@lsbu.ac.uk
or
Dr. Supevisor
Telephone number: XXXX E-mail: XXXX@lsbu.ac.uk

Finally, if you remain unhappy and wish to complain formally, you can contact the Chair of the University Research Ethics Committee. Details can be obtained from the university website: http://www.lsbu.ac.uk/rbdo/external/index.shtml

Appendix 7 Participant information sheet Head of Department

London South Bank University

Participant Information Sheet
Head of Department

The Practice Facilitator Role: it's Impact on Pre-Registration Nurse Education.

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

Ask me, the researcher, if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

The aim of the research study is to explore the role of the Practice Facilitator and the impact this role has had on Pre-Registration nurse education over time.

You have been chosen to be invited to participate in this study as you currently hold the position / have held the position of Head of Department at London South Bank University. In total approximately 36 people will be included in the study.

It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. No data on findings will be published before the submission of the thesis.

You are free to withdraw from the study, without giving a reason and not have your information included at any time up to the time of submission of the thesis. However, after that time, it would be impossible for the researcher to comply.

If you are willing to participate, the researcher will arrange to meet with you either in your Trust or at London South Bank University for one interview, lasting approximately one hour, at a mutually agreeable date and time. This study is planned to last five years but your involvement will be for one interview. During the interview, the researcher will explore with you the key elements of the Practice Facilitator post. For ease of later analysis, the researcher will audio record the discussion as well as take notes.

It is not anticipated that you will be at any disadvantage or suffer any risk from this study. Should a participant become upset during the one to one interview, the researcher will pause the interview and discuss in a supportive manner if the participant wishes to stop, pause, or reconvene the interview at a mutually agreed time. If the participant wishes to continue, the researcher will resume the interview.

If the participant wishes to pause for a while this will be facilitated as will reconvening at a mutually agreed time.

When the interview has been completed the researcher will discuss the experience with the participant to ensure appropriate support is accessed if required.

Should a significant issue in relation to practice become evident during the interview, the researcher will discuss this further with you in relation to organisational policies, procedures and Nursing and Midwifery Council guidance.

It is unlikely that you will gain any personal benefit from participating in this research. However, the information you share with the researcher will contribute to the further understanding of the role of the Practice Facilitator and it's impact on Pre-Registration nurse education over time.

All information received from you will be handled in a confidential manner and stored in a locked filing cabinet and on a password protected computer in an environment which is locked when not occupied. An encrypted data stick will be used to store data. Only the researcher and supervisors will have direct access to the information. Any reference to you will be coded and you will not be identifiable from information included in the thesis. This information will be held for five years following submission of the thesis and then destroyed in a confidential manner.

This study is designed to fulfil the requirements for a PhD at London South Bank University. It has been reviewed and ethically approved by the London South Bank University Research Ethics Committee. National Health Service (NHS) Research Governance approval has also been obtained.

If you have a concern about any aspect of this study, you should ask to speak with the researcher and I will do my best to answer your questions.

My contact details are;

Marie Horgan

Work address

Telephone number: XXXX
E-mail address: XXXX@lsbu.ac.uk

If you wish any further information regarding this study or have any complaints about the way you have been dealt with during the study or other concerns you can contact the Academic Supervisors for this study as follows:

Professor Director of studies
Telephone number: XXXX E-mail: XXXX@lsbu.ac.uk
or
Dr. Supervisor
Telephone number: XXXX E-mail: XXXX@lsbu.ac.uk

Finally, if you remain unhappy and wish to complain formally, you can contact the Chair of the University Research Ethics Committee. Details can be obtained from the university website: http://www.lsbu.ac.uk/rbdo/external/index.shtml

Appendix 8 Participant information sheet link lecturer focus group

London South Bank
University

Participant Information Sheet
Link Lecturer Focus Group

The Practice Facilitator Role: it's Impact on Pre-Registration Nurse Education.

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

Ask me, the researcher, if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

The aim of the research study is to explore the role of the Practice Facilitator and the impact this role has had on Pre-Registration nurse education over time.

You have been chosen to be invited to participate in this study as you currently hold the role of Link Lecturer at London South Bank University. In total approximately 36 people will be included in the study.

It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. No data on findings will be published before the submission of the thesis.

You are free to withdraw from the study, without giving a reason and not have your information included at any time up to the time of submission of the thesis. However, after that time, it would be impossible for the researcher to comply.

If you are willing to participate, the researcher will arrange to meet with you and other Link Lecturers at London South Bank University for one Focus Group, lasting approximately one hour, at a mutually agreeable date and time. This study is planned to last five years but your involvement will be for one interview. During the Focus Group, the researcher will explore with the group key elements of the Practice Facilitator post. For ease of later analysis, the researcher will audio record the discussion. The researcher will work with an observer, who will have signed a confidentiality document and who will take notes during the discussion in order to support data capture.

It is not anticipated that you will be at any disadvantage or suffer any risk from this study. Should a participant become upset during the one to one interview, the researcher will pause the interview and discuss in a supportive manner if the participant wishes to stop, pause, or reconvene the interview at a mutually agreed

time. If the participant wishes to continue, the researcher will resume the interview. If the participant wishes to pause for a while this will be facilitated as will reconvening at a mutually agreed time.

When the interview has been completed the researcher will discuss the experience with the participant to ensure appropriate support is accessed if required.

Should a significant issue in relation to practice become evident during the Focus Group, the researcher will discuss this further with the group in relation to organisational policies, procedures and Nursing and Midwifery Council guidance.

It is unlikely that you will gain any personal benefit from participating in this research. However, the information you share with the researcher will contribute to the further understanding of the role of the Practice Facilitator and it's impact on Pre-Registration nurse education over time.

All information received from you will be handled in a confidential manner and stored in a locked filing cabinet and on a password protected computer in an environment which is locked when not occupied. An encrypted data stick will be used to store data. Only the researcher and supervisors will have direct access to the information. Any reference to you will be coded and you will not be identifiable from information included in the thesis. This information will be held for five years following submission of the thesis and then destroyed in a confidential manner.

This study is designed to fulfil the requirements for a PhD at London South Bank University. It has been reviewed and ethically approved by the London South Bank University Research Ethics Committee. National Health Service (NHS) Research Governance approval has also been obtained.

If you have a concern about any aspect of this study, you should ask to speak with the researcher and I will do my best to answer your questions.

My contact details are;

Marie Horgan

Work address

Telephone number: XXXX
E-mail address: XXXX@lsbu.ac.uk

If you wish any further information regarding this study or have any complaints about the way you have been dealt with during the study or other concerns you can contact the Academic Supervisors for this study as follows:

Professor Director of studies
Telephone number: XXXX E-mail: XXXX@lsbu.ac.uk
or
Dr. Supervisor
Telephone number: XXXX E-mail: XXXX@lsbu.ac.uk

Finally, if you remain unhappy and wish to complain formally, you can contact the Chair of the University Research Ethics Committee. Details can be obtained from the university website: http://www.lsbu.ac.uk/rbdo/external/index.shtml

Appendix 9 Participant information sheet mentor focus group

London South Bank University

Participant Information Sheet
Mentor Focus Group

The Practice Facilitator Role: it's Impact on Pre-Registration Nurse Education.

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

Ask me, the researcher, if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

The aim of the research study is to explore the role of the Practice Facilitator and the impact this role has had on Pre-Registration nurse education over time.

You have been chosen to be invited to participate in this study as you currently hold the role of Mentor for Pre-Registration nurse students. In total approximately 36 people will be included in the study.

It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. No data on findings will be published before the submission of the thesis.

You are free to withdraw from the study, without giving a reason and not have your information included at any time up to the time of submission of the thesis. However, after that time, it would be impossible for the researcher to comply.

