'PLUGGING A HOLE AND LIGHTENING THE BURDEN': A PROCESS EVALUATION OF A PRACTICE EDUCATION TEAM

ABSTRACT

Aim: To investigate the perceptions of clinical and senior managers about the role of Practice Educators employed in one acute hospital in the UK.

Background: Producing nurses who are fit for practice, purpose and academic award is a key issue for nurse education partnership providers in the UK. Various new models for practice learning support structures and new roles within health care institutions have been established. To sustain funding and policy support for these models, there is a need for evaluation research.

Design: A process evaluation methodology was employed to determine the current value of a practice education team and to provide information to guide future direction.

Methods: Data were collected through semi-structured telephone interviews using a previously designed schedule. All senior nurse managers (N=5) and a purposive sample of clinical managers (n=13) who had personal experience of and perceptions about the role of practice educators provided the data.

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Interview notes were transcribed, coded and a thematic framework devised to present the results.

Results: A number of key themes emerged including: qualities needed for being a successful practice educator; visibility and presence of practice educators; providing a link with the university; 'plugging a hole' in supporting learning needs; providing relief to practitioners in dealing with 'the burden of students'; alleviating the 'plight of students'; and effects on student attrition.

Conclusions: Findings provided evidence for the continued funding of the practice educator role with improvements to be made in dealing with stakeholder expectations and outcomes.

Relevance to clinical practice: In the UK, there still remain concerns about the fitness for practice of newly registered nurses, prompting a recent national consultation by the professional regulating body. Despite fiscal pressures, recommendations for further strengthening of all systems that will support the quality of practice learning may continue to sustain practice learning support roles.

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INTRODUCTION

The need to improve the quality of practice based learning for nursing and other health care workers was highlighted ion the UK during the late 1990s (UKCC 1999, DoH 1999). In particular, partnerships processes between Higher Education Institutes (HEIs) and National Health Service (NHS) Trusts needed to be strengthened and expanded. Reforms included curriculum changes to allow student nurses to spend proportionally more time in practice learning. They also included a commitment to fund an improved system for providing quality structured support for students and their practice mentors/supervisors.

These recommendations, along with subsequent guidelines from the Nursing and Midwifery Council (NMC) (NMC 2002) and the Department of Health (DoH) in partnership with the English National Board (ENB) (DoH & ENB 2001) led to the development of new roles to support nurse learners in practice. 'Practice Educator' is one example of titles given to these new posts. ; others titles include 'Practice Learning Facilitators' or 'Clinical Placement Facilitators'. However, to date, posts have been developed in an ad hoc way within NHS Trusts in the UK; funding is provided by Workforce Development Confederations, more recently subsumed under Strategic Regional Health Authorities. In the Republic of Ireland (ROI), on the other hand, where similar posts were formally established nationwide in the mid 1990s to support new diploma level programmes for nurse education (Department of Health and

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Children , 2001),. However, future funding in the UK is not guaranteed. It could, therefore, be argued that the effectiveness of these posts in improving the quality of practice learning needs to be investigated through evaluation studies.

A proposal to initiate a new framework of support for improving the quality of practice education for preregistration nursing students, completing their programmes at a university in the south of England, was accepted and funded by Dorset and South Wiltshire Education Purchasing Consortium (2001). One of several NHS partnership sites linked with the university agreed to instigate this model for practice learning (Mallik & Aston, 2003; Mallik & Aylott 2005). As a result of this agreement, A senior manager (Associate Nurse Executive – Clinical Education) and a team of Practice Educators (PEs) were appointed to develop a Practice Education Team (PET) in a 500 bedded acute NHS Trust during the late autumn of 2001.

A key strategy was to recruit, as PEs, individuals with local, clinical expertise. Further personal and professional development to undertake the role was to be completed while in post. It is important to note that, unlike organisational posts in clinical placement facilitation nationally, job descriptions for these local PEs emphasised the 'education' role. Here, clear expectations of clinical credibility, role modelling, clinical skills teaching and support of clinical

effectiveness in each learning locality were outlined. Figure 1 provides an outline of the posts, whole time equivalents (WTEs) and areas covered.

