



Collaborative Learning in Practice (CLiP) in a London maternity ward—a qualitative pilot study

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ABSTRACT

Objectives: Collaborative Learning in Practice (CLiP) is one way of addressing an increase in student placement capacity and potentially improving the student learning experience overall. The aim of this article is to report the findings of a CLiP pilot study undertaken in a London hospital maternity ante- and postnatal ward.

Design: A qualitative explorative study design employing a descriptive online survey and individual semi-structured interviews to evaluate the experiences.

Setting: A London based hospital maternity ante- and postnatal ward

Participants: seven midwifery students from a mix of years (1–3) and six staff (all trained midwives)

Methods: The survey results and interview data were transcribed and thematically analysed to identify the barriers and enablers for CLiP

Results: Three themes emerged from the data: 1. Preparation for the CLiP pilot, 2. Peer-learning and collaboration as support and resource, 3. Independence and trust as drivers for learning.

Conclusions: The results are in-line with previously conducted CLiP studies. This study contributes to the findings around the set-up of CLiP in a demanding London maternity ward. It demonstrates that adequate preparation is vital, including the role of the CLiP educator to raise awareness, provide training and to support CLiP midwives. The CLiP hour appears beneficial since it offers protected reflection time. CLiP appeared to increase the clinical confidence of students, particularly more experienced students, through peer learning and independence. Larger-scale research is needed.

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Introduction

The challenge of providing quality placement opportunities for nursing and midwifery students is a major problem in increasing student numbers, both in the United Kingdom (UK) and internationally (Buchan et al., 2020; Spurlock, 2020). This has been exacerbated by the conditions of the ongoing Covid-19 pandemic where front line clinical staff including practice supervisors are at maximum capacity when considering workload, illness cover or falling ill themselves (Dewart et al., 2020).

In the UK, preceding the pandemic the Nursing and Midwifery Council (NMC) introduced new standards for student learning and assessment in practice (SSA), which came into effect in London in September 2019 (NMC, 2018). These standards removed the requirement for nursing and midwifery students to work with a

named mentor for 40% of the practice time and conditions were created to facilitate collaborative placement models. The latter allow students to undertake their practice placement in small groups and to be supervised and assessed by a number of qualified professionals.

There are already a variety of collaborative placement models in health care implemented in developed countries and their relative strengths are presented and discussed in another article << redacted for review >> however an optimal placement model has yet to be found (Forber et al., 2016; Millington et al., 2019). This paper presents a pilot study carried out with the Collaborative Learning in Practice (CLiP) model in a midwifery ward in a London hospital. The CLiP model utilises coaching techniques as the approach to supervision and a mixing of students from different year groups to work collaboratively in small groups.

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Background

The Collaborative Learning in Practice (CLiP) model is based on a coaching approach of supervision, which differs from the traditional 1-to-1 model of mentoring students. The CLiP philosophy is based upon peer learning, where students at different educational stages work together to plan, implement and evaluate care under one coach, who is a qualified practitioner (Williamson et al., 2020). In the UK, the James Paget University Hospitals NHS Foundation Trust (JPUH) developed the CLiP model after their educational leaders saw the 'the Amsterdam model' at the VU Medical Centre in Amsterdam (Lobo, 2017).

Concerns about practice education in healthcare led to the 'Shape of Caring Report' (Willis, 2015), which reported on whether current education and training in the UK was determined to be fit for purpose for care staff and registered nurses. It recommended the implementation of student placement models built on the principles of coaching and peer learning to improve quality and capacity in practice placements and listed JPUH's CLiP model as an example (Willis, 2015, p47). A coaching approach towards student supervision has already been successfully employed in Scandinavian countries (for instance, Hellström-Hyson et al., 2012).