If you are willing to participate, the researcher will arrange to meet with you and other Mentors, either in your Trust or at London South Bank University for one Focus Group, lasting approximately one hour, at a mutually agreeable date and time. This study is planned to last five years but your involvement will be for one interview. During the Focus Group, the researcher will explore with the group key elements of the Practice Facilitator post. For ease of later analysis, the researcher will audio record the discussion. The researcher will work with an observer, who will have signed a confidentiality document and who will take notes during the discussion in order to support data capture.

It is not anticipated that you will be at any disadvantage or suffer any risk from this study. Should a participant become upset during the one to one interview, the researcher will pause the interview and discuss in a supportive manner if the participant wishes to stop, pause, or reconvene the interview at a mutually agreed

time. If the participant wishes to continue, the researcher will resume the interview. If the participant wishes to pause for a while this will be facilitated as will reconvening at a mutually agreed time.

When the interview has been completed the researcher will discuss the experience with the participant to ensure appropriate support is accessed if required.

Should a significant issue in relation to practice become evident during the Focus Group, the researcher will discuss this further with the group in relation to organisational policies, procedures and Nursing and Midwifery Council guidance.

It is unlikely that you will gain any personal benefit from participating in this research. However, the information you share with the researcher will contribute to the further understanding of the role of the Practice Facilitator and it's impact on Pre-Registration nurse education over time.

All information received from you will be handled in a confidential manner and stored in a locked filing cabinet and on a password protected computer in an environment which is locked when not occupied. An encrypted data stick will be used to store data. Only the researcher and supervisors will have direct access to the information. Any reference to you will be coded and you will not be identifiable from information included in the thesis. This information will be held for five years following submission of the thesis and then destroyed in a confidential manner.

This study is designed to fulfil the requirements for a PhD at London South Bank University. It has been reviewed and ethically approved by the London South Bank University Research Ethics Committee. National Health Service (NHS) Research Governance approval has also been obtained.

If you have a concern about any aspect of this study, you should ask to speak with the researcher and I will do my best to answer your questions.

My contact details are;

Marie Horgan

Work address.

Telephone number: XXXX
E-mail address: XXXX@lsbu.ac.uk

If you wish any further information regarding this study or have any complaints about the way you have been dealt with during the study or other concerns you can contact the Academic Supervisors for this study as follows:

Professor Director of studies
Telephone number: XXXX E-mail: XXXXl@lsbu.ac.uk
or
Dr. Supervisor
Telephone number: XXXX E-mail: XXXX@lsbu.ac.uk

Finally, if you remain unhappy and wish to complain formally, you can contact the Chair of the University Research Ethics Committee. Details can be obtained from the university website: http://www.lsbu.ac.uk/rbdo/external/index.shtml

Appendix 10 Consent form one to one interview

London South Bank
University

CONSENT FORM
One to One Interview

The Practice Facilitator Role: it's Impact on Pre-Registration Nurse Education.

I have read the attached participant information sheet on the research in which I have been asked to participate and have been given a copy to keep. I have had the opportunity to discuss the details and ask questions about this information.

The researcher has explained the nature and purpose of the research and I believe that I understand what is being proposed.

I understand that my personal involvement and my particular data from this study will remain strictly confidential. Any reference to myself will be coded and information which might identify me as a participant will not be used in order to ensure my anonymity.

I have been informed about what the data collected in this investigation will be used for, to whom it may be disclosed, and how long it will be retained.

I understand that I am free to withdraw from the study at any time, without giving a reason for withdrawing.

I agree for the interview being audio recorded.

I hereby fully and freely consent to participate in the study.

Participant's Name: (Block Capitals) …….

Participant's Signature: ……..

Date: …….

As the researcher responsible for this study I confirm that I have explained to the participant named above the nature and purpose of the research to be undertaken.

Researcher's Name: ……

Researcher's Signature: ……..

Date: ……..

Appendix 11 Consent form link lecturer focus group

London South Bank
University

CONSENT FORM
Link Lecturer Focus Group

The Practice Facilitator Role: it's Impact on Pre-Registration Nurse Education.

I have read the attached participant information sheet on the research in which I have been asked to participate and have been given a copy to keep. I have had the opportunity to discuss the details and ask questions about this information.

The researcher has explained the nature and purpose of the research and I believe that I understand what is being proposed.

I understand that my personal involvement and my particular data from this study will remain strictly confidential. Any reference to myself will be coded and information which might identify me as a participant will not be used in order to ensure my anonymity.

I have been informed about what the data collected in this investigation will be used for, to whom it may be disclosed, and how long it will be retained.

I understand that I am free to withdraw from the study at any time, without giving a reason for withdrawing.

I agree for the focus group to be audio recorded.

I hereby fully and freely consent to participate in the study.

Participant's Name: (Block Capitals) …….

Participant's Signature: ……..

Date: …….

Participants Identification Code: …….

As the researcher responsible for this study I confirm that I have explained to the participant named above the nature and purpose of the research to be undertaken. The researcher will work with an observer who will have signed a confidentiality form and who will take notes during the discussion in order to support data capture.

Researcher's Name: …….
Researcher's Signature:……
Date: ……

Appendix 12 Consent form mentor focus group

London South Bank
University

CONSENT FORM
Mentor Focus Group

The Practice Facilitator Role: it's Impact on Pre-Registration Nurse Education.

I have read the attached information sheet on the research in which I have been asked to participate and have been given a copy to keep. I have had the opportunity to discuss the details and ask questions about this information.

The researcher has explained the nature and purpose of the research and I believe that I understand what is being proposed.

I understand that my personal involvement and my particular data from this study will remain strictly confidential. Any reference to myself will be coded and information which might identify me as a participant will not be used in order to ensure my anonymity.

I have been informed about what the data collected in this investigation will be used for, to whom it may be disclosed, and how long it will be retained.

I understand that I am free to withdraw from the study at any time, without giving a reason for withdrawing.

I agree for the focus group to be audio recorded.

I hereby fully and freely consent to participate in the study.

Participant's Name: (Block Capitals):…….
Participant's Signature:…….
Date: ……
Participants Identification Code: ……

As the researcher responsible for this study I confirm that I have explained to the participant named above the nature and purpose of the research to be undertaken. The researcher will work with an observer who will have signed a confidentiality form and who will take notes during the discussion in order to support data capture.

Researcher's Name: ……
Researcher's Signature: ……..
Date: ……..

Appendix 13 Topic guide for one to one semi-structured interviews: practice facilitators, education leads, heads of department

Topic Guide for one to one semi structured interviews.
Practice Facilitators / Education Leads / Heads of Department

Can you tell me why the Practice Facilitator role was established?

Can you tell me about your role as Practice Facilitator?
Prompts How long have you been in post?
What is the focus of your role?
What are the key elements of your role?

Has the focus of the role changed over time?
Prompts If so, can you describe what elements have changed?
When did the changes happen?
Do you know why the changes happened?
Who and what drives these changes?

Have key elements of the role stayed the same over time?
Prompts If so, can you tell me what these are?
Why do you think these elements have stayed the same?

What do you think has been the impact of the Practice Facilitator on Pre-Registration nurse education in the North East London health sector?
Prompts Can you describe in what area/s the role has had an impact?
What factors support the impact of the role?
What factors hinder the impact of the role?

How do you think your role impacts on Pre-Registration nurse education in your organisation?
Prompt Can you give me examples of any impact made?
What factors support the impact of the role?
What factors hinder the impact of the role?

Do you work with other Practice Facilitators across North East London?
Prompts What is the purpose of working with other Practice Facilitators?
What areas do you work on with other Practice Facilitators?
Is this on a regular basis? If so, why?
How does working with other Practice Facilitators have an impact on Pre-registration nurse education?
Can you give me examples of any impact made in your organisation?
Can you give me examples of any impact made in other organisations?

Do you think your role has an effect on the Education Lead in your organisation?
Prompts If so, describe

Do you think this is important?
If yes, can you tell me why?

Do you think your role has an effect on the post of Head of Department at London South Bank University?
Prompts If so, describe
Do you think this is important?
If yes, can you tell me why?

