REPORT ON FINAL PHASE
ON-LINE SURVEY (Phase 3)

NATIONAL GRADING OF PRACTICE IN PRE-REGISTRATION MIDWIFERY PROJECT

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CONDUCTED ON BEHALF OF THE LEAD MIDWIFE FOR EDUCATION UNITED KINGDOM (LME-UK) EXECUTIVE

Project website: https://www.plymouth.ac.uk/research/national-grading-of-practice-in-pre-registration-midwifery-project
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<thead>
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<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AEI</td>
<td>Approved Education Institution. This is the term used by the Nursing and Midwifery Council (NMC) for the universities or Higher Education Institutions (HEIs) delivering programmes approved by the NMC which lead to professional registration as a nurse or midwife.</td>
</tr>
<tr>
<td>Grade</td>
<td>A specific number, percentage or symbol awarded to represent a determined level of performance. For the purposes of this project, this term also includes descriptors representing such levels of performance (e.g.: fail, good, excellent).</td>
</tr>
<tr>
<td>Levels</td>
<td>A term used either for indicating academic or performance levels in the UK. Level 4 (SCQF 7) is identified as ‘certificate’ level, Level 5 (SCQF 8) is ‘diploma’ level, Level 6 (SCQF 9) is ‘degree’ level and Level 7 (SCQF 10) is ‘masters’ level.</td>
</tr>
<tr>
<td>Lexicon Framework</td>
<td>A tool devised by the project team which comprises key words relevant for academic levels 4-7 (SCQF 7-10) which may be used to indicate levels of performance in practice. These were compiled according to the frequency of words used in existing midwifery practice assessment documentation across the UK.</td>
</tr>
<tr>
<td>LME-UK Executive</td>
<td>United Kingdom Lead Midwife for Education Executive; a group of senior midwife academics. It is a requirement of the Nursing and Midwifery Council that an LME is appointed by each university in the United Kingdom which delivers pre-registration Midwifery education.</td>
</tr>
<tr>
<td>KSA</td>
<td>Knowledge, Skills and Attitudes (or Attributes). A recognised categorisation of components of learning which lead to competence in a defined role or profession. These were used in construction of the Lexicon Frameworks and Rubrics in this study.</td>
</tr>
<tr>
<td>Mentor</td>
<td>The term used in this study for the qualified nurse or midwife undertaking the assessment of practice for pre-registration nursing or midwifery students. This term reflects the NMC ‘Standards to support learning and assessment in practice’ which were in place at the time of the study. Although ‘sign-off mentor’ is the correct term for those assessing midwifery students throughout their programme and nursing students at point of registration, this has been simplified to the single term ‘mentor’ for ease of reading. It is also transferable to the new role of ‘practice assessor’ introduced in the new NMC education standards which have been published since the study was undertaken.</td>
</tr>
<tr>
<td>NMC</td>
<td>Nursing and Midwifery Council. This is the regulatory body for nurses and midwives in the United Kingdom, comprising England, Scotland, Wales and Northern Ireland. Their role is to protect the public through setting standards of education, training, conduct and performance.</td>
</tr>
<tr>
<td>PAD</td>
<td>Practice Assessment Document. The title used by some AEIs for the element of the ‘ongoing achievement record’ which reflects development and achievement of the requirements for practice competencies set by the NMC.</td>
</tr>
<tr>
<td>PAN London</td>
<td>A common midwifery practice assessment tool which is used by eight AEIs and their practice partners in London; a similar tool is used in nursing.</td>
</tr>
<tr>
<td>Rubric</td>
<td>A tool devised by the project team which comprises sets of statements representing levels of performance in practice for academic Levels 4-7 (SCQF 7-10), based on the Lexicon Frameworks which were drawn from words used in existing practice assessment documentation across the UK.</td>
</tr>
<tr>
<td>SCQF</td>
<td>Scottish Credit and Qualifications Framework; the national credit transfer system for all levels of qualifications in Scotland. SCQF Levels 7-10 equate to academic Levels 4-7 used in the rest of the United Kingdom.</td>
</tr>
<tr>
<td>Tripartite/ triad</td>
<td>A three-way meeting which may be face-to-face, over the telephone or via internet-based media involving the student, sign-off mentor and a midwifery lecturer, forming part of the process of the assessment of midwifery practice in some AEIs.</td>
</tr>
<tr>
<td>Wordle</td>
<td>Otherwise known as a ‘Word-cloud’, this comprises a visual representation of the frequency of words used in existing practice assessment documentation across the UK, on which the Lexicon Frameworks and Rubrics in this project have been based. Examples are shown in Appendix 2.</td>
</tr>
</tbody>
</table>
1. EXECUTIVE SUMMARY

1.1 Introduction

This report presents the findings from the third and final phase of a national project, conducted by and on behalf of the Lead Midwife for Education United Kingdom Executive (LME-UK), which has explored grading of practice in pre-registration midwifery programmes in the UK.

1.2 Contextual background

Grading of practice is at present a mandatory element of programmes leading to registration as a midwife in the United Kingdom. The midwifery pre-registration education standards are currently under review, and it is unknown whether grading itself will continue to be a requirement, or be implemented at the discretion of Approved Education Institutions (AEIs). The new standards for nursing and midwifery education state, however, that practice will continue to be assessed to determine progress and competence. The wider literature has shown that multiple challenges exist in the assessment of practice, including grading, although benefits are also noted.

It was recognised by the LME-UK Executive that a range of approaches was being taken across the country in applying the current Nursing and Midwifery Council (NMC) pre-registration midwifery education standards. Inconsistencies have also been noted in other literature and health professions. The LME-UK Executive therefore sought to identify and remedy some of these variations and achieve greater consistency between programmes leading to midwifery registration in the 55 AEIs.

The ‘National Grading of Practice in Pre-registration Midwifery Project’ (Figure 1) has been undertaken by a team of previous and current LMEs on behalf of the LME-UK Executive, comprising three phases – the first two having been published in journals and the third and final phase being the subject of this report:

![Figure 1: National Grading of Practice in Pre-registration Midwifery Project](image)

1.3 Study design

The third phase comprised a mixed method on-line survey which was made available to midwifery and nursing academics, clinicians and students across the UK, with the LMEs acting as gatekeepers. The survey explored participant views of their existing practice assessment tool, consideration of what contributes to a robust and reliable assessment process and perceptions of two proposed assessment tools developed by the research team: a Lexicon Framework and Rubric. Participants were also invited to comment on the potential for transferability of these proposed tools across all midwifery – and potentially nursing – programmes.
1.4 Key findings

1.4.1 Main themes (Section 4):

Seven main themes were identified through content analysis, comprising:
- Human factors
- Art of mentoring
- Structure of the tool
- Ongoing guidance and support of the assessor
- Other factors
- Purpose of assessment
- Standardisation

1.4.2 Existing tools and general principles of practice assessment (Section 4.2):

1.4.2a A fairly low level of confidence in the validity and reliability of existing assessment tools was reported, comprising fewer than 50% of all participants. Midwifery participants were slightly more confident in their existing assessment tools than nursing counterparts; clinicians in both professions were the most confident and students the least (4.2.1).

1.4.2b Participants were positive about the contribution of others to the assessment process (4.2.2).

1.4.2c Wording of the tool was perceived as more important to clinicians and students than academics, incorporating both the clarity of terminology and written explanation on how to award the grade (4.2.2c).

1.4.2d Better preparation of mentors and constant reinforcement could reduce variations in grading. Mentors needed to understand the importance of assessing the student’s abilities at that point in their programme and not as a qualified midwife (4.2.2d).

1.4.2d Ranking of factors which may contribute to a more reliable and valid assessment (4.2.3) included:

1) Assessing professional performance against set criteria rather than judgement of the individual was unanimously ranked highest.

2) The use of a clear set of statements linked to specific grades, descriptors or symbols indicating level of performance was ranked second highest overall and by midwifery participants.

3) Introduction of a national tool was popular in both nursing and midwifery; there was a clear appetite for national standardisation and greater consistency in practice assessment throughout the survey (4.2.3; 4.3.2; 4.4.8; 4.4.9; 4.5).

4) Involvement of key stakeholders in the development and review of assessment tools was also ranked highly in all categories.

5) There were mixed views on the benefits of grading practice (4.2.3; 4.4.9; 4.5).

1.4.3 Lexicon Frameworks (Section 4.3):

1.4.3a The majority of participants indicated that there was scope for use of the Lexicon Frameworks (4.3.1). Clinicians and students were particularly positive about the potential to use them. There was a higher level of confusion about their purpose amongst academics, although the majority indicated positivity towards their use in some capacity, with most considering they would be useful when developing new programmes. This further reinforces the importance of all stakeholders contributing to development of assessment tools to avoid making assumptions about understanding and application.
1.4.3b Scope for application of the Lexicon Frameworks to the new standards for education\textsuperscript{10-12} was evident. Participants were positive about their potential for documenting evidence to support a mentor’s decision or student’s self-assessment, as the main tool for grading or when developing a practice assessment document for a new pre-registration programme.

1.4.3c Some participants suggested that the Lexicon Frameworks would ensure a fairer grade and help promote standardisation (4.3.2).

1.4.3d Thematic analysis of qualitative responses in this section excluded ‘Human factors’, suggesting that the Lexicon Frameworks might enhance objectivity, leading to more reliable and robust assessment (4.3.1; 4.3.2).

1.4.4 Rubrics (Section 4.4):

1.4.4a Most participants found the Rubrics easy to use (4.4.5).

1.4.4b In all scenarios except Level 7 (SCQF 10 – 4.4.4), the majority aligned with the grade intended, demonstrating a good level of validity and inter-assessor reliability (4.4.1; 4.4.2; 4.4.3).

1.4.4c Findings from the scenarios suggested that grading using the Rubrics could be fairly reliable, even if the assessor had not worked with the student (4.4.1; 4.4.2; 4.4.3; 4.4.4; 4.4.6; 4.4.7; 4.4.8).

1.4.4d Findings from the scenarios supported the potential for other professions to contribute to the assessment, as the distribution of grades was similar in both midwifery and nursing for the majority of the hypothetical midwifery scenarios (4.4.1; 4.4.2; 4.4.3; 4.4.4).

1.4.4e Some concerns were raised about students’ understanding of the purpose of grading and determination of competence when they ‘failed to fail’ student ‘Grace’ (4.4.3), despite it being evident that her practice did not meet requirements and was clearly unsafe.

1.4.4f Challenges were demonstrated in identifying a grade at masters level for ‘Alba’ (4.4.4). The differences between this scenario and the others at Level 4-6 (SCQF 7-9) were quite marked, despite the same principles being followed. Exploratory research on masters level practice assessment would be useful.

1.4.4g There was a high level of consistency in responses about the potential for the Rubrics to be used in both midwifery and nursing (4.4.6; 4.4.7; 4.4.8; 4.4.9).

1.4.4h Participants were again positive about introducing a national assessment tool in midwifery and nursing (4.2.3; 4.4.8, 4.4.9, 4.5). Our Rubrics demonstrated scope for transferability, potentially enhancing standardisation.

1.4.5 Additional comments (Section 4.5):

1.4.5a Comments reinforced previous themes and sub-themes. The ‘Purpose of assessment’ and appetite for ‘Standardisation’ were particularly apparent.

1.4.5b Most participants were in favour of grading practice, but it was highlighted that its pitfalls could outweigh its advantages and it was important not to become fixated on the grade itself (4.4.8d).

1.4.5c The importance of ‘learning’ was emphasised.
1.5 Project outputs

- An 'Evidence Based Model for Professional Practice Assessment' has been developed from the concepts emerging from the findings (section 5.2).

- 'Key principles for assessing practice' are recommended for those devising and using practice assessment tools or involved in the process of assessing practice (section 5.3).

- A 'Practice Assessment Toolkit' is under development, including refined versions of the Lexicon Framework and Rubrics used in the survey. This will be open access and available on the project website (section 6.1).

*Figure 2: Project outputs*
2. INTRODUCTION

2.1 Structure and purpose

This report is intended for stakeholders involved in the assessment of practice in midwifery in the UK. This includes clinicians, academics in AEIs, the students themselves and the regulatory body who sets the standards for education – the Nursing and Midwifery Council. Our findings and recommendations may help inform development of the new standards for pre-registration midwifery education. The target audience extends beyond midwifery, however. Nursing participants were included in the survey and the findings may have resonance in this profession as well as others. It may therefore be of interest to anyone who facilitates learning and assesses students’ progress in a professional capacity, or to programme teams in educational institutions which are responsible for developing practice assessment documentation. This may extend to any country.