A variety of collaborative placement models exist in other parts of the world such as the Dedicated Education Unit (DEU), which was developed in Australia and has been widely used in Australia, New Zealand and the USA (Edgecombe et al., 1999; Schecter et al., 2017). To date, the CLiP model has exclusively been piloted in the UK << redacted for review >> although there is only one existing peer reviewed publication evaluating CLiP (Hill et al., 2020). Most of the published papers on CLiP address nursing students in hospital settings (Hill et al., 2015, 2020; Harvey and Uren, 2019; Underwood et al., 2019; Williamson et al., 2020). One pilot study was also rolled out with nursing students in the community (Williamson et al., 2020) and one in a maternity ward (Tweedie et al., 2019). A variation of the model, labelled 'Coaching and Peer-Assisted learning' (C-PAL), was trialled with mental health nurses (Wareing et al., 2018). Despite some variations in the model implementation, the overall findings are relatively consistent concerning (1) challenges around the model set-up, (2) the group placement experience for students and (3) the change in philosophy of supervision i.e. a coaching philosophy. The only published account of implementing CLiP in a maternity setting reports on the experiences of CLiP in the JPUH maternity ward (Tweedie et al., 2019), which is in a district general hospital based in the East of England. Although this account has been published, a rigorous evaluation of this implementation has yet to take place.

Our research reports on the evaluation of a CLiP pilot study, based on the implementation by Tweedie et al. (2019), but undertaken in a London hospital maternity ante- and postnatal ward. It could be argued that London maternity wards present a more challenging work environment than those in a District General Hospital due to higher numbers of women booked to use the service, a high turnover of staff, and a high number of complex women. It is hoped that our work will inform implementation of CLiP in inner city environments to complement the previous work of JPUH.

Methods

The aim of this paper is to report the findings of a CLiP pilot study undertaken in a London Hospital maternity ante- and postnatal ward. The objectives of the pilot study were firstly to explore the experience of student midwives who participated in the CLiP pilot and how it compared to other placement experiences and secondly to collate the views by staff about the implementation of the CLiP pilot and their participation in it.

The research questions were formulated as:

- What are the experiences of student midwives who participate in CLiP?
- What are the views of staff on the implementation of and their participation in CLiP?

Research design

A qualitative research design was used to gain a deep understanding of the experiences and issues concerning the implementation of CLiP from the participants' perspectives. Students were asked to complete a short descriptive survey after their CLiP placement. All participants (students and midwives) were individually interviewed either face to face or via a phone call or by collecting written answers. Thematic analysis was used to interpret the data and themes were checked by two researchers to ensure consensus (Braun and Clarke, 2006).

Setting

A UK inner-city hospital maternity ante- and postnatal ward, which was already an established midwifery student placement area.

The CLiP model

Diagram (Fig. 1) visualizes the structure and roles within this particular CLiP model. The CLiP midwife, who is the Practice Supervisor, supervises a trio of students to take on care planning and delivery for a specified number of women using coaching techniques based on the GROW model (Whitmore, 2017). GROW is an acronym and stands for GOAL (what do you want to achieve?), REALITY (what is your current situation?), OPTIONS (what could you do?) and WAY FORWARD (what will you do?); these questions guide the coach to listen and elicit the answers from the coachee before they act. The CLiP educator and the Higher Education Institution (HEI)'s Link lecturer support the CLiP midwife. The CLiP educator also facilitates the CLiP hour, which is one hour of protected learning time for the CLiP students on each shift. The Practice Assessor liaises with the CLiP midwife and other staff to assess the students' competency, in line with NMC standards (NMC, 2018).

There was three months' preparation time before the first scheduled group of CLiP students started a three-week placement. The preparations encompassed the recruitment of the CLiP educator, collection and development of training materials, organising training days for midwives and students and informing staff on the ward about CLiP. It was part of the role of the CLiP educator to support the preparation activities such as CLiP training days.

Ethics

Ethical approval for the evaluation of the CLiP pilot was awarded by the << redacted for review >> Ethics committee number: FREC-EHHS-19-2-8.1.1.