Do you think your role has an effect on the Mentor role?
Prompts If so, describe
Do you think this is important?
If yes, can you tell me why?

Do you think your role has an effect on the Link Lecturer role?
Prompts If so, describe
Do you think this is important?
If yes, can you tell me why?

Is the role valuable for Pre-Registration nurse education?
Prompts If so, can you tell me why?

Appendix 14 Topic guide for focus group interviews: link lecturers, mentors

Topic Guide for focus groups.
Link lecturers / Mentors

Can you tell me why the Practice Facilitator role was established?

Can you tell me about the role of the Practice Facilitator?
Prompts How long have the Practice Facilitators been in post?
What is the focus of the role?
What are the key elements of the role?

Has the focus of the role changed over time?
Prompts If so, can you describe what elements have changed?
When did the changes happen?
Do you know why the changes happened?
Who and what drives these changes?

Have key elements of the role stayed the same over time?
Prompts If so, can you tell me what these are?
Why do you think these elements have stayed the same?

What do you think has been the impact of the Practice Facilitator on Pre-Registration nurse education in the North East London health sector?
Prompts Can you describe in what area/s the role has had an impact?
What factors support the impact of the role?
What factors hinder the impact of the role?

How do you think the Practice Facilitator role impacts on Pre-Registration nurse education in your organisation?
Prompts Can you give me examples of any impact made?
What factors support the impact of the role?
What factors hinder the impact of the role?

Does your Practice Facilitator work with other Practice Facilitators across North East London?
Prompts What is the purpose of working with other Practice Facilitators?
What areas do they work on with other Practice Facilitators?
Is this on a regular basis? If so, why?
How does working with other Practice Facilitators have an impact on Pre-registration nurse education?
Can you give me examples of any impact made in your organisation?
Can you give me examples of any impact made in other organisations?

Do you think the role has an effect on the Education Lead in your organisation?
Prompts If so, describe
Do you think this is important?
If yes, can you tell me why?

Do you think your role has an effect on the post of Head of Department at London South Bank University?
Prompts If so, describe
Do you think this is important?
If yes, can you tell me why?

Do you think the role has an effect on the Mentor role?
Prompts If so, describe
Do you think this is important?
If yes, can you tell me why?

Do you think the role has an effect on the Link Lecturer role?
Prompts If so, describe
Do you think this is important?
If yes, can you tell me why?

Is the role valuable for Pre-Registration nurse education?
Prompts If so, can you tell me why?

Appendix 15 HEI research ethics committee research approval

London South Bank University

Direct line: xxxxx
E- mail: xxx@lsbu.ac.uk Ref:
UREC 1241

Marie Horgan

Dear Marie,

Re: The Practice Facilitator Role: its Impact on Pre-Registrtation Nurse Education (UREC number 1241)

Thank you for submitting this proposal and for your response to the reviewers' comments.

I am pleased to inform you that your application to the University Research Ethics Committee for the above study has been reviewed. The Chair is able to confirm that the study was completed in keeping with the London South Bank University Code of Practice for Research with Human Participants.

I wish you every success with your research.

Yours sincerely,

XXXX
Secretary, LSBU Research Ethics Committee

cc:

Prof Director of studies, Chair, LSBU Research Ethics Committee

Appendix 16 Integrated research application system (IRAS) completed document

NHS R&D Form IRAS Version 3.5

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
The PF Role: it's Impact on Pre-Reg Nurse Education Oct 12 Ver 2.0

1. Is your project research?

(●) Yes ( ) No

2. Select one category from the list below:

( ) Clinical trial of an investigational medicinal product
( ) Clinical investigation or other study of a medical device
( ) Combined trial of an investigational medicinal product and an investigational medical device
( ) Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
( ) Basic science study involving procedures with human participants
(●) Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
( ) Study involving qualitative methods only
( ) Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
( ) Study limited to working with data (specific project only)
( ) Research tissue bank
( ) Research database

If your work does not fit any of these categories, select the option below:

( ) Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	( ) Yes	(●) No
b) Will you be taking new human tissue samples (or other human biological samples)?	( ) Yes	(●) No
c) Will you be using existing human tissue samples (or other human biological samples)?	( ) Yes	(●) No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

[✓] England
[ ] Scotland
[ ] Wales
[ ] Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

- (●) England
- ( ) Scotland
- ( ) Wales
- ( ) Northern Ireland
- ( ) This study does not involve the NHS

4. Which review bodies are you applying to?

- [x] NHS/HSC Research and Development offices
- [ ] Social Care Research Ethics Committee
- [x] Research Ethics Committee
- [ ] National Information Governance Board for Health and Social Care (NIGB)
- [ ] National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D offices, the CI must create Site-Specific Information Forms for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.

5. Will any research sites in this study be NHS organisations?

(●) Yes ( ) No

5a. Are all the research costs and infrastructure costs for this study provided by an NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC) or NIHR Research Centre for Patient Safety & Service Quality in all study sites?

( ) Yes (●) No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP).

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) support and inclusion in the NIHR Clinical Research Network (CRN) Portfolio? Please see information button for further details.

( ) Yes (●) No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP) and you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form immediately after completing this project filter and before completing and submitting other applications.

6. Do you plan to include any participants who are children?

( ) Yes (●) No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

( ) Yes (●) No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the NIGB Ethics and Confidentiality Committee to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ◉ No

9. Is the study or any part of it being undertaken as an educational project?

◉ Yes ○ No

Please describe briefly the involvement of the student(s):
The Chief Investigator is the student who is completing an MPhil/Phd study at London South Bank University

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

◉ Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ◉ No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ◉ No

Integrated Research Application System
Application Form for Research administering questionnaires/interviews for quantitative analysis or mixed methodology study

NHS/HSC R&D Form (project information)

Please refer to the Submission and Checklist tabs for instructions on submitting R&D applications.

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
The PF Role: it's Impact on Pre-Reg Nurse Education Oct 12 Ver 2.0

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

The Practice Facilitator Role: it's Impact on Pre-Registration Nurse Education
October 2012 Version 2.0

A2-1. Educational projects

Name and contact details of student(s):

Student 1

Title	Forename/Initials	Surname
Miss	Marie	Horgan

Address [redacted]

Post Code

E-mail [redacted]

Telephone

Fax

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
MPhil/PhD

Name of educational establishment:
London South Bank University

Name and contact details of academic supervisor(s):

Academic supervisor 1

	Title	Forename/Initials	Surname
	[redacted]		[redacted]

Address	London South Bank University
	[redacted]
	[redacted]
Post Code	[redacted]
E-mail	[redacted]
Telephone	[redacted]
Fax	

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	Academic supervisor(s)
Student 1 Miss Marie Horgan	☐ [redacted]

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

- ◉ Student
- ○ Academic supervisor
- ○ Other

A3-1. Chief Investigator:

	Title	Forename/Initials	Surname
	Miss	Marie	Horgan

Post	
Qualifications	[redacted]
Employer	[redacted]
Work Address	[redacted]
Post Code	[redacted]
Work E-mail	[redacted]
* Personal E-mail	
Work Telephone	[redacted]
* Personal Telephone/Mobile	
Fax	

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and R&D reviewers that is sent to the CI.