An estimated ratio of 1:50 PEs to students was employed. Post holders were offered permanent NHS contracts on the understanding that funding would be sustained in the future. Each appointee also held honorary contracts with the university. Strong partnership working was encouraged between appointees and the university through input to relevant curriculum and practice learning committees. Key named lecturers continued to provide a support service to the NHS trust to those practice areas not appointing a PE and/or through supporting the on-going development of members of the PET. Negotiated partnerships promoted joint provision of university accredited mentorship preparation programmes on site and the PET completed all monitoring work to ensure quality of learning placements.

Core aims for the work of the PET described in this paper included:

- Improving the quality of practice learning through providing a scaffold of structured support for students and their practice mentors/supervisors
- Developing and auditing practice learning environments in line with professional (Nursing & Midwifery Council) and academic (Quality Assurance Agency) requirements

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- Preparing and instigating new areas/models for practice learning in order to increase capacity for student placements.

An evaluation study of the work of this PET, funded by the Workforce Development Confederation (WDC), was undertaken in 2003. The study was completed in two distinct parts to include: (1) an evaluation of the university model across all implementers, adopting a quantitative survey methodology (Redwood & Childs 2003); and (2) a commissioned qualitative evaluation study of the PET described in this paper (Hunt 2003). This paper presents results from the second qualitative component of the study. The discussion section describes issues arising from the results.

SUMMARY OF RELEVANT LITERATURE

The key to successful practice based learning is to ensure that students in the health care professions are provided with a 'scaffolding' of structured support (Quality Assurance Agency 2001, 2005). It is accepted in the UK that the majority of student support is currently delivered through practitioner-student partnerships in practice environments that are conducive to learning. For health care service and placement providers, tensions exist between the need to provide a quality and cost-effective service to patients/clients and the demands made on them in teaching and assessing increasing numbers of health care learners. Structured organisational support for the mentor is

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usually undertaken by an appointed named individual either employed by the Health Care Institution (HCI) or by the Higher Education Institution (HEI).

Historically, formal education support for student nurses has been provided through a number of different models including: the 'clinical teacher' model in the 1970s and 1980s (Roberston 1987, Martin 1989); the lecturer practitioner model in 1980s and 1990s (Lathlean 1995, Hollingworth 1997) and, from mid 1980s onwards, the 'link lecturer' model (Clifford 1993, Luker et al 1995, Day et al 1998, Ioannides 1999, Aston et al 2000).

The assimilation of nurse education into Higher Education in the early/mid 1990s did not change the obligation on teachers/lecturers to provide support for students in the practice setting (ENB 1997). However, Day et al (1998) revealed that university lecturers do not always have time to fulfil the link lecturer role and it may be given low priority at an individual and/or organisational level. Furthermore, there is a perceived lack of effectiveness of their role, particularly recognised by students and practitioners (Day et al 1998) and a suggestion that lecturers may lack clinical credibility to undertake the role (Humphreys et al. 2000, Murphy 2000).

A proliferation of 'new' support roles have emerged following the recommendations of the Peach Report with a consequent strengthening of partnerships between the HEIs and the HCIs (UKCC 1999, DoH 1999).

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Various titles have been given to these roles (Lambert & Glacken 2005). These include: clinical facilitators (Rowan & Barber 2000), clinical liaison lecturers (Ioannides 1999) clinical guides (Andrews & Roberts 2003) and practice placement facilitators (Clarke 2003 et al). The roles of post holders are diverse and clinically-based educational support may be offered to pre-registration nursing students (Clarke et al 2003), to qualified nurses (Smith & Smith 2003) and/or to health care support workers or within an interprofessional context (Reeves et al. 2002). Posts may also be established in combination with other roles (Trudigan 2000).