Participants

Purposeful sampling was conducted. The aim was to have four trios of midwifery students, each trio comprising a first, second- and third-year midwifery student. The Clinical Placement Facilitator (CPF), who oversees student placements in the organisation, allocated each trio to be supervised by one CLiP midwife for the duration of a three-week placement. The coordination of the trios was dependant on students' placement mapping allocation and learning needs. The CLiP midwives had received CLiP training and had worked as practice supervisors previously.

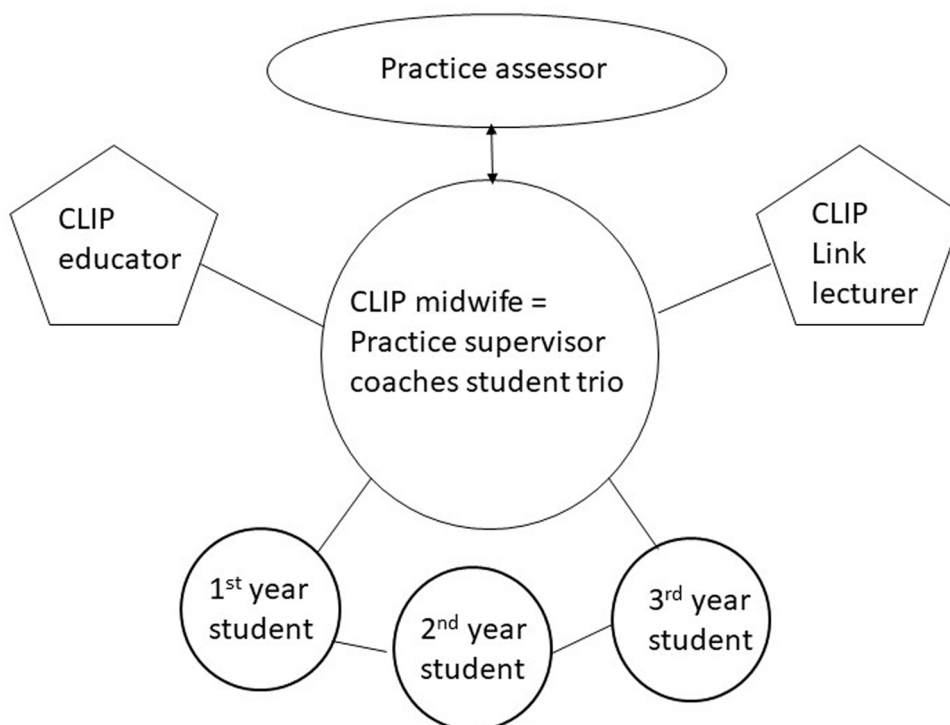


Fig 1. CLiP model as implemented in the first phase of this pilot.

Table 1
Overview of CLiP pilot participants.

Placement Jan 2020 (3 weeks)	Group of 3 students from 1st year, 2nd year and 3rd year	2 CLiP midwives
Placement Jan/Feb 2020 (3 weeks)	Group of 3 students from 1st year, 2nd year and 3rd year	3 CLiP Midwives
Placement Feb/March2020 (2 weeks)	Group of 3 students from 2nd year, 2nd year and 3rd year	2 CLiP midwives

The outbreak of the Covid pandemic however curtailed the full length of the pilot and the planned composition. Each trio were coached by up to three out of five CLiP trained midwives (see Table 1). In total, the number of participants in this pilot were nine midwifery students (three trios), five CLiP midwives working with the students, one CLiP educator, three other midwives who were involved in the setting up of the pilot (i.e. the CPF, Head of Midwifery and the ward manager).