	Title	Forename/Initials	Surname
	[redacted]		[redacted]
Address	[redacted]		
	[redacted]		
	[redacted]		
Post Code	[redacted]		
E-mail	[redacted]		
Telephone	[redacted]		
Fax			

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	UREC1241
Sponsor's/protocol number:	Not applicable
Protocol Version:	2.0
Protocol Date:	12/10/2012
Funder's reference number:	Not applicable
Project website: Not applicable	

Additional reference number(s):

Ref.Number Description	Reference Number

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

○ Yes ◉ No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, this summary will be published on the website of the National Research Ethics Service following the ethical review.*

The Practice Facilitator role was established in the late 1990s to support Pre-Registration nurse education at a time of change in education and health care delivery. This study seeks to explore the role of Practice Facilitators in North East London and their impact on Pre-Registration nurse education.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, R&D office or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

Potential that participants may reveal poor or unsafe practice. If this should happen the researcher will follow local NHS Trust and University policies.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply:*

- ☐ Case series/ case note review
- ☐ Case control
- ☐ Cohort observation
- ☐ Controlled trial without randomisation
- ☐ Cross-sectional study
- ☐ Database analysis
- ☐ Epidemiology
- ☐ Feasibility/ pilot study
- ☐ Laboratory study
- ☐ Metanalysis
- ☑ Qualitative research
- ☑ Questionnaire, interview or observation study
- ☐ Randomised controlled trial
- ☐ Other (please specify)

Case study

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

Research questions are;

1. What was the rationale for the introduction of the role of the Practice Facilitator?
2. How has the role of the Practice Facilitator changed over time?
3. How does the Practice Facilitator role function across a range of organisations?
4. How has the role of the Practice Facilitator impacted on Pre-Registration nurse education?
5. What effect has the role of the Practice Facilitator had on other key roles contributing to Pre-Registration nurse education?

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

Not applicable

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

No work has been completed on long term effect of these posts. Therefore reviewing the long term impact of these posts on Pre-Registration nurse education.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person.*

Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.

This research study is using a multiple case, mixed methods research methodology. This design has been selected as it enables the chief investigator to examine the role of the Practice Facilitator individually and as a post role across organisations.

Three primary data collection methods will be used which are
documentary analysis, one to one semi-structured interviews and focus groups.

Documents relating to Pre-Registration nurse education including those sourced from the Department of Health, Regulatory Body, NHS Trusts, Higher Education Institutions and other relevant organisations will be analysed.

One to one semi-structured interviews will be undertaken with Practice Facilitators, Education Leads and Heads of Department. Each participant will be invited to take part in one interview each for approximately one hour on one occassion.

Focus groups will be scheduled for Mentors and Link Lecturers. Each participant will be invited to take part in one interview each for approximately one hour on one occassion.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

- ☐ Design of the research
- ☐ Management of the research
- ☐ Undertaking the research
- ☐ Analysis of results
- ☐ Dissemination of findings
- ☑ None of the above

Give details of involvement, or if none please justify the absence of involvement.
The study question is focussed on the education of pre-registration nurse students and those professionals involved in pre-registration student nurse education.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A15. What is the sample group or cohort to be studied in this research?

Select all that apply:

- ☐ Blood
- ☐ Cancer
- ☐ Cardiovascular
- ☐ Congenital Disorders
- ☐ Dementias and Neurodegenerative Diseases
- ☐ Diabetes
- ☐ Ear
- ☐ Eye
- ☐ Generic Health Relevance
- ☐ Infection
- ☐ Inflammatory and Immune System
- ☐ Injuries and Accidents

- ☐ Mental Health
- ☐ Metabolic and Endocrine
- ☐ Musculoskeletal
- ☐ Neurological
- ☐ Oral and Gastrointestinal
- ☐ Paediatrics
- ☐ Renal and Urogenital
- ☐ Reproductive Health and Childbirth
- ☐ Respiratory
- ☐ Skin
- ☐ Stroke

Gender:	Male and female participants
Lower age limit:	Years
Upper age limit:	Years

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

Inclusion criteria identified policy documents and those professionals involved in pre-registration student nurse education.
The main documents identified are those sourced from the Department of Health, Regulatory Body, National Health Service Trusts and Higher Education Institutions. Study participants have been identified as follows;
Practice Facilitator/s, Education Leads, Heads of Department, Mentors and Link Lecturers.

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

Exclusion criteria applied to those not directly involved in Pre-Registration student nurse education.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
One to one interview	1	N/A	1hour	Chief investigator ie. Marie Horgan [redacted]
Focus Groups	1	N/A		Chief investigator ie. Marie Horgan Education/Training Department

A21. How long do you expect each participant to be in the study in total?

Each participant will be invited to take part in the study for one interview or one Focus Group.
Each interview will be scheduled for approximately one hour on one occassion.
Each Focus Group will be scheduled for approximately one hour on one occassion.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

Should a significant issue in relation to practice become evident during one to one interviews or focus groups, the researcher, as a registered nurse will discuss further with the participant/s in relation to organisational policies and procedures. This process is included in the participants information sheet.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

○ Yes ◉ No

A24. What is the potential for benefit to research participants?

The opportunity for participants viewpoint to be included in the analysis of the impact of the Practice Facilitators post in pre-registration student nurse education.

A26. What are the potential risks for the researchers themselves? *(if any)*

None identified.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?*For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

The chief investigator works with the potential participants in a professional capacity and therefore has access to their work contact details namely postal address, e-mail and work contact telephone numbers. Participants will be invited in writing to take part in the research and will be provided with written information on the purpose of the research and that they freely consent to take part. Participants are free to choose not to participate and reassured that choosing not to participate will have no affect on their collegiate relationship with the researcher or the university. The participant information sheet explains the purpose of the research, confidentiality, consent and the participant's right to not take part, or, indeed withdraw from the research study.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

○ Yes ◉ No

Please give details below:
No personal information is required to complete the research.

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

○ Yes ◉ No

A29. How and by whom will potential participants first be approached?

The potential participants are identified by post titles in the design of the study. Potential participants will be invited by a letter from the chief investigator to take part in the research.

A30-1. Will you obtain informed consent from or on behalf of research participants?

(●) Yes ( ) No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

Participants will be provided with a participant information sheet which provides information on the study.

The chief investigator will take written consent from the participant/s before interview or focus group using the consent form which has been approved by London South Bank University Research Ethic Committee.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

(●) Yes ( ) No

A31. How long will you allow potential participants to decide whether or not to take part?

Participants will be invited to take part in the research two weeks before further contact is made with the participant.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? *(e.g. translation, use of interpreters)*

The study has identified the potential participants and the chief investigator has not identified potential participants who might not adequately understand verbal or written information given in English, or who have special communication needs.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

( ) The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.

( ) The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

( ) The participant would continue to be included in the study.

( ) Not applicable – informed consent will not be sought from any participants in this research.

(●) Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

Written consent will be obtained from the participants, on each occasion (approximately one hour duration), prior to their participation in the study.

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)? *(Tick as appropriate)*

- [ ] Access to medical records by those outside the direct healthcare team
- [x] Electronic transfer by magnetic or optical media, email or computer networks
- [ ] Sharing of personal data with other organisations
- [ ] Export of personal data outside the EEA
- [ ] Use of personal addresses, postcodes, faxes, emails or telephone numbers
- [x] Publication of direct quotations from respondents
- [ ] Publication of data that might allow identification of individuals
- [x] Use of audio/visual recording devices
- [x] Storage of personal data on any of the following:
  - [ ] Manual files including X−rays
  - [ ] NHS computers
  - [x] Home or other personal computers
  - [x] University computers
  - [ ] Private company computers
  - [x] Laptop computers

Further details:
The chief investigator will use an encrypted data stick to which only the chief investigator has access.

A37. Please describe the physical security arrangements for storage of personal data during the study?

Data will be stored in a locked filing cabinet to which only the chief investigator has access. The locked filing cabinet will be in a locked office when not occupied. Computers will be password protected and an encrypted data stick will be used where only the chief investigator has access to complete the research.
Participants will be identified by a code which will be stored seperately from the data in a locked filing cabinet.

A38. How will you ensure the confidentiality of personal data? *Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

The chief investigator will record the name of the participant and their post which will subsequently be converted to a code. All participant's data will be coded before being made available in order to maintain anonymity and confidentiality. The codes will be stored seperately from the data file in a locked cabinet. Information which might identify a participant will not be used in order to ensure participants anonymity and maintain their confidentiality.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

The chief investigator.

Storage and use of data after the end of the study

A41. Where will the data generated by the study be analysed and by whom?