The structure of the report is set out in the ‘List of Contents’ on page 3. A glossary of terms can be found on page 5. The background to the study as well as aims and objectives are in section 2 and methodology in section 3. As the study formed the final phase of a national project and respondents to the survey represented 20 of the 55 AEIs, the findings are reported in detail in section 4, with a summary and reflections in sub-section 4.6. Conclusions and recommendations are in section 5, including explanation of the ‘Evidence Based Model for Professional Practice Assessment’ and a set of recommended key principles for assessing practice. Next steps and future considerations are in section 6. Examples of the documents used during the survey (including the research tools: Lexicon Frameworks and Rubrics) can be found in Appendix 1, and examples of the ‘Wordles’ which initially informed the research tools are in Appendix 2. An outline of the proposed ‘Practice Assessment Toolkit’ is in Appendix 3.

2.2 Background

2.2.1 Professional regulations:

Grading of practice, contributing to degree classification, is currently mandatory for programmes leading to registration as a midwife in the UK. The Nursing and Midwifery Council defines practice in this context as direct hands-on care. The NMC stipulates that a minimum of fifty percent of the programme is based in practice - although does not specify the proportion of attributed credits - aligning with the World Health Organisation requirement of a balance between theory and practice components. The International Confederation of Midwives further stipulates that sufficient practical experience should be included in midwifery programmes to attain, at a minimum, the ICM essential competencies for basic midwifery practice. This standard is incorporated globally; examples being Australia, the European Union and New Zealand. The process of grading practice in the UK must currently be undertaken by midwives who have received specific preparation and regular updating – termed ‘sign-off mentors’. Roles for those supporting and assessing midwifery and nursing students in practice will, however, be changing in the near future.

The NMC has recently published a new educational framework for nursing and midwifery and specific standards for pre-registration nursing education. Although neither the current nursing standards nor the newly published versions against which future nursing programmes will need to be approved specifically require grading of practice, standard 4.9 requires that “there is equal weighting in the assessment of theory and practice”. In the programme of change for education, the NMC is planning to consult on the new midwifery pre-registration education standards in early 2019 with publication and implementation in 2020. It is as yet unknown whether grading of practice which contributes to degree classification will continue to be a mandatory requirement, as is currently the case, or whether individual AEIs will determine whether or not to continue this
approach. Our team is actively contributing to the body of evidence to help inform decisions, having made the publications on the first two phases of this project\textsuperscript{5, 18} available to key staff at the NMC; they will also be alerted to the findings from this final phase\textsuperscript{6}.

2.2.2 National Grading of Practice in Pre-registration Midwifery Project:

2.2.2a Rationale for project:
Although the NMC sets the standards as the professional regulatory body, application of these is the responsibility of the individual programme teams in collaboration with clinical colleagues and subject to their AEI’s regulations. The complexity of ensuring consistency, reliability and validity in practice assessment tools and approaches is challenging\textsuperscript{26, 49, 52}. In 2013, members of the Lead Midwife for Education United Kingdom (LME-UK) Executive from the 55 AEs which deliver approved pre-registration midwifery programmes in the UK expressed concerns about apparent inconsistencies between interpretation and application of the NMC standards in relation to practice assessment. The decision was made to undertake a national project with a particular focus on grading of practice in pre-registration midwifery programmes\textsuperscript{6}. A small sub-group of previous and current LMEs, with a shared interest in practice assessment, forms the project team.

2.2.2b Phase 1:
The first phase, comprising a scoping exercise within the LME-UK Executive\textsuperscript{5}, found wide variations in the grading process including timing, people involved, components of assessment and credit weighting. Similar variations in approach and application of standards have been encountered in nursing literature\textsuperscript{41, 42}. The first phase\textsuperscript{5} also identified that midwifery students’ academic profiles had increased in about 50% of the AEs since the introduction of grading of practice. Grade inflation has been reported in a number of other studies, across a range of health professions\textsuperscript{27, 33, 48, 49}. Although various ‘moderating influences’ have been introduced in midwifery programmes to ameliorate this effect\textsuperscript{5}, the findings from this first phase supported a move to reducing variations in approach to practice assessment, with the intention of strengthening the robustness of the process.

2.2.2c Phase 2:
The second phase of the project comprised two stages: a mixed-method questionnaire followed by face-to-face discussion with the LME-UK Executive, using a Mini-Delphi approach\textsuperscript{18}. Twelve statements were drawn from the findings of the original scoping phase, and a process of participatory action research achieved consensus of terminology on a set of 11 core principles for grading of practice. One of these has led to the third and final phase of the project:

“A common set of grading criteria comprising qualitative comments which would attract different types of scoring (eg: %, mark, A-F etc depending on institutional requirements and programme preferences) will be developed to enhance standardisation of the measure of competence/performance in midwifery practice across the UK” (p58)\textsuperscript{18}.

2.2.2d Phase 3:
The third and final phase of the project has therefore sought to achieve this principle. It aligns with a need identified in the wider literature to develop new methods of assessment with known validity, reliability and predictive power\textsuperscript{31}. Use of rubrics to enhance reliability and reduce grade inflation has also been recommended\textsuperscript{22}.

2.3 Aims and objectives

The aim of this final phase of the national project was to develop a future-proofed framework or rubric of generic grading criteria, with the intention of enhancing standardisation of practice assessment while enabling flexibility regarding the awarding of specific grades or broader indicators of levels of attainment.
It was proposed that this would be suitable for use throughout all midwifery programmes and with any practice assessment tool, with scope to be adapted to individual institutions, and potentially to other professions. Although some authors suggest that standardisation in professional practice assessment may not be achievable, a national tool has been developed for physiotherapy in Australia and New Zealand. In the UK, common assessment tools have been developed for midwifery in Yorkshire and Humberside and PAN London tools are being used with some success in both midwifery and nursing. This study seeks to offer an alternative approach to accommodate variations within a generic framework; future-proofing against changes to requirements – or preferences - for graded or non-graded practice assessment.
3. METHODOLOGY

3.1 Study design

A descriptive exploratory study with a comparative element was undertaken through use of a predominantly quantitative on-line survey, with opportunity for additional qualitative comments. Views were sought on existing practice assessment tools, the proposed tools and the potential for these to be used across programmes and institutions. Although the primary aim was to explore their application to midwifery, the research team decided that richer data would be obtained if nursing participants were also invited to contribute. Demographic information about professional registration and stakeholder categories was therefore identified at the start of the survey to enable separation and comparison of responses within and between midwifery and nursing as well as categories of participants.

3.2 Development of the research tools

In the scoping exercise in the first phase of the project\textsuperscript{5}, the 55 LMEs had been requested to submit their existing practice assessment documents and processes for review. A total of 28 tools were received, which represented 37 AEIs (due to the common assessment tools used in Yorkshire and Humberside and PAN London institutions\textsuperscript{5, 13}) – thus 67.2% of the tools used in midwifery across the UK. For the purposes of the third phase, a matrix was created of these collated tools for academic Levels 4-7 (SCQF 7-10) and across all descriptor levels for performance. There was a wide variation in methods of recording these performance levels, and assessment criteria were categorised as a ‘best fit’ where not all were available. In total, seven sets were created for each of Levels 4-6 (SCQF 7-9) and five for Level 7 (SCQF 10); the latter only comprised four examples of assessment tools, and levels of performance were more limited. Generic terms were used such as ‘fail, good, excellent’ for the descriptor levels. Table 1 (also in Appendix 1a) shows the categorisation identified by the research team and examples of different scoring systems in use across the country:

<table>
<thead>
<tr>
<th>Undergraduate Degree Levels 4-6; SCQF Levels 7-9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear fail</td>
</tr>
<tr>
<td>Fail</td>
</tr>
<tr>
<td>Pass</td>
</tr>
<tr>
<td>Good</td>
</tr>
<tr>
<td>Very good</td>
</tr>
<tr>
<td>Excellent</td>
</tr>
<tr>
<td>Outstanding</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Masters Level 7; SCQF Level 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsatisfactory</td>
</tr>
<tr>
<td>Satisfactory</td>
</tr>
<tr>
<td>Good</td>
</tr>
<tr>
<td>Very good</td>
</tr>
<tr>
<td>Excellent</td>
</tr>
</tbody>
</table>

Table 1: Categorisation according to scoring systems in midwifery across UK universities
These sets were initially transferred to ‘Wordles’ (or ‘Word-clouds’\textsuperscript{14}) as a visual representation of the frequency words appeared in these various assessment tools (see Appendix 2). Some key patterns emerged. With support from a research assistant, the sets were next ranked in a spreadsheet by word frequency using ‘Word Count Tool’\textsuperscript{53}, with each word collated into its root form and derivatives. The words with highest frequency, comprising those constituting at least 0.2\% of words, were transferred to a Lexicon Framework and categorised according to their parts of speech: nouns (which were further segregated into their relevance to knowledge, skills, attitudes or ‘other’\textsuperscript{6}), adjectives, verbs, adverbs and prepositions. A pragmatic approach was taken to categorisation when derivatives could be used in different contexts; the most common category of usage was applied – ensuring that this was consistent within and between academic levels. In a banner above each part of speech, those words which appeared in at least six of the seven level descriptors (Levels 4-6/ SCQF 7-9) or all five of the descriptors (Level 7/ SCQF 10) were labelled ‘Key words’.

The sets of words in the Lexicon Frameworks (see Appendix 1b) were then converted to a generic range of statements relevant to ‘Knowledge’, ‘Skills’ and ‘Attitudes’, appropriate to the descriptor levels within each academic level\textsuperscript{1, 4, 8}. These comprised the Rubrics (see Appendix 1c). A footer for each column stated the level of supervision expected and the performance according to NMC standards or requirements\textsuperscript{1}. This was included to ensure that use of the tool would remain flexible and relevant to any specific competencies or proficiencies identified by the professional body in the future.

An on-line survey questionnaire using ‘SurveyMonkey’\textsuperscript{54} was then prepared which included quantitative questions, qualitative comments and an opportunity to test the reliability and validity of the Rubrics through scenarios. The sets of Lexicon Frameworks and Rubrics were uploaded to a website, hosted by the University of Plymouth, for participants to access during the survey\textsuperscript{6}.

3.3 Ethical approval

The survey was approved for national implementation by the University of Plymouth Faculty of Health and Human Sciences Research Ethics Committee. It was confirmed that approval was not needed via the Integrated Research Application System (IRAS)\textsuperscript{55} as clinicians were not being approached in their capacity as National Health Service (NHS) staff and no part of the research was being conducted on NHS premises; they were recruited via LMEs from the databases at the AEIs.

3.4 Pilot study

The survey and assessment tools were piloted with representatives from each of the participant categories at the University of Plymouth as well as the members of the research team. The data from the pilot was excluded from the study. Some refinements were made to the survey, Lexicon Frameworks and Rubrics on the basis of the feedback received.

3.5 Recruitment of participants

The LMEs were asked to act as gatekeepers in their institutions, inviting representation from the following categories of stakeholders:
- pre-registration students;
- post-registration students on mentorship and teaching courses who would be likely to have an interest in practice assessment and would potentially support pre-registration learners when on placement (representing clinicians);
- academics delivering pre-registration programmes.
The main focus was on midwifery, but LMEs were also asked to share the invitation with nursing representatives from the same categories. Initial invitations were circulated early in March 2018, two reminders were sent out and the survey closed on 31st March 2018.

3.6 Data analysis

The filtering option in SurveyMonkey was used to separate midwifery and nursing responses, and to further distinguish between the data from the categories of academics, clinicians and pre-registration students. This enabled some comparisons to be made between and within professions. Data was scrutinised and cleansed manually where discrepancies occurred (for example, removing from the data set all participants who had not progressed further than the demographic information).

Descriptive statistical analysis of quantitative components (giving numbers and percentages) was undertaken. The Principal Investigator undertook the initial full analysis, and this was cross-checked by another member of the team. The quantitative data analysis was then reviewed by the whole team via email and a face-to-face meeting.

Thematic content analysis of qualitative data was undertaken. The Principal Investigator analysed the full set of data, and each member of the team independently analysed a section. Codes and themes were cross-checked and agreed at the face-to-face team meeting.
4. FINDINGS

For ease of reading and differentiation between professional groups when reporting the findings, capitals have been applied throughout this section when referring to Midwifery or Nursing, although it is acknowledged that this is not common practice.