Data collection

The pilot ran from January to March 2020 and was curtailed by the outbreak of Covid-19. A short descriptive online survey was designed using closed and open questions to capture students' experiences directly after completing their placement (see appendix Survey questions). The survey responses were followed up with individual semi-structured interviews using mainly open questions such as "Tell me about the level of responsibility you have experienced?" (see appendix Interview Guide). The student interviews were conducted by <<redacted for review >>. Two interviews were held face-to-face and five over the telephone due to the Covid lockdown. Feedback from CLiP midwives was collected by <<redacted for review >> via semi-structured telephone interviews using open questions such as "What do you perceive to be the gains and losses of CLiP?". Written feedback was collected from the CLiP educator, Clinical Placement Facilitator (CPF) and the Head of Midwifery who could not take part in interviews due to time constraints. All interviews were between 30 and 60 min long,

audio recorded and transcribed verbatim. In total, empirical data was collected from seven out of nine participating midwifery students and from six out of nine midwifery staff.

Data analysis

The data was deductively and inductively analysed by going through a series of phases before developing the themes (Braun and Clarke, 2006). The researchers were familiar with themes developed in other CLiP research such as "peer support" (Williamson and Bruce, 2020), "adapting the environment" (Hill et al., 2020), therefore they had a starting point to work deductively, but also allowed themes to emerge as an inductive process. The first phase was data familiarisation: two of the authors << redacted for review >> conducted the interviews and read each other's transcripts and reviewed the survey data. The second phase generated the initial codes: the two authors looked for barriers and enablers to summarise initial findings with the wider research team. Phase 3 and 4 was concerned with searching for overarching themes and reviewing themes and subthemes (codes). This was an iterative process until agreement was reached and phase 5 'Defining and naming themes' took place. In the final phase i.e. producing the report, the authors <<redacted for review>> once more negotiated on selecting the key quotes to illustrate the themes. At times there was a degree of interconnectedness between the subthemes, which made a clear delineation challenging, but this was negotiated by the authors' discus-



Fig. 2. The themes and sub-themes after thematic analysis of the data.

sions and agreed upon for the purpose of the presentation of the results.

Results

Of the nine students who had taken part in the CLiP model, seven filled in the descriptive online survey and took part in follow up semi-structured interviews. One student decided to transfer to another hospital for personal reasons. Another one did not respond to follow-up emails. Of the five CLiP midwives, three were interviewed and two were unavailable due to health reasons. Written feedback was collected from three other midwives involved in the project.

The thematic analysis of the data by students and staff resulted in three themes.

1. Preparation for the CLiP pilot
2. Peer-learning and collaboration as a support and resource
3. Independence and trust as drivers for learning.

The subthemes i.e. the barriers and enablers for each theme are presented in Fig. 2 and discussed in detail under each theme heading.

Theme 1: Preparation for the CLiP pilot.

Enablers

Training for CLiP was crucial since it involved a change in approach by students and supervising midwives towards student supervision, most importantly introducing a coaching approach. The CLiP educator was instrumental in compiling the training materials (which were partly provided by HEE and by JPUH), raising awareness about CLiP, organising training days and offering ad-hoc 1-to-1 or small group training. Yet, she had to be inventive to engage staff due to time and workload constraints and she provides an example in her written feedback.

CLiP Educator: "I had to employ my own tactics such as providing refreshments and snacks in order to build relationships with the

midwives. Some were very keen and the midwives who I found were like-minded seemed to enjoy hearing about CLiP."

Feedback on the training confirmed that midwives considered themselves as naturally suited to coaching as a skill since their practice is centred around asking questions; a fundamental aspect of their daily clinical work, thus it did not take long for them to learn. Coaching was also considered to be a transferable skill for other areas of midwifery practice and the suggestion was made to have more CLiP educators to train a considerable number of midwives for supervision based on coaching.

CLiP midwife 4: "I would train more staff in coaching, as it is adaptable and can be used in any area. I think it would be better to have a couple of CLiP educators rather than 1 so that the workload could be split, or have the CLiP educator start a few months before CLiP started to be able to inform and train staff."

Preparing a variety of resources such as handbooks and e-learning material, which midwives and other staff could access at various times of the day to learn about CLiP was considered beneficial.