Data will be analysed in the chief investigator's office at London South Bank University by the chief investigator.

A42. Who will have control of and act as the custodian for the data generated by the study?

	Title	Forename/Initials	Surname
	Miss	Marie	Horgan
Post	[redacted]		
Qualifications	[redacted]		
Work Address	[redacted]		
Post Code	[redacted]		
Work Email	[redacted]		
Work Telephone	[redacted]		
Fax			

A43. How long will personal data be stored or accessed after the study has ended?

- ○ Less than 3 months
- ○ 3 – 6 months
- ◉ 6 – 12 months
- ○ 12 months – 3 years
- ○ Over 3 years

A44. For how long will you store research data generated by the study?

Years: 7
Months: 0

A45. Please give details of the long term arrangements for storage of research data after the study has ended. *Say where data will be stored, who will have access and the arrangements to ensure security.*

Data will be stored on password protected computer to which only the chief investigator has access.

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

○ Yes ◉ No

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

○ Yes ◉ No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ◉ No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

○ Yes ◉ No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

◉ Yes ○ No

Please give details, or justify if not registering the research.
Research sponsor is London South Bank University and has received approval from the London South Bank University Research Ethics committee.

The research will be registered on the [redacted] NHS Foundation Trust Research and Development website.

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

☑ Peer reviewed scientific journals
☐ Internal report
☐ Conference presentation
☐ Publication on website
☐ Other publication
☐ Submission to regulatory authorities
☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
☐ No plans to report or disseminate the results
☑ Other (please specify)
Complete thesis as part submission for MPhil/PhD. academic award.

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?

Identifiable personal data will not be published.

A53. Will you inform participants of the results?

(•) Yes ( ) No

Please give details of how you will inform participants or justify if not doing so.
Results will be available if thesis is successful for PhD. academic award.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? *Tick as appropriate:*

- [ ] Independent external review
- [ ] Review within a company
- [ ] Review within a multi−centre research group
- [x] Review within the Chief Investigator's institution or host organisation
- [ ] Review within the research team
- [x] Review by educational supervisor
- [ ] Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
An outline proposal was approved for MPhil/PhD studies by the University Research Degrees committee.
A detailed proposal and application for ethical review was submitted to the London South Bank University Research Ethics committee. These were ethically reviewed and approved by the London South Bank University Research Ethics committee.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A56. How have the statistical aspects of the research been reviewed? *Tick as appropriate:*

- [ ] Review by independent statistician commissioned by funder or sponsor
- [ ] Other review by independent statistician
- [ ] Review by company statistician
- [ ] Review by a statistician within the Chief Investigator's institution
- [ ] Review by a statistician within the research team or multi−centre group
- [ ] Review by educational supervisor
- [ ] Other review by individual with relevant statistical expertise
- [x] No review necessary as only frequencies and associations will be assessed – details of statistical input not required

In all cases please give details below of the individual responsible for reviewing the statistical aspects. If advice has been provided in confidence, give details of the department and institution concerned.

	Title Forename/Initials Surname
Department	[redacted]
Institution	[redacted]
Work Address	

Post Code
Telephone
Fax
Mobile
E-mail

Please enclose a copy of any available comments or reports from a statistician.

A57. What is the primary outcome measure for the study?

Is is a qualitative study therefore outcome is evaluating the experiences of participants to assess the impact of these posts over time.

A58. What are the secondary outcome measures? *(if any)*

Not applicable.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size: 36
Total international sample size (including UK): 0
Total in European Economic Area: 0

Further details:
Participants

7 Practice Facilitators - current in post
3 Practice Facilitators - former post holders

3 Education Leads

3 Heads of Department

10 Mentors

10 Link Lecturers

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

Predicated by the case study design. Purposive sampling.

A61. Will participants be allocated to groups at random?

○ Yes ◉ No

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

A framework analysis such as that of Ritchie and Spencer 1994 will be used. This will support the identification of themes and patterns and subsequent interpertation of the data.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

	Title	Forename/Initials	Surname
	Professor	[redacted]	[redacted]
Post	Director of Practice Development		
Qualifications	[redacted]		
Employer	[redacted]		
Work Address	[redacted]		
	[redacted]		
Post Code	[redacted]		
Telephone	[redacted]		
Fax			
Mobile			
Work Email	[redacted]		

	Title	Forename/Initials	Surname
	[redacted]	[redacted]	[redacted]
Post	Practice Education Facilitator		
Qualifications	[redacted]		
Employer	[redacted]		
Work Address	[redacted]		
	[redacted]		
Post Code	[redacted]		
Telephone	[redacted]		
Fax			
Mobile			
Work Email	[redacted]		

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status:
- ○ NHS or HSC care organisation
- ◉ Academic
- ○ Pharmaceutical industry
- ○ Medical device industry
- ○ Local Authority
- ○ Other social care provider (including voluntary sector or private organisation)
- ○ Other

Commercial status:

If Other, please specify:

Contact person

Name of organisation London South Bank University
Given name Pro Dean Research
Family name
Address [redacted]
Town/city [redacted]
Post code
Country
Telephone [redacted]
Fax
E-mail [redacted]

Is the sponsor based outside the UK?
○ Yes ◉ No

Under the Research Governance Framework for Health and Social Care, a sponsor outside the UK must appoint a legal representative established in the UK. Please consult the guidance notes.

A65. Has external funding for the research been secured?

☐ Funding secured from one or more funders
☐ External funding application to one or more funders in progress
☑ No application for external funding will be made

What type of research project is this?

○ Standalone project
○ Project that is part of a programme grant
○ Project that is part of a Centre grant
◉ Project that is part of a fellowship/ personal award/ research training award
○ Other

Other – please state:

A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) ? *Please give details of subcontractors if applicable.*

○ Yes ◉ No

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

○ Yes ◉ No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

Title Forename/Initials Surname
Trust research office

Organisation
Address
[redacted]
Post Code
Work Email
Telephone
Fax
Mobile

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 12/10/2012
Planned end date: 19/12/2014
Total duration:
Years: 2 Months: 2 Days: 7

A71-1. Is this study?

- ○ Single centre
- ◉ Multicentre

A71-2. Where will the research take place? *(Tick as appropriate)*

- ☑ England
- ☐ Scotland
- ☐ Wales
- ☐ Northern Ireland
- ☐ Other countries in European Economic Area

Total UK sites in study Three

Does this trial involve countries outside the EU?
○ Yes ◉ No

A72. What host organisations (NHS or other) in the UK will be responsible for the research sites? *Please indicate the type of organisation by ticking the box and give approximate numbers of planned research sites:*

☑ NHS organisations in England	3
☐ NHS organisations in Wales	
☐ NHS organisations in Scotland	
☐ HSC organisations in Northern Ireland	
☐ GP practices in England	
☐ GP practices in Wales	
☐ GP practices in Scotland	
☐ GP practices in Northern Ireland	

☐ Social care organisations	
☐ Phase 1 trial units	
☐ Prison establishments	
☐ Probation areas	
☐ Independent hospitals	
☑ Educational establishments	1
☐ Independent research units	
☐ Other (give details)	
Total UK sites in study:	4

A73-1. Will potential participants be identified through any organisations other than the research sites listed above?

○ Yes ◉ No

A74. What arrangements are in place for monitoring and auditing the conduct of the research?

Regular supervison meetings with study supervisors.

Annual review by Research Degree programmes Director and Research Degree Committee at London South Bank University.

A76. Insurance/ indemnity to meet potential legal liabilities

Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Indemnity is provided by London South Bank University.
Indemnity documents have been sent to the [redacted] Trust

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Indemnity is provided by London South Bank University.

Indemnity documents have been sent to the [redacted] Trust.

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

- [x] NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)
- [ ] Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Please enclose a copy of relevant documents.

