The experience of implementing Collaborative Learning in Practice (CLiP) in a London maternity ward

Background, Aims, Methods, Findings, Conclusion

Abstract

A Collaborative Leaning in Practice (CLiP) pilot study in a maternity unit in a London Trust has been carried out. CLiP is a model for supervising students in practice where they work in small groups under the guidance of a practice supervisor, who uses a coaching approach based on the GROW model. The drivers for the pilot arose from the Pan London Midwifery Expansion Placement project; with one of the key objectives being to increase placement capacity. The pilot's findings were that CLiP is one possible approach to increasing placement capacity whilst providing an equally enriching, if not improved, learning experience for the students. The improvements for the students were centred around peer support, gaining confidence and responsibility, team working skills, new learning opportunities and being better prepared for practice after graduation. Reflecting on the experience of implementing the first cycle of the pilot, this article aims to provide guidance to other health care education providers for implementing the CLiP model in practice placements. The guidance is centred around offering a modified CLiP model to start with, whilst establishing key personnel as CLiP champions and to provide adequate preparation for students, staff and the environment for this change in working with each other.

Introduction and background

In 2018 the Department of Health and Social Care announced plans to expand the numbers of registered midwives working in the NHS. In order to facilitate this growth, Health Education England (HEE) recognised the need to grow clinical placement capacity by 25% across England by 2022 (Health Education England 2019). In recent years the Clinical placement capacity has been fully utilised by the number of students in training and a range of pressures are being exerted on the system including staff turnover, the availability of appropriate practice supervisors and practice assessors and variations in the birthrate between services.

The work of the Pan London Midwifery Expansion Placement project, led by HEE (London) supported an initiative to introduce a pilot at Lewisham and Greenwich NHS Trust to organise midwifery students' learning in practice known as Collaborative Learning in Practice (CLiP). CLiP originated from the University of East Anglia and was successfully implemented first for nursing students and later for midwifery students at the local partner Trust, James Paget University Hospital (JPUH) (Hill et al. 2015; Tweedie et al. 2019; Hill et al. 2020). A visit to JPUH was the inspiration for research team, led by the University of Greenwich, to explore the feasibility of transferring the model to a London maternity unit serving a very differing demography and operating a service with a high turnover of women, which was frequently running at full capacity.

There is a growing body of evidence to support the benefits of CLiP such as effective team working, students' development in confidence and leadership skills in practice as well as preparing them more effectively for professional practice (Hill et al. 2015; Harvey and Uren 2019; [redacted]; Underwood et al. 2019; Hill et al. 2020; Williamson, Kane, et al. 2020; Williamson, Bunce, et al. 2020), whilst an increase in placement capacity was

achieved. In Greater Manchester, the model 'GM synergy', which is similarly based on the principles of peer learning and coaching was trialled and implemented by four universities and their health care partners (Leigh et al. 2019). Other Trusts, who reported similar models based on peer learning and coaching for student placements, are located around Plymouth, Yeovil, Bedfordshire and Staffordshire but solely concentrated on nursing students (Wareing et al. 2018; Harvey and Uren 2019; Underwood et al. 2019; Williamson, Kane, et al. 2020; Williamson, Bunce, et al. 2020). So far, only JPUHT rolled out CLiP on the maternity ward (Tweedie et al. 2019).

Therefore, the CLiP model was chosen for the pilot study to be implemented at the Queen Elizabeth Hospital (QE) in Greenwich, London. The first cycle of the pilot study was commenced in January 2020 but was curtailed by the COVID-19 pandemic in March 2020 ([redacted]). However, this allowed the research team and steering group members to reflect on the pilot and to apply changes for the second cycle of the pilot. The second cycle was initiated in October 2020 and is ongoing at the time of writing. This current article reports on the changes carried out in preparation for and at the beginning of the second cycle with intent to provide guidance to other health care education providers for their potential future implementation of CLiP. The findings on the placement experiences of the first cycle of the pilot by students and staff are reported in a forthcoming article.