CLiP midwife 4: "It is good to have different approaches to informing staff as not all are able to attend training due to shifts and unit capacity."

Visual prompts such as badges or different coloured lanyard were suggested to raise greater awareness of CLiP and that CLiP is taking place on this ward.

CLiP midwife 2: "If we can have something like a badge for the CLiP midwife. So that if any other midwives who are not aware see that, they will know that you are dealing with a trio."

Barriers

The greatest barrier was attendance at the training days and as the CLiP educator wrote, midwives did not have time to learn about CLiP during working hours.

CLiP educator: "Largely midwives did not want to hear about it during their working hours."

Midwives were either too busy with work, on sick or annual leave. The latter also made planning the workforce on the ward challenging. In hindsight, this may have been due to the onset of the Covid pandemic, but this was not known at the time.

CLiP midwife 5: *"There was an issue with timing and staffing at the time. Our sickness rate was much higher than average, which meant that midwives that were allocated to support this project were not available as much as we planned."*

Students were overall content with their own training but commented that training for the CLiP midwives and awareness around CLiP with other staff was most important.

Student C: *"Making sure that it's clear to all of the midwives on the ward and not just the midwives that are taking part what the CLiP entails."*

The CLiP educator had to build relationships with CLiP midwives as well as students, but this was challenging for her because although employed in the larger clinical setting, she had not worked in this maternity unit before. Therefore, she had to use her own tactics as described above to engage staff and students and to provide ad-hoc training on CLiP, rather than relying on formal training sessions.

Theme 2: Peer-learning and collaboration as support and resource.

Enablers

Students enjoyed working with fellow students since it provided them with emotional support and reduced their anxiety levels as well as providing peer support to clarify questions, solve problems and reflect on their own practice. At the beginning of their training, midwifery students particularly appreciated the presence of fellow students.

Student F: *"It was nice being with other students as well, so you felt like you were not the only one on shift. Because sometimes when you go to the hospital and you're the only student, it's a bit daunting."*

Working with fellow students from different years also allowed students to assess where they were with their own learning.

More experienced students appreciated the less experienced students since it pushed them to consolidate their own learning and address their own learning needs. The experience of working with students who needed some guidance, whilst working in a supportive environment, gave more experienced students confidence and a feeling of being more prepared for autonomous practice.

Student B: *"I did actually really like working with the other two students. I found it was really beneficial just because of the fact that I was put outside my comfort zone a little bit, not so much that I felt like I was completely on my own, but it gave me that independence to figure out what I did know and what I did not know, and work on that."*

Having fellow students present was perceived as a resource and allowed for collaborative problem solving; students worked together to address challenges no matter which year group they belonged to. In particular, students' use of accessible language to explain something appealed to other students and helped them understand the explanation better.

Students perceived the CLiP hour, when managed effectively, as very beneficial for peer discussion and reflection on their practice. The CLiP hour allowed students to reinforce their learning needs as well as to inform peers and staff about their learning goals. CLiP midwives also appreciated the CLiP hour as time to manifest learning from practice through reflection and they perceived it as important for developing the students' practice.

CLiP midwife 1: *"I thought that was really good because if there were any gaps or things they were not sure about then they could go*

off by themselves and research it and come back after their CLiP hour and try and implement what they'd learnt."

The CLiP hour was more useful during dayshifts than nightshifts, as students found it difficult to concentrate on learning in the early morning hours. A dedicated quiet space for the CLiP hour was provided to avoid the business of the ward and to facilitate reflection.

Barriers

Although students appreciated the group experience, the second- and third-year students also missed the traditional one-to-one mentoring experience. Whilst it was useful to have peers as a resource to learn from, students did not perceive students' feedback as having the same value as that of a qualified midwife. At times, students lacked trust in their fellow students' judgement.