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

- [ ] NHS indemnity scheme will apply (NHS sponsors only)
- [x] Other insurance or indemnity arrangements will apply (give details below)

Indemnity is provided by London South Bank University.
Indemnity documents have been sent to the [redacted] Trust

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

- [ ] NHS indemnity scheme will apply (protocol authors with NHS contracts only)
- [x] Other insurance or indemnity arrangements will apply (give details below)

Indemnity is provided by London South Bank University.
Indemnity documents have been sent to the [redacted] Trust

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

- [x] NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)

☐ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Please enclose a copy of relevant documents.

A78. Could the research lead to the development of a new product/process or the generation of intellectual property?

○ Yes ◉ No ○ Not sure

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For NHS sites, the host organisation is the Trust or Health Board. Where the research site is a primary care site, e.g. GP practice, please insert the host organisation (PCT or Health Board) in the Institution row and insert the research site (e.g. GP practice) in the Department row.*

Research site		Investigator/ Collaborator/ Contact	
Institution name		Title	Miss
Department name		First name/ Initials	Marie
Street address		Surname	Horgan
Town/city			
Post Code			
Institution name		Title	Miss
Department name		First name/ Initials	Marie
Street address		Surname	Horgan
Town/city			
Post Code			
Institution name		Title	Miss
Department name		First name/ Initials	Marie
Street address		Surname	Horgan
Town/city			
Post Code			

PART D: Declarations

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.

2. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.

3. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.

4. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.

5. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.

6. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.

7. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.

8. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 1998.

9. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:

    - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
    - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
    - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
    - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
    - May be sent by email to REC members.

10. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.

11. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication *(Not applicable for R&D Forms)*

NRES would like to include a contact point with the published summary of the study for those wishing to seek further information. We would be grateful if you would indicate one of the contact points below.

(•) Chief Investigator

( ) Sponsor

- ○ Study co-ordinator
- ○ Student
- ○ Other – please give details
- ○ None

Access to application for training purposes *(Not applicable for R&D Forms)*

Optional – please tick as appropriate:

☐ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

This section was signed electronically by Miss Marie Horgan on 18/04/2013 12:47.

Job Title/Post:	[redacted]
Organisation:	London South Bank University
Email:	[redacted]
Signature:	.....
Print Name:	Marie Horgan
Date:	27/03/2013 *(dd/mm/yyyy)*

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The duties of sponsors set out in the Research Governance Framework for Health and Social Care will be undertaken in relation to this research.
7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

This section was signed electronically by [redacted] on 19/04/2013 19:15.

Job Title/Post:	Pro Dean Research
Organisation:	London South Bank University
Email:	[redacted]

[redacted]

Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the Research Governance Framework for Health and Social Care.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

This section was signed electronically by [redacted] on 18/04/2013 13:22.

Job Title/Post:	[redacted]
Organisation:	London South Bank University
Email:	[redacted]

Appendix 17 Approval to conduct interviews on trust premises A

xxxx Trust

Joint Research Management Office
XXXX

Our ref: LOA-UR

Marie Horgan

18th February 2013

Email: XXXX .nhs.uk

Dear Ms Horgan

Letter of access for research

This letter confirms your right of access to conduct research through XXXX Health NHS Trust for the purpose and on the terms and conditions set out below. This right of access commences with immediate effect and ends on 31st December 2013 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research at XXXX Health NHS Trust has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor to XXXX Health NHS Trust premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through XXXX Health NHS Trust, you will remain accountable to your employer London South Bank University but you are required to follow the reasonable instructions of XXXX, Associate Director XXXX, in this NHS organisation or those given on her behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with XXXX Health NHS Trust policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with XXXX Health NHS Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on XXXX Health NHS Trust premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

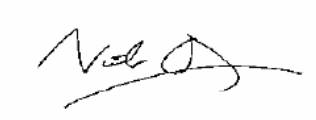
You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

XXXX Health NHS Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely



R&D Projects Manager

cc: XXXX, HR
XXXX

Appendix 18 Approval to conduct interviews on trust premises B

Date: 14th May 2013

Dear Marie Horgan,

Re: R&D Ref No. 2334 - The Practice Facilitator Role: It's Impact on Pre-Registration Nurse Education

I am pleased to inform you that the above named study has been granted approval and indemnity by Professor XXXX, Director of Research and Development at XXXX NHS Foundation Trust. You must act in accordance with the XXXX Trust's policies and procedures, which are available to you upon request, and the Research Governance Framework. Should any untoward events occur, it is **essential** that you contact your Trust supervisor and the Research and Development Office immediately. If patients or staff are involved in an incident, you should also contact the Governance and Assurance department, in XXXX, and complete the Incident and Reporting Form, namely the IR1 form.

You must inform the Research and Development Office if your project is amended and you need to re-submit it to the ethics committee or if your project terminates. This is necessary to ensure that your indemnity cover is valid and also helps the office to maintain up to date records.

You are also required to inform the Research and Development Office of any changes to the research team membership, or any changes in the circumstances of investigators that may have an impact on their suitability to conduct research.

Yours sincerely,

Signature xxxx

XXXX

Research and Development Manager, XXXX

Trust

Appendix 19 Approval to conduct interviews on trust premises C

XXXX NHS
University Hospitals
NHS Trust

Research & Development Office
XXXX

E-mail:Research.Development@xxxxhospitals.nhs.uk

Our Ref: R&D Recruitment//HORGAN/XXXX
Date: 22nd April 2013

Private and Confidential

Marie Horgan

XXXX

Dear Marie

Letter of access for research

This letter confirms your right of access to conduct research through XXXX Hospitals NHS Trust (XXXX) for the purpose and on the terms and conditions set out below. This right of access commences on 22/04/13 and ends on 31/12/14 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research at XXXX has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor to XXXX premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through XXXX, you will remain accountable to your employer London South Bank University but you are required to follow the reasonable instructions of

Dr XXXX (Associate Director of R&D) in this NHS organisation or those given on her behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with XXXX policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with XXXX in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on XXXX premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the Trust R&D Department prior to commencing your research role at the Trust.

You are required to ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

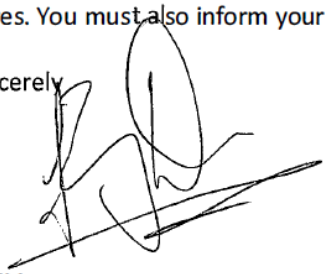
We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

XXXX will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely



Dr XXXX, Associate Director of R&D, XXXX On behalf of the Recruitment Department
XXXX Hospitals NHS Trust

cc: **XXXX**
HR Service Centre Coordinator,
XXXX@xxxxhospitals.nhs.uk

Appendix 20 Insurance and indemnity

London South Bank
University

www.lsbu.ac.uk

Pro Dean Research,
T: xxxx
Email: xxxx@lsbu.ac.uk

9 November 2012

Dear Sir

Title of study: ***The practice facilitators role: it's impact on pre-registration nurse education.***

Name of student: ***Marie Horgan***

LONDON SOUTH BANK UNIVERSITY is willing to take on the role of sponsor in relation to this research project, to be carried out by Marie Horgan who is currently a student studying for PhD. The research study is part of that award.The academic supervisor for the project is Professor XXXX.

I confirm that indemnity will be in place covering this project the details of the cover are in the attached statement of insurance cover.

All correspondence for the sponsor should be marked for the attention of Professor Pro Dean of Research.