Aims

The aims of the pilot study were two-fold. Firstly, the pilot aimed to gauge the transferability of the CLiP ™ model to a trust situated in the London region serving a different demographic of women and with a higher turnover of women and staff. Secondly,

the pilot study aimed to capture the experiences of the student midwives and staff who participated in the CLiP placement experience but the full details of the study are reported in [redacted]

Methods

A qualitative research design combined with pragmatic action research was chosen (McNiff 2013; Creswell and Creswell 2018). The qualitative approach supported the elicitation of in-depth experiences by participants by employing semi-structured interviews and the transcripts were analysed using thematic analysis (Braun and Clarke 2006); these results were reported in [redacted]). The pragmatic action research approach allowed the review of the changes in the cycles of implementation by following the steps of planning, acting, observing and reflecting. A steering group was formed at the beginning of the pilot, comprising 11 members, of which eight were employed by the Trust and three were members of the research team and not employed by the Trust. The steering group met regularly every 4 - 6 weeks to plan, implement and evaluate the pilot and to address any implementation concerns by finding solutions. Meeting agendas and summarising notes were shared between steering group members to facilitate reflection. Research team members regularly reflected on the activities and communicated these to steering group membership.

Participants in the first cycle of the CLiP pilot

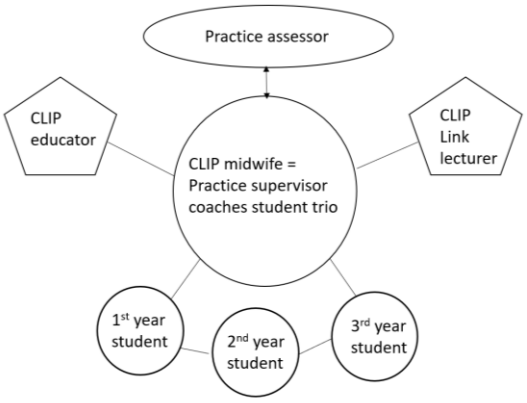
Nine midwifery students took part in the first cycle of the pilot on the combined ante- and postnatal ward at QE. They worked in groups of three, usually composed of first-, second- and third-year midwifery students. Each trio collaborated in six shifts over two weeks, where they had the responsibility of caring for a bay of women, which implies four women.

The students were supervised by the CLiP midwife, who held overall accountability for the care provided by all three students. The CliP midwife was trained in applying coaching techniques to supervision, which meant asking open questions and eliciting the knowledge from the students rather than directly telling and teaching them. These coaching techniques were based on Whitmore's GROW model, which stands for Goals, Reality, Options and Way forward (Whitmore 2017). For the first cycle five midwives were trained to be CLiP midwives by the CLiP educator (see Fig 1 diagram of the CLiP model as implemented in QE).

In cycle one, CLiP training consisted of a 2.5 hour long workshop for midwives and students to learn about the CLiP model, applying coaching techniques and to encourage a pro-active learning mindset (for the students). After this event, all workshop materials were made accessible online and individual one-to-one training was provided by the CLiP educator. It has been challenging to engage all midwives in training due to staff shortages during the pandemic, which is why online training has been made available.

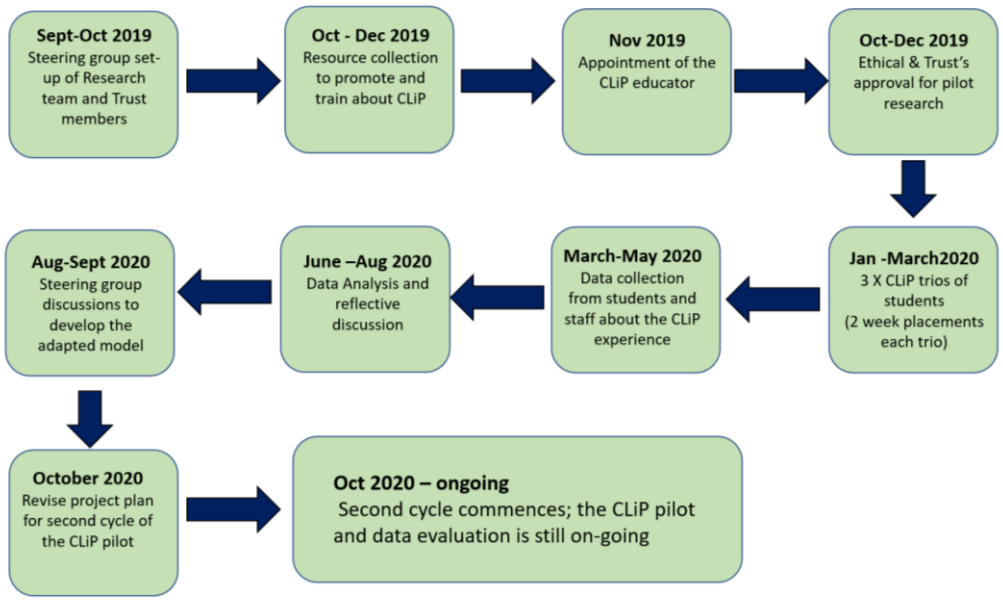
The CLiP educator was seconded on a 0.4 wte position (initially funded by Health Education England) to prepare students and staff for the CLiP placement experience, to support the CLiP midwives initially in structuring the CLiP shift and to facilitate the CLiP hour, which was a dedicated hour per shift for the students to reflect on their practice and to fill any knowledge gaps.