Student F: *"It's really hard because as a student like you know, you become friends with other students [and] when my friend's telling me that I've improved, you do not take it the same way, you sort of need that leadership you know, somebody else to tell you."*

Lack of awareness around CLiP on the ward was another strongly perceived barrier. Midwives and other staff who were not involved in the pilot noticed the group of three students and had their own thoughts about it. Students perceived this as negative and became self-conscious when exchanging information in small huddles. CLiP midwives had to defend their trio of students to other midwives who were not informed about CLiP. Students were also asked to do extra little jobs by midwives who were unaware of CLiP. One CLiP midwife explained in the interview that she had to make her colleagues aware that CLiP is a model where the students have allocated patients and are therefore occupied with their own workload and cannot be depended upon for other tasks.

CLiP midwife 2: *"The students will help, but [colleagues] be aware that they have got their allocated patients, they can help you but not, "let me use your student", no..."*

Theme 3: Independence and trust as drivers for Learning

Enablers

The CLiP midwives applied coaching techniques to supervision by asking students open questions and by providing space to test their skills. The midwives enjoyed seeing the students' confidence grow. CLiP midwives stood back and allowed the students to organise the learning themselves with the more experienced students teaching the less experienced ones.

CLiP midwife 1: *"It was nice to see them develop their confidence and leadership and nice to see the second-year student taking more responsibility over modelling good practice for the first-year students."*

CLiP midwives got to know their students' abilities in the first shifts and from there they would trust their students. This invested trust supported the students in growing confident in their own skills and in their professional self-efficacy. The CLiP midwife facilitated students to plan, deliver and evaluate care independently. The independence was a key aspect to the coaching approach since it provided space for students to apply their own learning in a safe way.

Student G: *"I think with CLiP I've definitely developed more confidence in planning care, because normally when you're with a mentor, just one-to-one you do not really, you plan the care together, you do not really get to plan the care by yourself, so I think that was a really good way of kind of like throwing you in the deep end and seeing what you can and can not do..."*

The descriptive survey results also showed that all CLiP students perceived that they had increased their confidence in teamwork, supporting other students and in delivering care. Students reported that staff from other professions such as paediatricians

recognised the CLiP students as responsible for delivering care and took time to explain their work. This interprofessional exchange further boosted students' confidence and provided them with a feeling of independence to handle care by themselves.

Student C: *"Being involved with the paediatricians was an eye-opener in that sense and I feel more confident to talk to other professionals as well."*

The CLiP midwife and students met frequently in huddles to update each other. Good communication between the CLiP midwife and the students was perceived as a key skill that was developed during CLiP and vital to effective team working. CLiP midwives felt the care for women improved during CLiP because the students' care contributed positively to the women's needs.

CLiP midwife 2: *"I think in terms of patient care, it was actually better because we sometimes have poor staffing levels which can affect the quality of care, so having two or three students with me I felt like patients were attended to more quickly and they seemed to enjoy having the students there and having their designated students, it was quite nice for them, I thought."*

Barriers

Although all CLiP midwives had some form of training, the application of the coaching approach varied greatly with the individual midwife. For example, CLiP midwife 2 noticed how she fell back into the old mentoring style from time to time:

CLiP midwife 2: *"Once a while I see myself drifting a little bit to the old mentoring system and I come back and say, "no, students need to be given the chance"."*

Working with three students meant the CLiP midwife had to spend some time initially to understand the students' levels and needs, but time was in short supply in the busy maternity ward.

The CLiP midwives especially needed to understand how confident the third-year student was to work with the second and first year student, when they were grouped after handover.

CLiP midwife 1: *"They each had their own objectives they wanted to achieve, it was quite hard to sit down with each student individually and go through their care and what they'd achieved on that shift. I found that quite difficult to do."*

The demanding ward environment also added barriers to the communication between students and midwife. Looking for the CLiP midwife, when something needed to be clarified, was time consuming. One of the less experienced students commented:

"Everything becomes really time consuming, like a job that would normally take 10 min if you're working with a midwife, but now she [the third year student] would have to report back to the midwife and then get the permission to do whatever she feels she needs to do."