Coding of qualitative quotations is shown in Table 2:

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Status or area of work</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>Midwife</td>
<td>RMA6 = Registered midwife employed by the university as a lecturer/ academic member of staff</td>
</tr>
<tr>
<td>N</td>
<td>Nurse</td>
<td>RNC4 = Registered nurse working in the clinical setting and employed by a hospital or community trust/ government/ private and voluntary sector/ other or is self employed</td>
</tr>
<tr>
<td>S</td>
<td>Student</td>
<td>SM7 = Student undertaking a programme in preparation for registration as a midwife</td>
</tr>
<tr>
<td>A</td>
<td>Academic</td>
<td>SN2 = Student undertaking a programme in preparation for registration as a nurse</td>
</tr>
<tr>
<td>C</td>
<td>Clinician</td>
<td></td>
</tr>
</tbody>
</table>

Table 2: Key for qualitative codes

4.1 Profiles of participants

4.1.1 Distribution:
Response rate of 170 participants (excluding non-respondents to the survey itself), representing 20 of the 55 AEIs and associated practice placements across the United Kingdom (36.36% representational response). Participants were based in England, Scotland and Wales.

![Figure 3: Country in the UK in which participants were practising or studying](image)

4.1.2 Registration:

![Figure 4: Main registration of participants](image)
4.1.3 Categories of participants:

Of the total participants (N=170), proportionate percentages of stakeholder categories comprising academics, clinicians and pre-registration students in both Midwifery and Nursing is seen in Table 3:

<table>
<thead>
<tr>
<th></th>
<th>MIDWIFERY (n=134)</th>
<th>NURSING (n=36)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academics</td>
<td>64 n=47.76% (37.65% of N)</td>
<td>15 n=41.67% (8.82% of N)</td>
</tr>
<tr>
<td>Clinicians</td>
<td>14 n=10.45% (8.24% of N)</td>
<td>8 n=22.22% (4.71% of N)</td>
</tr>
<tr>
<td>Students</td>
<td>56 n=41.79% (32.94% of N)</td>
<td>13 n=36.11% (7.65% of N)</td>
</tr>
</tbody>
</table>

Table 3: Categories of participants

4.1.4 Quantitative analysis:

- All of the UK apart from Northern Ireland was represented. Numbers were small overall, but proportions were fairly representative of the number of institutions delivering pre-registration Midwifery programmes in the different countries.
- Nearly four times as many Midwifery participants responded than Nursing.
- Similar proportions were noted between Midwifery and Nursing, and between academics and students in each of these professions. This facilitated some descriptive analytical comparisons. Proportionately fewer Nursing clinicians participated, however.

4.2 Current practice assessment tool

- No missing data; N=170 throughout this section

4.2.1 Confidence in reliability and/or validity of current practice assessment

![Figure 5: Comparison between midwifery and nursing: Confidence with current practice assessment tool](image)

4.2.1a Comparison between Midwifery and Nursing responses:

- Midwifery participants = 134 (100%, N=134)
- Nursing participants = 36 (100%, N=36)
- Similar pattern, but Midwifery participants (48.51%) indicated higher confidence levels ('confident' or 'very confident') than Nursing (27.78%).
4.2.1b Comparison between categories (academics, clinicians, students):

- In Midwifery, clinicians were the most confident (74.29%, n=9, N=14), followed by academics (51.56%, n=33, N=64) and then students (41.07%, n=23, N=56) who identified ‘very confident’ or ‘confident’
- In Nursing, clinicians were again the most confident (50%, n=4, N=8), followed by academics (26.67%, n=4, N=15) and students (15.38%, n=15.38%, N=13)

4.2.1c Quantitative analysis commentary:

- Across both Midwifery and Nursing, less than 50% of participants stated that they were ‘confident’ or ‘very confident’ in the reliability and or validity of their current assessment tool. When breaking the data down into sub-categories, however, there were noticeable differences between groups in Nursing, with students particularly lacking confidence in the existing tool. All categories in Midwifery appeared much more confident than their Nursing counterparts.
- In both Midwifery and Nursing, clinicians were most confident in the reliability and validity of assessment tools, and students the least.
- The wide range of assessment tools represented across the AEIs, and unknown proportion of participants using the same tool, limits other analysis.

4.2.1d Qualitative analysis commentary:

- Qualitative comments = 70
- The majority of qualitative responses were from Midwifery participants; the messages from Nursing were, however, very similar.
- All sub-categories expressed similar concerns. Academics focused more on the structure of the tool with both positive and negative comments – students and clinicians focused more on the assessor themselves, in general.
- The validity of the tool itself seemed to be more positively viewed than reliability of the process – the latter being very dependent on individual mentors’ perceptions, interpretations, approaches and application of the tool – the term ‘subjectivity’ was frequently used to reflect this. Large numbers of mentors using the documentation also contributed to perceptions of subjectivity.
- Some participants noted that the grade awarded was influenced by the relationship between the student and mentor, such as a previous working context (e.g.: care assistant).
- Comments were made that some mentors tended to award lower grades in earlier stages of the student’s programme – benchmarking them against expectations at point of registration (e.g.: SM39 quotation).
- Some participants highlighted that they had worked hard on new iterations of their documentation to improve the wording and offer guidelines to aid interpretations, with one saying it was now excellent. Several comments also identified that tripartite assessments helped reduce subjectivity.
- A number of themes were identified. Some had sub-themes eg: ‘Human factors’ comprised ‘subjectivity’ and ‘personal interpretation’. Positive comments were included under the relevant main themes.

- **Themes and sub-themes:**
  
  i. **Human factors**
     - Subjectivity – different people/ expectations/ parameters of measurement/ human errors
     - Personal interpretation – varying opinions/ perceptions/ harshness of the grader
     - Mentor-student relationship – personality/ existing friendships or professional history
     - Student’s experience - exposure/ placement
  
  ii. **The art of mentoring**
     - Understanding (positive) - increased understanding of the assessment process/how to apply the assessment criteria
     - Application (positive) – moving away from grade inflation
     - Application (negative) – not assessing underlying knowledge and grading accordingly, not reading or using documentation, incorrectly applying tool including reservations
about higher scores/ not using the full range, grading according to own expectations/ norm-referencing
- Accountability of role - competence as a health professional required

iii. Structure of the tool
- Simplification - descriptors wordy
- Differentiation – repetitive, more specificity needed in tool, more robust documentation needed with less subjective areas
- Quality assurance (positive) - validity of tool ++, some tools had improved (eg: PAN London, PAD), more confidence in current process, detailed descriptor of grade bands, traffic light and benchmark system, tripartite assessment/ academic moderation
- Quality assurance (negative) – tool skewed final degree classification

iv. Ongoing guidance and support of the assessor
- Clarification and guidance (positive) - some guidelines had improved
- Clarification and guidance (negative) - lack of clear guidance

v. Other factors
- Constraints – low staffing, mentor pressures
- Involvement of others - lack of triangulation

vi. Purpose
- Safe practice – tool enables determination of competence and failing student

“There is a wide variation in what different mentors expect from a student with some questioning the student to assess underlying knowledge or being open to questioning themselves whilst for others – be nice, carry the bag and do what I do being enough to secure a good grade.” (RMA3)

“I would say that I was confident in my own skills in order to achieve a successful outcome in placement areas, however, this also depends on what I am exposed to, where my placement area is and what kind of mentor I have. If my mentor is not familiar or confident with assessment criteria or procedures, this may impact on grading. Therefore if the same assessment is repeated, there may be different outcomes, due to individuality.” (SM26)

“Some mentors are unaware of how the grading criteria should be applied to students clinical practice therefore grading students lower in first year thinking they are unable to achieve a high grade.”(SM39)

“Some mentors are more harsh when grading students than others. Other mentors have also known some student midwives from when they were maternity assistants and have socialised with them outside of work, they have been known to grade these students very well, and I am not sure whether those students would have received the same grading from a different mentor who they did not know well.” (SM41)

“Reliability can be impaired by individual differences of opinion. In order to improve this (and assist with validity), the documentation needs to be more robust with less subjective areas – however, this is difficult as we are dealing with individuals and a lot of potential variables.” (RMA62)
4.2.2 Improvements to make the current practice assessment tool more reliable and valid:

Figure 6: Enhancing reliability and validity of current practice assessment tools

4.2.2a Comparison between Midwifery and Nursing responses:
- Midwifery participants = 134 (85.07%, N=134)
- Nursing participants = 36 (75%, N=36)
- Multiple options were available in this question.
- Overall, responses were very similar.
- More Midwifery participants appeared satisfied with the reliability and validity of their assessment tool, stating that ‘no improvements needed’ (7.46%) compared with Nursing (2.78%).
- No Nursing participants said that ‘fewer people should contribute to the assessment’, whereas 3.73% Midwifery participants stated that this would improve their tool.

4.2.2b Comparison between categories (academics, clinicians, students):
- In Midwifery, the main difference related to ‘wording needs to be clearer/ less ambiguous’ which was most highly rated by students (73.21%, n=41, N=56) compared with 43.75% academics and 35.71% clinicians. Clinicians rated ‘there needs to be a clearer written explanation of how to award the grade/ identify the level of performance’ highest (42.86%, n=6, N=14). Academics similarly rated this highest, together with ‘more preparation is needed for those who are assessing practice’ (53.13%, n=34, N=64) for each. Students also rated the statement ‘there needs to be a clearer written explanation of how to award the grade/ identify the level of performance’ highly (70.43%, n=40, N=56). In all sub-categories, ‘fewer people should contribute to the assessment’ was rated lowest.
- In Nursing, academics rated ‘more preparation is needed for those who are assessing practice’ highest (80%, n=12, N=15), clinicians rated ‘wording needs to be clearer/ less ambiguous’ highest (87.50%, n=7, N=8) and students gave equal highest rating to this and ‘there needs to be a clearer written explanation of how to award the grade/ identify the level of performance’ (61.54%, n=8, N=13). No Nursing participants stated that ‘fewer people should contribute to the assessment’.

4.2.2c Quantitative analysis commentary:
- The most popular improvement was ‘there needs to be a clearer written explanation of how to award the grade/ identify the level of performance’ (58.82% total participants). This was rated highly across both professions and the majority of sub-categories. This was closely followed by ‘wording needs to
be clearer/ less ambiguous’ (55.88%) and ‘more preparation is needed for those who are assessing practice’ (55.29%). It was therefore evident that clarity and guidance were of particular importance, and this was further supported in the breakdown of data for professions and sub-categories.

- Across both professions and all sub-categories there was very little appetite for fewer people to contribute to the assessment.
- Academics in both Midwifery and Nursing rated preparation of those assessing practice of greater importance than clinicians or students, whereas the wording of the tool was more important to both of these groups, incorporating both the clarity of terminology and written explanation on how to award the grade.

4.2.2d Qualitative analysis commentary:

- Qualitative comments = 37
- Midwifery participants provided the majority of the qualitative comments, although there were fewer than in the previous question. Academics particularly focused on mentor understanding and application as well as making comments about supporting mentors. Students’ comments focused particularly on the clarity of wording and specificity of criteria. Very few comments were made by clinicians.
- Minimal additional comments were made by Nursing participants. Academics highlighted failing to fail students, grade inflation and the need for greater simplification of the assessment tool. Students noted issues with mentors’ reluctance to grade higher. No clinicians made comments.
- Clinicians were less vocal in the qualitative element of the question. This may have been due to the provision of options in the question, rather than it being open-ended. Time pressures of answering the survey could also have contributed.
- It was suggested that better preparation of mentors and constant reinforcement could reduce variations in grading. There was a need for them to understand the importance of assessing the student as competent at the point in their programme and not as qualified midwives. Mentors also need to make their assessments based on the student’s performance, and not because they ‘like’ them.