Fig 1. Diagram of the CLiP model as implemented cycle one



The steering group met five times in the period from October 2019 to March 2020 and then again in September 2020. The timeline (Fig. 2) of the key steps in this pilot project are depicted as follows:

Fig 2. Timeline of key activities to implement the CLiP pilot at QE



Data collection

In March to May 2020 seven of the nine participating students and three CLiP midwives were interviewed after providing consent. The 30-60 minutes long recorded interviews were transcribed and analysed. The research team further collected written feedback from the CLiP educator, the Clinical Placement Facilitator and the Head of Midwifery, who were not available to take part in interviews. The latter three participants were also part of the steering group. The research team and steering group members reflected on the collected feedback, discussed and agreed on implementing key changes, which are reported in the findings section.

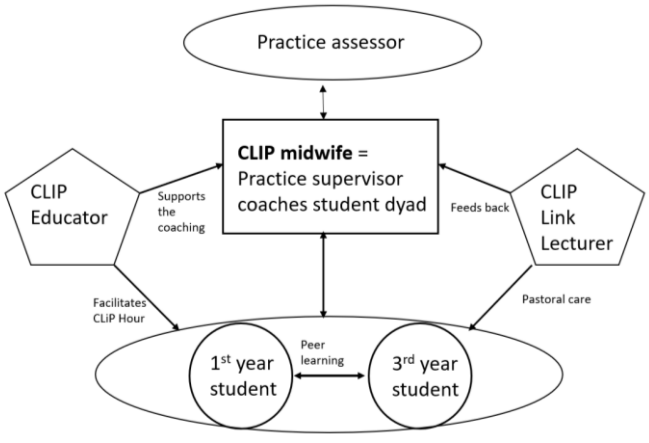
Findings

The qualitative findings on the experience of the CLiP placement model were in line with previous CLiP studies conducted in nursing and midwifery in the UK, which emphasised the benefits of peer learning and the coaching model for supervision; namely peer support, development of new skills such as team working, communication and leadership, and the autonomy in providing care independently increased their confidence (Hill et al. 2015; Harvey and Uren 2019; Tweedie et al. 2019; Underwood et al. 2019; Hill et al. 2020; Williamson, Kane, et al. 2020). The known challenges of CLiP as already reported (Harvey and Uren 2019; Underwood et al. 2019; Hill et al. 2020; Williamson, Kane, et al. 2020) were corroborated by this pilot since there were issues around the lack of awareness of CLiP, which affected the students' group experience, lack of time for signing off competencies and inconsistency in applying the coaching style supervision. The CLiP hour was perceived as beneficial to the students' learning experience since it provided space for personal assessment and reflection, however a dedicated space for it was suggested as it was difficult to hold within the demanding ward environment. It was more difficult to implement CLiP

on night shifts as there were generally fewer staff on shift and the CLiP educator was unable to work full night shifts due to her limited 0.4wte contract. Some of the CLiP midwives expressed difficulty in accommodating three students as it was difficult to facilitate them all working together. This usually resulted in a pair of students working together and one student working alongside the CLiP midwife.

