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Practice learning in nursing and midwifery education

An independent rapid review

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Contents

Executive summary

1 Nurses, midwives and nursing associates are a vital part of the health and care workforce. More than half of professionally qualified clinical staff in NHS hospital and community services are from these professions. Ensuring that we educate and train enough new nurses, midwives and nursing associates – with the right skills, knowledge and experience – is critical to meeting the current and future staffing needs of our health and care services.

2 A core part of pre-registration education is 'practice learning', which is intended to give students hands-on experience, exposure to different roles, supervision and feedback, and opportunities to build competencies. These include, for example, communicating with people who use services and carers, team-working, performing specific procedures and providing holistic care. Approved education institutions arrange practice learning while practice learning partners deliver it. It can take place in a range of settings, including in hospitals, general practice and the community. In terms of hours, practice learning currently accounts for half of nurses', midwives' and nursing associates' pre-registration education in the UK.

3 The Nursing & Midwifery Council (NMC) commissioned the Nuffield Trust, in partnership with the Florence Nightingale Foundation, to produce this independent report on practice learning. In the report we examine the evidence relating to regulations and standards, including to understand the factors that contribute to a positive learning environment or to inequity and learn about different practice learning opportunities across the UK and internationally. For this research, as well as reviewing existing literature, we also undertook focus groups, policy workshops and interviews with experts, staff and students, key stakeholders, members of the public and patient representatives. This summary outlines some of the key insights from the research, grouped into:

- evidence and views on practice learning hours and the births requirement

- how they compare to other countries' regulatory requirements
- the role of simulation in practice learning
- lessons on interpreting and implementing the practice learning requirements
- lessons on the design of practice learning opportunities
- factors that enable or hinder effective practice learning
- factors that enable or hinder equitable and inclusive practice learning
- key similarities and differences between professions and fields
- key similarities and differences across the UK nations.

Evidence and views on practice learning hours and the births requirement

4 There is limited published empirical evidence to determine the optimal number of practice learning hours needed to ensure safe and effective nursing and midwifery practice or support the current requirement. While some studies from outside the UK have explored the number of hours required to achieve sufficient competency among advanced practice nurses, for pre-registration education there is no conclusive evidence on the minimum number of in-person practice learning hours required.

5 Although approved education institutions in general told us they wanted greater flexibility, there was no clear agreement among our focus group participants or UK stakeholder interviewees on the optimal number of practice learning hours and whether the minimum 2,300 hours requirement for nursing and midwifery should change. There was consensus among stakeholders, including in our public and patient engagement, that the quality of practice learning mattered more than the duration of practice learning, and that the current approach led to variable experiences and failed to account for different students' needs. Some stakeholders suggested that the number of practice learning hours could be safely decreased, and this could support a more sustainable supply of clinical staff. However, others expressed concerns that doing so could undermine the status of the professions involved and be perceived as a response to funding and service pressures rather than a desire to improve patient care.

6 There is also limited evidence and mixed views on the optimal number of births required as part of midwifery educational standards. In the UK, NMC standards include specifying that midwives must facilitate at least 40 births, as well as a set number of learning opportunities across the whole continuum of care. The NMC's standards set principles that these births should be 'spontaneous and vaginal'.* But if this number cannot be achieved due to a lack of available women giving birth, the requirement can be met with 30 spontaneous births alongside assisting with 20 additional births. Across our research, we heard more about the practical challenges – for example, the decline in the proportion of spontaneous, vaginal births that meet the birth number requirement – as opposed to views on whether the level is appropriate in relation to ensuring graduates can deliver safe care.

7 The practice learning hours requirements for other professions vary significantly, and so do not readily suggest an optimal level. For example, the Health and Care Professions Council does not stipulate the number of hours that must be achieved for the allied health professions it regulates; instead, individual education institutions determine them, often informed by professional associations.

Similarities to and differences from other countries' regulatory requirements

8 Until the end of 2020, when the UK left the European Union (EU), an EU Directive on the recognition of professional qualifications (Directive 2005/36/EC) governed nursing and midwifery education and training in the UK. This aimed to establish minimum EU-wide standards for education and training. Since then, regulatory requirements in the UK have remained similar – but not identical – to those in the EU. There is substantial variation internationally regarding the regulation of practice hours; for example, Australia requires 800 hours whereas EU countries require 2,300 hours. Meanwhile, Norway and Sweden have both recently taken

* That is, without the use of clinical intervention to induce labour, and without the use of forceps, extraction or caesarean section.

pragmatic decisions to reduce the minimum number of births required from 50 to 40 in response to changing delivery patterns and pressures on clinical placements.

9 Nearly a quarter of nurses, midwives and nursing associates on the UK register are internationally educated. However, they accounted for around half of people joining the register for the first time in the year to March 2024. Conversely, the Republic of Ireland, for example, had 10,090 UK-trained nurses registered to practice there in 2022. The scale and pace of movement suggest that there could be significant consequences for nurses and midwives seeking to come to the UK or benefit from spending some of their career working abroad, without an appropriate level of consistency in the education requirements between countries. While the NMC has a process for recognising appropriate qualifications for people educated internationally, they are still required to undertake an exam to assess values and behaviours, and evidence-based practice. Australia similarly has mandatory practical exams only for registrants who were educated internationally, although a 2019 government review there suggested that it 'seems anomalous' to use different approaches for domestically and internally educated applicants.[29]

The role of simulation in practice learning

10 Simulation – which includes, for example, scenarios involving actors, or virtual-reality assisted learning – is intended to offer a safe and controlled learning environment and expose students to, for instance, rare or more complex cases. The current NMC standards for pre-registration nursing courses, initially introduced in response to the Covid-19 pandemic and subsequently retained, stipulate that a maximum of 600 hours of simulation can contribute to meeting the practice learning hours requirement. For midwifery, on the other hand, simulation cannot contribute to practice learning hours except for hard-to-achieve proficiencies.

11 The evidence base around the proportion of practice learning that should be delivered through simulation is limited, with most studies examining simulation as a bridging tool between theory and practice rather than

as a substitute for practice learning hours. There is wide variation in international standards, with typically restrictive levels in EU countries compared to, for example, the United States where up to half of clinical practice hours (which vary across the country) can be substituted for simulation in nursing courses.

12 In our engagement for this research, opinions on whether the amount of practice learning provided through simulation should be increased varied. Some policy-makers and midwife educators argued that the discrepancy between the use of simulation in nursing and in midwifery is not warranted, and standards should be better aligned across professions. There was consensus among stakeholders that simulation can be an invaluable tool for helping students build confidence and practice skills before working in real-world settings. The service users and members of the public we spoke to were generally not opposed to simulation but were clear it "depends on getting the balance right". However, participants often raised the resources and experience of staff needed to design and deliver effective simulation-based education, along with the labour-intensive nature of this, as key barriers to expanding its use.

Lessons on interpreting and implementing the practice learning requirements

13 We repeatedly heard confusion about what counts as a practice learning hour and what counts as theory. This included a view about mixed messages from the NMC about what counts towards the hours requirement, especially in the wake of additional flexibility afforded during the Covid-19 pandemic. The uncertainty was over, for example, the use of simulation, where decisions on whether it counted towards the practice learning hours requirement were sometimes made arbitrarily based on whether the simulation was conducted on education-owned or health care-owned property. In the midwifery profession, we heard some similar confusion on what instances the NMC deems it to be acceptable to reduce the births requirement from 40 to 30 births (plus care for an additional 20 women).

14 We also heard numerous examples of supernumerary status – meaning that students cannot be counted as part of the workforce when they are on a practice learning placement – not being upheld, as well as inconsistencies with counting breaks and lunch towards practice learning hours. Difficulties with navigating documentation for recording practice learning were a common thread throughout our focus groups. There were also inconsistencies in how proficiencies were signed off. For example, some supervisors signed off proficiencies based on reflection and discussion with the student, while others did not. These discrepancies risk undermining the assurance intended by having practice learning requirements, and also cause anxiety for students given the uncertainty.

15 The specific practice learning requirements appear to have unintended consequences. A common perception among educators, policy-makers and practitioners was that current proficiency requirements had made education task-oriented, which has inadvertently reduced complex care to a checklist of skills. Moreover, we heard that getting these proficiencies and procedures signed off and meeting the minimum practice learning hours were often a cause of significant anxiety for students. Similarly, we heard that the focus on the number of births was causing anxiety (and a barrier to progression) for midwifery students and might have unintended consequences around deprioritising continuity of care.

Lessons on the design of practice learning opportunities

16 Nursing, midwifery and nursing associate students are expected to be given opportunities to learn and provide care across a range of different learning environments. The benefits of this include gaining experience of a variety of services and settings, providing holistic care for the diversity of populations and helping ease pressure on securing placements. There appear to be widespread opportunities to expand the breadth of practice learning environments, particularly around services outside hospitals. However, participants raised common barriers, including a lack of practice supervision and assessment capacity, and resistance from students who

were concerned that such placements might not provide opportunities to achieve their proficiencies.

17 Insufficient funding was also often cited as a barrier. There can be substantial costs to providing practice learning, including the time of staff for supervision and assessment, and the training necessary to support their development in those roles. Unlike the other UK nations, England has a specific education tariff to contribute to the costs for practice learning partners; however, some felt that the level (around £100 a week per student) was inadequate to incentivise, for example, new or shorter placements. And there was still a substantial disparity in tariff funding of £32,552 for undergraduate medicine placements compared to £5,343 for nursing and other non-medical undergraduate clinical courses in 2023/24. Wales has been piloting specific funding for general practice to host placements.

18 A breadth of different types of practice learning and supervisory models exists internationally, including the traditional placement rotation model, the 'hub and spoke' model and peer-led, coaching-based models. In the Republic of Ireland, nursing and midwifery students complete a compulsory, paid clinical internship; elsewhere, in Canada, students spend their final year wholly on clinical placement. The evidence base on this is limited, with no single placement opportunity being 'optimal', and benefits and implementation challenges for each of the different models. Within the UK, we heard that there are opportunities to better stage placements throughout students' learning. For instance, some nursing students valued their community placements more in their third year as they had more autonomy and the opportunity to consolidate practice learning.

Factors that enable or hinder effective practice learning

19 There was consensus among those we interviewed that the quality of practice learning mattered more than the quantity of practice learning hours. Previous studies have established a link between the quality of the practice learning environment for students and the quality of care they

provide for years after graduation. We identified many different barriers to effective learning, including some already discussed around the breadth, structure, timing and location of practice learning experiences, existing pressure and strain that health and care services face, as well as team culture. Simple actions like using students' first names, properly inducting them and ensuring that wider staff are aware of their placement can significantly impact on the learning environment, but we heard these were all too often not done.

20 While there are ambitions to provide continuity of support and supervision, this is commonly cited as difficult to deliver. Factors such as changes in 2018, which made all registrants responsible for supervising, have broadened supervisory capacity – and these changes seem widely accepted – but the high proportion of registrants new to the profession or UK services (as at March 2024, around one in five had been on the NMC register fewer than three years) has exacerbated problems with ensuring supervisors are sufficiently experienced. We were consistently told that workload and a lack of protected time and recognition can hinder practice supervision.

21 There remains a risk that students not meeting the expected level are still progressing in their course. We were told a range of reasons for this apparent 'failure to fail', including feeling pressure not to fail students, a lack of information on performance (for example, supervisor feedback) and the potential workload that failing a student would entail. We found that practice assessors can find it challenging to fulfil their role because of a lack of support, training and protected time. There appear to be opportunities to strengthen practice supervision and assessment, including by investing in roles to better coordinate and bridge between theoretical and practice learning and assessment. The guidance and policies that accompany practice assessments are known to be important and, where inadequate, hinder appropriate assessment.

Factors that enable or hinder equitable and inclusive practice learning

22 The location and amount of practice learning can create significant financial pressures for students. We heard that the upfront cost as well as the time required to access placements – with particular challenges around public transport – can be a barrier to learning and, in some cases, students may not fulfil the placement as a result. Many students have to work to earn income to enable them to fund their studies; however, we heard that a lack of flexibility in the practice learning component can present a substantial barrier to doing so.

23 Students with lived experience of disability, neurodivergence or long-term conditions can, and do, graduate and go on to be employed in the health and care sector. However, we heard of instances where reasonable adjustments were not always considered when allocating practice learning opportunities and the view that some of the reasonable adjustments made for students during their practice learning were not reflective of what might actually be provided in the role after graduating, contributing to staff leaving soon after starting. We heard of a rising proportion of reasonable adjustment requests and, as well as ensuring occupational health services are appropriate, that improved dialogue at an earlier stage between practice learning partners and approved education institutions to reach decisions around reasonable adjustments could help manage this effectively.

24 Overlapping factors such as race, ethnicity, socioeconomic status and disability create significant barriers for students from underserved and minoritised backgrounds. These challenges manifest in various ways, such as:

- unequal allocation of high-quality placements
- biased, racist or discriminatory treatment from educators, peers and patients
- a lack of representation in leadership and faculty roles.

The compounded effects of these barriers not only hinder the academic and professional progression of affected students but also perpetuate systemic inequities within health care, limiting diversity and inclusivity in the workforce.

Key differences between professions and fields

25 While some of the challenges and opportunities are common across the professions and fields that the NMC registers, we heard some notable differences. In particular, we heard that nursing proficiencies – which are consistent across the fields – were not always felt to be applicable to certain fields, such as learning disability nursing or children's nursing. Furthermore, shortages in certain fields such as learning disability nursing also remain a particular problem in terms of access to appropriate supervision and assessment capacity, for example.

26 We identified some particular differences for those on apprenticeship education routes. These included:

- specific challenges with protecting practice learning time for apprenticeships, given the blurred boundaries between apprentices' education and employment as they are often in the same clinical environment
- sufficient recognition of their prior learning
- limited opportunities for learning experiences outside their employer.

However, some felt that they benefited from having an existing relationship with teams for the allocation of practice learning opportunities. Nursing associates, meanwhile, noted challenges around staff often failing to understand the difference between their role and registered nurse roles, and how the standards of proficiency differ. There were also differences in the requirements – and evidence and views on them – for midwifery, as already outlined on pages 3–4.

Key similarities and differences across the UK nations

27 The NMC regulates the UK's nurses and midwives. The role of the NMC in relation to practice learning includes setting the process for the approval of pre-registration programmes and publishing UK-wide standards for education programmes, supervision and assessment. There is a degree of overlap in staffing between the nations of the UK, with, for example, more than a fifth (22%) of NMC registrants with an address in Wales having trained elsewhere in the UK. This suggests a need for an appropriate level of consistency in approach between the nations if registrants are to be able to continue to take up roles throughout the UK.

28 The complex roles and responsibilities around practice learning more broadly – which include service regulators, commissioners, professional workforce bodies and workforce education teams – vary between the UK nations. The size and scale of nursing and midwifery educational pipelines also vary across the UK nations, impacting on the nature of relationships between the various organisations involved. This, in turn, has implications for who can provide assurances around practice learning and how these assurances can be implemented. In Northern Ireland, courses have remained closer to the EU-wide standards – including not using simulation for practice learning – which apply across the border in the Republic of Ireland. That said, due to the scope of our research, we were not able to confidently identify consistencies and differences between the UK nations for all the aspects of practice learning covered in this report; further work would be needed to do so.

29 Differences in geographies (and, specifically, the remoteness of potential practice learning partners), length of course and student funding and tuition fee arrangements also affect the challenges and opportunities around practice learning. While all approved education institutions and practice learning partners are required to have a process in place to ensure that all substantive practice learning environments are regularly reviewed and concerns are addressed, approaches to monitoring differ across the UK nations. The degree to which approaches are standardised across each of the nations also varies, and there appears to be scope to learn from local and regional practice to improve monitoring.

Concluding remarks

30 This is not the first time that reforms to the regulation of practice learning have been considered. However, it is timely that the topic is revisited, given the fast-changing landscape, with changing complexity of care, ambitions for more preventative and inclusive care, the drive for equity and diversity in the clinical workforce, digital technology and the demand for clinical leadership skills.

31 Given the large number of students entering education, the diverse range of skills, motivations and experience they bring and the vast array of roles that those completing training will go on to do – compounded by the difficulties of educating students in educational and practice settings that have broad ongoing pressures – the regulation of education is inherently hugely challenging. Having broad and flexible entry requirements can provide positive opportunities around inclusion, but also represent a challenge to achieving appropriate consistency in the standard of graduates.

32 To explore what actions our findings imply, it is useful to conceptualise the regulation and delivery of practice learning as a process from setting an approach through to the implementation of standards and monitoring (see Figure 1). Based on the research for this report, it is our view that the UK's regulatory requirements around practice learning are comprehensive, appearing for instance to go further than those in many other countries in some areas such as on continuity of care. However, describing standards is just part of the process and the varied interpretation and implementation of the standards and the under-pressure environment of many practice learning placements jeopardise this, to a degree.

Figure 1: Process for regulating and delivering practice learning

33 Our review identified barriers to and opportunities for effective practice learning across various aspects of its provision, including in relation to the application of the requirements, the location and environment of placements, practice supervision and practice assessment. We outline specific actions to improve the interpretation, implementation and monitoring of the requirements around (and quality of) practice learning – as well as a framework for exploring opportunities around the overarching approach to the regulation of practice learning and generating evidence to inform it – in Chapter 6.

34 There were some golden threads throughout our work that touch every aspect of practice learning and drive many of the deep-rooted challenges that make improvement difficult. These included:

- equality, diversity and inclusion (from both student and service user perspectives)
- the impact of costs and funding (from both student and provider perspectives)
- the effectiveness of coordination, collaboration and partnership between organisations
- protecting time in already overstretched teams (for the individual learners and for supervisors and assessors).

These recurrent themes are, in fact, areas of interest and concern more broadly in health and care policy-making and delivery. Practice learning regulation and wider policy will therefore need to be sufficiently consistent and aligned.

35 Ensuring that we educate and train enough new nurses, midwives and nursing associates – with the right competencies – is critical to meeting the current and future staffing needs of our health and care services. A central tenet to that will be practice learning, and the assurances taken on its appropriateness and quality. That other countries often face similar challenges regarding assurances on practice learning underlines the complexity of the problem. However, we hope that the insights from this research will contribute to future considerations about how wider governance in this area is structured and delivered.

About this report

Context

Practice learning is a core requirement for students wishing to become a nurse, midwife or nursing associate. It is a fundamental part of their education that enables them to apply the theoretical knowledge they have gained in the classroom to actual service users and real-world scenarios. Supporting access to a diverse range of high-quality practice learning opportunities is a key part of ensuring that nurses, midwives and nursing associates have the behaviours, skills and knowledge needed to deliver safe and effective care.

The challenges and importance of delivering effective practice learning have been heightened in light of ongoing system challenges. Persistent shortages in health and care staff have meant that services have been unable to keep up with demand, contributing to delays in care, low staff morale and historically high patient dissatisfaction with care. All parts of the UK are having to consider whether their domestic pipeline of nurses, midwives and nursing associates is sufficient.

While increasing the education and training pipeline is important for developing a workforce that can meet patient and service user needs, both now and in the future, doing so has important implications for the availability and quality of practice learning placements. NHS, social care and the education sector are already under significant pressure and report substantial staff shortages. This raises questions about the way practice learning can best adapt to accommodate growing numbers of students in a system already under significant strain, while maintaining public safety.

Standards around education and practice learning have changed over time and the Nursing & Midwifery Council (NMC) has sought to regularly review their appropriateness and opportunities for improvement. For example, in 2018, new national Standards for Student Supervision and Assessment (SSSA) replaced the previous ‘mentor’ and ‘sign-off mentor’ roles with three

new roles: practice supervisor, practice assessor and academic assessor. The changes differentiated support and supervision from assessment and made practice learning the responsibility of all practice nurses and midwives.

More recently, sociopolitical events have also prompted renewed interest in how practice learning is regulated. Up until the end of 2020 – when the transition period for the UK's departure from the European Union (EU) ended – an EU Directive on the recognition of professional qualifications (Directive 2005/36/EC) governed nursing and midwifery education, and aimed to establish minimum EU-wide standards for education and training. After leaving the EU, the NMC had additional flexibility on setting its standards and conducted a review to understand if there was any benefit in amending them. The Covid-19 pandemic has also disrupted existing approaches to practice learning, and has broadened the use of innovations such as simulation in nursing practice learning. More broadly, changes in the complexity of care, ambitions for a more preventative approach, digital technology, wider movement around embedding and reflecting equality, diversity and inclusion, and improving leadership skills all have implications for practice learning.

In addition, a recent independent review of the NMC, which highlighted various concerns and issues about the culture within the organisation and a link from that to its regulatory performance, has called into question how the nursing and midwifery professions are regulated more widely.[3]

Taken together, this context creates an important opportunity to re-examine the UK's existing approach to how practice learning is supported and regulated in the UK, and where there might be opportunities to align with future demand, evolving service user demographics and advancements in technology.

Our approach

In March 2024, the NMC commissioned the Nuffield Trust, who worked in partnership with the Florence Nightingale Foundation, to produce an independent report to:

- examine **current regulations and standards for practice learning in the UK**, the factors that shape their design, the trade-offs they involve and what we can learn from other countries with different approaches

- understand the factors that contribute to **a positive learning environment**, including **practice supervision and assessment**, and how to ensure that students get a **variety of learning experiences, support and resources** to help them meet their learning goals and develop the proficiencies needed to deliver safe, effective and person-centred care in a range of settings

- learn about different practice learning opportunities across the UK and internationally, and **what helps or hinders their effectiveness**

- explore different models for delivering practice learning, including opportunities for innovation such as the use of **simulation**

- understand the factors contributing to unfair treatment and inequity in how practice learning is accessed and experienced, and what might need to change to ensure greater **equity, inclusion and diversity** in the delivery of practice learning.

These aims represent a broad scope and we have not sought to be exhaustive in what we report but rather highlight the key, relevant findings which can then inform the NMC in this discovery phase in its consideration around the regulation of practice learning. There are also topics that are not included in our scope, including the design, delivery and assessment of the theory-based parts of education, and post-registration education and training (such as for advanced practice). Further, we focused on practice learning requirements, such as practice learning hours, rather than the timeframe or length of pre-registration courses.

Our research used a mix of methods including:

- reviewing previous research both from the UK and elsewhere where relevant
- analysing data on pre-entry qualifications and using the NMC register
- interviewing key experts
- holding focus groups with registered staff and students
- convening policy workshops for each of the four nations of the UK
- facilitating deliberative focus groups with members of the public and service user representatives.

We sought to be representative in terms of the demographics of participants, issues covered and different UK nations and report on this in more detail – along with providing further details on our methodology – in Appendix 1.

The report is structured as follows:

Chapter 1 provides an overview of the nursing, midwifery and nursing associate workforce, and of the education requirements for each profession; it also outlines the governance, infrastructure and funding arrangements around practice learning, and provides further detail on the policy context that underpins it.

Chapter 2 sets out the different regulatory requirements for practice learning in the UK and abroad, explains the evidence underpinning current standards and sets out the perspectives of different stakeholders on these requirements and the trade-offs they involve.

Chapter 3 outlines the regulatory requirements and evidence around the use of simulation in practice learning in the UK and internationally.

Chapter 4 discusses the breadth of settings in which practice learning takes place; the design and structure of practice learning; factors that contribute to a supportive practice learning environment; approaches to monitoring the quality of practice learning; and equality, diversity and inclusion considerations.

Chapter 5 examines the role of practice supervision and assessment, how these standards are operationalised and where there might be scope for improvement to better assure the competence of the nursing, midwifery and nursing associate professions.

Chapter 6 sets out key regulatory principles and outlines next steps and future actions for policy, practice and research.