- **Themes and sub-themes:**
  i. Human factors
    - **Subjectivity ++**
    - **Personal interpretation** - inconsistency between mentors, variation in expectation
    - **Mentor-student relationship**
  ii. Art of mentoring
    - **Application** - level of performance in relation to stage ++ not always understood/ applied, not to grade as qualified, top end of marks to be used, avoid grade/ degree inflation
    - **Accountability of role** - honest and correct use of tool, reading guidance, ownership of concerns, responsibility for ‘failing to fail’
  iii. Structure of the tool
    - **Simplification** - language verbose/ abstract, avoid unclear wording/ ambiguity, too many variables, remove grading
    - **Differentiation** - avoid repetition/ overlap between competencies and criteria, distinction between levels needed/ more specific for each year
    - **Quality assurance** – reinforce grade to enable consistency, moderate sign-off mentors
    - **Accessibility** - use of technology, needs to be electronic for more frequent access
  iv. Ongoing guidance and support of the assessor
    - **Clarification and guidance** - clear explanations needed, guidance on request, examples
    - **Preparation** - limited time/ opportunity to prepare mentors
    - **Support** - mentors often grading without support from academics, limited time to support them
  v. Other factors
    - **Constraints** - difficult for student to request a change of mentor, proportion of time with mentor/ student
vi. **Purpose of assessment**

- **Safe practice** – reason for using criteria/ correct use to ensure fail if needed
- **What to assess** – physical skills/ attributes/ knowledge/ some mentors assess ‘likability’ rather than performance or knowledge

“Liaison between different mentors. This is difficult with current clinical demands, but for some students several mentors may have expressed concerns but nothing is recorded, with each being reluctant to be the one to formally raise an issue.” (RMA3)

“It’s not about the tool but the confidence to use it honestly.” (RMC4)

“Many students in my cohort were given a low pass rate as our mentors were comparing us as first years to current third years and newly qualified. More instructions need to be given to mentors.” (SM14)

“Preparation for assessment in practice is significantly lacking (in my personal experience). Mentors do not understand the assessment process and grade students on factors such as ‘likability’ rather than performance or knowledge to practice.” (RMA17)

“Get rid of grading – hasn’t improved anything and inflates degree passes. A first in midwifery means nothing!” (RMA29)

“There continue to be problems with mentors ‘failing to fail’ in practice and excessively high marks given when grading is used.” (RNA8)

“When a student is good/ passing mentors decide what grade they want to give without reviewing the criteria. It is only when a student isn’t doing as well as the mentor thinks they should that the criteria comes into focus for them. Greater preparation and assessment of knowledge rather than just relying on what they witness in practice is needed.” (RMA61)

### 4.2.3 Factors which may contribute to a robust and reliable assessment process:

<table>
<thead>
<tr>
<th>STATEMENTS</th>
<th>SCORE</th>
<th>RANKING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(in descending order of importance)</td>
</tr>
<tr>
<td>The focus should be on objectively assessing the student’s performance in relation to knowledge, skills and personal attributes in the context of professional behaviour against set criteria, rather than just a subjective judgement of the individual</td>
<td>6.02</td>
<td>1</td>
</tr>
<tr>
<td>A clear set of statements needs to be provided, which is linked to specific grades/ descriptors/ symbols indicating level of performance (ie: a rubric)</td>
<td>5.56</td>
<td>2</td>
</tr>
<tr>
<td>The same assessment tool should be used nationally so that there is consistency</td>
<td>4.82</td>
<td>3</td>
</tr>
<tr>
<td>The assessment tool should be developed and reviewed by a team of key stakeholders (e.g.: clinicians, academics, students)</td>
<td>4.77</td>
<td>4</td>
</tr>
<tr>
<td>Academics should provide support to the clinicians who are responsible for assessing practice</td>
<td>4.46</td>
<td>5</td>
</tr>
<tr>
<td>Specific grades or symbols should be awarded, rather than pass/ refer</td>
<td>3.45</td>
<td>6</td>
</tr>
<tr>
<td>Those responsible for assessing students should apply the NMC Code (2015) to the process</td>
<td>3.45</td>
<td>6</td>
</tr>
<tr>
<td>Students should contribute to their own assessment</td>
<td>3.45</td>
<td>6</td>
</tr>
</tbody>
</table>

*Table 4: Overall ranking of factors contributing to robust and reliable assessment*
4.2.3a Comparison between Midwifery and Nursing responses (Table 5):

- Midwifery participants = 134 (85.07%, N=134)
- Nursing participants = 36 (75%, N=36)
- The focus on objectively assessing students’ performance against set criteria was consistently ranked highest in both Midwifery and Nursing as well as the full set of data.
- The use of a Rubric to support grades was ranked higher in Midwifery (2) than Nursing (4). This contrasted, however, with the higher ranking of ‘Specific grades or symbols should be awarded, rather then pass/refer’ in Nursing (6) than Midwifery (8).
- The involvement of students in contributing to their own assessment was ranked higher for Midwifery (6) than Nursing (8).
- Other statements were ranked consistently between Midwifery, Nursing and the total data.

<table>
<thead>
<tr>
<th>STATEMENTS</th>
<th>OVERALL RANKING</th>
<th>MIDWIFERY</th>
<th>NURSING</th>
</tr>
</thead>
<tbody>
<tr>
<td>The focus should be on objectively assessing the student’s performance in relation to knowledge, skills and personal attributes in the context of professional behaviour against set criteria, rather than just a subjective judgement of the individual</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>A clear set of statements needs to be provided, which is linked to specific grades/ descriptors/ symbols indicating level of performance (ie: a rubric)</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>The same assessment tool should be used nationally so that there is consistency</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>The assessment tool should be developed and reviewed by a team of key stakeholders (e.g.: clinicians, academics, students)</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Academics should provide support to the clinicians who are responsible for assessing practice</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Specific grades or symbols should be awarded, rather than pass/refer</td>
<td>6</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Those responsible for assessing students should apply the NMC Code (2015) to the process</td>
<td>6</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Students should contribute to their own assessment</td>
<td>6</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>

*Table 5: Comparative ranking of factors contributing to robust and reliable assessment*

4.2.3b Comparison between categories (academics, clinicians, students):

- In Midwifery, the pattern of ranking was virtually identical across all categories. All ranked ‘the focus should be on objectively assessing the student’s performance in relation to knowledge, skills and personal attributes in the context of professional behaviour against set criteria, rather than just a subjective judgement of the individual’ highest. A slight difference arose in which students identified ‘those responsible for assessing students should apply the NMC Code (2015) to the process’ marginally less important than ‘students should contribute to their own assessment’, with the weighting being opposite this in both academic and clinician sub-categories.

- In Nursing, less homogeneity was evident although rankings were not dissimilar. Key exceptions were that ‘the same assessment tool should be used nationally so that there is consistency’ was ranked highest by clinicians (score 7.25 compared with 5.27 for academics and 4.17 for students). ‘The assessment tool should be developed and reviewed by a team of key stakeholders’ was ranked higher by students (score 6.08) than academics (4.67) or clinicians (4.63). All groups stressed the importance of ‘the focus should be on objectively assessing the student’s performance in relation to knowledge, skills and personal attributes in the context of professional behaviour against set criteria, rather than just a subjective judgement of the individual’.

4.2.3c Quantitative analysis commentary:

- There was consistency in the top ranked statement relating to judging performance rather than the individual.
• There was clearly an appetite for standardisation of the assessment tool to enhance rigour across both professions and all sub-categories.
• Key stakeholders should be involved in the development and review of assessment tools.
• Nursing participants’ greater preference for ‘specific grades should be awarded, rather than pass/refer’ may have reflected the absence of an NMC requirement for grading in this profession. Midwifery responses were unexpectedly low for this statement, which may have reflected concerns about the robustness and fairness of the existing grading process. It was particularly interesting that – despite benefitting from the higher grades attracted by practice assessment – students did not rank this highly.
• Despite the recommendation of involvement of students in self-assessment in some literature, this did not appear to be of high importance – particularly in Nursing.

4.3 Lexicon Frameworks (see Appendix 1b)

• 29 participants skipped this section, so N=141 throughout.

4.3.1 Potential use of the Lexicon Frameworks:

4.3.1a Comparison between Midwifery and Nursing responses:
• Midwifery participants = 114 (85.07%, N=134)
• Nursing participants = 27 (75%, N=36)
• Multiple options were available in this question.
• Midwifery participants’ responses reflected those of the whole data set.
• Nursing participants’ responses were more homogenous, although ‘when writing evidence to support a mentor’s assessment of a student’s progress’ was particularly favoured (62.96%).
• Very similar proportions of each sub-group stated that they would not find them useful in any of the circumstances (14.91% Midwifery, 11.11% Nursing).
4.3.1b Comparison between categories (academics, clinicians, students):

- In Midwifery, there were some clear differences between categories. The most popular choices were:
  - Academics = ‘when developing a practice assessment document for a new pre-registration programme’ (77.19%, n=44, N=57) followed by ‘when writing evidence to support a mentor’s assessment of a student’s progress’ (57.89%, n=33, N=57)
  - Clinicians = ‘as the main tool when grading a pre-registration student’ (80%, n=8, N=10) followed by ‘when writing evidence to support a mentor’s assessment of a student’s progress’ (70%, n=7, N=10)
  - Students = ‘when writing evidence to support a mentor’s assessment of a student’s progress’ (48.94%, n=23, N=47) closely followed by both ‘when developing a practice assessment document for a new pre-registration programme’ and ‘when writing evidence to support a student’s self-assessment of their own progress’ (44.68%, n=21, N=47).

Therefore, the most commonly popular for all Midwifery categories was ‘when writing evidence to support a mentor’s assessment of a student’s progress’. The lowest for all was ‘I would not find them helpful in any of the above circumstances’ (academics=14.04%, clinicians=10%, students=17.02%)

- In Nursing, the most popular choices were:
  - Academics = ‘when developing a practice assessment document for a new pre-registration programme’ and ‘when writing evidence to support a mentor’s assessment of a student’s progress’ equally (75%, n=9, N=12)
  - Clinicians = equal weighting to ‘when developing a practice assessment document for a new pre-registration programme’ and ‘when writing evidence to support a student’s self-assessment of their own progress’ (71.43%, n=5, N=7)
  - Students = equal top weighting to three responses: ‘when writing evidence to support a mentor’s assessment of a student’s progress’, ‘when writing evidence to support a student’s self-assessment of their own progress’ and ‘as the main tool when grading a pre-registration student’ (50%, n=4, N=8).

As with Midwifery, the lowest response in each Nursing category was ‘I would not find them helpful in any of the above circumstances’ (academics=16.67%, clinicians=0%, students=12.5%). Of note, however, one of these academics noted in the qualitative responses that the Lexicon Framework was “such a useful resource”.

4.3.1c Quantitative analysis commentary:

- Participants appeared overall positive about the potential for the Lexicon Frameworks to be useful in some capacity. Only 14.18% stated that they would not find them helpful in any of the situations presented, and this was consistent across both Midwifery and Nursing.

- The most popular circumstances were ‘when developing a practice assessment document for a new pre-registration programme’ (58.87%) and ‘when writing evidence to support a mentor’s assessment of a student’s progress’ (56.74%); Nursing participants being particularly in favour of the latter.
4.3.1d Qualitative analysis commentary:

- Qualitative comments = 20
- Qualitative comments were predominantly negative as the question had requested that participants provide a rationale if they had not found the Lexicon Frameworks helpful in any of the circumstances presented; these had comprised only 20 participants (14.18%). Of these, one stated they had not been able to access them, one said ‘N/A’ and one that it was a useful resource. There were therefore only 17 negative comments from 121 participants, and two of these also included positive statements relating to the quality of the proposed Lexicon Frameworks.
- Clinicians seemed very positive overall, although academics appeared less certain about the purpose.
- The rationale provided by Midwifery academics to explain why they did not think the Lexicon Frameworks would be useful focused on not understanding their purpose, whereas students were more specific about the detail of words/structure. Only one clinician amongst all participants did not think that they would be helpful, stating that their existing system was similar but easier to view.

- **Themes and sub-themes:**
  - **ii. Art of mentoring**
    - Understanding – don’t understand the use of [Framework], clinicians would struggle, high degree of professional and academic understanding needed
    - Application – everyday vocabulary so how would this support?
  - **iii. Structure of the tool**
    - Simplification - over-complicated, too much information, too many derivatives, confusing ++, vague, current system similar but easier to view
    - Differentiation - needed between grades/levels ++, more variation across columns
    - Quality assurance (positive) – great idea, useful resource, key words more intuitive and helpful
  - **iv. Ongoing guidance and support of the assessor**
    - Clarification and guidance - practitioners need simple explanation
  - **vi. Purpose of assessment**
    - Transferability (positive) - could be useful if purpose/use understood

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“I feel that they could be useful if only I understood more about the purpose of the lexicon and how it is used.” (RMA1)

“Great idea but at the moment it is over complicated and ambiguous; my view is that clinicians would struggle with it.” (RMA2)

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4.3.2 Suggestions for improvement of the Lexicon Frameworks:

- Qualitative comments = 90
- Several suggestions were made which ranged from the global context of the tool to specifics of detail. The messages from Midwifery academics and students were very similar, covering the full range of themes. Clinicians were less vocal, with only four making brief comments linked to the sub-theme ‘clarification and guidance’. Amongst Nursing participants, four in each sub-category made comments but not all identified improvements. All Nursing responses reflected the same themes as Midwifery.
- Positivity was demonstrated, as some participants expressed an interest in the Lexicon Frameworks being developed further, refining and updating it.

