

**Project Initiation Document**

**Developing a Sustainable Practice Learning Model: Collaborative Learning in Practice**

**VERSION 7**

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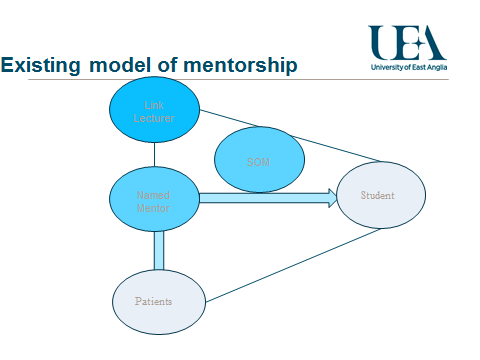
# Introduction

The purpose of this paper is to propose a project plan to develop an alternate model of student learning in clinical practice that is affordable, sustainable and ensures a high quality learning environment within the context of a changing NHS.

# Background

**2.1 Overview**

Currently all pre-registration nursing and midwifery programmes require that students spend at least fifty per cent of time in practice where students are supervised directly or indirectly by a qualified named mentor. Although the NMC standards suggests that no more than three students are allocated to any one mentor, within our group of Practice Education Partners (placement providers/employers) most mentors are allocated one student at a time with approximately forty per cent of a mentor’s time spent working with the students. This model of practice learning is highly dependent on, and limited to, the number of mentors available in the practice area.



The increase of skill mix in practice areas combined with a reduction in number of qualified mentors has placed a strain on the availability of student placement capacity. Furthermore, a strong theme emerging over the past year through mentor feedback highlights the burden of mentorship within the nursing and midwifery workforce. Thus, the current model of mentorship is unsustainable and there is a great need for the School of Nursing Sciences (NSC), University of East Anglia (UEA) together with our placement providers or employers and Health Education East of England (HEEoE) to work collaboratively to develop a more sustainable model of mentorship that offers increased capacity and at the same time provides a high quality learning environment. The increase in student nurse commissions makes the work proposed in this document imperative.

NSC UEA has an established collaborative relationship with VUmc Medical Centre, (VUmc), and Amsterdam. In October 2013 a small delegation from Norwich (with representative from NSC, placement providers or employers and HEEoE) visited VUmc to observe their new model of student support in the clinical practice area. Over the past five years VUmc has introduced a system of practice learning within the hospital known as ‘Real Life Learning Wards.’ This model of student learning is underpinned by the philosophy of students learning through care delivery adopting a coaching approach to learning. Previously a mentorship model similar to that used in the UK had been adopted, but the increasing lack of placement capacity has resulted in the development of a new system. Our Amsterdam colleagues report the new model has proved popular with positive results for mentors, students and patients.

**2.2 The Clip Approach**

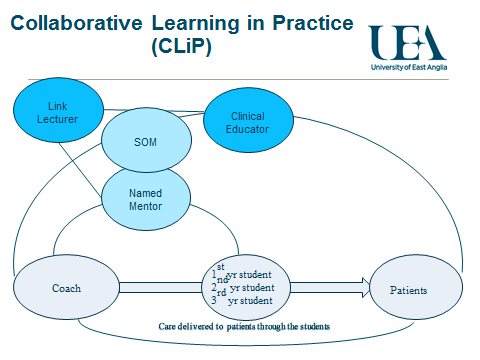
The CLiP project involves a change in:

1. the philosophical approach to practice learning and
2. the organisation of the practice learning environment.

The existing approach to practice learning uses a mentorship model. At its heart is a one-to-one relationship where the mentor, as the more experienced practitioner, passes on their wisdom and knowledge to the learner who theoretically wants to emulate the mentor by adopting their knowledge, skills and behaviour.

The new coaching approach to practice learning adopts a stronger focus toward self-learning and personal responsibility for learning. So the learning is more student led, is less focused on following the direction of the mentor and more focused on students taking responsibility in identifying their goals and objectives and working out how to meet them with the ‘coach’ offering guidance and critical challenge. It is suggested that one of the main strengths of this approach is that it increases motivation, confidence and competence in students and the student learning is not dependent on a single person. Students driving their own learning have the potential to also offer learning opportunities to their coaches. In this model, any of the registered nurses in the learning environment are able to coach for the day.

As identified earlier in the existing mentorship model, a student is allocated a named mentor who usually works 40% of their time with the student. On a ward with 3 students, 3 nurses would be involved in student supervision but are unable to devote all their time to student mentoring due to the need to be involved in ward management activities that exclude the student. In the coaching model, a student will still be allocated a named mentor but on a day-to-day basis be ‘coached’ by a registered nurse but not necessarily a mentor. One coach usually coaches between 2-3 students and this is the only job they do for that shift. This means that there are times when the named mentor can just be involved in patient care or ward management.



The practice learning area will be further supported by a Clinical Educator who will act as a source of expert advice and challenge to both students and mentors/coaches. They will support coaches/mentors in developing under-achieving students ensuring appropriate level of support and critical challenge is applied. In doing so it is anticipated that they will enhance learning for students, coaches and mentors.