Exploring differences between professions, fields, services and nations

Many of the issues we identify in this report appear to be relevant to each of the three professions and across the four nations of the UK; however, there are also notable differences. Where we identified differences we make them explicit in the text, but it is also important to note as a limitation of the study that the scale of the research did not enable us to consistently explore differences between professions, fields, services and nations across all the phenomena discussed.

Notes on terminology

Academic assessor: collates and confirms the student's achievement of proficiencies and programme outcomes in the academic environment for each part of the programme.

Approved education institution: the status awarded to an institution, part of an institution or a combination of institutions that work in partnership with practice learning partners after the NMC has approved a programme. Approved education institutions will have assured the NMC that they are accountable and capable of delivering approved education programmes. Approved education institutions typically include universities, or further education colleges, for example.

eMORA: an electronic portfolio containing all the practice documentation required for the duration of a midwifery student's journey in practice, which is intended to provide a comprehensive record of the student's professional development and performance in practice.

Nursing & Midwifery Council (NMC): the statutory regulator of nurses, midwives and nursing associates in the UK.

Placements (or practice learning opportunities): learning environments where students undertake practical activities to develop knowledge and skills relevant to their role. These can be real-life or simulated environments and can include non-clinical opportunities, such as in research, management or policy.

Practice assessor: assesses and confirms the student's achievement of practice learning objectives within practice learning experiences.

Practice learning/employer partner: an organisation that provides practice learning experiences for students, for example NHS trusts or health boards, GP surgeries or care homes.

Practice learning environment: includes any location (physical or virtual) where learning takes place as well as the system of shared values, beliefs and behaviours in that location.

Practice supervisor: an individual supervising a student on placement, who must be a registered health or social care professional and adhere to the Standards for Student Supervision and Assessment.

Preceptorship: a structured start for newly registered nurses, midwives and nursing associates.

Protected learning time: designated time in which students are supported to learn. All students are appropriately supervised until they have demonstrated proficiency in aspects of care (see also: *supernumerary status*).

Reasonable adjustments: changes in the way services are offered to prevent students with disabilities from being placed at a substantial disadvantage, ensuring a fair and equal chance of accessing services as set out in equalities and human rights legislation.

Recognition of prior learning: a process that enables previous certificated or experiential learning to be recognised and accepted as meeting some programme outcomes and requirements – this means it includes both theory and practice achievement.

Secondary care: covers an array of services including planned, urgent and emergency hospital care. In this report we are not using this term to cover community health care, tertiary (that is, more specialty) care or primary care (for example, general practice).

Simulated practice learning: practice learning scenarios are replicated, supported and complemented through a wide variety of simulation approaches (see *simulation* below).

Simulation: an artificial representation of a real-world practice scenario that supports student development and assessment through experiential learning, with the opportunity for repetition, feedback, evaluation and reflection. This

can include both physical simulation (for example, using manikins) as well as virtual simulation (for example, using virtual reality).

Standards for Student Supervision and Assessment (SSSA): NMC standards setting out the roles and responsibilities of practice supervisors, practice assessors and academic assessors. They also set out expectations for the learning, support and supervision of students in the practice environment. In addition, they specify how students should be assessed for theory and practice learning.

Supernumerary status: the individual (the student in this report) should not be counted as part of the workforce when they are on a learning placement in a clinical setting.

1 Introduction to pre-registration education and practice learning

Key points

- There is no one typical nurse, midwife or nursing associate job – these professions are large and diverse and cover a vast array of roles and settings such as in hospitals or community care.
- The domestic pipeline is large – some 30,400 individuals who trained in the UK joined the Nursing & Midwifery Council (NMC) professional register for these professions in the year to March 2024 – and students have a diverse range of life experience, academic results on entry and motivations.
- There is considerable movement of staff across the UK nations, as well as internationally, which highlights the importance of a degree of consistency and recognition of theoretical and practice learning standards and qualifications.
- The scale and pace of movement suggest that there could be significant consequences for nurses and midwives seeking to come to the UK or benefit from spending some of their career working abroad without an appropriate amount of consistency in the educational requirements between countries.
- The complex roles and responsibilities around practice learning – which include service regulators, commissioners, professional workforce bodies and workforce education teams – vary between the UK nations.
- While mechanisms to reimburse practice learning providers differ between the UK nations, insufficient funding was often cited in this research as a barrier to growing the breadth of learning opportunities.

This chapter provides background information on nurse, midwife and nursing associate education and the practice learning element of it. This context is important in relation to what assurances need to be taken on their skills, experiences and behaviours during their education. Specifically, we cover:

- the composition of nursing, midwifery and nursing associate professions
- the scale of the education pipeline
- entry requirements
- perspectives on the purpose and role of practice learning
- roles, responsibilities and funding in relation to practice learning.

Nurses, midwives and nursing associates

The composition of the professions

The nursing, midwifery and nursing associate professions together account for a vast proportion of the clinical workforce. For example, nurses and midwives account for more than a quarter of people working in NHS hospital and community services, and more than half of professionally qualified clinical staff.[4]

As of March 2024, in total, there were more than three-quarters of a million (around 765,100) registered nurses in the UK, 44,100 midwives and a further 6,400 professionals with both nursing and midwifery registration. The nursing associate role is regulated in England only, where there were 10,900 nursing associates. Combined, the number of these registered health and care professionals has increased by 128,200 (or 18%) in five years.[5] The number of nurses relative to the size of the population varies across the UK but, as broadly expected given the size of the UK nations, around four-fifths (81%) of these professionals registered in the UK live in England, a 10th (10%) live in Scotland, 5% live in Wales and 4% live in Northern Ireland.[5]

The work settings and services that nurses, midwives and nursing associates work in vary significantly across these roles. While there are some limitations

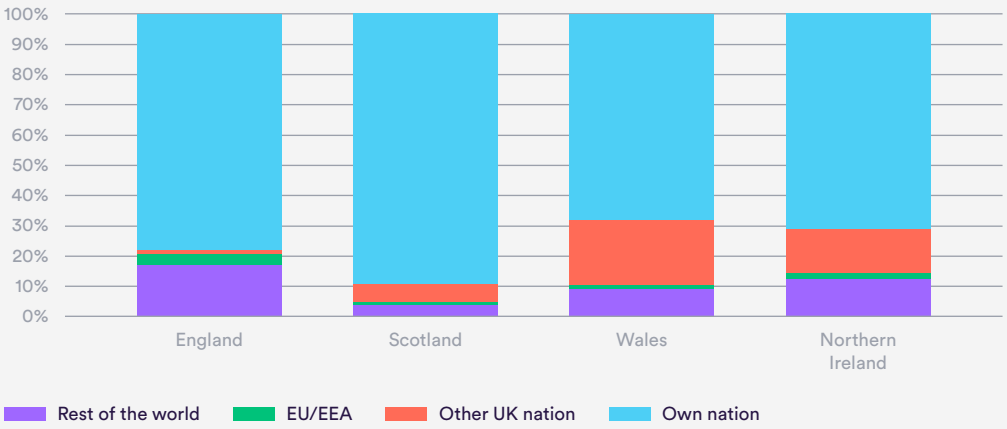
on the information available, data on those revalidating* suggest that around three in five nurses (59%) registered in the UK work in hospitals and secondary care, a fifth (19%) work in community settings and smaller percentages work in other sectors such as care homes (7%) and GP practices (6%). Around three-quarters of midwives work in maternity units or birth centres (42%) or hospitals (34%), with a further one in six (18%) recorded as working in community settings. Two-thirds (67%) of nursing associates are based in hospitals and a fifth (21%) are based in community settings. Additionally, nurses, midwives and nursing associates work in a range of other settings including in the public sector outside health care services (such as in the military or prisons), universities, independent and voluntary providers and research facilities.

Many nurses and midwives move between the nations of the UK over the course of their careers. For example, more than a fifth (22%) of NMC registrants with an address in Wales trained elsewhere in the UK (see Figure 2).† The scale of movement across the UK reiterates the need for an appropriate amount of consistency in the preparation of these professionals so that they can safely and effectively fill roles in any region or nation of the UK.

* The process that all nurses and midwives in the UK and nursing associates in England need to follow to maintain their registration with the NMC. These professionals need to revalidate every three years.

† Corresponding figures are as follows: 2% of NMC registrants with an address in England trained elsewhere in the UK, while 6% of registrants living in Scotland and 14% of registrants living in Northern Ireland trained elsewhere in the UK, as at March 2024.

Figure 2: Proportion of each UK nation's registered nurses, midwives and nursing associates who trained elsewhere, March 2024



Notes: Based on those with an address in each of the four UK nations, as of March 2024. Excludes those with no known country of training. EU = European Union and EEA = European Economic Area.

Source: Nuffield Trust analysis of NMC data

Moreover, a significant percentage of registered nurses and midwives in the UK have trained overseas, representing nearly a quarter (23%) of people on the current register. However, they accounted for around half (49%) of people joining the register for the first time in the year to March 2024.[5] The scale of overseas recruitment varies between the UK nations, with the proportion being four times higher for current registrants with an address in England (21%) compared to Scotland (5%) (see Figure 2). The source countries also vary somewhat across countries, with the Republic of Ireland contributing a higher proportion of registrants in Northern Ireland. India, the Philippines and Romania appear in the top five for each UK nation (see Table 1).

Table 1: List of the top five non-UK countries of training of registrants, by UK nation of address

England	Scotland	Wales	Northern Ireland
Philippines (38,256)	India (891)	India (1,459)	India (1,441)
India (33,709)	Philippines (764)	Philippines (1,369)	Philippines (1,251)
Nigeria (10,191)	Nigeria (321)	Romania (239)	Romania (274)
Romania (6,525)	Romania (144)	Nigeria (176)	Zimbabwe (250)
Ghana (4,234)	Poland (133)	Ghana (109)	Republic of Ireland (169)

Notes: Based on those with an address in each of the four UK nations, as of March 2024.
Source: Nuffield Trust analysis of NMC data

Some UK-trained staff also leave the UK to work in other countries.[6] While there are no comprehensive data on this, the piecemeal information available highlights common destinations of UK-trained nurses, including both European countries (notably the Republic of Ireland with 10,090 UK-trained nurses registered to practice there in 2022) and other parts of the world such as Australia (13,600 in 2021).[6] Given the current reliance on overseas recruitment – particularly in some parts of the UK – and the attractiveness of potential opportunities to work abroad (including temporarily) for some prospective candidates, careful consideration is needed to ensure appropriate recognition of practice learning across international borders.

Nurse, midwifery and nursing associate education

The most common routes into nursing or midwifery involve completing an undergraduate or postgraduate degree course. In England, there is a growing number entering through nursing associate roles (see Box 1) or degree apprenticeships. On the latter, in England, for example, the NHS Long Term Workforce Plan for England projected that apprenticeships would expand as a proportion of annual intakes from 9% in 2022 to 28% in 2031 for nursing, from 30% to 50% for nursing associates and from less than 1% to 5% for midwifery.[7]

There are many differences in the structure and funding of nursing and midwifery degrees across the UK nations. In England, students must currently pay up to £9,250 a year in tuition fees (much more if from outside the UK). In Scotland, Northern Ireland and Wales there are no costs to students for tuition fees in nursing or midwifery courses. However, in Wales, graduates must work in the NHS for two years to have their tuition fees waived. We cover the differences in maintenance loans in the subsection 'Costs and accessing practice learning settings' in Chapter 4. Another notable difference is that honours degrees in Scotland typically last four years rather than three.

Box 1: About the nursing associate role

Nursing associates were introduced in England in 2019, with the stated intention to bridge the gap between unregulated health care assistants and registered nurses.[1] Qualified nursing associates can go on to train towards a shortened (two-year) nurse degree apprenticeship.

Approved education institutions (for example, universities and further education colleges), together with practice learning partners, provide these pre-registration courses. The intention is that, during the courses, students are taught to, for example:

- understand, promote and facilitate safe and effective care
- know when to call for assistance and implement emergency measures, often working with other health professionals
- provide unbiased information and communicate effectively with a range of people seeking or requiring care or services
- promote health and wellbeing.[8]

Scale of the education pipeline

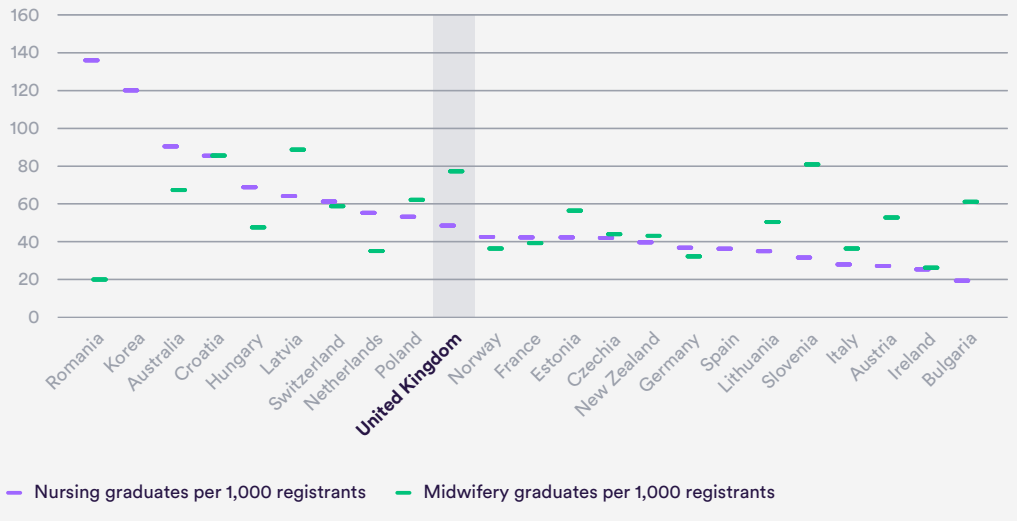
Across the UK, there are currently 909 accredited pre-registration nursing courses and 123 midwifery courses, while in England there are 111 nursing associate courses. In 2024/25, 23,800 applicants were accepted onto pre-registration courses in the UK, which is equivalent to that in 2019/20 but a significant fall (6,350 or 21%) compared to 2021/22 (during the Covid-19

pandemic). For midwifery, the number of applicants accepted fell from 4,170 in 2021/22 to 3,880 in 2024/25 (7%) but remain above 2019 levels (3,540).[9,*]

The scale of the domestic pipeline is also visible from the numbers joining the NMC professional register. In the year to March 2024, approximately 30,400 individuals who trained in the UK joined the register for the first time. This marks a significant increase of about 6,900 people (equivalent to 29%) compared to five years earlier, although this growth is not uniform across all fields and professions.

Examining the number of graduates in relation to the size of the workforce can provide insight into the scale of the domestic education and training pipeline. While international comparisons need to be treated with a degree of caution because of the differing nature of courses and data definitions, the UK seems to have had a fairly middling number of students completing pre-registration nursing courses in 2021 relative to the size of the profession (48 graduates per 1,000 registrants) (see Figure 3). In contrast, the number of midwives graduating was relatively high at 77 per 1,000 registrants (see Figure 3).[6]

Figure 3: Number of nursing and midwifery graduates relative to the size of the register, 2021



Note: Due to challenges with comparing specific data between countries, this figure should be interpreted with a degree of caution.

Source: Nuffield Trust analysis of OECD data

* Data from day 28 of clearing.

There are efforts in each of the four UK nations to expand the education pipeline for nurses and midwives. For example, in England, the NHS Long Term Workforce Plan projected an increase in the education and training intake for each profession but by varying amounts.[7] This ranged from roughly doubling for adult, learning disability and mental health nursing to a 13% increase for midwifery and plateauing in children's nursing over nine years. The relative increase for nursing associate training in England is projected to be even higher, more than doubling over the same timeframe. At the time of writing, Scotland was reportedly considering exploring the potential challenges and opportunities of the nursing associate role in the Scottish context, while the Welsh government had recently set out its intention to introduce the role.[10]

Entry requirements

In the UK, approved education institutions such as universities and further education colleges are responsible for setting entry requirements for their programmes. In comparator countries, while there is limited published information on their entry requirements, education institutions usually set them, and sometimes provinces do, as in Canada.[11] Universities are also responsible for ensuring that students' 'health and character' are sufficient to enable safe and effective practice upon entry and throughout the programme. The NMC requires approved education institutions and practice learning partners to ensure that students possess a variety of capabilities, values and proficiencies to meet programme outcomes (see Box 2).

Box 2: Entry requirements

Approved education institutions and practice learning partners are required to confirm that students:

- meet the entry criteria for the programme as the education institution has set out and are suitable for their intended profession
- demonstrate values and learn behaviours in accordance with the Code – which presents the professional standards of practice and behaviour for nurses, midwives and nursing associates

- have the capability to develop the required numeracy skills
- can demonstrate proficiency in the English language
- have the necessary capability in literacy
- have the necessary capability for digital and technological literacy.

Source: NMC[2]

There are differences among approved education institutions in the extent to which competencies and behaviours are expected of students entering education or whether these can be developed during the course. While the NMC standards emphasise the expectation to learn or develop behaviours or competencies, one recent comparative research paper suggested that the UK is considered to have 'values-based recruitment procedures' rather than emphasising the development of these qualities after entering the programme.[12]

For nursing and midwifery programmes, students usually need at least five General Certificates of Secondary Education (GCSEs) at grade 4/C or higher (including possibly English and a science subject), along with two A Levels or equivalent qualifications,* to get into an undergraduate degree.[13] Although there is limited evidence that entry requirements affect competency outcomes, the differences across universities in terms of what they require are significant. For example, entry requirements between nursing programmes can vary from 155 UCAS points (equivalent to A*AA) to 86 (equivalent to CCD). Even within the same course, there is a wide range, with one example programme accepting students with as few as 48 or as many as 176 UCAS points.[14,†] Using the most recently readily available data (for 2023/24), we plotted the range of UCAS points of students accepted onto different nursing

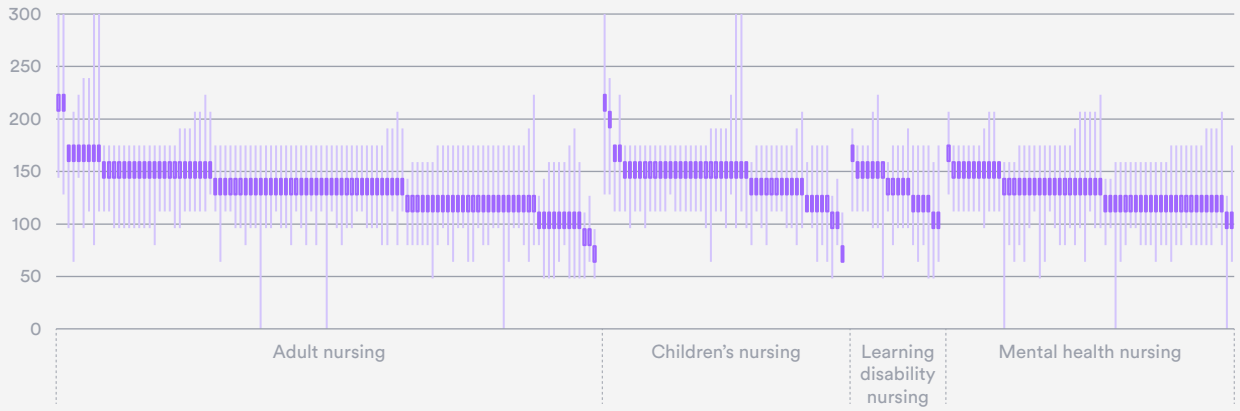
* Such as a T level or Business and Technology Education Council (BTEC) qualification.

† Publicly available data on UCAS points attained are no longer available as average per course but, in our previous work, we highlighted that for nursing in England, the reported average UCAS tariff points that new undergraduates held in 2018/19 ranged from 151 points (equivalent to A*AA at A Level) to 92 points (equivalent to CCC/CCD). See Palmer and others (2020) *Laying foundations: Attitudes and access to mental health nurse education*. Nuffield Trust.

courses in the UK, showing the lower 10th, 50th (median) range and higher 90th percentiles (see Figure 4; see Appendix 2 for UCAS data on midwifery and nursing associate courses). Unfortunately, the underlying data are only presented in ranges, which limits the analysis. However, the data do demonstrate significant differences within countries, professions and fields, and courses. Some universities offer foundation-year courses for those who do not meet the usual entry qualifications.[15] Given the ambition to increase the numbers being educated, admission thresholds for clinical courses may have to be lowered, which carries unknown consequences.

A previous consultation found mixed views on whether universities and practice learning partners should be allowed to set entry criteria for literacy, numeracy and digital literacy or whether the NMC should set them, although it was generally accepted that digital literacy was increasingly important. Educators suggested that numeracy skills taught in, for example, GCSE mathematics, did not necessarily reflect the numeracy skills needed for safe and effective practice, especially for neurodivergent students.[16]

Figure 4: Average UCAS grades of students accepted onto nursing courses in the UK for each course, by field of nursing, 2023/24



Notes: The minimum value of the boxplot is the lowest value of the UCAS grade range of the 10th percentile. The interquartile range is the UCAS grade range of the median. The maximum value is the highest value of the UCAS grade range of the 90th percentile. It is important to note that some universities and colleges accept a wider range of qualifications for entry to their courses, some of which are not accounted for in the UCAS tariff points. This means that the tariff-points data we show for some courses may not reflect the value and grades that some students accepted onto the course achieve. This may affect the majority of courses at institutions with higher proportions of international or non-UK intakes.

Source: Nuffield Trust analysis of the Discover Uni dataset for 2023/24

It is also important to recognise the breadth of life experience and motivations that students bring to training and education. In 2023, there were as many individuals accepted onto nursing courses aged over 36 (6,755) as there were 18-year-olds (6,595).[17] Students may also differ in the level of intrinsic motivation they have for wanting to become a nurse, midwife or nursing associate, which evidence has shown significantly influences a student's engagement, perseverance and, ultimately, their academic and professional attainment.[18] Having broad and flexible entry requirements can provide positive opportunities around inclusion but also represent a challenge to achieving appropriate consistency in the standard of graduates.