Post holders generally provide a co-ordination, advisory, and supportive role for both the learners and their mentors. They liaise and negotiate between the HEI and the HCI providing placements for the learner, problem solving any issues and advising on placement capacity and quality. Eraut (2003) is critical of the effectiveness of these roles in relation to the direct learning experiences of students, arguing that they are allocated to senior people who have relatively little contact with the learner.

Evaluation studies are conducted to determine the value or impact of a policy, programme, practice, or service, with a view to making recommendations for change (Clarke 1999). The processes involved may thus be complex necessitating a diversity of methodologies, frequently adopting a mixed methods approach (e.g. Drennan 2002, Clarke et al. 2003).

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A number of evaluation studies examining these 'new' roles have been undertaken in recent years adopting mixed methods approaches (e.g. Rowan & Barber 2000, Williamson & Webb 2001, Drennan 2002, Kelly et al 2002, Jowett & McMullan 2003, Clarke et al 2003). In these studies, views of the work of post holders have been gained from a range of nurse learners, mentors/supporters and peers. However, with a few exceptions (Williamson & Webb 2001, Clarke et al 2003), managers have rarely been involved in these evaluations.

Findings from the above studies indicate that: there is ambiguity and tension in the realisation of practice learning support roles (Williamson & Webb 2001); distribution of the roles are variable and uneven across NHS Trusts, diluting their impact with mentors and students (Jowett & McMullan 2003); roles, focussing specifically on improving clinical skills in selected practice areas in an acute NHS trust, were successful in achieving their outcomes (Ellis & Hogard 2003); clinical staff perceived that post holders improved their understanding of the needs of learners and learners appreciated the continuity of support offered within practice placements (Drennan 2002, Clarke et al. 2003). Most studies, however, comment on: the short-term nature of appointments;, the lack of role clarity in these developmental posts; and the insecurity for post holders because many are employed on time-limited projects with no commitment to sustained infrastructure development.

METHODS

The first stage of the evaluation study comprised a questionnaire survey with Associate Directors of Nursing for Clinical Learning, mentors and students in each of the four acute NHS Trusts involved in the project (Redwood & Childs 2003). The second stage, a commissioned qualitative study, reported in this paper, adopted a process evaluation methodology to determine the value and future direction of the PET in one participating NHS Trust (Ovretveit 1997). Process evaluation research explores how a programme changes and develops following initial implementation, thus providing the context within which to interpret outcomes (Clarke 1999). This component of the research comprised telephone interviews with a group of senior and clinical nursing managers in one participating NHS Trust to elicit their views on the work and role of the PET.

Approval to undertake this work was gained through the local research ethics committee, following which data were collected through semi-structured telephone interviews using three interview schedules, (one for each managerial grade of participants), designed specifically for the research. These data collection tools included topics such as: involvement in establishing PE posts, aspirations of the post at the inception of the new roles and for the future, contact with PEs, role of nurse education within NHS Trusts and within universities, and comparisons, contrasts and conflicts with other nursing roles (see Table 1).

Potential participants were personally approached and information about the content of the interviews was provided at this time. All Directorate Senior Nurses (DSNs) and the Acting Director of Nursing Services (N=5) agreed to participate. In addition, a purposive sample (Higginbottom 2004) of Clinical Managers (CMs) (n=13) from all Clinical Directorates within the Trust gave their consent to participate in the interviews. All selected managers had experience of working with members of the PET and were available to be interviewed within the limited timeframe set for completing the data collection.

Interviews were conducted by a qualitative interviewer experienced in telephone interview methods (Brown et al. 2002, Hunt, 1998). Interviews were not taped but copious notes were taken. Data were transcribed and entered into a word processor, coded manually by the researcher and a thematic framework was devised using a data reduction, display and verification model of analysis (Miles & Huberman 1993). Topics in the interview schedules guided the analysis. Data were 'reduced' with the emergence of key themes. These themes were then cut and pasted into separate files, aiding 'display'. From the key themes, sub categories emerged which further reduced the data, resulting in 'verification'. Full transcripts of the data were cross checked for agreement of emerging themes by a second researcher.