Yours sincerely,

Pro Dean Research

Appendix 21 Data management using Excel spreadsheets: illustrative example 'role availability'

Participant ID	STATEMENT	Source (LINE/S)	CODES	PATTERNS
HOD 2.	**We may have Link Lecturers going into practice and so on but these Practice Facilitators sit actually in the Trust so in terms of clinical governance, in terms of patient safety they will be the first group of people who will go to investigate anytime there is an incident out there**	**674-678**	**PFs easily accessible in the Trust versus Link Lecturer not as easily accessible**	**Importance of 50% practice element of curriculum / Role availability**
HOD 2.	**they will go and check they will ring the University almost immediately after and jointly we will agree the next stages**	**678-679**	**PF quick response to issues**	**Role availability / Decision making with HEI**
PF3	**My role I would say in a nutshell is facilitating so it is supporting Mentors on placement in terms of (2:30) providing education providing them with the Mentor updates we are involved in the Mentor preparation programme in the University, we are there as support for Mentors when and if they need us for advice for guidance regarding assessment processes, completing the documentation, if they have concerns about a student on placement and their progression they ring us they contact us. My role is very much going out into the practice areas literally walking the wards (3:00) and meeting and hopefully resolving issues at the time as opposed to waiting for them to be highlighted retrospectively.**	**46-55**	**Elements of role / Mentor updates / mentor support in documentation / assessment / on sit access**	**Role / Mentor support / Role availability**

PF3	**I think it is always changing and evolving and I think it is what you make of it as well because I was new to the Trust one of my key for me my personal objectives was to build up a rapport with staff in a clinical area (8:31) because I think the key thing is that staff feel that there is somebody that they can speak to or link with if they want advice and support so for me it was building up those professional relationships with managers and key Mentors in the areas so that they were aware of our role within the Trust but that they were aware that they would actually pick up the phone and make contact**	**147-154**	**Role influenced by post holder / staff support / mentor support / accessible on site**	**Role / Role evolution / Mentor support / Role availability**
PF5	**What we tend to do what I tend to do and our team tends to do is we do go to our clinical areas like at regular intervals so that we meet students when they come out in placements so the first week we do try to meet the students and then at regular intervals with them**	**54-57**	**Regular Presence in clinical areas / meet student in first week**	**Student support / Role availability**
PF5	**Accessible yeh**	**185**	**PF accessible**	**Role availability / Student support**

PF5	**when you think when you think nursing is a twenty four seven profession and in terms of student nurses allocation and placements (12:00) as well I suppose apart from the first years all the other students are as well on a twenty four seven placement and rotation and quite a lot of things in nursing as we do see is you know there are concerns the sooner they are dealt with the better rather than later so from that perspective having somebody whom both the students and the staff and the management feel happy that they can come to and liaise with and get advice and also assistance from is a key thing**	**197-204**	**Responding quickly to issues from staff and students / give assistance / gives advice**	**Role availability / Student support**
PF6	**I think its beneficial for the students because all they have to do is walk over and anything that they need they they can often get from us.**	**139-140**	**Easy access to PF for student**	**Student support / Role availability**
PF6	**I had a student last week that was struggling with the manual blood pressure and she was able to just walk over and we had a (8:00) teaching sort of half an hour teaching session had a teaching stethoscope and she was able to take my blood pressure and I could hear it with her so that's something that's almost immediate obviously we don't work week ends but it's something that we're we're always around they can always find us we can always sort of be there for them**	**140-146**	**Easy access to PF for student**	**Student support / Role availability**
PF6	**I think anywhere that has got Practice Educators they are all available**	**151-152**	**Easy access to Practice Educators for student**	**Role title / Student support / Role availability**

PF6	**I've recently been speaking to the girls in N and they are the same you know they'll go out and regularly see the students and are there for them**	**152-154**	**Easy access to PF at another Trust for student**	**Student support / Role availability**
PF6	**I think we're that we're that middle man that the students can go to and they do recognise us as being generally quite friendly and approachable and we're easy to get to we're in the same place you know and we do visit them very often and they get to know us I think its its one of the nice things for them to have as well as it being beneficial**	**729-733**	**Middleman / easy on site access for students / PF friendly & approachable / Visit students quite a lot**	**Role evolution / Role availability**
PF7	**They could be there, they probably played the same role as Link Lecturers played when the nursing was provided from schools of nursing in the hospitals (2.38) way back in the 1990s, so it was keeping the continuity between the Universities and placements and just making sure that everything can be dealt with immediately rather than somebody having to try and travel a long distance**	**34-39**	**PF role and Link lecturer role the same / PF role continuity between HEI & Trust / deal with issues immediately / travel distance**	**Role / Link Lecturer role / Theory practice link / Role availability**
PF7	**I think we had a lot of changes going on (3.54) and it was basically to keep continuity between, I'm just having a think about that one, it was about, it was about supporting staff, it wasn't just about distance or anything it was ensuring support for staff and students was actually there (4.19) in a local area.**	**51-55**	**Support staff / support for students / provided locally**	**Theory practice link / Student support / Mentor support / Role availability**

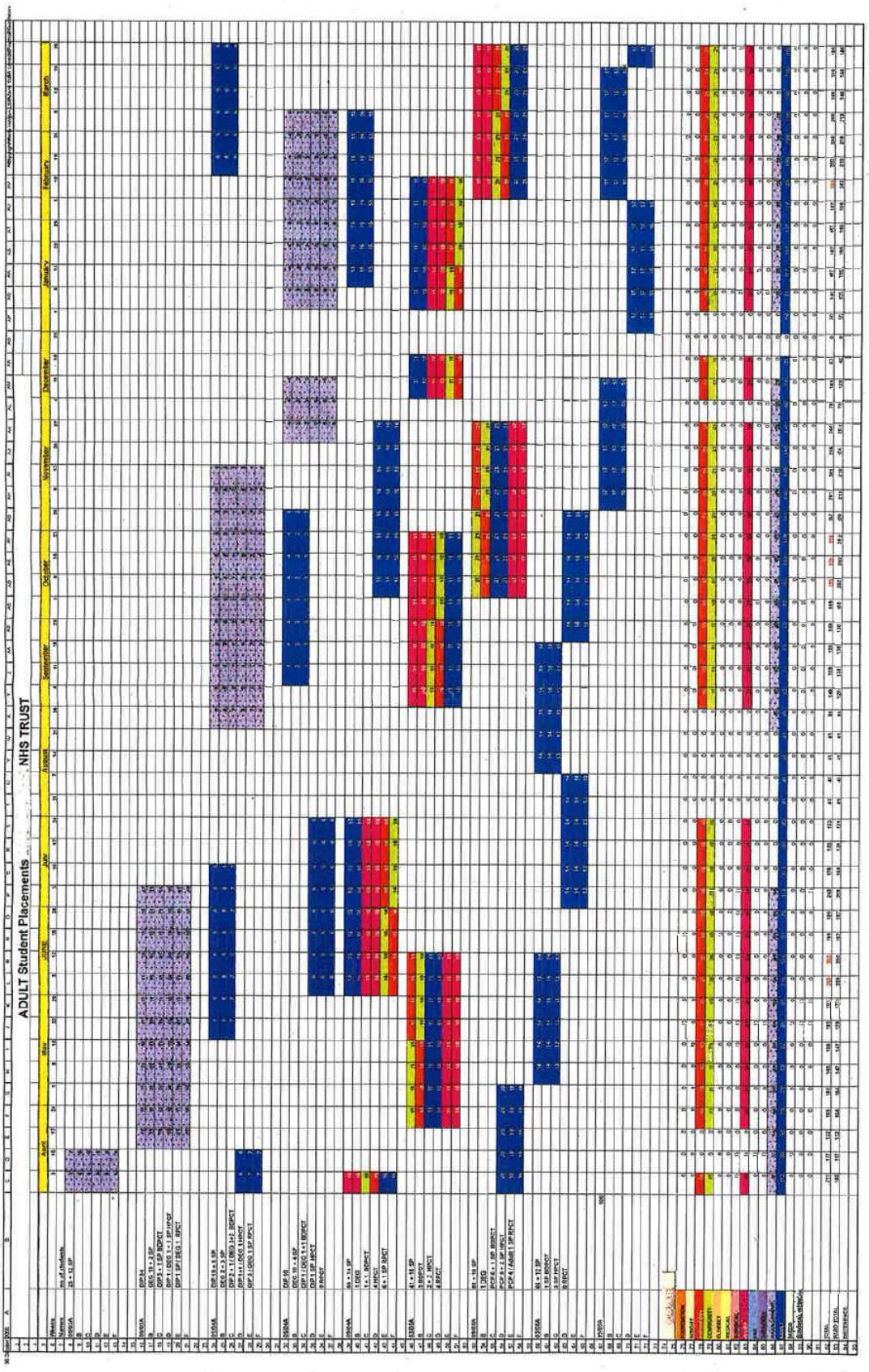
PF7	**because we're actually based in Trust we can drop everything and when emergency is needed we can get there and we're on site although my site does cover a big massive distance and it's a lot more accessible than if I was based at University**	**820-823**	**In Trust site / provide quick support for mentors**	**Mentor support / Role availability**
PF9	**Straight away, we go and find out what the problem is and then we will look at what the problem is, we won't recommend or do anything but we will be aware of it and we will come back and formulate something together with the University**	**647-650**	**PF respond quickly to mentor issue / discuss with mentor / PF contact HEI**	**Theory practice link / Mentor support / Role availability**
LL1	**the Practice Facilitators, I think, by virtue of the fact that they are employed within the Trust are possibly more accessible and can come at very short notice should a problem arises.**	**367-369**	**PF employed by Trust / accessible / provide support at short notice**	**Role / Role availability**
LL1	**I'm in the community, so that Practice Facilitator has a lot of travelling to do, we've got quite a few clinics and we've got a community hospital as well and she's forever looking at learning opportunities outside of that (32.50). So that Practice Facilitator is very busy, but I can tell they have built a good working relationship with the Mentors and it's received and given back**	**442-446**	**PF good working relationship with mentors / developing learning opportunities**	**Role evolution / Role availability / Mentor support**
MF1	**I think that the Clinical Nurse Tutor were a little bit before my day but I think M is very visual within the Trust, you know that she is there but it is not a hands on approach**	**412-414**	**Clinical nurse tutor prior to Mentor pre-reg training but PF very visual in Trust / PF not a hands on approach**	**Role availability / Role evolution / Clinical tutor**