Mentoring and coaching are both learning and development tools and there are advantages and disadvantages to both. The proposed changes will be fully compliant with the NMC Standards for Learning in Practice and practice areas will still be required to have mentors that have undergone the mentorship programme. The aim of the changes will be to enhance the skills of qualified mentors with coaching skills and train non-mentors to develop coaching skills. Thus with a large number of staff working in this style it has the capacity to influence the culture of the practice environment.

In order to reflect these principles the pilot project will be known as Collaborative Learning in Practice (CLiP)

# Purpose of the Pilot

**3.1** The purpose of the CLiP pilot is to test the feasibility of the VUMc model and to identify which elements are transferable to the UK context.

**3.2** Subject to approval and funding, a proof of principle study will be conducted to address the following questions:

* What are the essential elements/principles of the VUmc model?
* How was the model implemented in different settings (descriptive case studies)
* What are the components of a transferable model for implementation in UK settings?
* What are the aspects of the VUmc model that do not make an easy fit to the UK context?
* How can the essential principles of the VUmc model be applied across a range of different settings with a view to developing a local model?
* What do key participants report about the way in which the local model influences the capacity and quality of the learning environment?
* What do key participants report about the influence of the the local on the skills and competence of students ensuring they are fit to practise as newly qualified nurses?
* Does the local model ensure that efficacy of mentors is evaluated?
* What are the key research questions, outcome and process measures that should inform a substantive, comparative evaluation of CLiP (CLiP versus standard placement support)
* What are factors that can inform a cost consequence analysis?

# Implementation

**4.1** The CLiP project will have 2 implementation phases:

**Phase 1 implementation:**

**Phase 2 implementation:**

**4.2** The implementation of the project will include:

* + 1. Establishing the common principles and non-negotiable elements of the VUMC model for implementation (Appendix xx check list).
    2. Establishing what elements are negotiable depending on setting and circumstance to ensure some local flexibility
    3. Funding support to develop education infrastructure to gain assurance from partners by clear governance arrangements via clear implementation plans and risk registers to be updated monthly and will be reviewed by the steering group.
    4. Development and delivery of a coaching programme that is focused on a ‘whole ward’ development and also encompasses a process of cascading the training so that placement providers /employers will also be able to deliver the training
    5. Communicating and disseminating the project to other partners
    6. Evaluation

# Timescales

# Evaluation

# Governance & Reporting Structure

See Below

# Roles, responsibilities and accountability

Lines of accountability are as shown in the structure below, roles and responsibilities are detailed in Appendix 2

# Action Learning Sets

# Operational Group

# Steering Group

**Appendix 1**

# Principles of CLiP Project

* The philosophy of learning will be underpinned by a coaching style of mentorship
* The learning will strongly support a student led and peer learning philosophy
* There are three main roles identified in the model:
  + The clinical educator
  + The named mentor
  + The day coach

**The Clinical Educator**

* Clinical educators will oversee a maximum of two wards or practice areas.
* Their role is to provide training and support to the day coaches and named mentors of the pilot.
* Clinical educators will work with HEIs in supporting practice areas to correlate learning opportunities with learning outcomes.
* Clinical educators will support the practice areas in allocating students to patients
* Clinical educators to sit in on all student formative and summative practice assessments.

**Named Mentor**

* This role will be consistent with the NMC standards.
* Each named mentor will have a maximum of three students allocated.
* The named mentor will be responsible to liaise with others to develop an informed assessment of the student practice.
* The named mentor may request to spend time working with a student one-to-one
* The named mentor will be expected to meet regularly with the student to ensure they are meeting their learning outcomes.

**Day Coach**

* This must be a registered nurse but not necessarily a qualified mentor.
* They must be a regular ward based staff i.e. long term bank staff are suitable but short term or agency staff are not.
* Day coaches will have a maximum of three students per day.
* Day coach to have a maximum of 9 patients to care for that day with ideal standard that they will only have responsibility for the patients ‘their’ students have.
* The Day Coach has no other patient responsibilities.

**Students**

* Students will normally have a maximum of three patients allocated to them in relation to their developmental stage, their competency and complexity of the patient condition.
* In the final placement students are afforded some flexibility in order for them to incorporate management outcomes in their learning.

# Roles, responsibilities and accountability

**Appendix 2**

As shown in the Governance and Reporting Structure (section 7), the project is jointly led by HEI and Practice. Each organisation has a Project Director and Project Lead working collaboratively in partnership to deliver the project, supported by a project governance lead from HEEoE with responsibility for managing the governance processes. The funding bodies for delivery of the project are HEEoE via the Norfolk & Suffolk Workforce Partnership and UEA. Lines of accountability for these investments are within the structure above.

**Project Directors**

The Head of School or appointed representative is the Senior Responsible Officer (SRO) for UEA and the Director of Special Projects is the SRO for HEEoE. The project directors have ultimate authority and control of the project, its implementation evaluation and the final product.