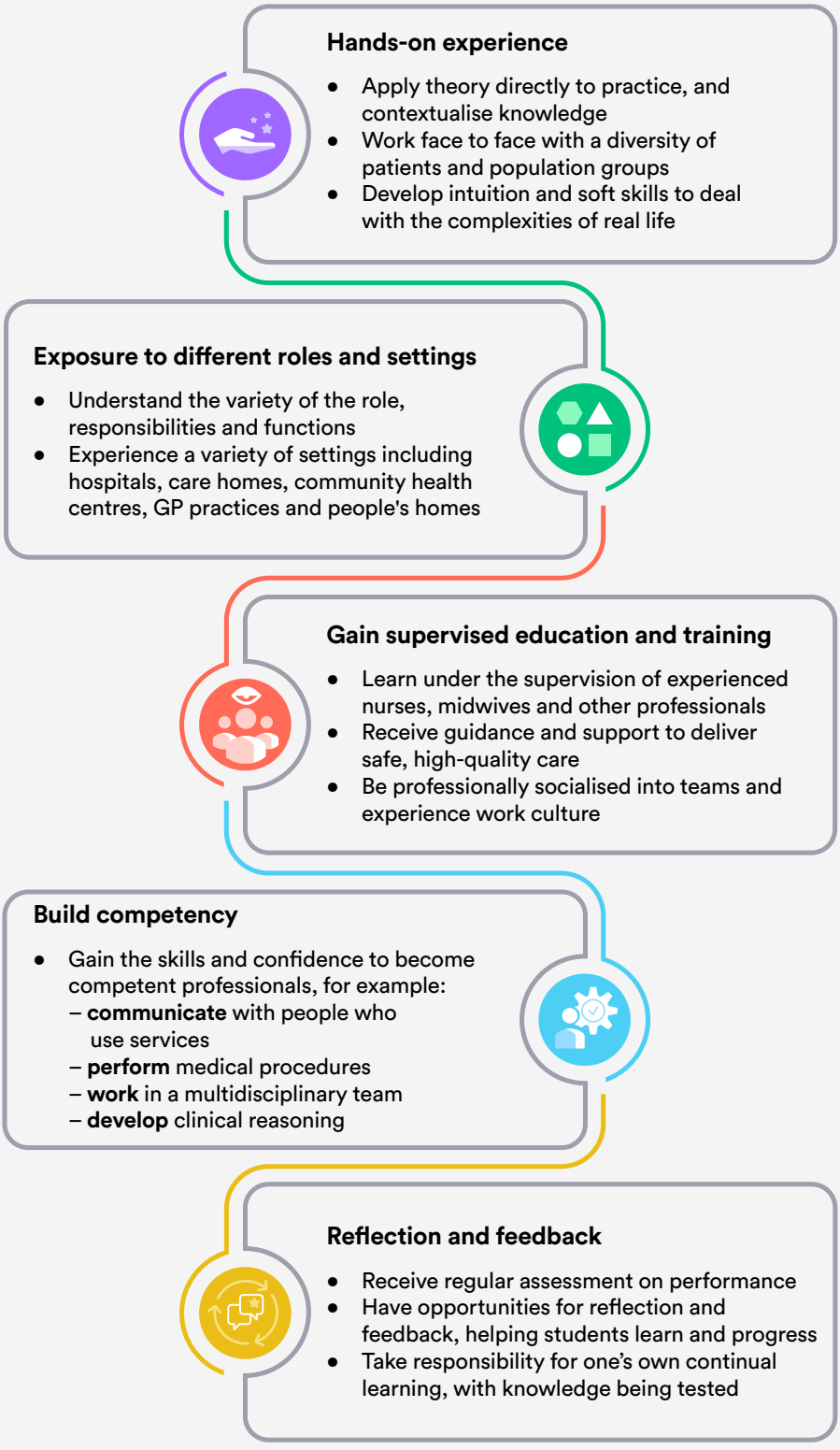
Practice learning

For nursing, midwifery and nursing associate courses, the NMC requires half of the programme to be 'practice learning'. This can take place in a range of settings, including in the home, community or hospitals, and potentially within independent, national or voluntary sector organisations.[8] The NMC notes that practice learning is intended to support students to 'develop professional behaviours and gain the experiences they need to deliver safe, kind and effective care when they qualify'.[19]

Perspectives on the purpose and role of practice learning

Practice learning serves different purposes. The published literature (from the UK and further afield) identifies a range of commonly stated aims of practice learning, including skills development, the application of theory, professional socialisation, competence building, job readiness and the consolidation of learning[18,20] as well as the development of the attitudes and competence needed to make continual improvements in the workplace after qualification (see Figure 5).[21]

Figure 5: Commonly stated aims of practice learning for student nurses and midwives



Sources: Amimaruddin and others (2022),[20] Berndtsson and others (2020),[21] Byfield (2019),[18] Hughes and others (2023)[106] and our focus groups

In our research, focus group participants (as well as wider stakeholders) tended to have a shared understanding of the role and aims of practice learning, emphasising the important role it has in shaping the professional identity of nurses, midwives and nursing associates and helping students to internalise the values, ethics and standards of their profession. Participants also spoke about its role in helping students experience and work with people along the whole patient journey, while providing a vital space for continuous learning and reflection.

Service users and members of the public we engaged with discussed how, to them, practice learning must put students in the best position to respond to any 'unknowns', complications or difficult scenarios. They suggested that the experience of and exposure to a range of different service users in practice learning was the best way to achieve this.

Roles and responsibilities around practice learning

As the independent professional regulator for nurses, midwives and nursing associates in the UK (see Box 3), the NMC has a key role in providing assurances on practice learning. This includes ensuring that pre-registration programmes meet their published standards (covering education, student supervision and assessment) – which are intended to guide students, professionals, practice learning partners and approved education institutions – through a detailed approval process. This process includes approval visits and the approval of any modifications to existing educational programmes. At the time of writing, the NMC was conducting a review on its approach to the quality assurance of education programmes, including mandatory exceptional reporting that all approved education institutions are asked to complete.

Box 3: Professional regulation of nurses, midwives and nursing associates in the UK

The regulation of certain professions is intended to protect the public from the potential harm that may arise from the delivery of health and social care services. Regulation can take various forms, with the most formal being 'statutory regulation' where professionals are legally required to be registered with a professional regulatory body. This ensures that only those on the register can legally describe themselves as regulated health care professionals.

Regulators have a responsibility to uphold professional standards and maintain public confidence in the professions. While health and care policies are mostly devolved, the system of professional regulation operates – for most professions – on a UK-wide basis.

The NMC serves as the independent regulator for nurses and midwives in the UK and nursing associates in England. The NMC establishes educational and professional standards and is responsible for investigating concerns about individuals and their fitness to practise.

Regulatory landscape

The roles and responsibilities around practice learning are complex. Professional regulation is typically not, in itself, sufficient assurance for protecting service users from harm and maintaining confidence in the regulated profession. The governance of professional practice can, in this respect, be considered in tiers, from self-regulation to team regulation, employment regulation and statutory regulation. There is a huge number of organisations involved in the wider assurance process – including regulators, professional associations, royal colleges and commissioners – with responsibilities such as registration, accreditation, policy-making, monitoring, investigations, inspections, imposing sanctions, quality improvement, analysis and the sharing of data, advice and support for the public and for organisations, representation, professional development and research. Not all have a direct role in providing assurance on practice learning, but many do.

There are significant differences in the organisational structures between the UK nations. The nations also differ significantly in terms of the size of their educational pipeline, with 864 accredited pre-registration nursing and

midwifery courses in England, compared to 86 in Scotland, 68 in Wales and 14 in Northern Ireland (see Table 2). The size and scale of nursing and midwifery educational pipelines across the different countries appear to affect the ability to manage, and the nature of, relationships. The equivalent of the NMC in the Republic of Ireland – the Nursing and Midwifery Board of Ireland – has approved some pre-registration nursing programmes in Northern Ireland, and the government in the Republic of Ireland has funded student nursing and midwifery places at Northern Ireland universities.

Table 2: Key organisations related to practice learning across the UK nations

	England	Scotland	Wales	Northern Ireland
Overall oversight of the system	Department of Health and Social Care	Health and Social Care Directorates	Department of Health and Social Services	Department of Health
Funders of university places	Office for Students	Scottish government	Welsh government	Northern Ireland executive
Commissioners of practice learning	Integrated care boards NHS England		Health Education and Improvement Wales	Department of Health*
Approved education programmes†	755 nursing programmes	78 nursing programmes	64 nursing programmes	12 nursing programmes
	109 midwifery programmes	8 midwifery programmes	4 midwifery programmes	2 midwifery programmes
	111 nursing associate programmes	N/A	N/A	N/A
	The Council of Deans of Health represents the UK's university faculties engaged in education and research for nursing and midwifery.			
Professional regulator	Nursing & Midwifery Council (NMC)			
Practice learning partners	NHS trusts/boards in England, Wales and Scotland; integrated health and social care trusts in Northern Ireland; general practice; independent sector; charities; social care; prisons; schools; arm's-length bodies‡			
Service regulator§	Care Quality Commission (CQC)	Healthcare Improvement Scotland	Healthcare Inspectorate Wales	Regulation and Quality Improvement Authority (RQIA)

Notes:
* Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) also supports the development of nurses and midwives by promoting high standards of practice, education and professional development.
† Data on programmes that the NMC has provided.
‡ The use of non-NHS hospital and community service providers differs between the UK nations, as we discuss in Chapter 4.
§ Practice learning can occur in non-health settings, such as education services, which have other regulators (for example, Ofsted in England).

The clarity of organisational responsibilities and accountabilities as well as the level of collaboration are important for the delivery of effective practice learning. We heard from our stakeholder interviewees that there were opportunities for better coordination and we discuss some of these later in the report, particularly between approved education institutions and practice learning partners (see section 'Collaboration, continuity and coordination' in Chapter 5, p. 119).

Universities typically expressed keenness for greater autonomy to design and implement practice learning. For example, we heard the view that "HEIs [higher education institutions] are given accountability of the programme but [are] not equal partners in the process" and felt that the NMC regulations were overly restrictive. We also heard that, in some instances, the Covid-19 pandemic had affected the nature of the relationship between practice learning partners and universities (with, for example, a reduced presence of lecturers in some practice learning environments due to restrictions on external visitors) and that this has not been restored.

A lack of coordination between some education and practice learning partners can also contribute to a theory–practice gap – an oft-cited challenge in the published literature and something that our stakeholders mentioned.[20,22,23] Some focus group participants reflected on how academic and practice learning are increasingly misaligned, not only in the content, access to and interpretation of the latest evidence, but also in the teaching methods and approach to learning deployed. We heard that a key driver of this is that faculty members can have weak links to current clinical practice, because of either restrictions on their role (as is the case in many countries) or weak partnerships between clinical practice sites and universities. This issue is not unique to the UK, as exemplified below in a quote from an expert in Norway.

What we do see is that there is a big gap between the theory and academic institution and the clinical practice clinics, which puts the students in rather awkward situations… Not only because they learn different things in the institution versus clinical practice, but because the institution may not be updated on the latest evidence… it's all very dependent on the faculties' interest and engagement.
Midwifery education lead

Funding practice learning placements

There can be a substantial cost to providing practice learning, for both practice learning partners and approved education institutions. These costs include the time of staff for supervision and assessment, and the training necessary to support their development in those roles (see Figure 6).

Figure 6: Examples of costs related to providing practice learning

Source: Nuffield Trust adapted from NHS England (2023)

One key difference between the nations of the UK is that in England there is funding, via NHS England, to contribute to the cost of practice learning placements, as set out in the education tariff. There are significant differences in funding levels between staff groups, however: while the difference has since decreased from around 10-fold, there was still a substantial disparity between the £32,552 for undergraduate medicine compared to £5,343* for nursing, midwifery and other non-medical undergraduate clinical courses in 2023/24.† This broadly works out as £100 a week per student, which we heard may be an inadequate incentive for short placements. Some costs for practice learning partners are met through other mechanisms with, for example, the approved education institutions in Scotland having responsibility to prepare practice supervisors and assessors free of charge.

* Figures given are minimum, with providers in high-cost areas receiving as much as 21% higher.

† Figures are for full-time equivalent rather than per student, on the basis that the full tariff will be paid for each 40.8 weeks of placement activity, and that one week represents 37.5 hours of placement activity.

2 Practice learning requirements – opportunities for the UK

Key points

- There is limited published empirical evidence to determine the optimal number of practice learning hours needed to ensure safe and effective practice or support the current 2,300 hours requirement.
- There was consensus among stakeholders that the quality of practice learning mattered more than its duration, and that current requirements need revisiting to better assure quality and reduce inconsistencies in experience.
- However, there was no clear agreement across all the stakeholders on what the optimal number of practice learning hours should be and whether the current requirement should be reduced.
- There is also limited evidence and mixed views on the optimal number of births, assessments and other learning objectives required as part of midwifery training standards.
- We repeatedly heard confusion about what counts as a practice learning hour and what is theory and that there is insufficient protection of students' 'supernumerary status' and protected learning time.
- The specific practice learning requirements appear to have unintended consequences, including anxiety for students and the promotion of task-oriented care rather than continuity of care.

This chapter provides an overview of current practice learning standards in the UK, and the evidence that underpins them. Specifically, it covers:

- what the regulatory requirements around practice learning are
- the evidence and views on the current requirements and precedent
- some key challenges that arise when applying the standards in practice, including how they are interpreted.

Overview of practice learning hours and requirements for nurses, midwives and nursing associates

In the UK, practice learning for nursing and midwifery students and trainee nursing associates involves developing proficiency in a range of skills, knowledge and behaviours across various settings. These standards are comprehensive and designed to ensure that graduates are fully prepared to deliver safe, effective and compassionate care once they qualify. The proficiencies overlap across the professions and are summarised in Table 3, and include things like gaining experience in caring for people who use services, decision-making and teamwork, all while ensuring public safety and quality of care. Students must also demonstrate competence in essential skills such as communication, leadership, patient assessment and understanding diverse patients.

Alongside proficiencies, the NMC requires students to complete a specified number of practice learning hours for each profession. These requirements are also summarised in Table 3 and discussed in detail in the following section.

Table 3: Key aspects of nursing, midwifery and nursing associate education and training requirements

	Nursing	Midwifery	Nursing associates
Practice learning hours and requirements	50% of course (equivalent to 2,300 hours)	50% of course (equivalent to 2,300 hours) Must also meet key practice learning requirements across the continuum of care, including: caring for 100 women (both antenatally and postnatally) and performing 40 births (see the subsection 'Midwifery', p. 48, for full details)	50% of course (equivalent to at least 1,150 hours)
Proficiencies	Students in each profession must demonstrate knowledge and skills in key areas to qualify for registration. These overlap between the professions, and include: • accountability • health promotion and prevention • needs assessment, care planning and/or care delivery, and monitoring • providing evidence-based and compassionate care • team-based working • quality improvement and safety • care coordination and integrated care. Midwifery standards also emphasise continuity of care, managing complications and providing universal care for all women and newborn infants.		

Evidence and perspectives on the requirements and precedent

The standards for practice learning for nursing and midwifery education and training in the UK have historically been aligned with an EU Directive on the recognition of professional qualifications (Directive 2005/36/EC), as well as the International Confederation of Midwives' Global Standards for Midwifery Education for midwifery.[24]

The subsections below discuss the evidence, precedent and perspectives from stakeholders that underpin these requirements, as well as how experiences vary internationally and by profession in the UK. We look first at practice learning hours requirements for becoming a registered nurse, before turning to requirements in midwifery (and discuss where there is overlap between the two).

Nursing

Evidence base

There is limited empirical evidence to determine the optimum number of practice learning hours needed to ensure safe and effective nursing practice. Very few studies have looked directly at this question, and when they have, they have tended to look at programmes outside the UK, limiting the generalisability of findings.[25,26]

Some studies from the United States have explored the number of hours required to ensure sufficient competency among advanced practice nurses, though for registered nurses and midwives there is no conclusive evidence on the quality and minimum number of in-person clinical practice learning hours needed to qualify.[27,28] For instance, one smaller-scale study comparing four pre-licensure nursing programmes in the United States found that licensure exam results were not commensurate with the number of clinical hours, which varied significantly across programmes.[26] A recent systematic review that the NMC commissioned also found no conclusive evidence that higher numbers of practice learning hours resulted in better outcomes.[11]

International experience and precedent

This gap in evidence has contributed to wide variation across countries in the number of practice learning hours required for nursing students to qualify.[11] For example, Australia currently requires a minimum of 800 hours, New Zealand requires 1,100 hours whereas European Union (EU) countries require 2,300 hours (see Table 4). It should also be noted that in 2019, an independent review into nursing standards in Australia recommended that the minimum number of practice learning hours be raised to 1,000 to be more aligned with international precedent.[29] And in New Zealand, a 2022 public consultation on nursing standards found little appetite for reducing the total number of minimum hours of clinical placements from 1,100 to 900 hours.[30]

But when drawing comparisons with other countries, it is important not to focus solely on differences in the number of hours required. For example, while Australia requires fewer minimum practice learning hours, experts noted that students tend to also experience smaller class sizes, which may allow for more personalised instruction and closer supervision. Service users and members of the public also raised concerns about making international comparisons on the number of hours requirements.

> **I think it's quite difficult to compare our university system and NHS services with other countries because there's quite a cultural difference and that really needs to be taken into account if we're going to look at things beyond the UK.**
> Service user

Not all countries stipulate a minimum requirement for practice learning hours, but of those that do, the UK and EU countries tend to have among the highest. Experts reflected how these differences tend to be a product of history, political decisions, as well as practical reasons around system capacity and the number of placement sites available. The literature backs this up, with one study finding that schools of nursing in the United States tend to set practice learning hours requirements on the basis of ritual, tradition, convenience and the availability of clinical sites in the absence of clear evidence or regulatory standards.[26]

Table 4: International comparison of minimum required practice learning hours for nursing

Country	Typical pre-registration programme duration	Minimum number of practice learning hours
UK	3 years	2,300
EU	3 years	2,300
United States	4 years	Varies by state, from 400 to 800, although typically at the upper end of this range (around 700 to 800)
Canada	4 years	Not specified (typically 50% of learning time)
Australia	3 years	800
New Zealand	3 years	1,100
India	4 years	4,656
Philippines	4 years	2,346

Sources: Harlow Consulting (2021) and NMC (2022)[11,31]

Stakeholder perspectives

There was no clear agreement among our focus groups participants or UK stakeholder interviewees on the ideal number of practice learning hours. Stakeholders highlighted various tensions and trade-offs in the current practice learning hour requirements, which need careful consideration when exploring potential future adaptations.

Quantity versus quality and the need for flexibility

Some educators and policy-makers argued that the hours requirement felt arbitrary and instead called for a more outcomes-based approach that would prioritise quality over quantity and allow flexibility in how practice learning was structured to better account for the different paces and ways that students learned. Similarly, when asked what is most important in assuring their confidence in the nursing (and midwifery) professions, service users agreed

that quality of practice learning mattered more than its duration, and generally supported a more targeted and flexible approach rather than a focus on hours.

> **For me it would make sense that the focus was on being competent in the key skills... that would make a lot more sense to me if that was signed off that somebody was competent... just the focus on hours doesn't make sense to me. I'd have a lot more confidence if it was on competency and key skills.**
> Service user

Some nurses felt that reducing the hours requirement might make it possible to reorient the focus of practice learning on quality and outcomes if it helped reduce pressure on students and supervisors.

> **Too often the focus for students is doing their hours rather than learning, and getting things signed off. I often hear students say 'I'm just here to make up hours' or something similar... but actually, they're there to learn first, and the number of hours happen to be the medium through which we're hoping that they're learning... It's a skewed view.**
> Nursing educator

Many reflected that reducing practice learning hours would be sensible if it gave current staff more bandwidth to provide dedicated teaching and supervision, and doing so could support a more sustainable supply of clinical staff. However, clinicians and service users also feared that this would be far from guaranteed in the current context. It would require strengthening assurance processes for practice learning partners and reducing overall pressure on the workforce to train, educate and supervise students (see Chapter 5).

It worries me slightly that things are changed without taking a moment to think about what we need to make this change easy. And if we're going to reduce hours we've got to set the conditions right for what a clinical environment or non-clinical environment needs to look like. What does a good placement activity look like? What's in place? What is their teaching approach? How have they created this safer learning environment?
Paediatric nurse

Risks of diluting the profession and the need for consistency

In contrast, some clinicians said that the current standard of 2,300 hours offered a useful minimum threshold and that reducing the practice learning hour requirement could risk diluting the profession. This is consistent with previous consultations into requirements for practice learning, where more than two-thirds of respondents (77%) favoured maintaining the equal 50/50 split between theory and practice learning hours (this consultation did not ask explicitly about the overall number of practice learning hours, only the ratio between theory and practice).[16]

Other educators cautioned that the number of practice learning hours is one of the most consistent elements across the four nations of the UK in terms of how nurses are trained, given the differences across countries described elsewhere in this report. Some nurses felt that ensuring this consistency is vital as nurses move throughout the UK (described in Chapter 1), so any discussion of changing hours would need to consider each devolved nation's context.

Midwifery

Across countries, the standards for education and training in midwifery tend to set out more focused requirements than standards for nursing. Alongside stipulating core competencies and practice learning hours, they dictate that practice learning in midwifery must meet a range of requirements, designed to ensure that students gain specific practical knowledge, such as a set number of births, antenatal examinations and other forms of support for all women and newborn infants. This involves providing holistic care to women on the

continuum from pregnancy to postnatal care, while also supporting diverse populations and complex cases.

In the UK, the NMC sets these learning objectives, which are compliant with the International Confederation of Midwives' (ICM) Global Standards for Midwifery Education and aligned with the EU Directive on the recognition of professional qualifications. Some of the key requirements are summarised in Box 4.

Box 4: Examples of midwifery practice learning requirements

- Conduct at least 100 antenatal examinations.
- Conduct 40 spontaneous vaginal births. In circumstances where 40 spontaneous vaginal births cannot be met owing to a lack of available women giving birth, it may be reduced to a minimum of 30, if the student assists with caring for an additional 20 births (these births must also meet certain criteria, but can include things like providing care during a vaginal instrumental birth).
- Gain experience with breech births (through simulation if necessary).
- Support and care for 100 women postnatally, including 100 healthy newborns.
- Provide care and support to 40 women with additional care needs or complications.
- Care for women across the life course with additional sexual and reproductive health needs.

Note: These requirements are not exhaustive. For a complete list of standards, please visit the NMC's website (www.nmc.org.uk).

Source: NMC (2024)[114]

International experience and precedent

Countries vary in how they set standards and learning objectives for the education of midwives, in terms of the number of births, examinations and other skills required to support the care of women and newborn infants (see Table 5). The EU Directive on the recognition of professional qualifications

sets a standard that midwife students must conduct at least 40 deliveries, which is also similar to what has been adopted in Australia and New Zealand. Norway and Sweden previously went beyond the EU requirement but have recently reduced the number of births required from 50 to 40, a pragmatic decision in both countries in part due to changing delivery patterns and pressures on clinical places. The EU Directive makes similar exceptions that birth requirements can be reduced to 30 if there are insufficient numbers of available women in labour, provided that the student also assists with 20 further deliveries.

Table 5: International comparison of the minimum required practice learning hours for midwifery

Country	Typical programme duration	Minimum practice learning hours	Birth requirements (minimum)
UK	3 years	50% of learning time (2,300 hours)	40
EU	3 years	A third of total learning time	40
United States	2 years of postgraduate study following bachelor degree	Not specified (typically more than 1,000 hours)	20
Canada	4 years	50% of learning time	Varies by province – can be as high as 60
Australia	3 years	50% of learning time	30
New Zealand	4 years	2,400 hours	40
Philippines	4 years	2,346 hours	N/A

Notes: These requirements are not exhaustive and, as in the UK, midwives will be expected to meet other learning objectives beyond birth requirements. In some countries, allowances are made for shortened courses for registered nurses.

Source: Harlow Consulting (2021)[11]

Stakeholder perspectives

Midwives had similar views to nurses on the practice learning hours requirement, agreeing that the quality of practice learning mattered more than the duration of it, and that the current approach led to variable experiences and failed to account for different students' needs.

As with practice learning hours, there is insufficient evidence and mixed views on the optimal number of births, examinations, observations and other forms of care that should be required as part of midwifery education to ensure competence and preparedness for practice. We heard the most contention and strongest views on the 40-birth requirement and whether it is fit for purpose, which is why it is discussed prominently below. The subsection that follows highlights the main tensions that stakeholders identified in relation to specific quantifiable practice requirements for midwifery, which must be balanced when thinking about how requirements might be adapted in the future. Midwife experts also raised broader concerns in how the standards are applied and implemented in practice, most of which overlap closely with concerns raised by nursing experts (taskification, balance of proficiencies, etc.). These are discussed in the following section, from page 64.

Quantity at the expense of continuity

Overall, midwives had concerns that the current requirements relied too much on quantitative assessment of skills (that is, requiring students to complete a certain number of assessments and births and support a specified number of women and newborn infants in their care), rather than learning outcomes. On the births requirement specifically, some midwives argued that the number has the unintended consequence of skewing focus on delivery, rather than supporting a holistic view of childbirth and labour. For example, educators recounted examples of students being rushed into a delivery suite just at the time of delivery to be able to count the birth. This undermines continuity of care, and limits students' ability to develop a holistic, person-centred approach, essential for effective midwifery practice. It is worth noting that instances such as these are not in line with the NMC's standards of care and for conducting a birth.