Another barrier was signing off the competencies in the Practice Assessment Document (PAD). The increased number of PADs, alongside the demands in the ward environment contributed to the fact that the PADs were not signed earlier. CLiP midwives also expressed that going through documentation and signing the competencies in the PADs was more time consuming for three students than for one.

Student G: *"The CLiP Midwife did not really have time to sit down with us and do our PADs and so it was kind of like left until kind of the last shift for her to sign everything off."*

However, with the high workload demands on the postnatal ward, this was not unusual amongst students working in the 'traditional' model of supervision.

Discussion

Our findings are overall consistent with findings reported in other CLiP studies concerning the challenges when setting up the model, the group placement experience for students and the

change to a coaching style supervision (Hill et al., 2015, 2020; Harvey and Uren, 2019; Underwood et al., 2019; Williamson and Kane, 2020). Our students reported gains in confidence, skills and enjoyed the peer support, but also a loss of individual 1-to-1 mentor time and stress around competencies being signed off, which was also found by Hill et al. (2015, 2020). Yet, the third-year students especially expressed the benefits of role modelling and how they gained a feeling of being more prepared for the transition to work after graduation, which is similar to Wareing's (2018) and Williamson and Bunce's (2020) findings.

However, some key differences can be observed from our pilot regarding a) the set-up and b) the context of a high turnover maternity ward environment. Regarding set-up in the UK, it needs to be noted that all previous reported CLiP evaluations (Hill et al., 2015, 2020; Harvey and Uren, 2019; Underwood et al., 2019; Williamson and Kane, 2020) have taken place under the previous NMC standards (NMC, 2008), which meant their models included coaches as well as mentors to comply with the requirement of 40% sign off mentor time.

Following the new standards for student supervision (NMC, 2018), our model included a CLiP educator, which was the equivalent to the 'Clinical educator' (Hill et al., 2020) or 'Practice educator' (Harvey and Uren, 2019; Williamson and Kane, 2020) although Williamson and Kane (2020) reported to have had only one practice educator at one of the four hospital sites. The models described by Underwood et al. (2019) and Wareing et al. (2018) did not have this additional support. Our CLiP educator was instrumental in raising awareness around CLiP and in providing training. She was also key in facilitating the CLiP hour for the students. The CLiP hour implied protected learning time for students to reflect on the events in practice and to work on any knowledge gaps. Only Hill et al. (2020) reported on protected learning time during CLiP at the JPUH. Our students recorded their learnings activities in a CLiP workbook. Other CLiP research described students filling in a daily learning log (Underwood et al., 2019; Hill et al., 2020) or learning diaries (Harvey and Uren, 2019), but students did not always comply with it (Wareing et al., 2018).

Our pilot corroborated that a lack of awareness around CLiP was a significant barrier to the learning experience. Previous work has emphasised the importance of preparing all staff for the introduction of the CLiP model, due to its different approach to student supervision and learning (Tweedie et al., 2019; Hill et al., 2015). In this respect it is beneficial to use clear labels and signs such as posters, differently coloured name tags and lanyards to show where CLiP takes place and who is involved; this should help other midwives unaware of CLiP not to interfere with the planned workload of the CLiP student trio.

Our findings emphasise the challenges related to the demanding environment of an ante-and postnatal ward in an inner city hospital. The CPF had an increased workload scheduling the students and matching the shift with CLiP trained midwives. The midwives' workload, alongside staff sickness and absences made it difficult to find time with students to judge their skill levels at the beginning of the CLiP placement and to sign off their competencies towards the end. In this respect it was even more important for the CLiP educator to be present and to support the CLiP midwife in organising the students' workload at the beginning of the placement cycle.