**The Project Directors Will:-**

* Be accountable to their individual organisations for successful delivery of the project
* Oversee delivery of the project in accordance with agreed parameters
* Chair the strategic steering group at 4 – 6 week intervals ( determined by need)
* Communicate progress and escalate risks to success of the project to internal and external stakeholders.
* Contribute to the design of the evaluation process in partnership with the project and research leads, undertaking responsibility for signing off agreed process
* Act as an expert resource for the project and governance leads and other project team members

**The Project Leads will:-**

* Deputise for the Project Directors as required
* Hold strategic planning of the project and be responsible for the assigning new areas to the project in accordance with the CLiP checklist criteria
* Work in partnership with the project governance lead and contribute to delivery of governance processes
* Chair the monthly operational group
* Lead on their respective Education and Service work streams, developing and supporting communities of practice e.g. for link lecturers and clinical educators
* Act as an expert resource for all members of the project team
* Communicate progress and escalate risks to success of the project to internal and external stakeholders.
* Be the point of contact for all Trust Leads
* Be responsible for budget management

**Trust Lead will:-**

* Set up project teams and act as a conduit between the HEI and the Trust
* Have responsibility of rolling out the model within their own Trusts, identifying the needs and working with the Project Lead to meet these needs and establishing a ‘training the trainers’ programme to roll out.

**Clinical Educator (CLiP)**

Each Trust will appoint a clinical educator; jointly funded by Health Education East of England for one year .The job description will be the same for all Trusts.

**The Clinical Educator will:-**

* Work with the link lecturer, the practice/ward manager and the Trust Lead to maximise the use of mentors, learning opportunities and operationalise the day-to-day activities of students and mentors/supervisors.
* Provide coaching support to coaches and mentors in practice
* Identify concerns /risks and escalating to the project lead/link lecturer

**Link Lecturers will:-**

* Work collaboratively with the Trust project teams to develop the project plans for each practice area.
* Provide support to the practice areas, working with Clinical Educators, Ward/Team managers and mentors to operationalise the allocation and supervision of students in relation to learning outcomes, learning needs and level of practice.
* Provide training for coaches in the practice area as part of the preparation for CLiP in collaboration with the clinical educator.
* Identify concerns/risks and escalate to the Project Lead

# CLiP Training Programme

**Appendix 3**

|  |  |
| --- | --- |
| 1. Advance Coaching for Link Lecturers (LL), Clinical Educators (CE) , Practice Area Leads, Mentors, PEFs, | * 2 hr session delivered at UEA * Multi- site participation * In-depth understanding of coaching and application of coaching skills to mentorship |
| 1. Introduction to CLiP | * Overview of the project * Standard presentation to be used for practice |
| 1. Coaching for Coaches I   (Introduction to Coaching) | * On-site training to de delivered by LL and CE * Training for all coaches (includes mentors, registered nurses, NAs & HCAs) * A number of sessions may be run in order to ensure everyone is trained * Introduces the philosophy of coaching * Practical engagement with coaching * Overview of what a coaching day might look like * Review of Miller’s Pyramid of assessment of competency |
| 1. Coaching for Coaches II   (Coaching in Practice) | * On-site training to be delivered by LL and CE * Training for all coaches (mentors and registered nurses only) * In-depth review of Situational Leadership Model * Review of current progress |
| 1. Advance coaching II | * For Clinical Educators * Managing conflict and challenge * Managing resistance |

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# CLiP Pilot Site Approval Checklist:

**Appendix 4**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Name of Organisation:** | **Pilot Area:** | | |
|  | **Project Link for Pilot Area:** | **Date:** | | |
|  |  | **RAG rating for each standard** | | |
| **Item** | **Minimum requirement based on the Project Initiation Document (PID)**  **Please denote status on the RAG rating** | **RED**  **standard not met** | **AMBER standard not currently met but could be meet with support** | **GREEN standard met** |
|  | **There is a named project lead for the identified pilot area who has had an initial discussion with the UEA Project Lead and Clinical Educator and is clear about the parameters of the project** |  |  |  |
|  | **Staffing levels allow for parameters of project to be met on a daily basis (i.e. allowing maximum of 9 patients for day coach and 3 students) without additional ward management or clinical workload** |  |  |  |
|  | **The model allows an increase in student capacity to support ratios of 3 students per day coach and mentor** |  |  |  |
|  | **There are no quality concerns around care or education which would adversely affect the learner** |  |  |  |
|  | **There is a Clinical Educator in post who has no more than 2 clinical areas to support in total** |  |  |  |
|  | **There is a link lecturer in place who is able to monitor and support the area on a weekly basis** |  |  |  |
|  | **Day Coaches, Mentors and Clinical Educators have all attended appropriate training and are deemed competent in applying the coaching model** |  |  |  |
|  | **The wider multi-disciplinary team have been supported in adopting the model** |  |  |  |
|  | **There is evidence of engagement from the organisation and project lead in supporting the model at both operational and Board level** |  |  |  |
|  | **There is a Senior Education Lead who has overall responsibility for the project within the organisation.** |  |  |  |
|  | **There is approval for the project at Board Level within the organisation.** |  |  |  |

**Please note:**

* **This document is to support the existing educational audit for the pilot area**
* **Areas which are Amber rated should be supported by completing the action plan below to evidence how the standards can be met.**