Some experts felt that moving away from proficiencies towards a case-study approach where students had to demonstrate continuity of care and how they supported a woman or birthing person in their entire maternity pathway

could reorient the focus of practice learning onto delivering person-centred, holistic care.

> **And I do think in midwifery, we must move away from the numbers and look more at outcomes. There's a number of proficiencies, and when that proficiency for birth or antenatal care is a signed-off, it's signed off. They're competent. They don't then need to tick the numbers. We see students jumping into rooms and not providing any of the intrapartum care. And in other cases, students will provide all the intrapartum care and when the delivery results in a C-section [caesarean-section] delivery, it doesn't count [towards the 40 births requirement].**
> Director of midwifery

> **I think case studies could better demonstrate how [a student] followed a woman's journey from its entirety and all the care that they've provided. What went well? What didn't go well? It would support reflective decision-making. Instead, students were driven by the competency document rather than what is overall experience.**
> Policy-maker

As with practice learning hours, midwifery experts also felt that the practice learning requirements risked emphasising the quantity of learning at the expense of quality, with students more preoccupied with meeting requirements rather than getting the most out of each practice learning experience. Midwifery students echoed this. They raised concerns about the practical challenges of meeting all the education and training requirements, with some pointing to an unhelpful narrative that midwifery 'is just delivering babies', when this is only one part of the childbirth experience.

But as in the case of practice learning hours, if the births requirement specifically was lowered, clinicians wanted greater assurances around the quality and consistency of practice learning.

We should be assessing quality and competency rather than just counting a certain number of times you do something. But I do understand some of the nervousness because if you take away the requirement for 40 births, then unless you have something stronger in its place there is a risk. But we're already in that risk place because students are not able to do 40 births and are counting other things.
Lead midwife for education

Accounting for shifts in maternity care

Patient advocates, service users and policy-makers also worried that the requirement that all 40 births be spontaneous and vaginal is increasingly out of step with changing demographics and preferences for childbirth among women and birthing people. For instance, in England and Wales, rates of induction and intervention have increased, with under half of births (46%) recorded as being spontaneous vaginal births.[32] Caesarean births make up 43% of births in England and Wales, reinforcing how birth is complex, varied and can be unpredictable.

A more diverse range of patients is what's needed. I would up the deliveries to 50 but I would include forceps, caesareans and ventouse [vacuum-assisted] deliveries. Because I think if you've been with a lady giving birth from the beginning to the point of a forceps delivery or caesarean, it's not fair to then say you've not given care to that woman... I think they're just as part of the birthing experience as a physiological birth these days.
Service user/patient advocate

The current NMC standards do recognise the complexity of childbirth, and require students to 'develop the required knowledge, skills and behaviours needed to support and care for no less than 40 women who have additional care needs or develop complications including those related to physical, psychological, social, cultural and spiritual factors'.[114]

However, in practice, midwives and students felt that the overriding principle for students to care for and facilitate 40 spontaneous and vaginal births emphasised these outcomes over other birthing options. Some feared that this may have the unintended consequence of limiting opportunities to provide personalised care to women and birthing people with diverse medical needs, preferences and circumstances that require alternative approaches.

But midwives equally had concerns about changing the principles around the 40 births requirement so that more births requiring clinical intervention could be counted. They argued that an understanding of physiological births and how labour progresses without intervention is fundamental to midwifery practice. International experts also shared the challenge of balancing these tensions. They stressed the impossibility of setting a universal standard on the number of births, which will vary by each country context and must account for their public's confidence in the profession and access to clinical practice and delivery patterns in each place.

In addition, concerning evolving fertility patterns, some midwives noted a lack of pregnant women in certain areas. When combined with a high number of student midwives competing for placements, it can be challenging to meet proficiencies. Educators reflected on how students often need to extend placements to meet all practice learning requirements. This raises questions about the role and purpose of the practice learning hours standard and how it works alongside proficiencies.

Ensuring exposure to diverse birthing experiences

On the other hand, several service users and midwives worried that reducing the number of births that student midwives must achieve could risk degrading the profession and limiting the exposure students have to a diverse range of births, though there may be more opportunities in loosening requirements around antenatal and postpartum checks.

For example, some midwives remarked how some skills are difficult to grasp because every human body is different. For instance, palpations may present differently on women or birthing people who are obese, or have pendulous abdomens, so reducing the birth requirement may limit the opportunities that midwives have to gain these experiences and skills on a diverse range of people. Other experts and service users feared that reducing the number of births could inadvertently reduce the diversity of birthing experience that midwifery students are exposed to.

Reducing the number of births could dilute that wealth of experience... that understanding and learning of what sounds sound like, what breathing sounds like, a chance to observe women that are silent, women that are screaming, women that are praying... understanding and learning different cultures and the diversity of how people behave.
Policy-maker

I would feel more comfortable knowing that my midwife had trained with a diverse range of patients. Women come in all shapes and sizes and we do need to see that as part of training.
Service user

Practice learning requirements for other professions in the UK

The requirements of clinical practice also vary substantially between professions. Neither the EU Directive on the recognition of professional qualifications nor the education standards that national regulators such as the General Medical Council (GMC), the General Dental Council or the Health and Care Professions Council set stipulate a required number of practice learning hours or a specific balance between theory and practice for professions such as doctors, dentists and physiotherapists. These decisions are left to the discretion of individual higher education institutions and shaped by the expectations of professional workforce bodies for these registrants.

But even though the exact number of practice learning hours is not formally set, medical doctors and dentists are required to gain sufficient in-practice training before registration. For instance, medical doctors must complete a GMC-approved practice-based foundation programme after completing their educational degree before they can apply for full registration.

An exception is the General Pharmaceutical Council, which does stipulate a number of practice learning hours, mandating that pharmacy students complete at least 90 hours of prescribing practice during their foundation training year. Likewise, though not a regulator, some professional associations define that the profession recognises a set number of practice learning hours. For example, the Chartered Society of Physiotherapy – a professional, educational and trade union body for this profession – requires that physiotherapists perform 1,000 practice learning hours to be a registered member of the Charter (approximately 90% of practising physiotherapists in the UK are members of the Charter).

Some policy-makers and clinicians pointed to these inconsistencies with other professions and questioned the rationale for stricter thresholds for nursing and midwifery.

We all know that nurses do more practice hours than any of the other health care professions and I don't know what the rationale for that is. Newly qualified social workers are working autonomously from day one, just them and their clients. Yes, they have supervision, but they've done far fewer hours, and they're deemed competent to do that. So there doesn't seem to be [a] rationale to my mind for the 2,300 [hours requirement].
Nursing educator

Implementing the requirements: challenges and unintended consequences

Balance of proficiency standards

Stakeholders we spoke to had mixed views about the balance of proficiency standards, and whether they were achieving the right balance between breadth and depth, as well as specialist and general skills.

Learning disability, mental health and children's nurses raised concerns that the comprehensive and holistic nature of proficiency standards meant that students training in these specialties felt pressure to meet outcomes not always relevant to their field. This is particularly hard when supervisors may not have recent experience of the core skills and procedures required for assessment, such as catheter management.

> **One of the issues we're having with proficiencies is that our students have a huge number of clinical skills that must be signed off. And we don't do things like venipuncture catheterisation. And you don't learn catheterisation in a day. So they need a good stint of time to do that. And then we're trying to squash in everything they need about learning disability nursing in a week and a half of a placement.**
> Practice educator

Even though the NMC standards for nursing and midwifery are broad and focus on a well-rounded set of proficiencies, some experts felt that, in practice, learning can become more skewed towards the technical aspects of care, and prioritise physical health skills (such as injections, taking vital signs and suturing), often at the expense of therapeutic or interpersonal skills (such as active listening, counselling techniques and empathetic practice).

Mental health and learning disability nurses noted it as a problem that there is one set of requirements for all fields of nursing, which meant they left training feeling unprepared for some of the core functions of the role. The potential

skew in focus especially concerned service users and the public, who noted that the ability to deliver compassionate and person-centred care is what made the biggest difference to their overall experience.

Meeting a lot of student nurses, it's the soft skills that matter most to me... little chit-chats that make you feel comfortable really helps because I'm autistic.
Service user

Within midwifery, advocates and service users felt it especially important that student midwives receive more training on supporting women and birthing people to cope with trauma, which will manifest differently depending on the person and situation, but is essential for helping people process their births.

It's important that midwives and student nurses are taught about trauma-informed care and for midwives birth trauma... I think that it should be part of every course, acknowledging that it can happen. You can deliver what you think is [a] completely textbook, physiological birth but there's something that that person finds traumatic and trauma is trauma, everybody's different.
Advocate

On the other hand, some clinicians raised concerns that current proficiency requirements would be better if they were more narrowly defined and focused more on clearly defining the skills required at the point of registration. They felt that the current breadth of proficiencies overwhelms the process, and that some standards would be better suited as employee requirements that nurses and midwives could develop as part of a structured career pathway (as in medicine).

Some things like cultural awareness has to be there, but that should be an employment requirement, never mind a regulatory requirement. I think we need to go back and redefine exactly what it is at the point of registration that we need an individual be able to do to be safe and protect the public. There's lots of nice things that we like to do. But actually, if we get down to the nitty gritty of it, and we look at a lot of the issues that are being identified, you can peel a lot of it back to basics: health assessment, decision-making, identifying deviation from normal, escalating deviation from normal, following through on an escalation whenever it doesn't get appropriately dealt with in the first instance... those are the core pieces, along with kindness and compassion.
Lead midwife for education

Interpreting requirements and variation

Many students and registrants noted confusion and ambiguity in what counts as practice learning and what counts as theory. For example, some students raised discrepancies in how universities treated 'clinical skills sessions', with some institutions always counting them as practice learning, and others only when they happened explicitly during the practice learning period.

We very much had this issue recently because there's been that argument as to what is actually classed as patient-facing learning. I think that's been the aspect that we've had to look into now. It's caused a bit of confusion. I think it's some people feel differently than others.
Midwifery clinical placement facilitator

Another issue is around how other time is accounted for as part of practice learning hours. We heard from students in England, for example, that there are inconsistencies in whether students can count lunch and breaks towards practice learning hours. Educators also noted differences in how reflective

practice is accounted for within practice learning hours, which many argued is key to developing reflective practitioners but is often not considered.

Other inconsistencies raised related to how competencies could be signed off, whether on the basis of observation, reflection or discussion with a supervisor. Although the Midwifery Ongoing Record of Achievement (MORA) and other practice assessment documents set clear principles in this regard, students reported variation in how they are applied and interpreted in practice, and a need for better clarity. As discussed in the section 'Decisions on progression' in Chapter 5, p. 112, some regions and nations of the UK have worked to ensure consistent documentation.

Students also reflected on the variable quality they observed across different practice learning settings, with some services consistently struggling to provide high-quality experiences. In midwifery, for example, focus group participants noted that their gynaecology placements in particular did not know how best to support midwifery students, and that the rotation was more nursing focused. Students also noted variations in what clinical skills they were allowed to carry out as part of their practice learning, with some practice learning partners allowing certain skills such as vitamin K injections for newborns, or cannulation, and others not – in part due to local policies. The quality of practice settings is discussed in more detail in Chapter 4.

Students and educators reflected on the need for greater guidance and clarification on how students can best be used and developed in placements to ensure high-quality experiences across providers.

Recognition of prior learning

For nursing and nursing associates (but not midwifery*), the NMC permits, at entry to the course, recognition of prior learning that can be mapped to expected proficiencies and programme outcomes up to a maximum of half of the programme. Three-quarters of respondents to a 2018 consultation agreed that the NMC should continue to set a maximum limit for recognition of

* However, for midwifery, qualified nurses can enter shortened courses through recognition of formal qualification/s. This is in line with the EU Directive on the recognition of professional qualifications.

prior learning, with half of those saying the 50% threshold was reasonable.[16] However, we still heard that some apprentices felt that – by typically having more experience in providing care – they were being unduly delayed in qualifying by the hours requirement. Similarly, we heard an example that the maximum recognition of prior learning had stopped a social worker from moving across to mental health nursing.

Understanding of the nursing associate role

Another source of ambiguity within practice learning is the role of nursing associates. Focus group participants noted how staff often fail to understand the difference between nursing associates and registered nurse roles, and how the standards of proficiency differ.

> **When you're looking at the standards of proficiency for nursing associates versus registered nurses. We've had to do an enormous amount of work with our clinical workforce to help them understand what the differences are in terms of expectation for those roles.**
> Children's nurse

This has implications for building the competencies of these distinct roles. If there is ambiguity around the scope of nursing associate roles, this might affect the quality of their practice learning experiences. We heard differing experiences from the nursing associate focus group on the quality of their placements. Some participants reflected positively on their placements while others felt the role was not clearly defined in their trust, which impacted on their experience of practice learning. There was also a level of confusion surrounding the nursing associate role in the service user and public focus groups. Participants sought clarification on the role in relation to other staff groups such as health care assistants.

Supernumerary status

NMC standards for pre-registration nursing and midwifery programmes state that approved education institutions and practice learning partners must 'ensure students are supernumerary',[2,114] meaning that students cannot be counted as part of the workforce when they are on a practice learning placement in a clinical setting. We also heard that there are local mechanisms for addressing issues around supernumerary status when raised. However, participants in our focus groups still observed that supernumerary status is commonly not upheld. A recent review of midwifery education and training supports this – stakeholders across all regions in England highlighted that, in practice, supernumerary status was not always upheld and emphasised that students should be learning and not working while on placement.[33]

In learning disability nursing, for example, supernumerary status was highlighted as being important to allow students to have time to build relationships with their service users. We also heard that there can be a particular challenge with protecting practice learning time for apprenticeships, given the blurred boundaries between their education and employment as they are often in the same clinical environment. Experts recognised the important role that practice education facilitators can have in ensuring that supernumerary status is upheld for students. Others noted how having an allocated practice supervisor was beneficial for protecting supernumerary status.

System capacity

A shared challenge felt across health and care systems is an inability to accommodate rising numbers of students and offer sufficient high-quality placements for practice learning. Experts both within the UK and abroad reflected on the challenges that supervisors face in trying to provide sufficient training and guidance while overseeing high volumes of students simultaneously. Students reflected on feeling like a burden to their supervisors and registered nurses and midwives, given how overstretched services are.

Services users and the members of public involved in our research were also acutely aware of how overstretched the health service currently is. Participants in our focus groups gave examples of where they have personally witnessed

poor supervision of students in the practice learning environment. At the same time, in overstretched health and care services, some service users noted how students can play a valuable role in offering the time and attention that overwhelmed staff may be unable to provide.

I was so grateful for the student nurses who were there for my birth because they were the ones who had time to sit with me and bring me tea and offer support afterwards when the midwives were otherwise too busy.
Service user

Other policy-makers and educators feared that the current standards exacerbated the current workforce crisis and made it difficult to deliver the number of students needed to meet future nursing needs. Requirements around clinical hours can make these problems worse by limiting flexibility and creating system 'bottlenecks'.[34] In England, the NHS Long Term Workforce Plan specifically encourages the NMC to consider how graduates can join the register after fewer practice hours – explicitly referencing a reduction from 2,300 to 1,800 hours – to enable the increase in training capacity required.[7] The Plan specifically cites 'flexibility' in how nurses are trained and leveraging new technologies (see the next chapter on simulation) as enablers of this. We also heard in our research, views linking practice hours to system capacity.

If you want more students, reduce the hours down. They still have to meet the same competency standards. No one is signing them off quicker, or faster. If you took out 500 hours, four students could become five overnight on placement capacity.
Nurse educator

'Taskification'

Another perception among educators, policy-makers and practitioners is that current practice requirements have made training task-oriented, with the unintended consequence of reducing complex care to a checklist of skills. Some nurses feared that this can undermine the development of clinical judgement and contributes to a mindset where students become more concerned with getting procedures and proficiencies signed off rather than achieving key learning outcomes. This is also apparent in midwifery, where participants noted that while having a set quantity of, for example, hours, births and assessments promotes consistency, just achieving these numbers does not measure the student's competency in carrying out the tasks.[35] Other research has highlighted the risk of the 'taskification' of clinical roles and the need for practice learning to better nurture the behaviours and values that are required of registrants to deliver person-centred care.[36]

The need to sign off certain proficiencies can also make students less willing to go on placements outside hospitals or to see their benefit. Even though standards can be met in any setting (and there is no requirement for them to be focused on acute care), nursing educators reflected on how, in practice, curricula and proficiency requirements can still perpetuate a narrow understanding of what it means to be a nurse where a holistic range of experiences and skills are needed. For example, one focus group participant from a Scottish university noted receiving backlash from students following the introduction of a social care placement as students' expectations of clinical placement were heavily centred around it being in secondary care. Chapter 4 provides more discussion on the role of different settings in practice learning and exposure to different service users and skills.

Administrative burden of proficiency sign-off

Students and educators also remarked on the administrative challenges involved in practice learning and the requirements for signing off different proficiencies. For example, in midwifery, we heard about challenges due to the eMORA – the electronic portfolio containing all the practice documentation required for the duration of a midwifery student's training and education. Students struggled with the burden of having to ask for their proficiencies to be signed off via the electronic system, especially in busy delivery wards.

Similarly, we heard frustration about challenges in accessing the eMORA, with supervisors not being able to log in and some not able to access computers, creating delays or barriers in getting proficiencies signed off.

Supervisors also noted the lack of time allocated to fill out the eMORA. In addition, different eMORA platforms are used across approved education institutions, which means trusts hosting multiple institutions' midwifery students have to navigate two to three different platforms, increasing the administrative burden. There is currently an ongoing evaluation of the eMORA system to identify potential improvements and opportunities for future use.

While nursing staff and nursing associates did not discuss comparable administrative burdens for these professions or those explicitly related to the practice assessment document, this does not infer that they do not exist. It is also important to note that there have been some regional and national initiatives to make documentation and processes more consistent, which, in turn, will reduce the administrative burden.

Student health and wellbeing

Some student nurses and midwives in the UK face significant challenges to their health and wellbeing during training. Students in our focus groups reported high levels of stress and exhaustion from working in high-pressure environments, often with minimal support. The stress of completing practice learning requirements and completing the number of practice learning hours exacerbated these pressures and made it difficult for some students to learn and get the most out of their education and training opportunities.

> **I've had students who I think are maybe having a crisis in their personal life or who have become ill, and that pressure of 'I gotta get my hours' has made them not able to take their time to look after themselves and it's become a really frightening thing...**
> Learning disability nurse

The majority of reflections we heard on health and wellbeing related to the experience of student nurses and midwives rather than nursing associates but this does not mean that nursing associates do not also experience hardship or stress as part of their education and training.

Students also emphasised the financial burden of training and education, including high tuition fees and the lack of financial support available during practice learning training, as major causes of distress. Issues around access to practice learning and financial hardship are further discussed in Chapter 4.

3 Use of simulation

Key points

- The evidence base around the proportion of practice learning that could be delivered through simulation is difficult to generalise.
- There is wide variation in international standards, with typically restrictive levels in EU countries compared to, for example, up to 50% of clinical practice in nursing courses being substituted for simulation in the United States as of 2015.
- There was consensus among stakeholders that simulation can be an invaluable tool for helping students build confidence and practice skills before working in real-world settings.
- Some policy-makers and midwife educators argued that the discrepancy between the use of simulation in nursing and midwifery is not warranted, and that standards should be better aligned across professions.
- The labour-intensive nature, resources and experience of staff needed to design and deliver effective simulated learning were often raised as a key barrier to expanding the use of simulation.

This chapter provides an overview of simulation learning in nursing and midwifery education, highlighting its role, purpose and the regulatory requirements that underpin its use. It covers:

- the different functions that simulation can have in practice learning
- the current standards that apply to its use in the UK
- the evidence on and international experience of simulation
- stakeholders' views on the challenges, opportunities and trade-offs around using simulation in practice learning.

Overview of simulation learning: role, purpose and regulatory requirements

Simulation has been defined in the literature as 'approximations to reality that require trainees to react to problems or conditions as they would under genuine circumstances'.[115] In April 2023, the NMC revised its definition for simulated learning to mean 'an educational method which uses a variety of modalities to support students in developing their knowledge, behaviours and skills, with the opportunity for repetition, feedback, evaluation and reflection to achieve their programme outcomes and be confirmed as capable of safe and effective practice'.[2]

Simulation can involve both 'low' and 'high' fidelity approaches in terms of the degree of realism or authenticity they invoke (see Table 6), and it has at least two distinct roles in clinical practice learning.[37] First, it offers a safe and controlled environment where students can practise and develop their skills without the risk of harming people in their care. Second, it can expose students to high-stakes scenarios that may be rare in practice but potentially catastrophic, for example handling deteriorating patients, managing patients having a cardiac arrest or dealing with post-partum haemorrhage.

Table 6: Lower- to higher-fidelity simulation examples

Lower-fidelity simulation techniques	Higher-fidelity simulation techniques
Low-fidelity manikins (for example, a limb for catheterisation, manikins for cardiopulmonary resuscitation – CPR)	Standardised patients (for example, patient actors)
E-learning to master specific tasks (for example, a computer-generated anaesthetic machine)	Simulated environments (for example, recreated work environments with multi-professional teams)
Virtual reality	'Integrated' simulators (for example, life-like manikins with complex computer programming)

Current standards around simulation

NMC practice standards on the use of simulation differ between nursing and midwifery. In the case of nursing, the standards stipulate that up to 600 hours of practice learning can be simulated. This was a change from 300 hours, brought out during the Covid-19 pandemic in response to decreased practice learning placement capacity, but the NMC has since permanently adopted it and approved education institutions can now use it.[38] Approved education institutions must gain authorisation to increase hours of simulated practice learning from the NMC. Simulated practice learning must meet all NMC standards for pre-registration nursing programmes for practice learning.[38]

For student midwives, simulation is used extensively as part of their education, but mostly to support the theory component of learning and to act as a bridge for practice learning. Simulated learning is only allowed to count towards practice learning hours for hard-to-achieve proficiencies, for example when active participation is not possible because of a lack of breech births. Other procedures, such as performing an episiotomy and initiating suturing, can also be conducted in simulated situations if necessary. This is aligned with the EU Directive on the recognition of professional qualifications, which does not explicitly mention simulation except regarding midwifery education where it is only permitted in specific scenarios.

Some policy-makers and midwife educators in our research argued that the discrepancy between the use of simulation in nursing and midwifery is not warranted, and that standards should be better aligned across professions. Particularly in midwifery for high-risk situations that are rare, some stakeholders felt that standards should be adapted to allow for more simulated practice learning.

Our learners need to demonstrate confidence as well as competence and some of them will not have been exposed to a massive haemorrhage or a breeched birth or a woman having a cardiac arrest, and we need to be able to put them in those simulated situations. We know that the evidence is overwhelming for other professions and that simulation can help build confidence and competence. I think we have to be braver.
Lead midwife for education

Evidence on the use of simulation for practice learning

The evidence base around the proportion of practice learning that could be delivered through simulation is limited, with most research examining simulation as a bridging tool between theory and practice rather than a substitute for non-simulated practice learning hours. In this way, simulation is used to connect theoretical knowledge and practice and provide students the chance to apply their learning in realistic yet low-risk environments before supporting people in health and care settings.

Another limitation of the evidence base on simulation is the variety of models and types of simulation available, making it challenging to translate and generalise findings on simulation to other forms of simulation, courses or settings. In the context of the resources required for simulation (discussed later in this chapter), there is also a paucity of data examining the cost-effectiveness of different approaches.

Previous reviews have found no definitive answer on whether simulated practice learning can fully replace patient-based education in nursing, although some studies suggest it may not significantly affect competency or critical thinking.