RESULTS

Eighteen semi-structured telephone interviews were completed. All participants had personal experiences of and perceptions about the role of the PE. The majority of participants were women and had trained and worked within the participating NHS Trust throughout their nursing careers. Clinical managers (n =13) were employed at F or G Grade. Demographic data related to years of experience and professional/academic development were not collected. To preserve anonymity, with such a small local sample size, pseudonyms have been ascribed to participants and their roles not identified. Eight key themes from the telephone interviews are presented in this paper. These include: 'being a successful PE', 'a link with the university', 'plugging a hole', 'visibility of PEs', 'a team member, guest or stranger', 'the burden of students', ' the plight of students' and 'student attrition'.

Being a successful PE

In this theme participants focused on the traits and backgrounds important in becoming a successful PE. Clinical background and knowledge of specialist field was of paramount importance to most respondents. This was particularly valued in high technical clinical areas where up-to-date knowledge was viewed to be important. This is illustrated by Lorna who said:

*The [specialty] area was more or less high dependency and there was a lot of invasive monitoring and I think the person in post hadn't acquired that opportunity to get up to date with that invasive equipment (*Lorna)

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Most referred to the successes of the PE as being grounded in the right person for the job. This included: having good communication and interpersonal skills; being diplomatic; and being dynamic. Only a few viewed academic qualifications as being important.

A link with the university

A second key theme concerns the value placed upon PEs as links with the university. Most participants had some experience of working within the Trust prior to the inception of PEs and thus had prior experience of the link lecturer role. The varying relationships with link lecturers are epitomised by the following quote:

*We have a link tutor who has recently changed. The one we had originally was brilliant and would come round every week, very easy to get hold of, leave a message on the answer phone and he would get back to you. The one we have at the moment manages to be on site on a Monday when we rarely have any students here and I've literally only said, "hello" and "goodbye" when she passes the nurses station, so the links aren't very close. (*Brenda*)*

Since the inception of the PE role however, it was felt by most participants, that links with the university had been significantly strengthened, with PEs

having an increased *'foot in each camp'* (Deirdre). For many, this meant student issues were more immediately addressed.

Plugging a hole

A third theme concerns an overt lack of educational support for students within the Trust prior to the inception of PEs. This is epitomised by Nettie who commented:

*I think (PE role) stemmed from concerns that we raised about support for student nurses on the ward. We were seeing significant numbers of students dropping out. I don't think that necessarily we were worse than any where else at the time but nationally it was a concern (*Nettie)

For most participants, the perception was that students were better supported within the clinical setting since the creation of the PE, thus 'plugging a hole'. Some participants acknowledged that the educational requirements of other nurses such as permanent qualified and unqualified staff were being met elsewhere. However, for most, students were seen as only one group of staff requiring educational support. Thus, whether PEs filled an educational gap thereby 'plugging a hole', depended in part on how the hole was viewed. Gaps in educational support for permanent staff such as preceptees and health care support workers remained present. As Nettie again commented: *'I felt and still feel, there was a gap across all of those areas'.*

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Visibility of PEs

Most participants talked about the visibility or presence of PEs. However a pectrum of visibility was apparent. For some, it was perceived that PEs were ever present on the ward, benefiting both staff's relationships with PEs and student learning and morale. For others, PEs were not viewed as ever present on the ward but it was felt that sufficient input was provided by PEs to clinical areas. For most however, PEs were not viewed as being as visible in clinical areas as was initially envisaged or preferred. The reasons given for this were varied but frequently they included a recognition that post holders were part time or pressured to do other duties which took them away from clinical areas. In addition, respondents, in some instances, indicated that personalities were such that they lacked a 'presence'.