Overall, our findings demonstrate that adequate preparation and awareness raising activities and training resources are even more important in a busy hospital unit. The CLiP educator appears to have a more vital role in this environment by providing on-going support to CLiP midwives and raising awareness around CLiP also with the multi-professional team (e.g. paediatricians) and with the wider population of midwives including bank staff. As in previous CLiP research (Hill et al., 2015), the CLiP educator / facilita-

tor was found to be fundamental to the success of implementing CLiP, there is yet a need to develop evidence whether a CLiP educator is needed in the same way once the model is implemented and established. If the pilot had been able to run to completion, it is likely that more staff would have become familiar with CLiP as more trios of students were placed in the ward. This may have enhanced understanding of the CLiP model within the ward-based team.

When rolling out any future coaching based placement models, terminology and role clarifications need to be considered and ideally a consistent taxonomy built (Forber et al., 2016); a lack of role clarification was an issue that was also experienced with the implementation of other placement models, such as DEUs (Crawford et al., 2018). At the same time, it can be argued that once a collaborative placement model based on peer learning and coaching is successfully adopted in a clinical setting, the 'supporter' role (e.g. the CLiP educator) may become redundant. For example, forms of 'structured learning activities' (Stenberg et al., 2020) could be implemented in the peer learning activities, which could sit alongside the coaching model for supervision. As << redacted for review >> had also noted in their review that feedback from a qualified professional is potentially more beneficial for senior students nearing qualification since peers cannot substitute for the trustworthiness of the feedback commentary by someone regularly working in practice. It may be that finding the right balance of feedback provided by qualified staff (e.g. higher trustworthiness) and feedback by peers (e.g. more accessible language) and a mixture between coaching (providing space for independence) and mentoring (guiding the more junior students) could be the solution.

Lastly, questions need to be raised as to whether the CLiP model can be transferred to other clinical settings such as the labour ward and not only in the UK, but also in other countries and health systems. The answer will depend on many factors relating to the specific placement context and area. For example, Williamson and Bunce's (2020) study found that CLiP adapted well for students in General Practice surgeries since it was a clinical area, but not so much in nursing homes because students did not perceive it as an area in which to develop new skills (Williamson and Bunce, 2020).

Limitations

This pilot research has been a small-scale study with students from one University in a maternity ward in one London Hospital for a defined period of time, which was curtailed by the COVID-19 pandemic outbreak, and we cannot claim that this experience is wholly transferrable. More research with a larger study is needed. At the same time, we argue that our findings can contribute to the existing evidence base to support the effective implementation of CLiP as a collaborative learning and placement model into other contexts, including other midwifery placement contexts. We anticipate that these findings will be useful to others implementing a CLiP type model of student supervision in practice.

Conclusions

Our results are in-line with previous CLiP evaluations carried out in nursing and midwifery in the UK, which suggest that the preparation of students and staff as well as the wider practice environment is vital to the success of CLiP and to allow students' confidence and competence to develop. Our pilot study in an inner-city ante-post natal ward contributes specifically to findings around the experiences of CLiP in a demanding ward environment. The CLiP educator plays an instrumental role in raising awareness and training, by supporting the coaches and by facilitating the CLiP

hour. The CLiP hour is key for students to consolidate their learning experiences from practice. Preparation of key CLiP staff, particularly the CLiP midwives who supervise the students, is vital to success. Overall, more research is needed using the CLiP approach with a larger number of student midwives in different settings and in different clinical facilities to corroborate the findings of this pilot.

Ethical approval

Ethical approval for the evaluation of the CLiP pilot was awarded by the University of Greenwich Ethics Committee with number: FREC-EHHS-19-2-8.1.1.

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Declaration of Competing Interest

None declared.

CRediT authorship contribution statement

Marianne Markowski: Conceptualization, Methodology, Writing – original draft, Investigation, Formal analysis, Writing – review & editing. **Carole Yearley:** Methodology, Writing – original draft, Investigation, Formal analysis. **Heather Bower:** Conceptualization, Writing – review & editing.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:[10.1016/j.midw.2022.103360](https://doi.org/10.1016/j.midw.2022.103360).

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