For example, a systematic review from 2019[39] looked directly at using simulation as a substitute for clinical practice learning hours. It included 10 studies representing 2,370 students from three health disciplines in four countries. Although spanning professions outside nursing and midwifery, the

bulk of papers (seven out of 10) related to pre-licensure nursing. It found the quality of these studies to be moderate to high, but with considerable variation in the ratio of simulation to practice, the duration of simulation and the outcomes explored. The nursing studies found that simulation could replace a proportion of in-practice learning without negative effects on students' clinical competence or readiness for practice. However, the review concluded that evidence on the ideal ratio for substitution is limited and inconsistent, and more rigorous studies would be needed to inform accreditation and policy development.

Most of the nursing studies in the review come from the United States. Notable papers include a National Council of State Boards of Nursing (NCSBN) study – a longitudinal, randomised controlled trial that tested proportionally replacing clinical hours with simulation in pre-registration nursing education.[40] The results of this study showed that students who replaced 50% of their traditional clinical experience with simulation had no significant difference in terms of knowledge base, clinical competence, critical thinking or readiness for practice, despite already relatively lower practice learning hours requirements in the United States. However, the study did not result in a universal recommendation regarding the substitution of clinical hours, noting that – as participating programmes had, for example, staff formally trained in simulation, subject matter experts providing debriefing, and high-quality equipment – the results may not be generalisable to all educational programmes.

Other studies from the United States show similar findings, including a 2008 randomised controlled trial that found that nursing students (n=71) using simulation gained equivalent nursing knowledge from two weeks of simulation as two weeks of in-practice learning.[116] Another study focusing specifically on mental health nursing found that students who substituted three of 12 clinical weeks with simulation had equivalent mental health knowledge and self-confidence to those who did not receive any simulated training.[41]

More recently, the Council of Deans of Health conducted a systematic review, finding that simulated practice learning could effectively replace some clinical practice learning hours in nursing education, improving educational assessment outcomes with large effect size.[42] Educational assessment

outcomes were defined in a variety of ways, but included things like exam results, knowledge tests and clinical placement grades. The review did find that two studies recorded a higher drop-out rate with more simulated learning, one of which suggested this may be due to students failing exams. Overall, there was no evidence on patient-based outcomes or resource implications.

The NMC has also recently commissioned an evaluation of simulated practice learning in pre-registration nursing programmes across 19 approved education institutions.[43] These institutions are all universities and the NMC has approved them to deliver up to 600 hours of the required 2,300 practice hours through simulation. The evaluation found that although the Covid-19 pandemic prompted the increased use of simulated practice learning in nursing, it is now seen as a valued part of practice learning for students. Consistent with other findings, results from the study showed that simulated practice learning offered a safe and supportive environment for students to reflect, learn and improve their confidence. Importantly, it also ensured equitable access to students to practise scenarios and proficiencies that may otherwise be opportunistic in a practice learning environment.

International experience

Simulation is commonplace in most nursing and midwifery courses internationally, although the levels allowed as a replacement for clinical practice learning hours vary by country (see Table 7). Countries following the EU Directive on the recognition of professional qualifications tend to be the strictest, limiting simulated practice in midwifery to breech births and episiotomies. With nursing, restrictions are placed on the use of simulation because of language in the EU Directive that defines clinical practice learning as being 'in direct contact with a healthy or sick individual'.

Outside the EU, most countries' standards make no explicit statement on the role of simulation as a substitution for clinical practice. Only in the United States are there clearly established rules on the use of simulation in practice learning hours, although this does vary by state. Since 2015, up to 50% of clinical practice in nursing courses can be substituted for simulation following results of the NCSBN study (see above).

New Zealand is an exception when it comes to simulation, where up to 240 hours of midwifery practice learning can be completed through simulation, but its use is limited in nursing. A 2022 consultation on replacing up to 200 clinical hours of clinical practice learning with simulation received favourable views, but the Nursing Council of New Zealand opted to maintain current standards because of concerns raised about how consistency of quality would be ensured.[30]

Standards in Australia explicitly state that simulated practice is not permitted in place of practice learning hours (for both nursing and midwifery). Experts reflected that this is partly because of the low minimum threshold that Australia requires for practice learning hours to begin with (simulation is used more broadly to support theoretical education and as a bridge to practice learning in both Australia and New Zealand).[44]

Table 7: International comparison of simulation hours for nursing and midwifery practice learning

Country	Nursing	Midwifery
UK	Up to 600	Simulation hours do not count towards practice learning hours unless by exception (for example, breech births)
EU	N/A as the EU Directive describes clinical training as being in direct contact with a healthy or sick individual and/or community	Simulation hours do not count towards practice learning hours unless by exception (for example, breech births)
United States	Up to 50% of programme hours	Unspecified
Australia	Simulation cannot be counted towards practice learning hours	Simulation cannot be counted towards practice learning hours
New Zealand	Simulation cannot be counted towards practice learning hours	Up to 240 hours
Philippines	800+ hours	Unspecified

Sources: Harlow Consulting (2021)[11] and NMC (2022)[31]

Stakeholder perspectives: balancing the trade-offs

Opinions varied in our engagement on whether the amount of learning provided through simulation should be increased, or its use limited. And we did not hear a clear consensus on what an acceptable number of replacement hours for simulation could be. In a 2017 NMC consultation, the vast majority of respondents thought the cap on simulation in nurse education (then 300 hours) should be retained.[16]

This section details the different trade-offs that stakeholders raised, discussing the key opportunities involved in simulation and the core risks to be navigated if expanding its use. Some professions had more scepticism, especially children's and mental health nursing where scenarios are more difficult to replicate realistically.

Service users and the public, while recognising the important role that simulation can play – especially for exposure to rare situations – worried about simulation's ability to fully substitute real-world practice when it comes to developing empathetic practice and person-centred care. Service users and the public were generally not opposed to simulation but were clear that it should not be a "substitute – it's an add-on" and it "depends on getting the balance right". Participants were also unclear on the number of hours of simulation that would be acceptable.

People are complex, they're not simple and I think [simulation] really focuses on the medical and not the social and cultural aspect as well and that is a huge part of what's being considered when you're treating someone.

I think simulation for procedures is really important but I'm not sure how I feel about 600 hours. I think that seems like an awful lot when actually we need to get people understanding the whole experience of caring for people and simulation just is not going to do that.
Service user

Opportunities

Improving access to controlled, high-quality training environment

In focus groups and interviews, those advocating for greater use of simulation emphasised its efficacy in creating a safe and controlled environment to gain knowledge and skills. Some educators argued that this is especially important given the variable quality of placements that students experience, as simulation could help create a level playing field and ensure access to more personalised supervision and time for reflection.

Service users, members of the public, students and educators alike all spoke about how simulation can be especially important in the earlier stages of education and training, for students to practise carrying out skills such as cannulation before working with real patients. It is also often the only exposure to and practice that students have with rare but potentially life-threatening or catastrophic events, such as neonatal resuscitation and breech delivery in midwifery.

> **I think it definitely has its place particularly with specific skills, for example, taking bloods, you want to learn on a dummy first of all because... it's not very nice to stick needles in somebody... as a patient who's vulnerable you don't want somebody learning on you and doing it four times to try and take your blood.**
> Service user

This benefit around practice and confidence is true not only for clinical skills, but also for communication skills and multi-professional team-based working. For example, educators remarked on how simulation is especially important for helping students master how to deliver complex information or identify safeguarding issues, given that most students will only have observed but never led the delivery of complicated or distressing information to patients, carers and their families.

Targeted learning and reflective practice

Unlike in real-world practice settings, simulated environments can also provide more time and space for debriefings and reflective practice, and peer

support with fellow students. Some educators argued that simulation can be especially helpful in the first year of programmes to bridge the gap between theory and practice, and there might be merit in concentrating simulated placements in this window. This would ensure students have fundamental skills before entering real-world placements and could count towards their overall practice learning hours. Similar reflections were made in our focus groups with service users and the public. Educators also reflected on how simulation can better provide targeted learning, particularly on skills or competencies where students may be having the most difficulty.

[Simulation] can be set up so that if you see that a student is having difficulty, you can stop and have that debrief in that moment, which can be quite difficult in an acute clinical setting because invariably there's something else that needs to be done or another conversation or another meeting. And so it gets missed or lost.
Nurse educator

Capacity and easing pressures

Simulation can also play an important role in increasing placement capacity and creating access to practice learning when there are insufficient numbers of clinical practice places. Educators noted how, if adequately resourced, it can reduce pressure on staff in clinical environments where there is limited bandwidth. This is especially true for skills such as communication and those described above, when practice learning partners are struggling to meet all NMC proficiency standards and guarantee time for adequate supervision.

Challenges

Resource implications

While participants in our research viewed simulation as useful for providing a wider range of learning opportunities in both theory and practice settings, stakeholders also raised concerns about its sustainability and ability to expand capacity in the system. A key barrier is the resource implications involved, and the costs of transitioning some clinical training away from practice sites to education institutions.

Simulation – particularly high-fidelity models – is expensive and labour intensive and requires significant capital investment in the form of laboratory equipment, programmable manikins, virtual reality or trained patient actors. It also requires extra staffing in terms of dedicated practice assessors and supervisors. There is currently a limited number of high-level facilities in the UK to expand simulation capacity across all providers. Previous research, working with midwifery stakeholders, identified the risk that the high costs associated with simulation could promote unequal access. Simulation also requires significant training and staff time, and experts across countries and practice contexts cited a lack of faculty resources to use simulation in a standardised way.[39]

A recent survey by the Council of Deans of Health reinforces these concerns, where respondents noted the limited number of facilities with adequate physical space and advanced technology, and funding, as major constraints.[42] Despite these concerns, service users and the public who participated in our research had more confidence in intensive high-fidelity simulation.

> **I think I would feel confident if the training was completed through high-fidelity simulation approaches. I think the low-fidelity one sounds too controlled [an] environment and too far removed from the majority of situations that nurses and midwives would actually find themselves in.**
> Service user

This was also a key finding in an NMC evaluation,[43] which highlighted the financial and staffing challenges associated with simulated practice learning, with many approved education institutions concerned about their ability to sustain its use without significant investment and ongoing funding streams. We heard that the funding for simulation differed between the UK nations, particularly in light of changes in allocations during the Covid-19 pandemic, which may contribute to discrepancies in the ability of the different education institutions to provide simulation.

Generalisability

The effectiveness of simulation also depends on its quality and applicability to real-world settings. For example, paediatric nurses reflected on how newly registered nurses can be unprepared to carry out tasks such as managing cannulation in children, as their only exposure has been through simulation using adult-sized arms and adult-sized equipment. Children's and mental health nurses reflected on how their work can be inherently very unpredictable and complex, and therefore the divide between real-world and simulated practice is far greater (as exemplified in the quote below). But in other universities, nursing educators commented on how modern simulation has evolved to reflect a much broader range of conditions and experiences, including, for example, children with Down's syndrome.

> **There's a real difference between taking blood or putting a cannula into a prosthetic limb. Even when we have access to smaller limbs, it's not the same as a child that's thrashing around or is upset, that's the tricky bit. It's also tricky to make sure that you can explain the procedure in an age-appropriate way, and actually decide whether this procedure is required or not.**
> Children's nurse

Moreover, evaluations have found that students in these fields of nursing (that is, mental health, children's and learning disabilities specialties) found value in simulation for providing exposure to proficiencies they did not otherwise experience as part of their allocated practice learning placements.[43]

Lack of standardisation

Educators also spoke about the lack of a standardised approach to simulation in nursing education and the need for more guidance and support to ensure greater consistency in its use. While simulated practice learning can have an important role, policy-makers and experts noted that its ability to contribute towards practice learning hours depends on the intensity and quality and the degree of deliberative practice involved, suggesting a role for more structured guidelines and a consistent framework.

Simulated learning is very purposeful and the conversations I've been having with other universities are about how we make it authentic, contextual and ensure we're preparing the learners and staff... So one hour of simulated practice does not always equal one hour in the practice setting, which comes down to the intensity, personnel and support in place.
Educator

While variety in approach to simulation can have a place, depending on the specific learning needs of students and types of skills and knowledge being taught, some educators noted how different approved education institutions' use of simulation varied, sometimes with incomplete policies to define its use. This raises concerns around quality assurance and what gets counted as simulation hours within practice learning, and the need for greater governance to support its use.

4 Placement settings, services and environment

Key points

- A breadth of different types of practice learning exist internationally, each with certain benefits and implementation challenges, although the evidence base is limited, with no single placement opportunity being 'optimal'.
- We identified many different enablers and barriers to high-quality practice learning, including the structure, timing and location of practice learning experiences, the extent of existing pressure and strain that health and care staff face as well as team culture.
- There appear to be widespread opportunities to expand the breadth of practice learning environments, particularly around using services outside hospitals, with students typically valuing placements that expose them to different roles, settings and populations.
- However, there are common barriers around doing so, including supervision and assessment capacity and, at times, resistance from some students who are concerned that such placements might not provide opportunities to achieve their proficiencies.
- The location and amount of practice learning can cause significant financial pressures for students, and some students who share protected characteristics or are from low-income households encounter barriers or discrimination, which can affect their learning experience and wellbeing.
- There may be scope to improve the consistency of quality assurance on placements, learning from approaches elsewhere and exploring the prospect of standardising student feedback at national level to inform the quality of practice learning.

This chapter describes the factors that support effective practice learning, covering the:

- variety of practice learning settings and the challenges in delivering an appropriate balance between them
- structure of practice learning, drawing on the published evidence and experience from the UK and internationally to pull out lessons and opportunities
- major challenges in assuring the quality of practice learning, including equality, diversity and inclusion considerations.

Use of different settings and services and practice learning outside hospital

Nursing, midwifery and nursing associate students are expected to learn and provide care across a range of different learning environments to enable them to achieve their learning outcomes and gain experience of providing care for the diversity of populations.[45]

Benefits to using a range of settings

There are many potential benefits from using a broader range of settings for practice learning opportunities. The literature and experts we spoke to point to several, including:

- exposing students to the broad scope of potential roles available once they graduate, to support more informed decisions about career paths and the varied opportunities available – this includes specialist roles within a profession, for example students in midwifery reflected on the benefits of working alongside bereavement midwives, diabetes midwives and others to better understand the breadth of the profession and shape their development

- easing pressure on securing placements, particularly in an overstretched system when many placements are oversubscribed – students reflected

frequently on the challenges around competition for limited practice learning opportunities, which is exacerbated where multiple universities have nursing and midwifery courses in one area feeding into one secondary care provider

- developing a more well-rounded and holistic set of skills and experience needed to deliver person-centred care – for example, studies have found that specific training and observation in social care settings improved students' ability to interpret non-verbal cues, address concerns and tailor care more effectively, delivering higher-quality care to older adults.[46,47,48,49]

Nursing and midwifery students spoke about the positive experiences they had in community placements. These typically included experience in people's own homes, health centres, birthing centres, care homes or schools. Many students noted the level of continuity of supervision they received. We heard that, unlike in hospital care settings, students often worked within the same team, allowing for a firmer sense of belonging. Similar accounts have been reported in the context of district nursing: see Dickson and others (2015)[50] and the subsection 'Practice learning environment' later in this chapter, p. 94. Student nurses also commented that they had more time for teaching, debriefing and one-to-one supervision in the community, and it was not until they had placements in these settings that some students felt they had their learning needs identified.

Community placements also play an important role in preparing a future workforce where care is intended to be increasingly delivered outside hospital.[21] Experts noted the vital role that community placements have in equipping students with the skills to deliver holistic care, and recognise how a person's social circumstances and living conditions will impact their overall health.

[Working in community settings] opened my eyes to how much of what makes people healthy or not healthy does not happen in clinical settings. It happens at home, and so much of what I was sharing with people as a nurse was irrelevant to their lives. I would tell them don't eat canned

food because you're a cardiac patient and there's sodium [in it]. But they only had someone shop for them once a month. So what are you going to eat? You're going to eat a lot of canned food. Or I would say don't climb stairs. And they lived in a third-floor walk-up [a building with several floors but no lift, just stairs].
International expert and mental health nurse

The shift towards more community-based and preventative care models means that student nurses must also gain experience in primary care, mental health and other out-of-hospital settings. Balancing these diverse learning opportunities with student expectations requires careful management to ensure that students appreciate the full scope of nursing and midwifery practice and understand the importance of providing holistic care across various care settings.

The service user and public focus groups highlighted that some settings fostered better engagement with students. For example, some raised that it felt easier to talk to student nurses in general practice, as it is a more familiar environment for service users compared to a hospital setting, which some participants described as stressful and unfamiliar. In hospital settings, participants described it as more challenging and burdensome to interact with students due to being seriously unwell.

Students also noted the benefit of practice learning in other community settings. Learning disability nursing students highlighted how schools provided a vital opportunity for students to develop their conversation skills and observe behaviour. However, some stakeholders felt that there is a lack of clarity on how the practice assessment and supervision standards could be delivered in such settings. Participants also raised the importance of working in inclusion health settings, such as blood-borne virus clinics within addiction rehabilitation centres, hostels for asylum seekers or people experiencing homelessness and specialist GP services for refugees. These experiences afforded students an opportunity to improve their assessment and communication skills by working with service users with a diverse range of lived experiences.

Challenges and opportunities around settings

Expanding beyond the hospital sector and acute care

Despite efforts to diversify the variety of settings that students are exposed to, and the benefits of community placements described above, there was a perception among nursing and midwifery students and experts that practice learning is predominantly focused on acute care, occurring specifically in hospital settings.

> **Student midwives' perception is that the vast majority of their time should be, and is expected to be, spent on [a] labour ward. And I think our job is really encouraging students to see the value in other placement areas.**
> Senior lecturer in practice learning

This is a particular concern for care of older people, mental health, learning disability and children's nursing where students can often have limited exposure and fail to gain the key skills or experience needed to provide well-rounded care. The literature reinforces these concerns. It has shown that most practice learning experiences take place in hospital settings.[46] In addition, one recent review, albeit covering a broader set of clinical trainees, found that from the 500 learning environments, 440 were NHS settings, 54 were care homes, three were hospice settings, one was a private clinic, one was a third sector setting and one was a local authority area.[51]

Ambiguity about counting placements

The NMC does not specify what settings constitute a practice learning environment, with approved education institutions and practice learning partners responsible for deciding which environments to use and evidencing that they meet the expected standards. There was some concern across various focus group participants that this creates ambiguity, and it has become increasingly difficult to determine what settings count as placements. Some experts reflected on how current practice requirements for proficiencies reinforce this (see Chapter 2), as they tend to be perceived as acute-care oriented in their nature and may skew perceptions on what is required to be a nurse.

[We hear from students:] 'I don't understand why I'm going to work with this voluntary organisation who does outreach work around young people's mental health in the community. To me that doesn't seem like nursing, and I can't get any of my proficiencies done there.'
Children and young people's nurse

Lack of available student nurse placements in primary care, social care and other community settings

The lack of balance across different placement settings is often a result of the difficulty education providers and students face in securing placements in these settings. For instance, experts in Scotland, Northern Ireland and England noted the challenges in securing placements within general practice despite a desire to expand opportunities in this area. Data on practice learning opportunities within general practice are limited; however, one 2015 survey indicated that only 27% of employers offered placements to pre-registration nursing students, compared to 62% offering placements to medical students.[52] More recently, one survey found that 41% of student nurses surveyed had undertaken practice learning within secondary care, 16% in community settings and only 3% in general practice and 2% within learning disability services* in Scotland.[51]

As independent businesses, GP surgeries are often reluctant to take on student nurses unless there is sufficient funding attached to cover costs (see the subsection 'Funding practice learning placements' in Chapter 1, p. 39.) There are also often a limited number of registrants in settings outside hospital care to act as practice supervisors or assessors. However, there are some innovative examples of how areas are working around these challenges. For example, in London, one programme has allocated students to a primary care network, which allocates and rotates students' placements across members – enabling them to achieve their multidisciplinary skills and experience different aspects of care. There is anecdotal evidence to suggest that coordinating practice learning in this way aids practice assessors as it

* An ongoing review in Scotland of learning disability nursing is intended to address some of the challenges involved.

allows timetables to be planned in advance and workloads to be spread out and shared across the primary care network team.[53,54]

In Scotland, care home education facilitators support nurses and other suitably prepared staff to undertake student supervision and assessment, as practice supervisors or practice assessors, which contributes to the professional development of the care home workforce. In Wales, Health Education and Improvement Wales introduced the care home education facilitator role for a two-year period from 2021 in each region, to expand placements within care homes by working closely with potential practice learning partners, including care homes.[55] A pilot scheme is also being delivered to introduce funding specifically to incentivise and support practice learning opportunities in primary care (which, so far, has been positively received by Welsh stakeholders). Focus group participants from Northern Ireland called for similar supports to bolster the infrastructure for practice learning in these areas.

Insufficient capacity

An interlinked challenge to limited numbers of placements in the community is that there is a lack of practice assessors and practice supervisors to accommodate increased numbers of students. To address this, some universities in England have developed a bank of these roles that enables students to go to placements in settings such as nursing homes. We also heard from stakeholders about the value of 'long-arm supervision models', where practice supervisors can support students at a distance, enabling, for example, children's nursing students to undertake practice learning in school settings.[56]

Specifically, participants in the nursing profession spoke of increased challenges in identifying and arranging practice supervisors in the voluntary sector, shelters, prisons and schools following the introduction of the Standards for Student Supervision and Assessment[57] (see Chapter 5, p. 107), with some paediatric nurses describing how this has led to a loss in placement capacity.

And as is the case in the NHS, not all nursing care homes and other types of social care providers are able to provide and ensure quality clinical experiences. Underfunding and limited human resources capacity in some

parts of the social care sector can affect how well these settings are able to accommodate students, despite the essential role of nurses in the settings.[48,58]

Student buy-in

As noted previously, a key challenge to diversifying practice learning placements is students' expectation and desire to work within secondary care settings, which is traditionally viewed (and often portrayed by the media) as the core of nursing and midwifery practice.

> **Sometimes we are fighting against sort of ingrained ideas about what nursing actually is to someone... often many of them come in with the assumption that they need to be in a hospital environment to feel like they're a nurse.**
> Children's nurse

> **... the expectation that [students] have very heavily acute-focused placements... it can be incredibly challenging for us.**
> Educator

For example, we heard that many nursing students anticipate and initially prefer placements in hospitals where the fast-paced, high-intensity environment aligns with their preconceived ideas about the nursing role. In midwifery, we heard many students only wanted their placements on labour wards as this is where they could increase their number of births. This requires addressing potential biases and misconceptions about the value of placements outside secondary care, ensuring that all students receive a well-rounded education that prepares them for the broad range of roles that these professions can fulfil.

To achieve this, several approved education institutions recommended sequencing student nurse training so that placements in community settings come later (for example, in the third year) when nursing students have a better grasp of the interprofessional and holistic nature of their role. Stakeholders also spoke about the importance of developing clear learning objectives and

using universities' practice workbooks (a self-directed learning tool), so that nursing students, for example, understand the benefits and know exactly what the placement is intended to achieve.

Sustainability

As part of taking advantage of opportunities that do exist around developing the range of practice learning experiences, sustainability and factors such as carbon footprint should be a consideration. The NMC has a role to play in encouraging and supporting sustainable practice in approved education programmes. As outlined in the recently published NMC environmental sustainability document,[59] the NMC plans to set formal sustainability requirements for education, with a target to incorporate practising in a sustainable way into the education standards by 2029.

We did not hear any evidence specifically relating to climate change or sustainability. However, travel to placements was raised across focus groups, with students evidencing that often public transport routes were not available. Both staff and students highlighted long travel times to placements, with examples given of up to 90 minutes of travel to placements, and a lack of options for those undertaking night shifts. Consideration should be given to how to reduce the environmental impact of travelling to placements, for example through public transport or electric vehicle schemes, recognising that this will have greater implications for some settings compared to others, for example rural and remote placements.