A team member, guest or stranger

A diversity of relationships between PEs and the wider nursing teams were described in the data. On the whole the PE could be deemed as (1) being a team member, (2) being a guest to the clinical area or, in the extreme, (3) being a stranger with little to no input into the day-to-day management of students.

(1) Being a team member

PEs were seldom viewed as close members of clinical nursing teams. When they were, PEs were viewed as peers from which mutual support could be gained and ideas regarding student and educational issues be mutually exchanged. In addition, 'being a team member' might also mean that PEs regularly attended and participated in ward team meetings. Being a team member is illustrated by Mary who observed:

They have to have a good relationship with the ward staff and they've got to feel part of the team. I think that's why it's been so successful Mary

(2) Being a guest

On the whole, PEs were viewed as being part of a wider, extended team of health care professionals, such as physiotherapists and nurse specialists, who attended clinical areas as guests. Here, PEs would usually be invited to attend the clinical area rather than being ever present. This might include a telephone call to a PE regarding a problem with a student which may need resolving or an invitation to attend a ward nursing team meeting. An example of PEs being viewed as guests is depicted by one participant who supposed, *'I mean she's a member of the team, she's one of the - we work closely with the physios, OTs, doctors. I think we see her as part of the extended team'* (Abigail).

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(3) Being a stranger

More rarely, PEs were viewed as strangers, being far removed from the clinical nursing team and in extreme examples, antagonistic to the workings of the clinical environment. This is depicted by one participant who considered that PEs not only lacked visibility but also, due to lack of teamwork, arranged formal teaching for students which conflicted with student learning opportunities provided clinically. She suggested: *They (students) go off sometimes and they have teaching sessions which are always at a bad time of the day, you know, lunchtime ……. we always let the students go but they're at lunchtime when it's nice – I mean students need to be able to feed, to do meals and all those sorts of things (*Brenda). Whatever the relationship described, most participants aspired to closer relationships working between ward nursing staff and the PEs.

Lightening the burden of students

The value and necessity of students' clinical placements were recognised, for students themselves, for the clinical area and Trust as a whole and for the future benefits of the NHS. However, for some, students and their teaching needs were viewed as placing additional burdens on the existing pressures of hectic clinical workloads. A variety of solutions was offered to relieve the burdens placed upon staff. However, in general, the PEs were viewed as relieving much of the day-to-day pressures placed upon nursing staff either by: (i) lightening the burden of nurses in charge of wards in pursuing students

not turning up for work, (ii) relieving CMs in assisting students in resolving personal difficulties or (iii) simply lightning the work load of nurses in clinical settings by caring for patients with students for a span of duty or undertaking drug rounds.

The plight of students

In general, students were viewed as a group of health care professionals in need of particular care. For some participants, this was viewed, to be related in part, to 21st century culture and education. For example, university students were sometimes seen to carry greater amounts of 'emotional baggage' compared with yesteryear's students.

Respondents suggested that there were larger numbers of mature students in higher education, with greater personal and social needs compared with younger students. Students were also viewed to be studying in an era when more consideration is given to their personal needs compared with nurse education of previous decades. The current educational system also led some participants to consider that students were less a part of the 'NHS culture' and ward nursing teams compared to their own experiences of different training systems as students. Furthermore, participants were mindful of current nursing shortages and the need to nurture students to completion of their training.

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With these factors in mind, in addition to instilling 'the culture of nursing' into students, the PE role was greatly valued for its championing the causes of students, acting as pastoral carer or as Deidre put it: *'it's a bit like being a house mother or something'*. However the role was viewed, participants were unanimous that the PE role was of great value to student personal well being and education.

Student attrition

As can be seen from the themes developed thus far, most participants valued the work of PEs, particularly for the personal support provided to students and some qualified nurses. Furthermore, most felt positively that the PE role had in some way benefited the retention of students, enabling and encouraging them to gain nurse registration. Examples of this were given particularly by some CMs who had encountered difficulties with particular students which, with the help of the PE, it was felt, were eased, or resolved enabling students to continue with their education.