Reflection on these findings around the challenges contributed to re-drawing the CLiP model in preparation for the second cycle of the pilot (see Fig 3). The modified version of CLiP model involves a dyad of students, preferably one from the 3rd year and one from 1st year. This ensures a more manageable set-up in a demanding environment because the learning between the students is more clearly defined and it allows staff and students as well as other personnel to get used to the change from individual mentoring to student group work and coaching. Coaching a dyad rather than a trio also meant that CLiP midwives were able to manage their time more effectively in relation to signing off competencies.

Figure 3. The revised CLiP model for the second cycle of the pilot



To address the challenges around the lack of CLiP awareness it was decided to recruit a CLiP educator seconded from the same hospital. This CLiP educator started the role five weeks

before the first dyad of students commenced in November 2020. Being seconded from the same hospital meant the CLiP educator had already established working relationships with colleagues and knowledge of the internal processes, whilst staff already had some understanding of CLiP from the first cycle. Before the first dyad started the CLiP educator was able to offer more targeted CLiP awareness and introduction courses for staff and students. She further used this preparation time to (re-)design information posters and to compile learning resources, which were made available to all staff in different formats. Online resources and in particular videos were useful since they are easily accessible any time of the day.

To achieve greater consistency in applying the coaching style supervision, the CLiP educator trained at least three CLiP midwives before the first dyad started, and she worked with those at the beginning of the first CLiP shifts to support the co-ordination of the shifts. These midwives have also agreed to be champions to promote the model further.

In addition, the Clinical Placement Facilitator, a Trust based, clinical midwifery educator role to coordinate student placements allocations, made sure that all CLiP midwives were clearly indicated as CLiP midwives in internal rota planning and communication, so that supervising CLiP midwives were not unexpectedly allocated to other locations in the hospital.

During the shifts, CLiP midwives were asked to write the name of the students on the board in the ward so that colleagues could quickly identify which women were allocated to which CLiP students. Other health professionals such as neonatal nurses and paediatricians, who frequently entered the ward were also more clearly informed about CLiP, so they addressed the students directly concerning the care of their women and babies.

Lastly, the CLiP educator booked a room for the designated CLiP ™ hour at a regular time and took the students away from the ward to ensure they had space for their reflection and learning.

Reactions to the 2nd cycle of CLiP Pilot experience to date

The interview data from the second cycle of the pilot is currently still being analysed, but so far it shows promising improvements. The CLiP midwives and students rated their CLiP experience highly.

First Year student: *"I really enjoyed CLiP like 100%. I'd do it a million times again just because I really felt I gained a lot of confidence, because you were given that extra freedom to go off and create care plans and think of what step you're going to do next instead of your mentor saying, 'okay, have you done this, this and this?' which you would normally experience. Then you have to action it and~~,~~ then you report back to them and if you have any struggles or queries, then they're there to help, so it is quite reassuring, it gives you that allowance to actually feel you're controlling the care for the woman, which I loved."*

Third Year student: *"Now, I'm middle of third year I just wanted a bit more of the independence to kind of prove to myself, if anything, that I knew what I was doing. And that's exactly what it's done. Being able to look after a bay on my own and know that I've got the support there if I needed it, but ultimately it was up to me. I thought it was going to be quite stressful, but it wasn't stressful, really, at all, because you're working together as a team."*

None of the students mentioned difficulties in having their competencies signed off. All third year students described the boost in confidence based on the independence and trust they were given. They felt re-assured and better prepared to manage the workload when they graduate. The junior midwifery students expressed how they felt more relaxed and were able to ask questions which they might have not asked their practice supervisor. Both student groups rated the CLiP hour highly as time to reflect on their learning and identify any gaps.

First Year Midwifery student: *"One of the things I highlighted that I wanted to do in my CLiP hour was improve my medicines management, just learning common doses and names and all of those sort of jazz that I use in the postnatal ward, so she [the CLiP educator] spoke to one of the pharmacists and she created a chart and updated her chart on loads of common things and then she emailed it over to us, which is a lifesaver, so it's really, really handy."*

The CLiP midwives enjoyed coaching the students since they were facilitating their learning from a distance and could see the students' professional identity develop.