Structure of placement learning

Breadth of types of practice learning opportunities

There are range of ways that practice learning placements are set up and delivered, both within the UK and internationally. The current NMC standards framework for nursing and midwifery education require that approved education institutions and practice learning partners design curricula that integrate theory and practice in a progressively complex manner. These standards also emphasise that curricula should be organised in a way that helps students effectively manage their learning experiences. Additionally, the NMC Standards for Student Supervision and Assessment specify that learning experiences should be customised to match the student's stage of learning.[57]

In the UK, practice learning has traditionally been structured by rotating students through a range of services or using a 'hub and spoke' model (see Table 8). However, a range of approaches have evolved. Other countries are also using various approaches in terms of structuring placement learning opportunities (see Table 8). The Republic of Ireland stands apart in being the only country where nursing and midwifery students complete a compulsory, paid clinical internship component as part of a direct-entry undergraduate course.[11] Elsewhere, in Canada, the clinical component increases as students advance, and in their final year, students are wholly on clinical placement. The final term (an unpaid 'clerkship') comprises acting as a fully competent, independent caregiver, with minimal supervision from midwives.[11]

Table 8: Select examples of different types of practice learning opportunities (UK and internationally)

Example countries	Opportunity	Description of approach
UK		
UK and internationally (for example, Australia and the United States)	Traditional rotational approach[60]/'facilitation model'/'preceptor' model (Australia, United States)	Students are 'buddied' or work with a clinician during one or more shifts as a short-term arrangement.
UK and internationally (for example, Norway)	Group model/peer learning/'student ward'	Student-led, peer-led clinics are run under the supervision of qualified staff (for example, a birth centre or postnatal clinic).
UK	Hub and spoke[61]	Students are allocated to a 'hub' organisation, from which they are dispatched out to shorter 'spoke' placements in different settings, to broaden their understanding of patient care pathways and the wider health and care system.
UK	Coaching and Peer-Assisted Learning (C-PAL) and Collaborative Learning in Practice (CLiP)[62,63]	These are structured, coaching-based approaches where students work together in groups under clinical supervision, and are encouraged to take the lead in their practice and learning outcomes.
UK	Collaborative virtual or technology-enhanced placement[64]	Students are able to use digital platforms to have contact with patients and staff, for example, to observe a virtual consultation between a practitioner and a patient or hold one themselves. These placements may be used to gain experience in specific settings, for example health visiting or school nursing.
UK (Wales)	Consolidation Placement/ Supervised Practice Placement (midwifery)[65]	Before qualifying, midwifery students undertake a final 12-week placement. They are typically allocated to the health board they are streamed to, to help consolidate their learning, build their confidence and become familiar with systems.

Example countries	Opportunity	Description of approach
International		
Australia	Collaborative Clinical Education/Placement models[66]	These models are framed around strategic academic–practice partnerships. In a Collaborative Clinical Placement Program (CCPP), students work alongside a clinician for the duration of the placement, at a single organisation, with support from university clinical facilitators. A Dedicated Education Unit (DEU) is a variant of the CCPP whereby student clinical learning is maximised with features that include reflection, peer teaching and guidance from a mix of staff.
Canada	Clerkship	Students spend their final year on clinical placement, culminating in an unpaid clerkship in the final term.
Republic of Ireland	Paid clinical internship[11]	Nursing and midwifery students complete a compulsory, paid clinical internship component as part of a four-year direct-entry undergraduate course.

Few systematic review papers in our literature search directly compared these different placement opportunities in terms of outcomes.[60,67,68] While the evidence base is therefore still emergent, with no single placement opportunity being 'optimal', there is evidence to suggest a range of benefits for each of the different approaches.

The traditional rotational model – which is widely and commonly used across the UK and internationally, in which a student is paired with a registrant for a short term – has benefits for exposing students to a range of clinical experiences. However, it may not offer as holistic an understanding of the whole patient journey as placements that are compartmentalised.[69] The hub-and-spoke approach has not been scaled comprehensively across or within the UK's devolved nations; however, evidence suggests that where it has been implemented locally, students and supervisors have evaluated it favourably in terms of developing student resilience, independence and sense of belonging; as well as enabling both approved education institutions and practice learning partners to increase placement capacity.[61] However, implementing this model requires additional organisation and the mapping of students to placements based on their learning requirements and student initiative.

The Collaborative Learning in Practice (CLiP) model aims to enable students to learn from and coach one another, and take the lead on their own learning and development. Some stakeholders in England described the CLiP model as one that both nursing and midwifery students valued in terms of assessing their own learning and supporting the learning of others. However, some academic leaders noted that the model requires careful design and stable staffing to oversee and provide support for the model – such as collaborative learning facilitators who make daily visits to provide support to students and staff implementing the model.[70] Other students described the use of students coaching one another as helping with capacity, requiring fewer qualified members of staff to oversee students. However, experiences were not universally positive – with some feedback from nursing associates that the quality of CLiP placements varied significantly depending on how they were implemented and the training of staff and some disparity between the experiences of nursing associates and student nurses more generally.

I felt that it was really dependent on where you were on placement... it was a shame because we heard experiences of those in more acute settings doing CLiP, running a bay and getting great things out of it. And so I felt the need to hub and spoke elsewhere during placement to make the most of those opportunities.
Nursing associate

We heard one reflection from a service user who received nursing care as part of a CLiP model. They spoke of the confusion that can arise when students are all at different years in their course, making it difficult for patients to gauge their level of competency.

Norwegian midwife educators who have deployed the group model noted how it enables peer support, and helps bridge more experienced third-year students with first-year students, while also building their leadership skills. There is evidence to suggest that the Dedicated Education Unit model (in which a student works alongside a registrant for their entire placement, with structured reflection, peer teaching and guidance from a mix of staff) can effectively: build competence in providing high-quality care, safety skills,

knowledge and attitudes;[66] improve student confidence in identifying their learning needs; and increase the 'workplace readiness' of students. Another study suggested that supervision is better organised in these collaborative learning environments in terms of resources and role clarity.[67]

The structure of practice opportunities is not the only – and likely not even the most important – influence on quality of learning. A comparative review of different models of undergraduate nurse clinical education found that regardless of the approach used, there are important factors that transcend the 'models' and contextual constraints. These include:

- professional relationships
- the need for consistency and continuity in clinical education delivery (see the next subsection)
- the opportunity for varied clinical education/supervision models
- ensuring the viability of the model to function as designed.[60]

Challenges and opportunities around structure

While our research did not identify an optimal model, it did highlight some considerations about how models are structured, including how they are organised and timed.

Logistics and organisation

One strategy we heard being piloted to help students better manage the development of the required competencies is the publication of the draft form of all their placements over the whole year and using this as the basis of a conversation with their academic tutor to earmark which placements are more likely best for certain competencies (practice learning lead, adult nursing focus group). Similarly, hub-and-spoke models typically involve changes in how placements are planned, for example the creation of databases of community services available and their geographical locations.[61] We heard from current professionals about the level of organisation needed to arrange and align coaching-based learning models, as third-year and first-year students are rarely in the same clinical area at the same time. Lastly, some practice learning partners described piloting, to positive effect, off-duty rosters for the entire academic year to be provided to midwifery students from the outset; by enabling students to have their rosters 12 months in advance, this

may be one way to help them juggle their wider curriculum and coursework alongside their practice learning requirements.

Staging and timing

Practice learning experiences can be beneficial when the timing of course content aligns closely with practice learning, a point that the literature supports.[20] In the Philippines, for example, clinical educators blend classroom learning with practice learning in a model known as Related Learning Experiences – whereby students learn the theory at the beginning of the week and then apply that knowledge during clinical placements later in the same week. However, we heard it was often difficult to achieve this level of integration within the UK.[31] The literature also points to the importance of timing taught content – such as on mental health – earlier in the programme rather than in the final year, to support students to get the most out of placements.[71]

Some types of practice learning opportunities were seen as more beneficial in the later years of study, as students accumulate greater knowledge and experience. We heard that first-year nursing students often lack the breadth of knowledge needed to fully benefit from placements outside secondary care. Similarly, we heard examples of successful programmes where third-year students spent time in community settings to consolidate their learning skills and managed a small caseload. The literature similarly discusses the benefits of community-based caseload management for third-year nursing students and emphasises the importance of gradually increasing responsibility to boost student confidence.[50,72]

Length of placement

Some participants raised the length of placement as important. In particular, we heard, for example, from learning disability nurses that longer placements – lasting in some cases up to a year – are vital for providing an opportunity to develop team and patient relationships, and having continuity of care.

[W]ith people with learning disability... often the relationship takes time to develop and we might be learning communication skills and adapting to the needs of the client that we have... My experience in community learning disability nursing is that episodes of care are much, much longer than in other types of community work.
Learning disability nurse

My final-year placement was a year... It gave me an ability to really dig a bit deeper... Try out things, rework them and kind of adapt my own practice.
Learning disability nurse

Quality of, and access to, practice learning

The effectiveness of practice learning hinges on the quality of placements and the learning environment in which they take place.

Practice learning environment

The NMC stipulates clear requirements for these environments, including that all staff within a practice learning environment play a part in student learning.[73] In addition, all students must be allocated a nominated person[74] to act on concerns on their behalf.

A major focus of the published literature is on the learning environment, and its effect on student outcomes and learning experiences. Several studies have linked the quality of the clinical learning environment in which students undertake practice learning with the quality of care graduates provide for years after graduation.[75] It is also well established in the evidence that organisational culture plays a crucial role in creating a positive learning environment for nursing and midwifery students and nursing associates. A supportive and inclusive culture fosters collaboration, open communication

and general mentorship, which are essential for effective learning.[75,76] When students feel valued, psychologically safe and integrated into the team, they are more likely to develop the confidence, competence and professional skills required for the role.[77]

> **[L]eaders have to be able to role model that they show humility, that they show if they've got something wrong and they're able to learn from that... being able to challenge when something doesn't align with our values in a way that's safe and in a way that avoids blame culture.**
> Mental health nurse

The broader literature supports these views. It highlights the importance of creating a wider culture of continuous, ongoing learning.[66] Research also indicates that students bring fresh perspectives to the workplace, and can prompt staff to reflect on their own practice.[47] Factors such as a supportive learning environment during clinical placements, opportunities to observe positive professional relationships and strong, general mentorship all enhance the development of patient safety competencies.[78]

The literature also emphasises active student involvement in clinical processes, effective communication and feedback as key components of the student learning experience. Moreover, studies show that staff, especially nurse educators, role modelling caring behaviours positively influences students' caring behaviours.[79]

A recurring theme for nursing, midwifery and nursing associates is the importance of fostering a sense of belonging within practice learning environments. Students suggested that simple actions such as using students' first names, a comprehensive induction and ensuring that wider staff are aware of their integration into the team can significantly impact their experience. This sense of belonging is crucial; extensive research shows that positive and supportive interpersonal relationships enhance a student's confidence, competence, performance in clinical settings and overall learning experience.[75,76,77,80] Some registrants also noted how a strong sense of belonging can influence students' willingness to work for an employer post-qualification, even if it requires relocation.

Participants noted that involving students in decisions around placements, as well as holding preparation and debriefing sessions, were key to effective learning. In Wales, we heard that pre-planning between practice staff and learning disability nursing students was key to them maximising their learning within a short placement at the practice learning partner.

Finally, although not a long-term solution, some positive experiences during the Covid-19 pandemic were noted, where students who moved into paid employment earlier were well supported, which helped develop their skills and sense of belonging. While a range of different factors may have been at play – such as a greater sense of team support and cohesion due to the pandemic, as well as paid employment – this type of 'organisational socialisation' is well documented in the literature.[81]

Overstretched services

There are well-known examples of breakdowns in organisational culture within practice learning partners that limit their ability to deliver high-quality learning opportunities. Recent NMC monitoring reports suggest that turnover and other challenges are impacting on some approved education institutions' and practice learning partners' ability to, for example, optimise safety and quality in all practice learning environments, to ensure the safety of students or to provide a variety of learning opportunities for students.[82,83] In part, these working environments are a reflection of the strain and pressures on the health and care system, which has lacked sufficient numbers of staff to meet increasing patient need for care over a number of years.[84] Participants in our midwifery student focus groups told us they were able to benefit from continuity of supervision in community services, as a result of teams of midwives working together in these settings.

Both nursing and midwifery registrants spoke of the importance of a shared responsibility among all staff for the teaching and education of students. However, the published literature suggests that, in practice, a lack of headspace can contribute to an environment where students are treated with hostility, inhibiting their learning by depriving them of handover sheets or labouring women to care for.[85] The pressure services face may also affect the quality of care that students are exposed to as, despite well-established evidence on the importance of the practice learning environment, across the range of stakeholders we consistently heard a disconnect between what is

understood as best practice and what many students and staff experience in their daily work.

Monitoring and assuring quality

To ensure quality of practice learning, the NMC monitors approved education institutions through various methods, including annual self-reporting, listening events, monitoring visits, exception reporting and extraordinary reviews.[86] The NMC requires approved education institutions and practice learning partners to have processes that ensure all substantive practice learning environments are regularly reviewed and concerns are addressed effectively.[87] In addition, NHS England's Workforce, Training and Education Directorate is formally responsible for ensuring that there are high-quality learning environments for all health care learners in England.[88]

Approaches to monitoring quality of practice learning vary across the devolved nations of the UK, as well as internationally. While an evaluative comparative assessment of monitoring approaches was outside the scope of this work, we heard the following:

- In Wales, the commissioning process was being seen as both a quality-monitoring tool and an effort to drive innovation. Health Education and Improvement Wales has awarded education contracts to each approved education institution, and these involve regular performance reporting and quality monitoring against required contract criteria. Additionally, education audits are conducted as part of the governance system to ensure the quality of placements. These audits assess various factors, such as the number of practice supervisors available, the types of experiences students have and the arrangements for student inductions, including the preparation of induction packs.

- In Northern Ireland, stakeholders described using placement data to understand why students may not wish to undertake practice learning in certain areas. There was also a call for gathering student feedback earlier in the process to allow for quicker responses and timely improvements.

- In Australia, student feedback on the quality of placements is systematically collected at national level by a designated National

Placement Evaluation Centre (The Australian National Placement Evaluation Centre). The Centre is jointly funded by the Council of Deans of Nursing and Midwifery and the Australian Nursing and Midwifery Accreditation Council, and aims to generate a national register of placement quality data through a Placement Evaluation Tool.[29]

Our research found that there are limited metrics and evaluations available to understand the effect of practice learning on clinical and patient outcomes. Most studies we reviewed, and participants we spoke to, considered outcomes such as student experience and proficiency.

Some midwifery educators in England commented on risks with sending students to new practice learning partners that are less well known to the approved education institution, specifically around the quality of learning that the student may receive when in practice.

[W]hether we like it or not, they will learn sometimes bad habits through practice... [the university teaches] what we would call the gold standard in our policies and evidence base... sometimes it can be challenging because they might learn things that we don't want them to learn.
Midwifery lecturer

In addition to the responsibilities of approved education institutions and practice learning partners to review learning environments, the NMC guidance states that the onus is also on students 'to take responsibility for their own learning, to seek out learning experiences and develop their own practice'[89] and 'to seek out learning experiences from all those who can provide them across the multidisciplinary team, not just from nurses, midwives and nursing associates'.[73] However, we heard there was sometimes a discrepancy between the guidance and reality, with some describing a lag in sharing feedback on the quality of practice learning between students, their universities and the practice learning partner.

[O]ur students seem to accept nowadays that they'll get good and bad placements, which I think is unfortunate and there's a variety of reasons for that... They don't speak up and they don't give the feedback that they maybe do need to give to the teams that are looking after them.
Policy workshop participant

With respect to other health professions, there are some similarities and differences in terms of how the quality of practice learning is monitored and quality assured. The Health and Care Professions Council – the regulator for many allied health professions – is similarly responsible for approving their approved education institution programmes. Whereas the NMC requires each approved education institution to work with their practice learning partners to complete an annual self-reflective exercise on how they are continuing to meet the regulator's standards,[90] which is similar to the annual reporting that the General Osteopathic Council requires,[91] the Health and Care Professions Council adopts a 'right touch' performance review process, inviting approved education institutions to submit portfolios periodically in which they self-reflect on their performance,[92] alongside other quality activities, such as reviewing student attrition data and student feedback data (for example drawn from the National Student Survey). One participant reiterated that challenges in quality assuring new pre-registration programmes appear to exist for wider health professions too.

[I]t can be quite difficult to assess quality because you can have quality mechanisms in place, but then actually you don't know how well an education provider will oversee, manage, ensure the quality of practice-based learning until they're doing it. You can see that they've got good plans in place, but ultimately sort of you know, you know the proof is always in how those things have been applied.
Policy-maker

Internationally, some countries are exploring more significant reforms to the quality assurance of practice learning. In Australia, for example, inconsistencies in the quality of practice learning opportunities prompted an independent review into nursing education. The review proposed that higher education bodies could organise and fund the accreditation of clinical placement providers, and that only practice learning hours undertaken at these accredited providers would count towards meeting practice hours requirements. However, the review noted that 'accrediting clinical placements will be costly, and HEPs [higher education providers] may need access to extra resources to fund a clinical placement accreditation system'.[29] The policy does not yet appear to have been enacted.

Equality, diversity and inclusion considerations

Inequity, racism and discrimination

Practice learning offers a first-hand experience of working within health care services, but it may be the student's first experience of systemic disadvantages, ward culture[93] and a clinical environment.

Intersectional issues of inequity, racism and discrimination in the education and training of nurses and midwives create significant barriers for students from minority ethnic backgrounds and other underserved backgrounds. These challenges can manifest in various ways, such as:

- unequal access to high-quality placements
- biased treatment from educators, peers and patients
- a lack of representation in leadership and faculty roles.[94,95,96]

Experts spoke about how, even in environments with high levels of diversity, there are often low levels of inclusion. This can lead to feelings of isolation, lower self-esteem and reduced confidence among marginalised students who share protected characteristics, impacting their overall educational experience and performance. Additionally, these issues may contribute to higher dropout rates, reduced opportunities for career advancement and a decreased likelihood of these students remaining in the profession after qualification.

It's shocking how quickly we observe students going from knowing something is wrong when they observe discrimination, to accepting it 'as just the way it is'. What is enabling that? What is it about the environment and socialisation into these careers that is eroding that resistance?
Policy expert

There was a concern among experts that racism gets embedded in organisational culture despite anti-racism policies and statements to the contrary. For example, experts described how certain initiatives, like Freedom to Speak Up Guardians – who are independent and impartial people intended to help staff raise issues without fear of negative consequences – are not always working as intended. In addition, while NMC standards for education state that approved education institutions and practice learning partners should ensure all educators and assessors receive relevant induction and training on equality, diversity and inclusion, focus group participants stressed the limited time made available to complete this training.

The NMC requires that all students have access to a nominated person who can actively support them and address any concerns they might have while in a practice placement learning environment. Many participants praised the practice education facilitators in providing this role. However, experts noted how essential it is to have Black and minority ethnic communities represented in more senior positions of nursing and midwifery, to be able to provide senior mentorship and contribute to a psychologically safe environment for students to raise concerns.

However, research has also shown how students tend to feel powerless in a clinical environment due to the hierarchical structure and power imbalance that their position holds, which can perpetuate cycles of mistreatment.[77,94,97] Published literature suggests that students tend to err on the side of not raising concerns due to factors such as limited autonomy, insufficient support or fears of damaging personal relationships with staff.[97] Certainly, we heard that there could be potential for students to have more longstanding relationships with a nominated person to enable to them ask questions (or raise concerns) in a more psychologically safe space.

Reasonable adjustments

The NMC Standards for Student Supervision and Assessment (SSSA) require that learning experiences be inclusive and cater to the diverse needs of all students, with adjustments provided according to equalities and human rights legislation. Requests for such adjustments should be reasonable, necessary and reviewed over time.[57] In addition, there is available guidance for supporting neurodiverse students during practice learning and, for example, the pan-London practice assessment document includes an orientation checklist to be completed when starting new placements, which covers reasonable adjustments. The latter checklist ensures that students have the opportunity to discuss any reasonable adjustments with their practice supervisor at the start of the placement.

Evidence from student nurse peer networks suggests that common barriers to widening participation in practice learning include:

- poor communication between approved education institutions and placement providers
- challenges in accommodating reasonable adjustments
- a lack of staff knowledge on supporting students with specific needs.

Some students may also hesitate to disclose their needs due to fears of bias.[98]

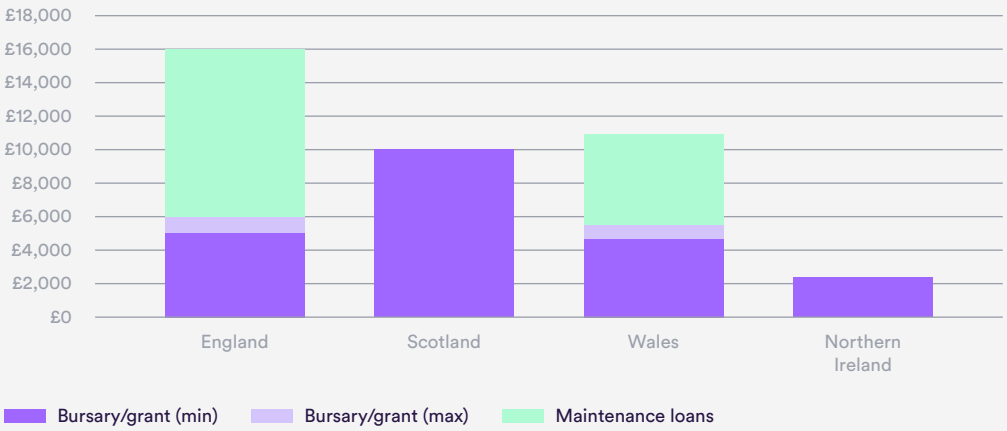
Concerns were raised that some adjustments made during practice learning may not reflect the realities of newly qualified roles, as this 'sets students up to fail' if they expect flexibility and support is typically unavailable, contributing to early staff turnover. However, stakeholders also emphasised the need for more flexible and inclusive practices within some practice learning environments to better represent and support the future workforce.

Some providers struggle to implement reasonable adjustments, such as accommodating students who cannot work night shifts, and educators raised concerns about the how well private occupational health providers are equipped to conduct assessments of students who may need reasonable adjustments. We heard, for example, about inadequate assessments of students with complex mental health conditions being conducted over a 10-minute virtual call. Improved early dialogue between practice learning partners and approved education institutions could help identify, and manage, students' requests more effectively.

Costs and accessing practice learning settings

There are notable differences in the funding available for maintenance costs between students in the different UK nations. While a comprehensive review of student funding and support was outside the scope of this research, experts noted that the extent to which students experience financial hardship, and the different types of financial support students have access to during training, vary by nation. Scotland has the highest levels of (non-repayable) bursaries or grants, whereas student financing in England is more reliant on loans through national student loan schemes for covering maintenance costs (see Figure 7).

Figure 7: Annual maintenance loans, bursaries and grants available to students on nursing or midwifery courses, by UK nation



Notes: Fees, maintenance loans (via national student loan schemes) and bursaries are for the 2023/24 academic year except for Northern Ireland (2022/23). The student bursary in year 4 in Scotland reduces to £7,500. Figures for each nation typically apply to those who are also domiciled in that nation.

Sources: GOV.UK, Student Awards Agency Scotland, University of South Wales, University of Swansea, Student Finance Northern Ireland, Ulster University and House of Commons Library

We heard instances of student nurses and midwives having to take on work outside their training and education to be able to afford rent and food, and instances of students facing food insecurity and needing to use food banks, compounding issues of burnout and anxiety and making it difficult for some students to carry on in their training. Some educators felt that, particularly for students from disadvantaged backgrounds, the current standards extended the time they spent on placement and restricted their ability to work.