Notable examples of preventing student attrition were cited by two participants. In each example, prior to the appointment of PEs, it was considered that students' experiences of placements were negative and that recruitment to their clinical areas of junior nursing staff was difficult. However, both participants felt strongly that PEs had contributed strongly in recent

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times to students' wellbeing, on completion of their training, returning to wards to apply for positions as junior qualified staff.

DISCUSSION

Criticisms of Project 2000 during the early 1990s revealed rifts between practice and education and poor preparation of students to practice as registered nurses. Since this criticism, nursing has looked for creative ways in which newly trained nurses would be 'fit for purpose' (Kenny 2004). This has led to the development of a number of new roles to support practice-based learning, including the PE role. The particular application of the PE roles described in this article is unique in the UK as the number of 'clinical placement facilitator' post holders nationally has been reduced overall resulting in severe service dilution. with single post holders providing a service for one large acute NHS Trust or even a number of Trusts.

By contrast, the model described in this paper most closely resembles the ROI model of 'Clinical Placement Co- Ordinators' (CPCs) which has been positively evaluated (Simons et al. 1998, Department of Health and Children 2001, Drennan 2002). The CPC model continues to be supported as the model of choice for the newly instigated all graduate programmes commenced in Ireland in the autumn of 2002 (An Bord Altranais 2003). The ROI model allows a much lower ratio of student numbers to each Clinical Education Facilitator (approx 1:30) and ensures that they are local, available

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and visible in placement areas when needed. The focus of the role is on student support for all issues while on practice placements. They do not take on the direct patient contact clinical teaching role of the practitioner. Over time and with the stability of funding accorded to post holders, their roles have become more clearly defined and accepted by all key stakeholders (Drennan 2002).

Post holders of the CPC roles in the ROI are required to have at least three to five years clinical experience, two to three of which must have included supporting student nurses in the workplace. Academic preparation at first degree level was recommended, though not essential, as development to that level could be achieved while in post (Department of Health and Children 2001). Given the present ethos in nursing which pays high credence to academic performance, a surprising feature of the findings from this research is that the possession of academic qualifications by PEs were viewed of little importance by managers. Rather, traits of post holders reflect the strategy adopted in the employment of PEs in that they should possess local expertise and good interpersonal and communications skills. Similar to other studies, the issue of clinical credibility remains important to the perceived success of the PE role (Mallik and Aylott 2005).

Visibility in the practice area and providing a key link with the university also echo the findings of previous studies exploring the link lecturer role in the

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practice setting (Day et al. 1998, Aston et al. 2000). Work overload has also been depicted in evaluation studies exploring practice-based learning support roles (Williamson & Webb 2001). In this study the visibility of PEs varied. This was important to some respondents and not to others. However, a key factor in the visibility of PEs lay in their perceived workload. Since some PEs worked part-time this might influence their relative visibility (see Fig 1). However, a degree of visibility is important to reduce the potential to be viewed as a 'stranger'. It is evident that these expectations are key to the relationships developed between PEs and managers within clinical areas. They should be explored further to ensure the continuing support of all managers for the PE role.

The emergence of 'the plight of students' theme reflects the current diversity in nursing recruitment. This diversity may be of paramount importance in considering future PE posts and in the traits required to undertake such positions. The emotional labour of supporting student nurses has been recognised (Smith & Gray 2001, Löfmark & Wikblad 2001) and a key skill required of students is that they learn to integrate into the culture and 'communities of practice' (Wenger 1998, Spouse 1998).   Managers recognised the specific student and mentor support role undertaken by the PEs as important in 'lightening the burden of students' for their mentors. Clarke et al (2003) and Drennan (2002) found that students recognised that these roles are as essential to mitigate the management of problems for them

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and their mentors. In particular, they reference to the continuity offered by having the post holder based within the practice environment. As found in this study, a more long term positive outcome of immediate problem management by the PE is the retention of students and subsequent recruitment to the qualified workforce.