- **Themes and sub-themes:**
  - **iii. Structure of the tool**
    - Simplification – liked simplicity (positive), need fewer derivatives, reduce number of words++, less repetition, less academic words
Differentiation – need discrete terms/ clearer categories ++, specific terms for grades/ levels, fewer categories/ grade bands, include level descriptors within each box, add grading bands/ percentages in headings, list of words with score depending on context, colour coding, sub-categorise adjectives/ verbs

Quality assurance (positive) – grading system excellent, would ensure a fairer grade, no further suggestions, develop/ refine/ update

Accessibility – electronic for access by students/ assessors/ more widely available and easily accessible, make more user-friendly: key words, appearance

iv. Ongoing guidance and support of the assessor
   - Clarification/ guidance - more explanation of how to use/ interpret/ clearer to understand ++, definitions needed/ clarify terms and purpose, explain how to move beyond categories/ achieve higher grades, include description of what students would ‘look like’

vi. Purpose of assessment
   - Safe practice (positive) – would encourage self-improvement
   - What to assess - link to NMC standards, more holistic, articulate professionalism, add words eg: safe/ minimal or indirect supervision/ observational/ reflective and reflexive practice/ synthesis L6-7/ clinical skills, include bullet points for students to meet/ range of statements

i. Standardisation
   - Transferability (positive) – ensure standardisation achieved across all universities, make more widely available, great start

“Make the difference between each category very clear, this way students can understand how to progress from one category to the next one.” (SM7)

“Reduce the number of words within the lexicon as there may be too many for busy mentors to review.” (RMA12)

“Ensure that students and mentors have them electronically and that IT systems are in place to support them, enabling feedback that would be in line with the terminology of the Lexicon Frameworks and therefore fair, reliable and more accurate.” (RMA17)

“Transforming the lexicon frameworks into a digital tool which students/assessors can access to evaluate work would be advantageous as this would encourage self-improvement in students and assist assessors in grading consistently.” (SM26)

“A description of what a student should ‘look like’ at each level i.e.: A good student will be able to...in relation to the words on the framework.” (RMA43)
4.4 Rubrics (see Appendix 1c)

- 44 participants skipped this section, so N=126 throughout.

4.4.1 Scenario 1: Justina, a first-year student at the end of her community placement, undertakes booking appointments in a structured and woman-centred way, participates confidently in antenatal clinics and conducts postnatal examinations of women and their babies under direct supervision of the midwife. Her knowledge of basic Midwifery theory is generally very good. She has recently identified that she is hesitant about discussing screening choices, but is planning to read up further on the evidence to gain more confidence. What overall grade would you give this student, using the rubric for academic level 4 (SCQF 7)?

**Figure 9: Comparison between midwifery and nursing: Scenario 1 - Justina**

4.4.1a Comparison between Midwifery and Nursing responses:
- Midwifery participants = 105 (78.36%, N=134)
- Nursing participants = 21 (58.33%, N=36)
- Midwifery participants strongly favoured ‘very good’ (60.95%) compared with Nursing, who also favoured this by a narrow margin (38.10% for ‘very good’ and 38.33% for ‘good’).
- The profiles were otherwise similar, with a bell-shaped distribution curve (although slightly skewed to the right for Nursing).

4.4.1b Comparison between categories (academics, clinicians, students):
- In Midwifery, academic and students demonstrated virtually identical profiles, reflecting that of the main data, and with ‘very good’ clearly the most popular (65.38% and 56.82% respectively). The majority of clinicians also identified ‘very good’ most frequently (55.56%), but ‘good’ followed fairly closely (33.33%).
- In Nursing, the greatest consistency was demonstrated by clinicians, all of whom scored ‘good’ (60%) or ‘very good’ (40%). Students were next most consistent, with the majority scoring ‘very good’ (57.14%), 28.57% ‘excellent’ and 14.29% ‘good’. The most variation was seen amongst academics, with 33.33% scoring ‘good’ and 22.22% equally ‘pass’, ‘very good’ and ‘excellent’.
- In all but one category, the intended grade of ‘very good’ was most commonly scored. The only exception to this was Nursing academics.
4.4.1c Quantitative analysis commentary:
- The majority of respondents in all groups (57.14% overall) identified the grade as ‘very good’, which was what had been intended in the scenario. This consistency suggests an element of inter-assessor reliability.
- It was understandable that there was greater consistency between Midwifery participants as they would have been more familiar with the profession/ context and programme requirements and probably had experience of assessing (or being assessed as) first year students. It was, however, reassuring that Nursing also focused on the ‘middle’ grades of ‘good’ or ‘very good’.
- All graphs showed a bell-shaped distribution curve with minimal outliers, although Nursing showed a slightly positive skew.

4.4.2 Scenario 2: Phoebe, who is completing her second year, applies theory to practice and her clinical skills are sound. She needs to be more proactive in explaining care decisions, especially when there are deviations from the normal. She undertakes conversations with women regarding options for pain relief and adapts her style to accommodate differences in women’s prior knowledge when communicating with them. She has identified that she would like to be more confident in approaching members of the wider multi-disciplinary team in her next placement. What overall grade would you give this student, using the rubric for academic level 5 (SCQF 8)?

![Figure 10: Comparison between midwifery and nursing: Scenario 2 - Phoebe](image)

4.4.2a Comparison between Midwifery and Nursing responses:
- Midwifery participants = 105 (78.36%, N=134)
- Nursing participants = 21 (58.33%, N=36)
- Midwifery participants strongly favoured ‘good’ (62.86%) compared with Nursing, who slightly favoured ‘very good’ above this by a narrow margin (42.86% for ‘very good’ and 38.10% for ‘good’).
- The profiles were otherwise similar, with a bell-shaped distribution curve.

4.4.2b Comparison between categories (academics, clinicians, students):
- In Midwifery, all sub-categories scored ‘good’ most frequently (academics = 67.31%, clinicians = 55.56%, students = 59.09%). Clinicians were most consistent, with the remainder scoring ‘very good’ (44.44%). All categories included ‘very good’ as an option, with 19.23% academics also stating ‘pass’ and 9.09% students also stating ‘excellent’.
• In Nursing, academics were most consistent, with 55.56% scoring ‘very good’ and 44.44% ‘good’. The clinicians were the most accurate, with the majority (60%) scoring ‘good’. Students showed the greatest range of responses, from ‘pass’ to ‘excellent’.

• There was consistency within and between professional groups insofar that ‘good’ (the intended grade) and ‘very good’ were the most commonly scored. Clinicians in both professions were most consistent.

4.4.2c Quantitative analysis commentary:

• The majority of respondents (58.73%) identified the grade as ‘good’, which was what had been intended in the scenario. This consistency suggests an element of inter-assessor reliability.

• It was understandable that there was greater consistency between Midwifery participants as they would have been more familiar with the profession/ context and programme requirements and probably had experience of assessing (or being assessed as) second year students. It was, however, reassuring that Nursing also focused on the ‘middle’ grades of ‘good’ or ‘very good’.

• All graphs showed a bell-shaped distribution curve with minimal outliers, although Midwifery was slightly skewed to the left. Perhaps Midwives have higher expectations, or their responses may reflect their the need for autonomous practice at point of registration in this profession.

4.4.3 Scenario 3: In her final placement Grace, a third-year student, has forgotten to listen to the fetal heart when admitting women in labour on three separate occasions. The mentor, Tim, has had to remind Grace to undertake this care. On one occasion Grace had not anticipated birth despite changes in the woman’s behaviour, and this resulted in a formal complaint. This has made Tim hesitant to leave Grace unsupervised with women. Tim does, however, note that Grace is always kind and compassionate to the women and works well within the team. What overall grade would you give this student, using the rubric for academic level 6 (SCQF 9)?

Figure 11: Comparison between midwifery and nursing: Scenario 3 - Grace

4.4.3a Comparison between Midwifery and Nursing responses:

• Midwifery participants = 105 (78.36%, N=134)
• Nursing participants = 211 (58.33%, N=36)

• All participants strongly favoured ‘fail’ (64.29% overall; Midwifery 60.95%; Nursing 80.95%).
• In Midwifery, 88.57% identified ‘fail’ or ‘clear fail’, which was very similar to 85.71% in Nursing, although more Midwifery participants made a distinction between the two degrees of failure.

• The profiles were otherwise similar, although Midwifery had one outlier who awarded ‘excellent’.
4.4.3b Comparison between categories (academics, clinicians, students):

- In Midwifery, although there was overall consistency between academics and clinicians in failing ‘Grace’, one academic awarded a pass. There was great variation in the students’ scoring, however. Although the majority failed ‘Grace’ (75%), 18.18% (n=8) awarded a ‘pass’, 4.55% (n=2) stated ‘good’ and 2.27% (n=1) ‘excellent’.
- In Nursing, the vast majority of participants in all categories failed ‘Grace’ (academics = 88.89%, clinicians = 80%, students = 85.72%). One clinician and student awarded a ‘pass’ and one academic stated ‘good’.
- In all categories, numbers were small amongst those who passed ‘Grace’.

4.4.3c Quantitative analysis commentary:

- The variation among Midwifery students was surprising, and a little concerning. This was an interesting finding, as it raised questions about the students’ interpretation and appreciation of the importance of safe practice – thus linking with the theme of ‘Purpose of assessment’.
- The very clear majority of respondents correctly identifying that ‘Grace’ had not achieved provided evidence of a high level of consistency and therefore inter-assessor reliability. It was notable that the profiles were so similar, despite the different professional groups.
- This finding reflects some of the wider literature, which suggests that it can be easier to determine ‘pass/ refer’ compared with more specific grading. It is, however, interesting that there was more specificity in the distinction between ‘clear fail’ and ‘fail’ amongst Midwifery participants, and this may be due to the greater familiarity with awarding specific grades compared with Nursing, in which it is currently not mandatory to grade practice.

4.4.4 Scenario 4: Alba is at the end of her three-year Midwifery programme, which she is undertaking at masters level. She is able to prioritise care for six women at a time on the postnatal ward, including those with complications. Her knowledge is sound and her practice is well organised, but she has a tendency to take a task orientated approach to her responsibilities. She is, however, caring to the women. Throughout her programme, Alba has shown a willingness to respond to feedback. What overall grade would you give this student, using the rubric for academic level 7 (SCQF 10)?

Figure 12: Comparison between midwifery and nursing: Scenario 4 - Alba
4.4.4a Comparison between Midwifery and Nursing responses:
- Midwifery participants = 105 (78.36%, N=134)
- Nursing participants = 21 (58.33%, N=36)
- Profiles were overall similar, although Midwifery had 2 (1.90%) outliers who awarded ‘unsatisfactory’ and 11 (10.48%) who awarded ‘excellent’; a greater range of grades was therefore evident than in Nursing.

4.4.4b Comparison between categories (academics, clinicians, students):
- In Midwifery, there was greatest discrepancy in this scenario, across all categories. Although ‘good’ and ‘very good’ were most popular (academics = 61.54%, clinicians = 88.89% and students = 70.45%), all grades were included by students, four of the five by academics and three by clinicians.
- In Nursing, grading was more consistent across the categories – with all identifying only ‘satisfactory’, ‘good’ and ‘very good’. As in Midwifery, ‘good’ and ‘very good’ were most popular (academics = 88.89%, clinicians = 80%, students = 85.74%).

4.4.4c Quantitative analysis commentary:
- Findings were less decisive across groups in this scenario. The intended grade had been ‘good’, and 34.92% participants awarded this grade. There was some consistency in that 89.68% awarded grades of ‘satisfactory’, ‘good’ or ‘very good’ – although it was noted that Midwifery participants included outliers on both sides of this range.
- Greater consistency across the categories was demonstrated in Nursing than Midwifery, which may have suggested greater objectivity due to unfamiliarity with the Midwifery programme and grading process.
- It is unclear what the rationale was for the noticeably weaker inter-assessor reliability in this scenario compared with those for Levels 4-6 (SCQF 7-9). Some of the practicalities in devising this scenario are outlined below, and may have been contributory factors. Other suggestions relating to assessing practice at masters level are briefly discussed in section 4.6.
  - The Rubrics had been developed from the assessment tools provided by LMEs, and only 4 examples at masters level were available, compared with 28 of Levels 4-6 (SCQF 7-9). The Lexicon Frameworks from which they had been derived were therefore briefer, with less variation in terminology. It is evident from some of the qualitative responses that there were ‘missing’ words which individuals had expected to see in this particular Rubric. Only 5 categories were used, compared with the 7 in Levels 4-6 (SCQF 7-9).
  - The ‘Wordles’ (see Appendix 2) used for visual representation of the Lexicon Frameworks omitted any reference to the NMC in L7 (SCQF 10) and there was a marked emphasis on ‘student’ in contrast to the consistently high frequency of ‘practice’ and appearance of ‘NMC’ in the L4-6 (SCQF 7-9) Wordles and Lexicon Frameworks.
  - As with all the scenarios, the weakness may have been in the wording in the scenarios rather than the Rubrics themselves. The differences between this one and the others at Level 4-6 (SCQF 7-9) were quite marked, however, despite the same principles being followed.
4.4.5  Ease of application of rubrics to the scenarios:

Figure 13: Comparison between midwifery and nursing: Ease of using Rubrics

4.4.5a  Comparison between Midwifery and Nursing responses:
- Midwifery participants = 105 (78.36%, N=134)
- Nursing participants = 21 (58.33%, N=36)
- ‘Easy’ or ‘very easy’ = Midwifery 71.42%; Nursing 66.66%

4.4.5b  Comparison between categories (academics, clinicians, students):
- In Midwifery, most of the academics and students identified ‘easy’ (academics = 71.15%, students = 56.82%), with 78.84% (n=41, N=52) academics and 63.64% (n=28, N=44) students saying ‘easy’ or ‘very easy’. Clinicians were split equally between ‘very easy’, ‘easy’ or ‘not easy’ (33.33%, n=3, N=9) each, so the majority of Midwifery participants still found the Rubrics ‘very easy’ or ‘easy’. Nobody said that they had found the exercise ‘very difficult’.
- In Nursing, the majority of all categories identified ‘easy’ (academics = 66.67%, clinicians = 60%, students = 57.14%). A total of 77.78% academics identified either ‘very easy’ or ‘easy’, but no clinicians or students stated ‘very easy’. As in Midwifery, no Nursing participants found the exercise ‘very difficult’.