MF1	**There is always someone in the Trust who you know if there is a problem it's either the Mentor or students can talk to.**	**431-433**	**Available in Trust for mentor support / student support**	**Role / Mentor support / Student support / Role availability**
MF1	**They are always around, anytime you call them we got M's mobile and we can call her on the mobile and even if she is at X hospital she gets back to us as soon as possible.**	**447-449**	**PF always around / contactable / responsive to mentor contact**	**Mentor support / Role availability**
MF2	**I think is a very valuable because they are very quick if there is anything to update or I mean picking solving the problems before the Link, Link Lecturers come**	**477-479**	**Mentor value of role / mentor update / PF problem solving / quick response / solve problems before link lecturer arrives**	**Role value / Link Lecturer availability / Role availability**
MF2	**They always there first anyway to reach I think is better to, its good for them to continue**	**479-480**	**PF respond quickly to issues**	**Role value / Link Lecturer availability / Role availability**
MFG 3	**with the role of the Practice Facilitators that has become easier now because rather than going to Link Lecturer you will go to the Practice Facilitator**	**569-571**	**Mentor will now contact PF with any issue rather than LL**	**Theory practice link / Lack of Link Lecturer availability / Role availability**
MFG 3	**And they are on site which is quite handy you know**	**611**	**PF on Trust site**	**Role / Role availability**
MFG 3	**I think so because you have a lot of difficulties particularly in that sense of the Practice Facilitator to get a Link Lecturer to come in, you know they are quite busy doing lectures or off site (41.17) but now they are here so we can just 'phone them or email them and they respond**	**615-618**	**Mentor have a lot of difficulty getting the Link Lecturer to attend / Link lecturers are off site and busy doing lectures / PF just 'phone or email and they respond**	**Role / Role availability / Link Lecturer availability**

MFG 4	**I think as well that her role, it depends (8.06) you might not have access to her for any particular reason but as soon as there is an issue and you want to discuss something she's there and she is very supportive and so there is other elements to her role that you access**	**177-180**	**PF accessible to mentor issues / PF supportive of mentors**	**Mentor support / Role availability**
MFG 4	**all the time that I have known our current PEF she has provided support, she has arranged Mentorship updates, she has been there for advice, she's been you know guiding and advising, she's been easily accessible, so I don't know, that's been constant,**	**225-228**	**Mentor support / mentor updates / mentor advice / mentor guidance / easily accessible**	**Mentor support / Role availability / NMC standards**
MFG 4	**The Link Lecturer isn't massively in evidence in my area of practice that I am aware of, so without the Practice Facilitator we would be unsupported (15.17) in many ways.**	**311-313**	**Link lecturer not in evidence / without PF mentor unsupported**	**Link lecturer availability / Role availability / Role title**
MFG 4	**I didn't know that the Link Lecturer have been off for a while or even replaced because now I don't go through the Link Lecturer I go through our PEF (15.29) all the time.**	**315-317**	**Mentor unaware that LL was off or had been replaced / mentor point of contact is the PF**	**Link lecturer availability / Role availability / Role title**
MFG 4	**I can't remember the last time I had an issue or a question surrounding some form of Mentorship, student training, placement where I didn't by pass our current PEF and go to LSBU. It's just not something I do now with all due respect to the Link Lecturer**	**317-320**	**Mentor refers student issues to PF / mentor does not refer to Link lecturer**	**Link lecturer availability / Role availability / Role title**

MFG 4	**For me the PEF is the one who has organised the Link Lecturer coming down so today, this morning they came down to the midpoint review of my Pre-Reg student and they were in the meeting with the PEF (16.11) but they only came down because it was under the PEFs instructions to do so**	**322-325**	**PF organises link lecturer attendance for student assessment issue / mentor, PF and student at the mid-point interview / link lecturer only attended because PF instructions to do so**	**Link lecturer availability / Role availability / Role title / Mentor support / Student support**
MFG 4	**I wouldn't choose to go to the Link Lecturer I would choose to go to the PEF first. I just feel that she has a greater understanding of practice, the changes that are in practice the implications for the District Nurses and Mentoring Pre Reg students and of DN students and is much more accessible**	**331-334**	**Mentor chooses not to refer issues to the LL / PF has a greater understanding of practice / PF understands implications for practice on District nurse education and Pre-Reg students / PF is much more accessible**	**Role value / Role availability / Link Lecturer role / Mentor support**
MFG 4	**I would agree. I have attended many Mentorship updates that had the Link Lecturer and the PEF. They were no better than the ones just with the PEF.**	**336-338**	**PF and LL delivering mentor update / quality of mentor update delivered only by PF comparable**	**Role value / Role availability / Link Lecturer role / Mentor support / NMC standards**

Appendix 22 Example of placement mapping



Appendix 23 Journal extracts

Date	Journal extracts
21/03/2016	Continuing to having IT problems with uploading attachments
22/03/2016	Hoping supervisors give positive feedback to my thinking in my early stages of writing. Have been working on Chapter 2 since last supervision. At times, difficult to sit and write after a busy day at work.
18/04/2016	Feel more confident now in discussing Lipsky with my supervisors. I find it really useful to have to articulate why Lipsky is relevant to my study as it helps me clarify my thoughts and also it makes me read!
11/05/2016	Finding it difficult to find the time but have completed work on Chapter 3 and managed to get it to my supervisors in time for next supervision. Looking forward to discussions of this at supervision.
23/05/2016	Reflecting on my last supervision meeting, I have decided to use the themes from the results chapter in preference to using the research questions to structure the discussion chapter. I am still feeling my way as to how to write this but will discuss this at supervision. Need to carefully think it through first so I can discuss I have discovered today the Res 4 annual report is due for submission by Friday 27 May 16 (it is early this year). Got in contact with my supervisors to let them know. It is going to take us all a while to get used to the latest set of regulations I have completed an electronic version and circulated it to my supervisors.