The location and amount of practice learning can therefore cause additional, significant financial pressures for students. Even though some expenses can be claimed, we heard that the upfront cost of (as well as time for) accessing placements – particularly public transport travel costs – can be a barrier to learning, with some students not attending their placement, even though this could delay their completion of the course. We heard that in Scotland's remote and rural regions, for example, these access issues as well as accommodation costs can be a particular issue.

We heard that apprentices – who, in the case of degree apprenticeships, are typically paid at Band 4 (with a starting basic salary of £25,147 in 2023/24) – may also struggle with the costs associated with travelling. Some nursing and midwifery students are eligible to access the NHS Learning Support Fund in England, with allowances including a training grant (£5,000 a year), parental support (£2,000), exceptional support (up to £3,000) and travel and dual accommodation expenses.[99] However, this financial support seems to be little known among students, and challenges appear to remain around the adequacy of the support,[100] the retrospective nature of making a claim (meaning students are still required to bear the costs upfront) and the process for submitting a claim. Across the UK, some wider initiatives appear to be effective such as the provision, where possible, of pooled transport for placements in Wales.

Students with disabilities may be eligible for Disabled Students' Allowance (DSA) to cover course-related costs. However, the challenges of accessing practice learning can be particularly acute for students with parental or caring responsibilities. These include:

- coordinating the timing of placements with childcare drop-off
- the rigidity of some practice shifts
- the requirement in some places that students attend an entire shift for it to count towards practice learning hours.

This may have a particular impact on some fields of nursing, as mental health, learning disability and nursing associates are more likely to have a greater proportion of mature students.[101,102]

The NMC standards set out the expectation that approved education institutions and practice learning partners ensure students experience the range of hours expected when practising after qualifying, and we heard a general understanding that students need to be exposed to the professional role. However, it was also suggested that some restrictions and burdens of practice learning may be out of kilter with the fact that everyone in the NHS has the right to request flexible working from day one of employment and this might be potentially excluding students who could still fully contribute in the role.

We heard that allowing for more substantive breaks in the practice learning could provide students with an opportunity to earn if this is necessary. We heard from educators and policy-makers that greater flexibility could also mean permitting students to opt for an alternative course calendar, where they still completed the same amount of hours but could choose the duration of time that they did it over. In Australia, a collaborative clinical placements model (CCPM) was found to have particularly benefited mature students who had caring duties as they were able to better plan their time and reduce travel time.[67]

Allocation of opportunities

The process of the allocation of practice learning varies significantly by approved education institution and practice learning partner. For example, during our focus groups, some nursing students expressed frustration about their choices not being respected, while others reported that they were not given the chance to express their preferences at all. Given limited placement capacity, the allocation decisions are inherently difficult and, as is the case for most placements in Scotland, there are processes in place to try to take account of preferences in a systematic way. However, where there are inconsistencies, this can lead to dissatisfaction and feelings of unfairness among students. This dynamic also contributes to the equality, diversity and inclusion issues raised above.

The allocation of practice learning opportunities can also create a competitive environment where students or students' groups are pitted against each other for the same spot. For example, we heard from midwifery staff about the challenges that can arise when multiple, different education providers allocate all their students to a single NHS trust, creating challenges for all

students to have equal opportunity to access valuable learning experiences. Notably, we also heard that apprentices may sometimes get priority due to their existing relationships with employers. Additionally, final-year nursing and midwifery students are often given precedence, especially in secondary care settings, over students in other years due to the pressure of completing their proficiencies. When opportunities are insufficient, this can potentially create backlog problems that will perpetuate this prioritisation in later years of the programme.

We heard from nursing associates that the allocation of opportunities could prove challenging. In particular, some expressed frustration about how learning opportunities were allocated, with priority given to other professions.

> **It was always the student nurses who've got the opportunities. It was always the third years who got to do medication rounds. It was always the third years who got to cannulate... And I felt, if anything, I'd deskilled on some of those placements because I didn't have the chance to practise those skills.**
> Nursing associate

5 Practice supervision and assessment

Key points

- We regularly heard about issues around a lack of protected time for individuals to undertake practice supervision and assessment to a high standard, as well as limitations to the current standards and approach for their training.
- While there are ambitions to provide continuity of support and supervision, this is commonly cited as difficult to deliver.
- There remains a risk that students not meeting the expected level are still progressing in their course.
- We were told a range of reasons for this apparent 'failure to fail', including feeling pressure not to fail students, a lack of information on performance and the potential workload that failing a student would entail.
- While the NMC has a process for recognising appropriate qualifications for people educated internationally, these people are still required to undertake an exam to assess their values and behaviours, and evidence-based practice (unlike for those who are educated and train in the UK).
- There appear to be opportunities to strengthen practice supervision and assessment, including by investing in roles to address what is currently, at times, disjointed working between education, clinical practice and assessment.

The supervision and assessment of students is critical to ensure that students meet the required outcomes of their chosen programme and are capable of safe, effective and kind practice. However, a lack of supervision and assessment capacity was regularly highlighted in our research as an issue. In fact, a recent review of practice education in Scotland suggests that around 9% of all practice learning environments had no identified practice supervisor on shift, while 10% had no practice assessor on shift, although the results should be treated with a degree of caution.[51,*]

While all staff are expected to support students' learning where appropriate, there are specific roles relating to practice learning as defined in the standards: practice supervisor, practice assessor and academic assessor. This chapter covers:

- practice supervisors, including their availability and preparation
- practice assessors, including how the role is supported
- other facilitators and challenges around practice supervision and assessment.

It's much more about ... who your assessors or supervisors are in that place than what the place is... it almost doesn't matter what the service is or what the placement is. It's the people who lead and oversee that service.
Mental health nurse

* This study used survey data and the researchers note that interpretation of the relevant survey question may have meant that respondents only recorded named practice supervisors/assessors and suggest viewing these percentages with caution. Additionally, the research included a number of allied health professionals so is not exclusive to nursing and midwifery.

Practice supervisors

Practice supervisors support and supervise students' learning in the practice learning environment. All students must be supervised while learning in practice environments. However, the practice supervisors can specify what level of supervision is appropriate, and the level or form of practice supervision can decrease or change in line with the student's proficiency and confidence.[89] The level of supervision will also vary depending on other student characteristics and, for example, the type of support they need throughout their degree, from the first year to the final year.[103]

Capacity for, and continuity of, practice supervision

During our research, we heard about the benefits to practice supervisors of supervision and a general understanding of why the current supervision arrangements are in place. In particular – and notwithstanding the challenges, which we discuss later – the literature, as well as participants for example in our nursing focus groups, noted some positive experiences around practice supervision, including the potentially symbiotic, mutually beneficial relationship, given the student can potentially bring contemporary theoretical knowledge while the supervisor will have more experience.[103] We did not identify any appetite to roll back on the changes in 2018, which made all registrants responsible for supervising and so broadening capacity to do so. However, capacity constraints were still raised. Some participants commented on the risk that the changing balance of the midwifery profession, including increasing numbers of clinical support workers, created a challenge given they cannot supervise, or sign off competencies.

While there are ambitions to provide continuity of support and supervision, this is commonly cited as difficult to deliver. The NMC standards on supervision and assessment set out the expectation that 'there is sufficient coordination and continuity of support and supervision of students to ensure safe and effective learning experiences'.[57] Students may benefit from a range of different people supporting their learning but there are some recognised benefits to having some continuity, including potentially incentivising supervisors to invest more in the student's development. However, we heard, for example in one of our focus groups with midwives, about situations of

having a new student every shift and then the need to quickly assess their level of competence and development needs.

We also heard that, as a result of short staffing, some specialties lacked practice supervision and assessment from staff in their field of nursing. The current challenges around capacity also need to be seen in the context of ambitions to increase the scale of the clinical education pipelines, which will likely require additional capacity from academic and clinical educators, supervisors and assessors to accommodate increasing numbers of students, many of whom are already under pressure and working within a system already struggling to meet the demands placed on it.

I was never mentored or had a practice assessor... who was a learning disability nurse. So throughout my student career I was never mentored by anyone in the profession. Although we were taught by learning disability nurses in university, I think because the number of us LD [learning disability] nurses in practice is very few and far between we don't have enough practice placements.
Learning disability nurse

Experience and knowledge of practice supervisors

We heard in our research that the high proportion of nursing and midwifery registrants with limited experience in practice or UK health services represents a challenge to ensuring sufficient capacity to provide appropriate supervision. As at March 2024, around one in five (19%) of professionals had been on the NMC register fewer than three years, with around 7% having been on the register for less than a year. Also, as mentioned in the section 'The composition of the professions' in Chapter 1, nearly a quarter (23%) of people on the register trained oversees and they accounted for around half (49%) of people joining the register for the first time in the year to March 2024.[5]

There are no standards set for the training of supervisors in the UK and we heard from some registrants that their training to undertake the supervisor role was very limited. In other countries, such as Canada and the Republic of Ireland, training for similar roles is mandatory and more standardised.

The challenge for supervisors to support students to meet proficiencies is not limited to those new to UK health services. In one children's nursing focus group, participants discussed the challenge of managing their clinical workloads alongside supervising students to help meet their proficiencies. Similarly, across the midwifery and adult nursing focus groups, we heard the term 'student fatigue', referring to the difficulty of providing good-quality and supportive teaching while still providing care for service users.

More generally, there is a risk that practice supervisors are not practising in the most state-of-the-art way; one international review identified evidence that sometimes clinical staff taught students the way they practised, which was not necessarily evidence based or what students were taught in the classroom.[76] In particular, in the learning disability focus group we heard one example of a learning disability nurse teaching venipuncture (phlebotomy) by simulation, a skill they had not undertaken in seven years.

Midwives also raised concerns around the changing makeup of the midwifery workforce, with reportedly a higher proportion of younger staff, meaning fewer years of applied experience in supporting students to flourish compared to more experienced staff. Another concern related to the longer preceptorship period for internationally trained midwives. And midwives described potential competition arising between preceptees and students for practice learning opportunities in certain areas.

Another issue relates to equity and inclusion, and the value in having practice supervisors and educators who reflect the community they are working in. Experts noted how difficult it can be for students from Black and minority ethnic backgrounds to learn in environments that lack racial diversity (see the quote below). We also heard about the importance of supervisors facilitating an inclusive environment that encourages open dialogue, mutual respect and collaboration, allowing students from all backgrounds to feel a sense of belonging.

If you're in a practice learning environment that's homogeneous in terms of ethnicity, then it's very difficult for people of colour to really be themselves and be vulnerable. And [nursing and midwifery] are professions where one really has to expose oneself, because you are dealing with people, and you need to get to the bolts of who you are to be able to provide care in a holistic way.
Policy-maker and lead midwife

Practice assessors

In the UK, all students on an NMC-approved programme are assigned a practice assessor who is supposed to work in partnership with the student's academic assessor to evaluate and recommend the student for progression for each part of the programme, in line with programme standards.[57] In this section, we discuss some of the challenges and opportunities around assessment. For context, however, it is important to recognise that assessment is complex and has proved a challenge for many countries.

The assessment of nursing students' competence in nursing is a matter of concern worldwide and the complexity of assessment has challenged educators for decades.
Immonen and others (2019)[104]

Decisions on progression

There remains a risk that students not meeting the expected level are still progressing in their course. We heard, from a midwifery focus group, examples of students reaching the end of their midwifery course and being failed at the last point, despite concerns being raised throughout their training but not properly documented. Additionally, in one of our policy workshops, participants noted that some practice assessors do not feel well prepared to have difficult conversation with students who are not achieving their competencies and are therefore reluctant to fail them. One of the motivations

for moving from a single mentor to separate assessors and supervisors was to disaggregate the support and the assessment functions and remove what was perceived to be a 'failure to fail' phenomenon. However, we heard concerns from our focus groups with registrants and interviewees about there still being a 'failure to fail' students who have not yet demonstrated an ability to practise safely.

We heard about a range of reasons for this apparent 'failure to fail'. Some current registrants told us that they felt pressure not to fail students, although the underlying reasons appear to vary. We heard that a lack of information on performance – including supervisor feedback, even when written, not always being guaranteed to get to the assessor – can undermine the ability to fail a student. Previous international literature has highlighted that supervisors do not necessarily always feel that ownership, they might not always provide that feedback or they are not getting the time to provide the feedback.[105] Some registrants appeared to perceive failing students as counterproductive, given the workforce shortages, while others noted the disincentive of the extra work involved in failing a student.

Model for assessment

Another hindrance to assessments is around the accompanying policies and procedures to guide practice assessors when deciding on whether to progress students. These are often limited – creating uncertainty in assessing students in their practice – and there is a lack of evidence to inform and evaluate them. This challenge is not unique to the UK; in Australia, student appeals suggest assessors' *ad hoc* use of policies and a need for clearer guidance from approved education institutions.[106] However, while the challenges around applying assessment policies are well established, so too are the enablers, including:

- having clear processes (developed for internal use to explain how policies are operationalised)
- clearly communicating the procedure for managing students who are not meeting the expected standards
- providing guidance to help assessors differentiate between a pass and a fail
- ensuring assessment policy and processes are accessible.[106]

There are choices about how to conceptualise practice assessment, which, in turn, have implications for how it is delivered. Previous literature has highlighted the different models to conceptualise the clinical professions and, during education, student assessment could focus on, for example, behaviours, general attributes such as knowledge of critical thinking, or more holistically cover value and skills.[57] Many participants, including children's nurses, members of the Council of Deans of Health and interviewees suggested that there could be a move towards an outcomes-based approach with more focus on, for example, critical thinking. One participant in the children's nursing focus group reflected positively on the role of action learning sets, peer-to-peer discussions and critique to help develop critical thinking skills. A study on assessing nursing students' personal qualities also found that assessors want students to demonstrate critical thinking.[105]

The underlying assessment philosophy also has consequences in terms of how the assessments are conducted, including using submission of a portfolio, direct observation, structured exams, interviews, reflective journals and rating scales.[22] Some professions assess all students through a national exam at the end of their education programme – students must pass this exam in order to register. Internationally, some nursing and midwifery boards also require students to pass an exam before registering. Other approaches include a more standardised approach to assessment in clinical practice, such as the forms used in physiotherapy in the UK or for nursing and midwifery in Australia (see Table 9).

Table 9: Examples of different approaches to assessment

Profession	Approach to assessment in the UK	
Medical doctor	Newly introduced Medical Licensing Assessment	
Pharmacist	Registration assessment exam	
Physiotherapist	Common Placement Assessment Form (CPAF) – a standardised form used to assess all physiotherapy students across clinical placement settings and universities	
Physician associate	Physician Associate National Examination (PANE) – includes a written and a clinical element (Objective Structured Clinical Examination [OSCE])	
International examples	**Nursing**	**Midwifery**
Australia	Australian Nurse Student Assessment Tool (ANSAT) used in practice learning – includes a scoring sheet with 23 items, feedback and examples	Australian Midwifery Student Assessment Tool (AMSAT) – made up of three tools including a scoring sheet to record the assessor's rating of 25 items, a feedback sheet and behavioural examples
United States	National Council Licensure Examination	American Midwifery Certification Examination
Canada	Canadian Practical Nurse Registration Examination	Canadian Midwifery Registration Examination
New Zealand	State Final Examination	National Midwifery Examination

Source: Nuffield Trust analysis of various documents

There are many assessment approaches and tools available;* however, there is limited evidence in the literature on whether these different approaches to assessment are reliable or valid.[57] There is no clear consensus on the best approach to assessment; however, a recent scoping review suggests that the exam used for overseas recruits 'appears to be an effective assessment process for both technical and nontechnical skills in terms of consistency and capacity to identify students' strengths and weaknesses'.[107] This paper focused on the Australian context and notably did not include a quality assessment of

* Examples of assessment instruments include the Objective Structured Clinical Examination (OSCE), which is used for overseas recruits joining the UK register.

included literature. A 2019 government review in Australia suggested that it 'seems anomalous' to use different approaches for domestically and internally educated applicants.[29]

No one single correct approach exists to performing assessment of nursing students' competence, which is suitable in all different contexts.
Immonen and others (2019).[104]

The decision on the model of assessment is taken locally.[74] Scotland, Wales and Northern Ireland have their own standardised practice assessment documents for nursing, which are mapped to the proficiencies. The Scottish practice assessment document (SPAD) was developed in collaboration with approved education institutions across Scotland. All pre-registration nursing students in Scotland must complete the SPAD. The electronic document details proficiencies, skills, attitudes, values and behaviours. The Northern Ireland practice assessment document for nursing (NIPAD) was developed in collaboration with approved education institutions alongside service users, students and practice providers. It also includes guidelines detailing the role of practice and academic staff in the supervision and assessment of practice learning. Similarly, the all-Wales practice assessment document (PAD) was developed in collaboration with approved education institutions and practice partners as well as Health Education and Improvement Wales. Alongside receiving feedback from practice supervisors and practice assessors, students can also receive feedback from service users through the all-Wales PAD. We heard from staff about the value of having a standardised practice assessment document.

In Northern Ireland we've worked very hard across all our AEIs [approved education institutions] to have a common PAD, I think that's very good practice and it was a huge piece of work... I think having [a] common practice assessment document is very important.
Children's nursing lecturer, Northern Ireland

Participants in the children's nursing focus group also discussed the idea of a specific children's nursing practice assessment document. We heard this was already in place in Northern Ireland but that it very closely mirrors the NIPAD.

Nursing in England, on the other hand, does not have a standardised practice assessment document; however, approved education institutions across London have developed a pan-London practice assessment document (PLPAD) alongside practice partners, staff, students and service users. The pan-London group also have a practice assessment document for nursing associates. There are a number of regional PADs for nursing, including the Midlands, Yorkshire, North East and East practice assessment document (MYE PAD). For midwifery, the eMORA (see the section 'Administrative burden of proficiency sign-off', in Chapter 2, p. 64) is standardised and used across England and Northern Ireland. Scotland and Wales each have separate midwifery practice assessment documents (mPADs).

The NMC had previously suggested that it wanted the same assessment criteria. However, we did hear a view from both the university and supervisor perspective that the current criteria used – typically just 'pass' or 'fail' – was restrictive and that a sliding scale that captures the level of which students might be above, at or below expectations might be more helpful. This is similar to the Australian nurse/midwifery student assessment tool, where students are given a rating of one through to five on their ability to perform a behaviour or practice.[108] In the Republic of Ireland, students are assessed as being novice, advanced beginner or competent, which appears to allow for a more detailed assessment and measure of student progression.

We need then to think more innovatively about the sorts of models that one uses to deliver that assessment. And you know there are... some areas where that's already happening.
Policy-maker, UK-wide

Preparation and protecting time for practice assessors

We heard across different focus groups that practice assessors can find it challenging to fulfil their role because of a lack of support, training and protected time. The NMC standards for student supervision and assessment set out the expectation that approved education institutions, together with practice learning partners, ensure that practice assessors, for example, receive ongoing support and training on their role, and have the experience of or undertake preparation around communication skills, conducting assessments and providing feedback.[57]

We heard that a lack of time for appropriate reflection and feedback to support learning was sometimes compromising the application of the standards for assessment, and some students and supervisors reported that the availability of the practice assessor was sometimes an issue. This has been highlighted in a Health Education England review of pre-registration midwifery education and training and newly qualified experience, where midwifery stakeholders identified the importance of protected time to allow reflection and feedback, and staff shortages were raised as a key barrier to achieving this.[109] As with practice supervisors, a lack of preparation was raised, although we heard there was potential to, for example, use role-playing simulation to provide support and development for assessors.

The NMC standards state that 'practice assessors are not simultaneously the practice supervisor… for the same student'.[57] However, in one Scottish review,[51] 178 practice learning environments reported staff acting as practice supervisors and practice assessors simultaneously. Although staff acting in the practice supervisor role for one student and in the practice assessor role for another could explain this, the possible impact on staff workload is concerning.[51]

Other facilitators and challenges around practice supervision and assessment

Professionalisation of education roles

The supervision and assessment roles within nursing, midwifery and nursing associates are often not perceived to be valued. We heard from the adult nursing focus group that supervision and assessment were often treated as a 'bolt-on' to clinical work and that there was an opportunity to professionalise them to incentivise participation. This is true of other countries – for example in Australia, where managers or educators do not consistently recognise the 'dual responsibility' of the preceptor (mentor) role, leading preceptors to become unmotivated over time.[110] Levers include enhancing the status and reward of education roles, such as providing recognition and accreditation, and creating career pathways and opportunities.

Additionally, the practice assessor role is often perceived to be a burden. In particular, we heard of challenges when practice supervisors and practice assessors take students from different approved education institutions as this requires a sufficient understanding of the proficiencies and programme outcomes that each of the students they supervise or assess is aiming to achieve. It may also require using different methods (for example, software packages for eMORAs) for recording activity in relation to the role.

Collaboration, continuity and coordination

We heard that, at times, there was disjointed working between education, clinical practice and assessment. Some participants alluded to competition between approved education institutions to secure practice learning opportunities, and an emerging "patchwork quilt of placement capacity", which requires ongoing efforts across approved education institutions and practice learning partners to coordinate activity. In particular, there may be scope for more consistent and thorough involvement of the supervisor in assessments. There is a wealth of evidence about the importance of collaboration between academic lecturers and clinical supervisors, particularly given the importance of integrating the theoretical and practice parts of education.[21] However, we heard that there has, in particular,

sometimes been a lack of established relationship between education and practice staff – particularly since the Covid-19 pandemic and given that some of the roles, including academic assessors, are still fairly new – which has made the process of raising concerns about students who are not meeting standards more challenging.

As part of the collaborative approach, students also need to be engaged in the assessment process.[57] However, we heard that a lack of continuity of practice assessor was – among other things – hindering students' engagement. While the requirement for a student to have a different academic assessor each year may minimise risk of bias and ensure greater independence during practice assessment, educators felt that this was at a cost of continuity and could make it harder to sign off students at the end of their programme.

There appear to be opportunities to support improvements around collaboration in supervision and assessment. For instance, we heard from midwives that regular (for example, fortnightly) meetings between regional directors of midwifery can be helpful for addressing issues in a timely manner. Other opportunities cited included the appointment of specific roles. More broadly, we heard that the practice education teams within practice learning providers were an important facilitator of more effective and coordinated learning. Coordinators of practice learning are expected to have oversight of all placements and how they support students to meet their learning outcomes and NMC standards. The NMC states that approved education institutions 'may appoint additional roles to support student learning and assessment across theory and practice; we do not mandate these roles – this is a local decision for the [institution] to take'.[111]

Specifically, we heard in the context of Northern Ireland the importance of the role of 'link lecturers' (see the quote below). These roles can help coordinate and also, for example, advocate for students. Such roles include:

- practice education facilitators – of which, for example, Health Education and Improvement Wales funds 60 full-time equivalents who work directly within its health boards
- regional directors for midwifery and nursing
- care home education facilitators.