4.4.5c  Quantitative analysis commentary:
- No participants stated that it had been ‘very difficult’ to grade the scenarios using the Rubrics. Considering the short period in which participants were introduced to the Rubrics (the average time taken to complete the survey was 14 minutes), it was reassuring how positive the responses were about the ease of using them.
- The profiles of all groups were very similar which supports the potential for the tool to be transferable across programmes and professions.
- Testing the tool against hypothetical scenarios during the survey resulted in similar findings. This suggests that the tool has a level of validity and reliability.
4.4.6 Suggestions for improvement of the Rubrics:

- Qualitative comments = 76
- A number of suggestions were made, ranging from the global context to specific detail – particularly in relation to ‘simplification’ and ‘differentiation’. Approximately half of all Midwifery participants provided further suggestions although only a few were made by Nursing participants.

- **Themes and sub-themes:**
  
  i. **Human factors**
  - Subjectivity - challenges are in people rather than processes
  - Personal interpretation – open to interpretation, different personalities/ expectations/ views
  - Mentor-student relationship – continuity, beneficial if know each other well
  
  ii. **Art of mentoring**
  - Application - level of learning/ stage must be taken into account
  
  iii. **Structure of the tool**
  - Simplification (positive) – Rubrics are clear, good job of simplifying a complex beast, no suggestions
  - Simplification – less words ++, merge terminology in L7
  - Differentiation (positive) - levels reflected well, failing descriptors clear
  - Differentiation – clearer distinction between levels of performance ++, ability to mark separately ++/ compare across placements, L7 least differentiated, more descriptor phrases, break down KSA further – more options make grade easier to justify, how to award grades if components not consistently in category/ cross boundaries +++, one fail category, marks/ percentagess for each section ++
  - Quality assurance (positive) – Rubrics less subjective than other tools, fit for purpose
  - Quality assurance - need to be more explicit/ detailed/ specific/ measurable
  - Accessibility - change axis of table, key descriptors in bold, more colourful, digital
  
  iv. **Ongoing guidance and support of the assessor**
  - Clarification and guidance - how to use better/ more consistently, provide examples
  
  vi. **Purpose of assessment**
  - Safe practice – needs to be articulated in all grade boundaries, possibility of confusing confidence with competence
  - What to assess - Add words: sensitivity to woman in L7, ‘demonstrates advocacy for the woman’, same aspects across columns eg: team-working, need list of relevant words and grades alongside document
  - Learning - needs opportunity for written feedback from mentor/ student
  
  vii. **Standardisation**
  - Transferability - more useful than Lexicon, good job

“The rubrics are clear, the challenges in practice are around people rather than processes. Difference in personality, expectation, previous experiences (maybe with the last student) or even just the student (or mentor) having a bad day.” (RMA3)

“All three levels reflect that level well. There are still areas for subjectivity, but far less than in other grading situations.” (RMA31)

“It is always going to be complex…but I think this does a good job of simplifying a complex beast.” (RMA40)

“Need clearer guidance for grading when there is a mix of grades across criteria, i.e. two good and one adequate – how to arrive at final grading.” (RMA54)

“What differentiates excellent and comprehensive, what would we expect for these terms to be applied? This is the question from mentors consistently. The failing descriptors are clear but when trying to accurately apply the descriptors between the good and outstanding criteria it becomes less clear.” (RMA61)
4.4.7 Potential use of Rubrics as a ‘stand-alone’ practice assessment tool:

4.4.7a Comparison between Midwifery and Nursing responses:
- Midwifery participants = 105 (78.36%, N=134)
- Nursing participants = 21 (58.33%, N=36)
- Marginally more Nursing participants answered ‘yes’ to the potential for use as a stand-alone practice assessment tool (52.38% Nursing versus 45.71% Midwifery), however 35.24% Midwifery participants said ‘maybe’ compared with 28.57% Nursing – resulting in identical combinations.

4.4.7b Comparison between categories (academics, clinicians, students):
- In Midwifery, profiles of all categories were very similar and reflected those in the main data set. Of all categories, the clinicians demonstrated most positivity towards the potential for ‘stand-alone’ use of the Rubrics (88.88%, n=8, N=9) stating ‘yes’ or ‘maybe’.
- In Nursing, profiles were more varied. Academics were particularly positive about the potential for Rubrics to be used as a ‘stand-alone’ assessment tool, with 77.78% (n=7, N=9) saying ‘yes’ and the remainder saying ‘maybe’. Students were least positive, with a total of 57.14% saying ‘yes’ or ‘maybe’. Clinician responses reflected the profile seen in Midwifery, with 80% seeing some potential.

4.4.7c Quantitative analysis commentary:
- Some potential for use as a ‘stand-alone’ practice assessment tool was noted by 80.96% participants overall, and 80.95% of both Midwifery and Nursing sub-groups, with only 19.05% in each group saying that this was not the case.
- Profiles in Midwifery and Nursing as a whole as well as across the majority of sub-categories were virtually identical, demonstrating a high level of consistency in responses to this question in relation to positivity towards potential use, thereby enhancing generalisability of findings despite the small numbers (particularly in Nursing).

4.4.7d Qualitative analysis commentary:
- Qualitative comments = 36
- A number of positive comments were made. Suggestions included specific detail and more holistic context. Similar proportions of Midwifery and Nursing participants made comments, comprising 20% and 14% respectively.
- Common themes were identified across both professions, with all main themes reflected, and the theme of ‘Standardisation’ becoming understandably more pronounced, due to the context of the question. The ‘Purpose of assessment’ also became a stronger theme.
Themes and sub-themes:

i. Human factors
   - Personal interpretation - individual variations/ human errors persist
   - Mentor-student relationship – require close working relationship/ continuity

iii. Structure of the tool
   - Simplification (positive) – simple to use, clear terminology, clear expectations,
   - Simplification – ambiguous, need less words
   - Differentiation (positive) - different wording for each, made sense in relation to scenario
   - Differentiation – some statements are between levels/ further refinements of levels of performance needed ++, allow for separate areas/ categories for assessment and different performance, more detail needed
   - Quality assurance (positive) - great system, excellent tool, would help remove subjectivity of grading
   - Quality assurance - needs clear relationship with marking scheme to determine grades/ in combination with written evidence from students/ need to be other ways of assessing

iv. Ongoing guidance and support of the assessor
   - Clarification and guidance – explanation
   - Preparation – training needed

v. Other factors
   - Constraints - staffing levels, lack of opportunity

vi. Purpose of assessment
   - Safe practice (positive) – would make action plan development easier, useful tool to identify and support underachieving student
   - What to assess - competencies/ clinical and communication skills needed ++, needs to be more holistic
   - Learning (positive) – can see where to improve
   - Learning – students need more feedback, mentors also need to write feedback/ give examples, current local tool is a tick-box rather than developing Midwifery skills

vii. Standardisation
   - Transferability (positive) – has potential, much better than existing tool, yes ++
   - Consistency (positive) - provides continuity, easier to give standardised response

“They require a close working relationship between a mentor and student. If the assessor has not worked much with the student, the judgements are very difficult to make.” (SM2)

“The assessment of individual competencies is often dependent on opportunity, the ability to use knowledge, demonstrate woman focussed care, awareness of professional responsibilities and to use reflection should enable students to become more competent in all midwifery skills. In many ways the current MPAD encourages students to focus on ticking off boxes rather than developing midwifery skills.” (RMA3)

“Much better than what is currently used locally – easier to give a standardised response that is fair to the student, where the student can see where things may have needed to be improved (rather than a personal opinion, not based necessarily as fact).” (RMA17)

“These tools were very simple to use, the terminology is clear and I imagine having worked with a student for a whole placement rather than making an assessment from a brief paragraph as per the scenarios would be even easier. I feel it would be clear to both the student and the mentor or what is expected of them at that point in their training and would be a useful tool in identifying and supporting an underachieving student, this in turn would make completing an action plan easier.” (RMC13)

“I think they would help remove some of the subjectivity with which numbers are applied to grades currently.” (SM37)
4.4.8 Potential use of Rubrics in combination with existing tool:

Figure 15: Comparison between midwifery and nursing: Potential for combination of Rubrics with existing tool

### 4.4.8a Comparison between Midwifery and Nursing responses:
- Midwifery participants = 105 (78.36%, N=134)
- Nursing participants = 21 (58.33%, N=36)
- Marginally more Nursing participants were positive about use of the Rubrics in combination with existing practice assessment tools:
  - ‘Yes’ = 65.71% Midwifery; 66.67% Nursing
  - ‘Maybe’ = 26.67% Midwifery; 28.57% Nursing
- Total indicating potential = 92.38% Midwifery; 95.24% Nursing

### 4.4.8b Comparison between categories (academics, clinicians, students):
- In Midwifery, students were particular positive, with 75% (n=33, N=44) answering ‘yes’. In total, all categories were overall positive about the potential for the Rubrics to be used in combination with the local tool, with 86.54% (n=45, N=52) academics, 100% clinicians (N=9) and 97.73% (n=43, N=44) students stating ‘yes’ or ‘maybe’.
- In Nursing, both academics and clinicians were positive about the potential use, with none saying ‘no’ and 77.78% (n=7, N=9) and 80% (n=4, N=5) respectively saying ‘yes’. Students were also overall positive, although ‘yes’ and ‘maybe’ were equally split at 42.86% (n=3, N=7) each.

### 4.4.8c Quantitative analysis commentary:
- Potential for use of the Rubrics in combination with the local practice assessment tool was noted by 92.85% participants overall (92.38% Midwifery and 95.24% Nursing sub-groups), with 65.71% (Midwifery) and 66.67% (Nursing) saying ‘yes’. There was therefore a high level of confidence in using these in conjunction with existing practice assessment tools.
- Responses to this question were more positive than to the previous one about use of the Rubrics as a ‘stand-alone’ assessment tool; suggesting that they could be complementary and perhaps the weaknesses of one would be strengthened by the other.
- Profiles were again virtually identical across the professions, demonstrating a high level of consistency in responses to this question, and thereby greatly enhancing generalisability of findings.
4.4.8d Qualitative analysis commentary:

- Qualitative comments = 24
- The majority of comments were made by Midwifery participants, and most were positive. Others related to similarities with existing tools and suggestions already highlighted in earlier sections about clarification and differentiation. The ‘Purpose of assessment’ became a stronger theme.
- **Themes and sub-themes:**
  i. **Human factors**
     - Subjectivity - take into account human error
  iii. **Structure of the tool**
     - Simplification (positive) – much easier, easier to avoid grade inflation, clearer to follow/grade as a Rubric, user-friendly to students and mentors, good as familiar with Rubrics for academic marking/already used similar tool ++
     - Simplification - keep terminology simple, could confuse clinicians if used with current tool ++
     - Differentiation – what ‘good’ means, could be confusion if different performance in different areas, need to link to areas of practice
     - Quality assurance - subjective like current tool, clinical academics should assess [in practice] to understand the barriers
  iv. **Ongoing guidance and support of the assessor**
     - Clarification and guidance (positive) – provides clearer guidance for marking
     - Clarification and guidance - emphasise appropriate use
  v. **Other factors**
     - Involvement of others – helpful when making decisions
  vi. **Purpose of assessment**
     - What to assess - support grade not determine it, avoid fixation on grade – describe student’s achievement then award grade
     - Learning – describe what has done well and areas for development
  vii. **Standardisation**
     - Transferability (positive) – scope to combine, should replace existing tool
     - Consistency (positive) - should aim for national grading tool

“A much easier assessment and easier to grade students accordingly (rather than the inflated practice grades we currently see).” (RMA17)

“We need to move staff and students away from being fixated on a grade. What we want to tease out is what was done well and what areas require further development. The practice assessment tool should, as accurately as possible, describe student achievement and after that a grade or mark is awarded.” (RMA26)

“I think this should replace the one that is in place at present, although similar in many ways, the terms are far more user friendly and possibly more acceptable to clinicians and students alike.” (RMA31)

“I feel clinical academics should have the ability to come and assess you in practice to understand the potential barriers to effective supervised practice.” (SN4)

“We should aim for a national grading tool.” (RMA42)
4.4.9 Potential use of Rubrics across all institutions or programmes:

4.4.9a Comparison between Midwifery and Nursing responses:

- Midwifery participants = 105 (78.36%, N=134)
- Nursing participants = 21 (58.33%, N=36)
- The majority of participants responded according to their professional group, but 4 of the Midwifery group commented regarding Nursing. All Nursing participants only commented on Nursing programmes.
- Very similar results were noted for positivity towards use across Midwifery (73.33%) and Nursing (71.43% + 0.95% from the Midwifery responses = 72.38%).
- Only 3 Midwifery participants (2.86%) and one Nursing participant (0.95%) stated that the Rubrics would not have potential to be used across all institutions/programmes.