CLiP midwife 3: *"It was nice watching them like grow and develop and change throughout the shifts…[] It was more like we were colleagues rather than a midwife and students, which I think was good."*

Next steps and implications for the future

The CLiP model demonstrates a sustainable means to expand clinical placement capacity and grow the future midwifery workforce to ensure provision of a dynamic profession that

meets the needs of every mother and her family. Of equal importance, CLiP has demonstrated several qualitative benefits of a coaching model as an innovate means of supervising and supporting students to learn and work together in practice. This new approach requires a mind-set shift, away from the legacy of the traditional one- to-one mentor/mentee model where a student's learning is directed, work is allocated and practice supervisors do the same work as before, but with a student. In contrast a coaching model such as CLiP operates as a micro team, where the coach steps back allowing the two (or three) students under her/his supervision to learn by providing care to an allocated group of mothers and babies, asking questions and observing students' practice (Hellström-Hyson et al. 2012). It is hoped that this model can be rolled out to other areas of the maternity services in the next phase of the project, such as community, although there is very little experience of this elsewhere.

The publication and adoption of the new Standards for Student Supervision and Assessment (NMC 2018) are timely and align with the principles of CLiP as students are no longer restricted to working with a "sign off" mentor for forty per cent of their practice time. With CLiP, the new standards enable students to be supervised by a "CLiP midwife" who acts as a practice supervisor within the clinical area which is used as a complete learning environment. This includes students working and learning alongside each other, demonstrating the value of peer learning (Markowski et al. 2021). By the nature of their professional roles, midwives are natural coaches, adapting easily to the coaching aspect of CLiP, thus the CLiP midwife becomes a role model, demonstrating coaching skills to students who develop these as learners. Tweedy et al. (2019) report that engaging with CLiP as a student enables a more seamless adaptation to becoming a newly qualified midwife as CLiP helps to develop confidence and leadership skills and enhances effective team working. This

has also been borne out by our own research. In a demanding and fast paced practice environment, an initiative which facilitates greater preparedness for working after registration is a vital factor in the retention of the newly qualified workforce in the early stages of their careers, as described in the HEE's RePair Project (Health Education England 2018). Our research has limitations since it is a pilot study, which implies a small sample and data collection was affected by the Covid pandemic (lack of time by staff and students, who were interviewed via video call). However, this CLiP pilot has contributed to an evidence base demonstrating the benefits of CLiP and the model's transferability. The experiences gained and lessons learned provide assurance that it is feasible to implement CLiP into a demanding London maternity unit, however ongoing research is required to evaluate the long-term impacts of a consistent coaching model of supervision on the next generation of midwives.

Keywords: Collaborative Learning in Practice, CLiP, London hospital, Midwifery ward, coaching, student placement experience

Key points:

- CLiP is one possible approach to increasing placement capacity whilst providing an enriching learning experience for the students
- This research contributes to the growing body of evidence for the benefits of CLiP such as effective team working, students' development in confidence and leadership skills and being better prepared for professional practice

- To ease into the change from the traditional one-to-one model into a coaching mindset, the authors developed a modified version of the CLiP model, which involves a dyad of students (3rd year and 1st year) to enable a more manageable set-up in a demanding environment and to support learning between the students.

- To address the challenges around lack of CLiP awareness in the hospital it will be beneficial to employ a CLiP educator seconded from the same hospital, to develop a variety of training materials and to offer bespoke training.

- All CLiP midwives need to be clearly identified as CLiP midwives in internal rota planning and on shift so that supervising CLiP midwives were not unexpectedly allocated to other clinical areas to ensure consistency in supervision can be offered.

- The CLiP hour (the students' protected learning time) needs to ideally take place at a regular time and in a dedicated room away from the clinical area, so students have space for learning and reflection.

Reflective questions:

1. If you were to adopt a phased introduction of the CLiP coaching model in your Trust, which clinical area(s) might enable a smooth initial introduction of the model?

2. What factors enable or inhibit the smooth transition from the traditional 'one to one' mentor/mentee model to a model where learning is directed by the student?

3. What existing resources does your trust have to implement the CLiP Coaching model?

4. How will the demands of maternity service ensure that students are still able to participate in peer learning without compromising on the needs of the service?

5. What might be the advantages and disadvantages for students and educators, in working in a peer-to-peer learning environment compared with the traditional one-to-one model of supervision?

Conflict of interest disclosure

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