Other countries have more specific standards around capacity to coordinate and manage practice learning. For example, in the Republic of Ireland, the Nursing and Midwifery Board of Ireland's standards state that one clinical placement coordinator is required for every 30 nursing students or for every 15 midwifery students, with 0.5 of an allocated liaison officer for up to 50 midwifery students.[112,113]

The role of the link lecturer [is] to make sure that both students and staff feel supported and that there's a clear, open, two-way communication and support for both students and practice assessors through the practice educators who are in post and that there's good communication, good relationships between the universities and the placement areas. Very often, if there is a problem, it's really essential that the link lecturer knows that really early on so that they can work to enable supportive mechanisms to be put in place.
Policy workshop participant

6 Discussion

Practice learning is a core requirement for students wishing to become a nurse, midwife or nursing associate. It remains a fundamental part of nursing, midwifery and nursing associate education that enables students to apply the theoretical knowledge they have gained in the classroom to actual service users and real-world scenarios, as well as take their learning from practice to the classroom. However, the practice learning landscape has changed and continues to do so given, but not limited to:

- additional flexibility that leaving the EU provides the NMC
- the Covid-19 pandemic, which resulted in innovation in practice learning and simulation
- calls in the NHS Long Term Workforce Plan[7] in England for the NMC to reduce the practice hours requirement to release educational capacity to increase student numbers
- the changing profile of the professional register
- changes in the complexity of care and ambitions for a more preventative approach
- digital technology and innovation in clinical care and how, for example, the availability of artificial intelligence (AI) affects education and the ability to assess students through coursework
- the wider movement around embedding and reflecting equality, diversity and inclusion in the NHS and other workforces
- demand for improved clinical leadership skills.

We found limited evidence to underpin some of the regulatory requirements – including the number of practice learning hours and births – but there was

also a lack of consensus from those we engaged with and a lack of consistency between countries and other professions to inform what more optimal levels would be. Moreover, we found inconsistencies in how the requirements are interpreted and challenges in how the standards are implemented, including supervision and assessment. However, we also identified reasons for optimism, given the range of promising approaches to practice learning that can be evaluated and learnt from, as well as overall general willingness across the systems and services involved to improve practice learning.

Published evaluations exploring different approaches to practice learning have typically looked at effects on student satisfaction rather than other outcomes such as improvements to skills, knowledge and confidence. Moreover, some of the older evidence has become less relevant, given the changes in the education and service provision landscapes, and there are difficulties in translating and transferring international evidence to a UK setting.

It is important to note other limitations in our research. This was a six-month rapid study and the announcement of the general election in May 2024, the subsequent pre-election period that affected the availability of government and NHS staff, and the summer holiday season, for example, had an impact on recruitment to our focus groups and policy workshops. We sought to talk to a diverse range of stakeholders and others – and added additional elements to our research to fill shortfalls (including an initial shortage of early-career registrants in our focus groups) – however, due to some individuals dropping out, some focus groups did not have, for example, representation from across the UK's devolved nations for some groups. We discuss the limitations further in Appendix 1.

Decision-making in evidence-poor areas

There is a clear opportunity for organisations with responsibility for regulation to address the limitations around a lack of evidence, and support the generation of further evidence to better understand how practice learning affects core outcomes, such as the safety and effectiveness of care.

Our view is that the next steps on exploring the regulation of practice learning should look beyond reviewing existing evidence on regulation and support

the wider research ecosystem to produce new insights on, for example, the effectiveness of different practice learning models, assessment approaches and simulation. There is especially a dearth of evidence on how different approaches to practice learning – including assessment approaches, recognition of prior learning and entry requirements – affect patient and clinical outcomes and students' knowledge. Use of simulation in midwifery remains another under-studied area. These efforts to fill gaps in the evidence base should involve piloting different approaches in a safe manner.

But the lack of evidence should not be taken to mean that more cannot be done now to improve practice learning. The range of challenges highlighted throughout this report, such as the challenge in meeting the regulatory requirements and also ensuring effective supervision and assessment, create an urgency to explore regulatory options. Meanwhile, there appears to be a need to improve current understanding and implementation of the requirements in the short term – while evidence is still being generated – to ensure the public's confidence in the professions and give future nurses, midwives and nursing associates every chance at success in their field. We heard – including in the quote below, which was made in the context of the challenges that overstretched providers can face in providing effective learning opportunities – frustration that policy-making in this area has not been bolder.

> **It's tedious to still be having this conversation when we've known the problems for a long time. We should be further along because our ethos is good. We just need to execute it well. And to execute it well, people need to be courageous and brave and say to those in power this capacity will not do... We owe the public this... unless we start being courageous and having robust conversations, well, in 10 years' time there, you'll be back here doing something quite similar.**
> Midwifery expert

Principles for setting the regulatory framework

This research was not intended to define what the single best regulatory approach is. In any case, the limited nature of the published evidence base, the different contexts overseas where much of the literature is from, and a lack of consensus from our research participants on certain aspects, would make such a specific conclusion impossible. However, there are existing expectations around professional regulation, including that it is proportionate, consistent, targeted, transparent, accountable and agile. In addition, we believe our research suggests that the following principles, which we expand on below, should inform considerations about changes to regulation for practice learning. The approach should be:

- future proofed
- aware of the consequences of alignment, or not, with other clinical professions, between UK nations or with international regulation
- underpinned by wider partnership and coordination
- conscious of, and likely mitigate against the risks of, unintended consequences
- explained clearly – including the underpinning rationale for the approach – to stakeholders.

First, the regulation of practice learning needs to be **future proofed**. This is especially important given ambitions to expand education and training pipelines, move care into the community, invest more in preventative care, advancements in care and technology, and potential changes in regulatory requirements for practice learning in the EU and elsewhere. It should also provide sufficient assurance for a larger and perhaps more heterogenous set of staff seeking to work in the nursing, midwifery and nursing associate professions. For practice learning to be fit for purpose still in five, 10 or more years' time, regulation must take account of the ongoing changes to the roles and services that future generations of nurses, midwives and nursing associates will be expected to deliver.

Second, the regulatory approach should be balanced, proportionate and sufficiently **aligned** with other clinical professions and across the UK. For

example, a solution should be sufficiently consistent across the UK, given the scale of movement of nurses and midwives between the four nations of the UK, without unduly fettering the flexibility for each nation to ensure the regulatory system is fit for purpose for its needs. Proficiencies could also better reflect the specific skills and competencies needed in different fields of nursing. The current holistic approach may have the unintended consequence of students training in specialist areas of nursing feeling underprepared in key skills they need for the role.

Similarly, the degree of alignment with international regulation has implications for inward and outward movement of nurses, with alignment with EU regulations a particular consideration for the movement of these professionals across the Irish border. Sufficient alignment with other professions might also be a key consideration where, for example, individuals from different professions end up working in the same role, which can happen with individuals from nursing and psychology backgrounds working in community mental health services, for instance. Experts also saw an opportunity to bring standards for simulated practice learning in midwifery in line with nursing.

Third, **wider partnership and coordination** across the education, policy and practice sectors will be required to address all the risks as well as deliver on the opportunities around the effectiveness of practice learning. The trade-offs with any chosen approach to regulation should be explicit so that risks can be mitigated across the wider assurance framework. Whatever statutory regulation is – or is not – in place, employers and individual practitioners will retain many responsibilities. Practice learning partners and approved education institutions will have to be part of the solution and any statutory regulatory changes should not be seen as providing all the necessary information and assurance.

Fourth, any regulatory decisions need to be conscious of, and likely mitigate against the risks of, **unintended consequences**. Changing the regulation of practice learning could, for instance, have implications for:

- professional as well as public confidence in the professions
- the capacity and stability of the health and education workforces, given existing pressures and staff turnover in both sectors

- student drop-out rates
- the perceptions of prospective students.

In the absence of compelling evidence on the optimal form of regulation, the ultimate approach necessarily becomes dictated by culture, norms, precedent, experience and philosophies around risk. This highlights the **importance of articulating to stakeholders** why the regulatory approach to programme standards, student proficiencies, supervision and assessment aligns with the risks they seek to mitigate. This should include consideration of the current depth of practice assessment and supervision – for example, should students be required to demonstrate proficiency just once or multiple times? – and whether the assurance is about having demonstrated all proficiencies at the point of joining the professional register or demonstrating an ability to recognise the scope of practice and learn skills accordingly.

Specific areas for action

We consider that the UK regulatory requirements around practice learning are comprehensive, appearing for instance to go further than those in many other countries in some areas. But while comprehensive and holistic on paper, the varied interpretation and implementation of them within a system under pressure undermines the outcomes these standards intend to deliver. Our review identified barriers and opportunities for effective practice learning across various aspects of its provision, including in relation to the application of the requirements, the location and environment of placements, practice supervision and assessment.

Our view is that it would be a mistake to try to distil the overarching policy question about how to effectively educate tomorrow's clinicians into solely whether specific regulations, such as the number of practice learning hours, the number of births to be conducted or the contribution of simulation, should be increased or decreased.

Rather, regulation must be viewed in the round and any consideration of changing some of the regulatory requirements, such as practice learning hours or number of births, would need to be made alongside other changes to the assurance framework, including the breadth, quality and assessment of

experiences. Delivering against these areas for action would fall across a range of different organisations, which may differ between the UK nations and more regionally to reflect specific contexts.

Here, we outline specific areas for action to help the next phase of regulation better account for the trade-offs and challenges described in this report, and improve practice learning for future nurses, midwives and nursing associates.

Interpretation, implementation and quality

- Given the confusion and conflicting interpretations around the requirements for both nursing and midwifery, steps should be taken to further **communicate and clarify the regulations** to ensure consistency, including those relating to what counts as practice learning hours, the use of reflection for signing off proficiencies, and (within midwifery) when the '30+20' births standard is applicable.

- Better sharing of guidance documents (many of which already exist and offer supportive information to aid interpretation) is needed to **assure consistent understanding** across education providers and practice learning partners. There is also scope for developing a robust mechanism for assessing how well students, supervisors, assessors and educators understand the NMC standards.

- Further work is needed to **evaluate mechanisms for supporting students** around financial, access and related issues, including those from low-income households or with caring responsibilities. This should include appraising the feasibility and impact of existing approaches, such as the publication of the draft form of all their placement timings and locations over the whole year to enable better planning.

- Overwhelmingly, stakeholders shared concerns about inconsistencies in the quality of practice learning. This calls for better data and the evaluation of practice learning partners in order to spot issues and know where and when improvements are needed. Lessons should be learnt from good practice across the UK and from other countries such as Australia that are systematically **collecting feedback from students** on the quality of practice learning partners to be able to understand issues in real time.

- More transparent and robust **primary research** is needed to evaluate the impact of different methods and levels of simulated learning on effective practice and the quality of learning. There are limited studies available, most of which took place outside the UK context, with most focusing on student educational attainment rather than patient-based outcomes, cost-effectiveness or resource implications.

Organisation and coordination

- Agreed strategies are needed in each UK nation for an **appropriately broad range of learning opportunities** to deliver the necessary capacity levels to meet expectations for future education numbers.

- To support these strategies, there needs to be urgent further consideration of the **mechanisms – including funding** – for incentivising a sufficient, broad, high-quality set of placements. Funding arrangements vary between countries and, in some cases, courses but we heard consistently about the benefits of funding being more accessible and transparent.

- Lessons could be learnt from how practice learning is organised, funded, recognised and protected in **other professions**, particularly medicine. This should include lessons on protecting and accounting for supervision, assessment and related roles in job plans.

- Greater assurances should be sought from approved education institutions and practice learning partners on their **roles, responsibilities and capacity to ensure they are well coordinated**. In addition, given the importance of student engagement and psychological safety, there should be greater transparency and assurances around the capacity of roles to support students and address their concerns.

Supervision and assessment

- A collaborative approach should be taken to learn lessons from various solutions suggested for ensuring **sufficient and appropriate supervision for students**. This includes broadening the pool of supervisors, providing flexibility and autonomy for supervision arrangements, and addressing the workload and time pressures of supervisors.

- Expectations and requirements for **training and support for practice supervisors, practice assessors and educators** need to be better understood, building on existing policies and frameworks on this in the individual UK nations. Urgent consideration is also needed on how to recognise, protect and value practice supervisor and assessor and education roles within job plans, pay and progression.

- There is scope to consider the extent to which the current **model and methods of practice assessment** align with the programme outcomes, proficiencies and standards of the NMC. The current regulatory approach around practice learning takes a considerable amount of its assurances based on the amount of exposure to and activity within practice learning rather than being more outcomes focused. Given the size and diversity of the educational cohorts and registered professions, our view is that there should be consideration around the different options for ensuring the valid, reliable and fair assessment of students.

Appendix 1: Our approach

This rapid study was conducted over a six-month period (March to September 2024), building on previous comparative research that the Nursing & Midwifery Council (NMC) commissioned on the topic of practice learning.[11]

Aims

The aims of the research were as follows:

1 Identify the role and purpose of practice learning across the UK, and understand the extent to which this differs from that in other countries.

2 Identify factors that influence the design of practice learning both across the UK and internationally.

3 Investigate the breadth of different types of opportunities for practice learning, and how these are being implemented (for example, simulation and variation in practice learning hours), both across the UK and internationally. This will include seeking to understand the impacts of these different types of practice learning.

4 Identify factors that enable or hinder effective, high-quality, equitable and inclusive practice learning. These may include:

- protected learning time
- measures to ensure equity and inclusion
- differences by setting or specialty
- commissioning and funding policy and practice.

Scope

In this research we focused on practice learning for student nurses, student midwives and trainee nursing associates across all four devolved nations of the UK. We excluded forms of practice learning undertaken post-qualification (for example, after completion of a pre-registration undergraduate degree), such as preceptorships, from the scope of the research. We focused on practice learning requirements, such as practice learning hours, rather than the timeframe or length of pre-registration courses.

Methodology

Our research involved a mix of methods, which are detailed below. We sought to be representative in terms of the demographics of participants, issues covered and the four different UK nations.

Literature review

We conducted a rapid evidence review of academic and grey literature. The HSMC Knowledge and Evidence Service at the University of Birmingham conducted an initial search in April 2024 across five databases: CINAHL; the Healthcare Management Information Consortium (HMIC) database; MEDLINE; PsycINFO; and the Social Sciences Citation Index (SSCI).

The search returned 318 systematic review papers on practice learning, 1,554 recently published papers (2022–24) on practice learning and 6,118 papers on simulation specifically. Due to the breadth and volume of literature, the systematic review papers were prioritised in order to map the arms of the existing evidence base, and papers sourced through the wider searches were used to address any emerging gaps in the evidence. Titles and abstracts were allocated across the full research team, and screened against inclusion criteria and for potential relevance to the study. The full team discussed papers that did not contain abstracts, and papers that garnered differences of opinion, to resolve those differences. After screening, 126 systematic reviews were included for full-text review. The NMC and expert interviewees shared key, seminal papers in the grey literature, and further references were snowballed

through the research team manually handsearching. Further details on the search strategy are available from the authors on request.

Data analysis

We analysed publicly available and bespoke datasets, including:

- data from the Organisation for Economic Co-operation and Development (OECD) on the number of nursing and midwifery graduates and registrants in 2021 across OECD countries
- Discover Uni (formerly Unistats) data for the Universities and Colleges Admissions Service (UCAS) tariff points of accepted students in 2023
- NMC registration data for the contextual exploration of registered nurses, midwives and nursing associates and their training background.

The analysis on the average UCAS grades of students accepted onto nursing, midwifery and nursing associate courses excludes courses including a foundation year.

The NMC provided the latest (at the time of writing) available data on the number of accredited pre-registration nursing courses, midwifery courses and nursing associate courses across the UK.

We also requested data on the distribution of practice learning placements, the number of students in practice learning placements by partner and quality management feedback to NHS England, NHS Scotland, Health Education and Improvement Wales, Health and Social Care Northern Ireland and the Northern Ireland Practice & Education Council for Nursing and Midwifery. However, we were limited by each organisation's lack of data collection around these topics.

Further details on the data analysis are available on request.

Engagement with experts in the field

A total of 30 interviews were conducted with key experts in the field, within the UK and internationally. These included academics, policy-makers, professional leaders in health and care, approved education institutions,

regulators, employers (practice learning partners) and commissioners of placements. The NMC, the Florence Nightingale Foundation and the Nuffield Trust nominated experts for interviews and the research team selected interviewees to ensure a spread of expertise across professions, sectors, settings and countries.

A template semi-structured interview schedule was prepared for UK interviewees and international interviewees based on core lines of inquiry in our research, and emerging insights from the literature review. The interview schedule covered key themes, including but not limited to:

- factors affecting the design and delivery of practice learning
- the role of and evidence base around simulation
- evidence and views on practice learning requirements
- challenges and barriers for students of different backgrounds
- the role of policy, regulation and institutional support in practice learning.

International interviewees were also asked to consider specific questions regarding policy on and the regulation of practice learning in their countries, and to reflect on transferrable learning for the UK nations.

Questions in the interview schedules were further tailored and adapted (a) for each interviewee based on their field of expertise and experience and (b) iteratively as the research progressed, to reach saturation of data.

Policy workshops

Four two-hour online policy workshops were held over July 2024, engaging senior decision-makers and policy-makers in each UK nation. These involved 28 individuals in total, spanning senior professional leaders, professional bodies, universities and providers across each nation. Discussion was focused on three broad themes:

- requirements for practice learning
- the practice learning environment, practice supervision and assessment
- the regulatory landscape and policy enablers.

As part of our engagement with wider stakeholders, one additional online workshop with more than 50 lead midwives for education was held in May, and one online workshop with nine university stakeholders was held in July.

Staff, student and nursing associate focus groups

We ran a series of focus groups, each lasting 90 minutes, with staff, student nurses and midwives, and nursing associates:

- One in-person focus group was held with nursing students in May.
- One online focus group was held with midwifery students in July.
- One in-person focus group was held with early-career nurses and midwives in June.
- Two online focus groups were held with midwives, in June and July respectively.
- One online focus group was held with nursing associates in June.
- Four online focus groups were held, one for each nursing specialty, with staff working in adult nursing, children's nursing, learning disability nursing and mental health nursing, over June and July.

Four out of the 10 focus groups included participants from the midwifery profession, in addition to the workshop held with over 50 lead midwives for education. In total, 81 staff, student nurses and midwives, and nursing associates from across the UK nations participated in the focus groups.

Participants were recruited using an online survey, which was sent to the NMC's community of interest and the Florence Nightingale Foundation's early career network, and put on social media. Participants were selected to ensure a spread of ages, sexes, UK nations and regions within England. Participants were also over-recruited from across the UK nations to mitigate against any dropouts on the day, and dates were selected to enable their participation as far as possible. However, as discussed in the 'Limitations of the study' section below, we were not able to achieve coverage of all UK nations (or other important characteristics) for all of the focus groups.

A semi-structured focus group schedule was prepared for focus group facilitators, based on core lines of inquiry in our research, and emerging

insights from the expert interviews and literature review. The schedule covered key themes, including but not limited to:

- the role and purpose of practice learning
- views on the settings, services and clinical areas used for practice learning
- knowledge and skills gained through practice learning
- challenges and opportunities around using simulation
- views on practice learning requirements
- the protection and recognition of supervisor and assessor roles
- challenges for students from different backgrounds.

Questions were tailored for the different audiences in each focus group.

Public and service user focus groups

Three two-hour, online deliberative focus groups with members of the public and service user groups were held in September (see Table A1). Public contributors were recruited via a number of universities' existing patient and public involvement and engagement panels and networks. Universities circulated an online survey, to collate expressions of interest and to ensure a diverse sample. The online survey was also circulated within the Patients Association's e-newsletter, targeting contributors from across the UK nations. More than 34 charities across the UK were prioritised and issued direct invites, with support from the NMC public engagement team. Charities representing health conditions that disproportionately affect Black and Black British communities were invited, as well as smaller voluntary, community and social enterprise organisations such as inclusion health charities, to try to recruit as diverse a sample of service user representatives as possible.

Table A1: Purposive sample for the public and service user focus groups

Focus groups	Participant characteristics
Three two-hour focus groups with members of the public and service user representatives; 27 attended in total.	All participants had experience of nursing and/or midwifery care within the past 10 years, either for themselves or someone they care for.
	Participants from across all four UK nations were invited. However, participants who attended the focus groups were from England, Wales and Northern Ireland.
	There was an even balance of sexes, and participants with experience of gender reassignment. There was a spread of ethnicities and ages, although no participants were in the age brackets 18–24 or 85+ years. A number of participants had long-term physical and/or mental health conditions, or disabilities (including, for example, learning disabilities and autism).

Limitations of the study

This was a six-month rapid study with fixed milestones for data collection. The announcement of the general election in May 2024 initially affected recruitment to the policy workshops, due to the subsequent pre-election period, which affected the availability of government and NHS staff. Regarding the focus groups with service users and members of the public, the summer holiday season affected recruitment, and while a diverse sample was invited, no participants from Scotland attended.

Staff who expressed an interest in our registrant focus groups tended to be more senior, experienced and in educator roles (at universities and providers) rather than registrants in the early stages of their career (for example, one to three years). However, a number of early-career staff across both the nursing and the midwifery professions were recruited to an in-person focus group that the Florence Nightingale Foundation hosted.

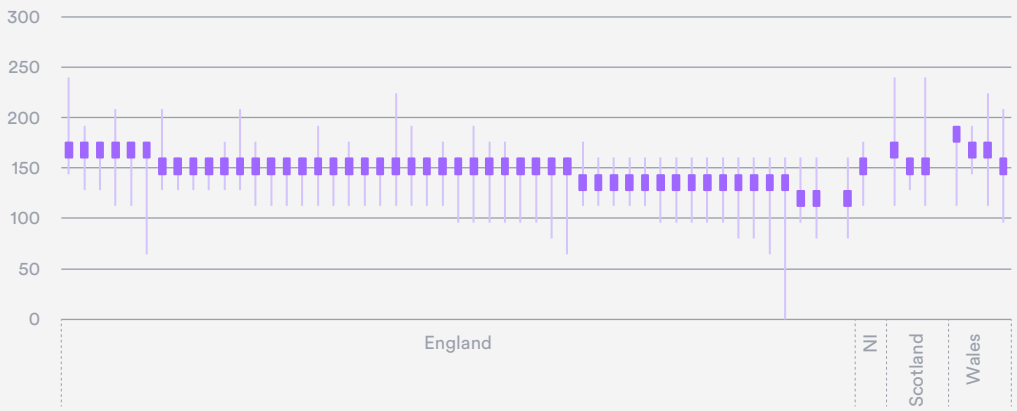
Across the focus groups, dates and times were selected to best accommodate participants from the UK's devolved nations. However, unfortunately, some participants dropped out on the day of the event.

Convenience sampling was used to recruit a sufficient number of participants for the student midwife focus group. As a result, there was not as wide a range of representation of the devolved nations or regions within England as in the other focus groups.

While we conducted additional research, including follow-up one-to-one interviews, to fill apparent gaps in the coverage of our engagement exercises, the limitations outlined here need to be recognised when developing policies, and further research and consultation may be needed.

Appendix 2: Additional charts

Figure A1: Average UCAS grades of students accepted onto midwifery courses in the UK, shown by course, 2023/24



Notes: It is important to note that some universities and colleges accept a wider range of qualifications for entry to their courses, some of which are not accounted for in the UCAS tariff points. This means that the tariff-points data we show for some courses may not reflect the value and grades that some students accepted onto the course achieved. This may affect the majority of courses at institutions with higher proportions of international or non-UK intakes. The minimum value of the boxplot is the lowest value of the UCAS grade range of the 10th percentile. The interquartile range is the UCAS grade range of the median. The maximum value is the highest value of the UCAS grade range of the 90th percentile.

Source: Nuffield Trust analysis of Discover Uni dataset for 2023/24

Figure A2: Average UCAS grades of students accepted onto nursing associates courses in England, shown by course, 2023/24

Notes: It is important to note that some universities and colleges accept a wider range of qualifications for entry to their courses, some of which are not accounted for in the UCAS tariff points. This means that the tariff-points data we show for some courses may not reflect the value and grades that some students accepted onto the course achieved. This may affect the majority of courses at institutions with higher proportions of international or non-UK intakes. The minimum value of the boxplot is the lowest value of the UCAS grade range of the 10th percentile. The interquartile range is the UCAS grade range of the median. The maximum value is the highest value of the UCAS grade range of the 90th percentile.

Source: Nuffield Trust analysis of Discover Uni dataset for 2023/24

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