4.4.9b Comparison between categories (academics, clinicians, students):

- In Midwifery, all categories were very positive, with 69.23% (n=36, N=52) academics, 77.78% (n=7, N=9) clinicians and 77.27% (n=34, N=44) students saying ‘yes – Midwifery’. Only 2 academics (3.85%) and one student (2.27%) said ‘no – not in Midwifery’. The remainder of clinicians and students said ‘maybe in Midwifery’. There was an anomaly in that 4 Midwifery academics responded regarding Nursing – one saying ‘yes’, 2 saying ‘maybe’ and one saying ‘no’ in relation to Nursing; their views on application of the Rubrics to Midwifery programmes were therefore unknown.
- In Nursing, all categories saw potential for use across programmes, however the academics were most positive, with 100% stating ‘yes – Nursing’. Clinicians were next most positive, with 80% selecting this option. Students were least positive, with only 28.57% saying ‘yes’ and the majority (71.43%) saying ‘maybe in Nursing’.

4.4.9c Quantitative analysis commentary:

- There was a high level of positivity towards the potential for the Rubrics to be used across both Midwifery and Nursing, with results very consistent between the participant sub-groups.
- The anomaly about 4 Midwifery academics responding in relation to application to Nursing programmes may have reflected misinterpretation of the question, or perhaps some academics taught across both Midwifery and Nursing programmes. The pattern of this sub-group reflected that of the whole, however.
4.4.9d Qualitative analysis commentary:

- Qualitative comments = 9
- Only a few additional comments were made. Some of the Midwifery participants across all categories suggested that the Rubrics could be transferable to Nursing, and a Nursing student suggested that they could also be transferable to Midwifery.

Themes and sub-themes:

vi. Purpose of assessment
   - Safe practice - uncertainty about principle of grading in relation to patient safety

vii. Standardisation
   - Transferability (positive) - both professions ++
   - Consistency (positive) - standardisation important ++ of marking procedure/ proportion of grades/ national agreement

4.5 Additional comments

- Qualitative comments = 26
- ‘Additional comments’ were predominantly about mentorship and grading in general. There were some references to the Rubrics and Lexicon Frameworks which were overall positive. One participant said that the questionnaire had not been user-friendly.
- The majority of comments were made by Midwifery academics and students; none were made by clinicians. Only 4 comments were made across the Nursing categories, 2 of which re-emphasised positivity towards the proposed tool across professions and nationally. The others focused on the emphasis on practice grades, with a clinician wanting a more minimalistic approach and a student wanting a stronger focus on placement grades and links with safety.

Themes and sub-themes:

i. Human factors
   - Subjectivity – subjectivity, unfair
   - Personal interpretation - doves/ hawks
   - Mentor-student relationship - mentors pressurised by students

ii. Art of mentoring
   - Understanding - rationale of formative and summative assessment is poorly understood
   - Application - practice grades don’t always reflect ability or academic grades/ lack of correlation, difficult to get mentors to sign documents
   - Accountability of role – good mentor can quickly assess pass/ fail, recognition of the importance of the clinical skills document
iii. **Structure of the tool**
- **Simplification** (positive) – Rubric and Lexicon appear simple to engage with, clear grading and easy to mark
- **Simplification** – as simple and least wordy as possible ++, simpler approach with room for comments, language of current local tool too academic
- **Differentiation** – clarity between descriptors, remove duplications, more detail, specific marks, preference for pass/ fail with feedback descriptors ++ as pitfalls of grading can outweigh advantages
- **Quality assurance** – tripartite difficult, students need to be able to provide evidence to contend decision, reliance of students on grade inflation, complexities of practice make grading unfair, whole mentoring system is not working

iv. **Ongoing guidance and support of the assessor**
- **Clarification and guidance** - more explanation
- **Preparation** - consistent and clear training for mentors, new NMC standards – potential loss of preparation standard
- **Support** - mentors need support

v. **Other factors**
- **Constraints** – time, appropriate placement for the assessment (e.g.: medicines management), sufficient time in placement
- **Involvement of others** – aids objectivity and decision-making (e.g.: link lecturers/ clinical practice facilitators/clinical tutor/academics/ peers), new NMC standards [increased]

vi. **Purpose of assessment**
- **Safe practice** – students can do well but still be unsafe
- **What to assess** - insufficient assessment of knowledge/ understanding, not enough emphasis on practice (credit weighting), dependent on new NMC standards
- **Learning** - grading gives students indication of standard of performance

vii. **Standardisation**
- **Transferability** (positive) – Rubrics and Lexicon Frameworks have potential ++ (with some more work), thank you for highlighting important area
- **Consistency** (positive) - supportive of national tool/ standardisation ++ (e.g.: PAN London), beneficial to profession
- **Consistency** - variation results in lack of consistency, mentor consistency is needed
“I think that at times the grading of practice can do is give the students a clearer indication of the standard of their performance. I would be in favour of a standardised national approach to practice assessment and grading as there are so many models and approaches in use that I feel consistency would be beneficial to the profession and hopefully it could be evaluated more easily to ensure that the tool is robust and valid.” (RMA1)

“The rationale of formative and summative assessment is poorly understood...As a lecturer, I find that currently 95% of my students find themselves graded as ‘excellent’, this does not always reflect their academic grades or my understanding of their ability. In addition, I am also aware of mentors who feel that students put them under pressure to award them an excellent grade because others have done. Personally, I would prefer to go back to a pass/fail system.” (RMA3)

“It is not the assessment tool that needs to be reviewed. It is the whole mentoring system that is not working.” (SM10)

“I have found this difficult as it makes the assumption that we should grade practice which I think should be carefully debated first. Medical education has I believe stopped this practice recognising its pitfalls outweigh its advantages.” (RMA28)

“Both the Rubric and Lexicon Framework appear simple to engage with and would assist in providing more detailed assessments of individual’s practice. I would be happy if my University used these, and ideally it would/ could be used nationally in order to obtain more reliable and valid feedback on individual’s practice.” (SN2)

“Not enough emphasis is given to placement grades as it only makes up elements of a 30 credit module out of the 120 when students need to be competent in providing care. Basically you can be referred each year on placements and still be graded a 1st class hons degree as the student may be academically sound. Then once qualified could be an unsafe nurse.” (SN3)

“I also think that students tend to rely on good placement grades to bump up their overall grades.” (SM37)

“Sometimes less is more...A good mentor can assess quickly if a student will pass or fail.” (RNC7)

“The complexities of practice grading with doves/hawks makes it so subjective and relatively unfair for students, especially when it contributes to their degree classification. I think a pass/fail system using descriptors for feedback may be more useful for mentors and students.” (RMA61)

“There is such variety in grading, it is so difficult for mentors/ clinical staff to be confident about the ability of newly qualified midwives. This lack of consistency really undermines decision making in Trusts that have more than one HEI.” (RMA62)

“I think there needs to be a national grading system, so all midwives are grading uniformly.” (SM53)
4.6 Summary and reflections on findings

4.6.1 Main themes:
Seven main themes were identified through content analysis, comprising:

- Human factors
- Art of mentoring
- Structure of the tool
- Ongoing guidance and support of the assessor
- Other factors
- Purpose of assessment
- Standardisation

Mapping of themes and sub-themes across the survey is shown in Table 6:

<table>
<thead>
<tr>
<th>MAIN THEMES</th>
<th>SUB-THEMES</th>
<th>4.2 Current Assessment Tool</th>
<th>4.3 Lexicon Frameworks</th>
<th>4.4 Rubrics</th>
<th>4.5 Additional Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Human factors</td>
<td>Subjectivity</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personal interpretation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mentor-student relationship</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Student’s experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Art of mentoring</td>
<td>Understanding</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Application</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Accountability of role</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Structure of the tool</td>
<td>Simplification</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Differentiation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Quality assurance</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Accessibility</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>(iv) Ongoing guidance and support of the assessor</td>
<td>Clarification and guidance</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Preparation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v) Other factors</td>
<td>Constraints</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Involvement of others</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>(vi) Purpose of assessment</td>
<td>Safe practice</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>What to assess</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Learning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(vii) Standardisation</td>
<td>Transferability</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Consistency</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

Table 6: Mapping of thematic analysis

4.6.2 Existing tools and general principles of practice assessment (Section 4.2):

4.6.2a A fairly low level of confidence in the validity and reliability of existing assessment tools was reported, comprising fewer than 50% of all participants. This appeared to relate particularly to reliability – some positive comments were made about improved validity. Midwifery participants were slightly more confident in their existing assessment tools than nursing counterparts; clinicians in both professions were the most confident and students the least (4.2.1). The higher levels of confidence amongst midwifery participants may have
been influenced by the normally closer contact between universities and placements in this profession - in part due to the smaller numbers of students and also the focus on tripartite approaches to assessment in some partnerships\(^5\). The clinicians’ confidence in both midwifery and nursing may have contributed to the limited number of qualitative comments made by this category of participants.

4.6.2b Participants were positive about the contribution of others to the assessment process (4.2.2). Despite this general positivity, five midwifery participants suggested that fewer people should be involved, and a comment was made that subjectivity could be increased if more mentors used the assessment documentation.

4.6.2c Wording of the tool was perceived as more important to clinicians and students than academics, incorporating both the clarity of terminology and written explanation on how to award the grade (4.2.2c). This highlights the importance of engaging with key stakeholders when developing practice assessment tools and documentation.

4.6.2d Better preparation of mentors and constant reinforcement could reduce variations in grading. Mentors needed to understand the importance of assessing the student’s abilities at that point in their programme and not as a qualified midwife (4.2.2d).

4.6.2e Ranking of factors which may contribute to a more reliable and valid assessment (4.2.3) included:

1) Assessing professional performance against set criteria rather than judgement of the individual was unanimously ranked highest. This reinforced the similar emphasis placed by LME-UK Executive on this core principle during the second phase of the project\(^18\).

2) The use of a clear set of statements linked to specific grades, descriptors or symbols indicating level of performance was ranked second highest overall and by midwifery participants. This justified introduction of both the Lexicon Framework and Rubric in this survey, aligning with the earlier phases of the project\(^18\) as well as the wider literature\(^22, 31\). This finding re-emphasised the importance of clear terminology and expectations, and also appeared to suggest a desire to differentiate between levels of performance.

3) Introduction of a national tool was popular in both nursing and midwifery; there was a clear appetite for national standardisation and greater consistency in practice assessment throughout the survey (4.2.3; 4.3.2; 4.4.8; 4.4.9; 4.5). This view was demonstrated across all categories of participants, reinforcing the views of the LMEs as well as findings in the wider literature\(^5, 13, 18, 22, 31, 37, 38, 48\).

4) Involvement of key stakeholders in the development and review of assessment tools was also ranked highly in all categories, further supporting one of the core principles identified by the LME-UK Executive\(^18\).

5) There were mixed views on the benefits of grading practice (4.2.3; 4.4.9; 4.5). The low score for grading in midwifery was particularly interesting; some qualitative comments (4.2; 4.5) suggested that a pass/fail approach may be preferable. Although the LME-UK Executive had earlier agreed the core principle that a specific grade should be awarded\(^18\), the third phase survey found that opinions were divided. Midwifery responses could have reflected concerns about the robustness and fairness of the grading process, whereas nursing participants’ greater preference for grading may have been due to the absence of this as an NMC requirement in their programmes. Grade inflation is well documented as a concern in the literature\(^27, 13, 48, 49\), however it was particularly interesting that – despite benefitting from the
higher marks attracted by practice assessment – midwifery students awarded this aspect a lower rating.