'Plugging a hole' in educational support for groups of nurses other than pre-registration learners, would require revision of the locally adopted model of PE. At the time of undertaking the study, the PET had already expanded its remit to include the assimilation of a team of assessors/verifiers for members of health care staff completing National Vocational Qualifications (NVQs) in care and therapy. Other team members had been added who had a specific remit for supporting overseas 'adaptees' and newly qualified staff nurses. Team members with specific clinical expertise also contributed to the portfolio of training offered by the Continuing Professional Development (CPD) nursing team within the Trust. A strategy to integrate the team and thus provide learning support for all learners in a particular learning locality was being developed (Redwood & Childs 2003).

Practice Placement Facilitators (PPFs) in Clarke et al's (2003) study also viewed themselves as 'plugging holes' and reference was made to the extent to which the PPFs were supplementing the co-existing university-employed 'link lecturer'. Clarke et al (2003) also discuss the tensions involved in

ensuring partnership working where role functions might overlap. Within the model described in this study, tensions and expectations of both partners were resolved. This situation occurred because of the size of the team, the strategic and operational roles developed over time and the practice learning service provided for the Trust and the University. Participants viewed relationships with the local university to be strengthened following the inception of the PE post. Although positive partnership working was the norm, how academic staff within the university viewed these links and their concurrent diminished roles specifically as 'link lecturers' had not been empirically tested and would require further investigation.

CONCLUSION

In an era when nurse education is undertaken in partnership between universities and NHS Trusts, this research has suggested that in one NHS Trust in Southern England, the role of the PE has been greatly valued in terms of 'plugging a hole' and 'lightening burdens' in both student support and academic links with universities. Issues still to be addressed include the expectations of mentors and managers regarding the level of visibility and support for mentors from PEs. Evaluation was completed 18 months after the formation of the PET. Sustained funding has assured the ongoing development of the team and their workload.

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Recommendations arising from the findings have been realised to include PEs:

- contracting with clinical areas to improve visibility and ensure realistic expectations
- addressing the learning needs of all levels of learners to provide a cross professional approach including a re-focusing on 'mentors as learners'

The delivery of nurse education has historically been criticised for firstly being too clinically-focused with limited academic development and later, following the implementation of Project 2000, too academic with limited preparation of newly qualified nurses to practice nursing. Recommendations from reports at the end of the 1990s (UKCC 1999, DoH 1999) necessitated a re-think of curriculum models and practice learning support systems.

Despite positive evaluations, funded support systems have remained fragile. The cost containment agenda, that permeates both the NHS and the Higher Education sector prevents further development. Despite the rhetoric of support for the practice learning agenda, there remains a lack of overall national commitment to funding and sustaining a valid and reliable practice learning support structure. As stated by Clarke et al (2003) there still remains a constant pressure on a disproportionate number of practice staff supporting an increasing number of learners. It is not surprising that, nationally, there

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remain concerns about the fitness for practice of newly registered nurses (Duffy 2004) prompting further consultation of the key stakeholders by the NMC in 2005 (NMC 2005). The consultation document recommends acceptance of a further strengthening of all systems that will support the quality of practice learning. Outcomes of the NMC consultation will be published in 2006.

Overall it is therefore difficult to predict future trends. If the current system of education delivery is to remain divided between education and care providers then the future of the PE, with the successes of the role identified both through this research and other studies, needs to be safe guarded. However, with funds for these posts frequently provided for finite periods of time, uncertainty around their future remains problematic. Findings from this study have positively impacted on the continuation of the posts evaluated. Further research and the adoption of an interprofessional approach to meeting changing agendas in the delivery of health and social care may assist in the future security of PETs.

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