4.6.3 **Lexicon Frameworks** *(Section 4.3)*:

4.6.3a The majority of participants indicated that there was *scope for use of the Lexicon Frameworks* *(4.3.1)*. Clinicians were particularly positive about the potential to use them, either as the main tool for grading or when writing supportive evidence towards their assessment *(4.3.1b)*. Students were similarly positive about using the Lexicon Frameworks either when mentors or they themselves were writing evidence to support assessment. There was a higher level of confusion about their purpose amongst academics, although the majority indicated positivity towards their use in some capacity, with most considering they would be useful when developing new programmes. This further reinforces the importance of all stakeholders contributing to development of assessment tools to avoid making assumptions about understanding and application.

4.6.3b *Scope for application of the Lexicon Frameworks to the new standards for education* *(10-12)* was evident. Participants were positive about their potential for documenting evidence to support a mentor’s decision or student’s self-assessment, as the main tool for grading or when developing a practice assessment document for a new pre-registration programme. The new education standards separate the roles of practice supervisor and practice assessor, and there is potential for a wider range of registrants to contribute to the documented evidence supporting practice assessment, which may enhance the relevance and scope of this tool *(4.3.1)*. All nursing and midwifery programmes will be requiring re-approval by 2020 to align with the NMC’s programme of change for education, and will therefore be required to develop new practice assessment documentation *(12)*. The new nursing standards have already been published *(16, 17)*, and midwifery standards are in the early stages of review and consultation *(1)*. Our Lexicon Frameworks may therefore contribute to programme development across the AEIs in the UK.

4.6.3c Some participants suggested that the Lexicon Frameworks would *ensure a fairer grade and help promote standardisation* *(4.3.2)*. This further supports findings throughout the survey about the general wish to enhance rigour of practice assessment.

4.6.3d Thematic analysis of qualitative responses in this section excluded ‘Human factors’, suggesting that the Lexicon Frameworks might enhance objectivity, leading to more reliable and robust assessment *(4.3.1; 4.3.2)*. Sub-themes of ‘accountability of the role’, ‘preparation’, ‘support’, ‘constraints’, ‘involvement of others’, ‘learning’ and ‘consistency’ were also absent (see Table 6) – whereas these were seen in all other sections.

4.6.3e Suggestions to improve the Lexicon Frameworks included *(4.3.2)*:

- Simplifying, including fewer words
- More discrete terminology for each level descriptor
- Link words to form a rubric (aligning with the next part of the survey in section 4.4)
- Clarify purpose and how to use them
- Provide examples
- Make them widely accessible, including electronic formats

4.6.4 **Rubrics** *(Section 4.4)*:

4.6.4a Most participants found the *Rubrics easy to use* *(4.4.5)*.

4.6.4b In all scenarios except Level 7 *(SCQF 10 – 4.4.4)*, the majority aligned with the grade intended, demonstrating a *good level of validity and inter-assessor reliability* *(4.4.1; 4.4.2; 4.4.3)*. It is
to be noted that participants were responding to a hypothetical midwifery scenario, measured against a criterion-referenced grid; the subjectivity of personalities who knew each other (i.e.: the ‘individual’) was therefore removed.

4.6.4c Findings from the scenarios suggested that grading using the Rubrics could be fairly reliable, even if the assessor had not worked with the student (4.4.1; 4.4.2; 4.4.3; 4.4.5; 4.4.6; 4.4.7; 4.4.8). As in the Lexicon Frameworks, this is helpful in the current context of changes to the NMC education standards which separate the role of mentor into ‘practice supervisor’ and ‘practice (and academic) assessor’10, 11. In contrast with current requirements for the mentor or sign-off mentor to have directly or indirectly supervised the student for a minimum of 40% of practice hours9, the future assessor may not necessarily have spent much time working directly with them.

4.6.4d Findings from the scenarios supported the potential for other professions to contribute to the assessment, as the distribution of grades was similar in both midwifery and nursing for the majority of the hypothetical midwifery scenarios (4.4.1; 4.4.2; 4.4.3; 4.4.4). Inclusion of nursing introduced a further element of objectivity as participants were less familiar with the context and professional or programme expectations. This, again, aligns with the changes to the NMC education standards which will increase reliance on the contribution of other health professions in the collation of evidence as practice supervisors10, 11.

4.6.4e Concerns were raised about some students’ understanding of the purpose of grading and determination of competence when they ‘failed to fail’ student ‘Grace’ (4.4.3), despite it being evident that her practice did not meet requirements and was clearly unsafe. The fact that one midwifery academic also passed her was similarly of concern.

4.6.4f Challenges were demonstrated in identifying a grade at masters level for ‘Alba’ (4.4.4). The differences between this scenario and the others at Level 4-6 (SCQF 7-9) were quite marked, despite the same principles being followed. Some suggestions have been made regarding the limitations to the range of available assessment tools at this academic level15, and the consequent implications on the construction of this scenario and Rubric (4.4.4c). The fact that nursing responses were more consistent raised questions as to whether unfamiliarity with programmes or expectations could reduce subjectivity. Exploratory research on masters level practice assessment would be useful. Consideration of factors could include what defines masters level in relation to practice, noting that both degree and masters levels have the same NMC requirements for entry to the register1. Whether or not it is appropriate to assess practice at masters level in pre-registration midwifery, or whether this should be limited to the academic component of programmes (despite the challenges this might present in implementing AEI regulations) could also be considered.

4.6.4g There was a high level of consistency in responses about the potential for the Rubrics to be used in both midwifery and nursing (4.4.6; 4.4.7; 4.4.8; 4.4.9). Although the Rubrics clearly need some refinement, participants were overall positive that they generally achieved their purpose (4.4, 4.5). The correlation between responses from both midwifery and nursing was helpful in drawing conclusions, as this introduced an ‘external’ viewpoint.

4.6.4h Participants were again positive about introducing a national assessment tool in midwifery and nursing (4.2.3; 4.4.8, 4.4.9, 4.5). Our Rubrics demonstrated scope for transferability, potentially enhancing standardisation. It was suggested that greater familiarity with the assessment tool would further enhance reliability in its use. Our evidence adds to the literature supporting this proposal, and the success to date of the common assessment tools used in midwifery in York and Humber5 and PAN London midwifery and nursing13. This study could therefore be helpful in informing the new midwifery standards12, 15.
4.6.4i Suggestions to improve the Rubrics included (4.4.6):
- providing guidance on grading or scoring when performance fell in different areas
- differentiating more clearly between level descriptors and columns
- reviewing some of the terminology, especially for Level 7 (SCQF 10)
- including examples
- including the grades in the heading
- highlighting key words

4.6.5 Additional comments (Section 4.5):

4.6.5a Comments reinforced previous themes and sub-themes. The ‘Purpose of assessment’ and appetite for ‘Standardisation’ were particularly apparent. Some comments focused on the proposed tools, but others were more generic.

4.6.5b Most participants were in favour of grading practice, but it was highlighted that its pitfalls could outweigh its advantages and it was important not to become fixated on the grade itself (4.4.8d).

4.6.5c The importance of ‘learning’ was emphasised. Both the students and mentors need to understand and recognise performance and achievement in practice.

4.6.5d Themes focused on the necessity for explicit assessment tools for which mentors are trained.

4.6.6 Strengths and limitations of our study:

Comparisons between professions and sub-categories produced some interesting findings. It must, however, be noted that numbers were smaller in nursing (particularly when sub-categorised) which resulted in a greater impact on comparative percentages. The patterns when highlighting similarities and differences were considered more important than the statistics themselves. Overall, there were considerable similarities between midwifery and nursing views. Within professions, there were many similarities but also some notable differences in focus. A number of comments around practice assessment and mentorship in general were raised which have wider application and reinforce existing literature.

4.6.6a Strengths:
1) Involvement of the LME-UK Executive throughout the project via an action research approach, led by a core research team, has enabled consideration of a wide range of views in all stages, drawing on individual expertise. This strengthens the credibility of the findings and outputs which have emerged from the project. It has also promoted ownership of the project outcomes.
2) Representation from 20 AEs in the survey meant that a wide range of previous experiences of different assessment tools and approaches contributed to responses. This greatly enhanced generalisability of findings.
3) Inclusion of academics, clinicians and students provided a wide range of views and experiences, enhancing generalisability of findings.
4) Inclusion of nursing participants broadened application and enhanced objectivity, further supporting the potential for this generic tool to be used in other programmes.
5) Differences were generally minimal between midwifery and nursing, so there was clear evidence of some transferability across professions.
6) Despite the average length of time for completing the full survey being only 14 minutes, participants were able to provide a good amount of data and were clearly thoughtful about their decisions and comments. They were able to evaluate the Lexicon Frameworks and Rubrics within this time-frame, and to demonstrate application of the latter through
completion of the scenario assessments. This suggests that the tools were fairly readily understood and used.

7) Inclusion of qualitative components provided a very useful range of additional comments, opinions and suggestions to be voiced. There was consistency in many of the qualitative comments, which strengthens the evidence base as well as facilitating modification of the tools.

8) Use of the website enabled access to the core documents during the survey and provided a forum for wider dissemination of this phase and the project as a whole.

4.6.6b Limitations:

1) A number of respondents had only completed the section on demographic information. It is assumed that they did not keep both the survey and website documents open and therefore exited the survey before these sections could be completed. Exclusion of these participants ensured that the data presented was accurate and meaningful, but the reduction in available information was disappointing.

2) It was valuable to gain feedback from nursing participants. A larger sample would have been beneficial and further enhanced rigour and generalisability of the findings. It was, however, understandable that there would be a higher response rate amongst midwifery participants, due to the professional focus of the survey.

3) It would have been useful to have increased clinician representation with a particular focus on those who were mentors. This would, however, have necessitated IRAS ethical approval which would have taken longer and compromised availability of the findings within the time constraints of development of the new NMC standards.
5. CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

It was evident throughout our survey that an appetite for ‘Standardisation’ in professional practice assessment exists nationally. A number of positive comments were made about the potential for our tools to move towards this across both midwifery and nursing professions and in all categories of participants.

Grading continues to bring both benefits and challenges – our findings supporting those of the wider literature5,18-40. The tendency towards grade inflation highlighted in this and other publications27,33,48,49 may be advantageous towards students’ academic profiles but can also be perceived as a negative outcome, reflecting the inconsistencies of individuals and tools. Some participants indicated a preference for pass or refer, although descriptors were deemed valuable in indicating levels of performance, identifying gaps and guiding students’ learning.

Some ‘Human factors’ in practice assessment are inevitable. It has, however, been demonstrated that validity and reliability of tools can be improved if care is taken over their construction, and clear guidance and support are given to those using them. Our Lexicon Frameworks and Rubrics appear to fulfil some important functions, and participants have suggested that they demonstrate the potential to enhance the validity and reliability of practice assessment in midwifery education – particularly in the current context of changing NMC standards10-12,15-17. We believe that an appreciation of the ‘Purpose of assessment’ by all stakeholders is also fundamental to the process.

In drawing together the findings from our survey, we have produced a set of outputs shown in Figure 2. These are explained further in sections 5.2, 5.3 and 6.1.

- An ‘Evidence Based Model for Professional Practice Assessment’ has been developed from the concepts emerging from the findings (section 5.2).
- 'Key principles for assessing practice' are recommended for those devising and using practice assessment tools or involved in the process of assessing practice (section 5.3).
- A ‘Practice Assessment Toolkit’ is under development, including refined versions of the Lexicon Framework and Rubrics used in the survey. This will be open access and available on the project website6 (section 6.1).

Figure 2: Project outputs
5.2 Development of a conceptual model

Our study has highlighted that grading tools are very challenging to create. Enhancement to the rigour of assessment includes ‘simplification’ and ‘differentiation’. Participants valued ‘accessibility’, and ‘quality assurance’ was key. It is not feasible to suggest that any tool will ever be perfect. Even if the ‘Structure of the tool’ appears valid, reliability remains an issue. The fact that the majority of participants identified the intended grade in the degree level scenarios was reassuring from a validity and reliability perspective, but discrepancies in the grades awarded highlights the potential for ‘Human factors’ of ‘subjectivity’ and varied ‘personal interpretation’ to persist. The ‘mentor-student relationship’ forms a significant element in the process, and the ‘student’s experience’ is also relevant.

The ‘Art of mentoring’ requires ‘understanding’ and correct ‘application’ of the assessment tool and process, with ‘accountability’ a vital aspect of the role. To achieve this, ‘Ongoing guidance and support of the assessor’ is needed, through ‘preparation’, ‘clarification and guidance’ and continued ‘support’.

‘Other factors’ also influence robust and reliable assessment. Although ‘involvement of others’ was generally seen to be beneficial, this could also compromise consistency. Other ‘constraints’ included staffing levels, time together for mentor and student or opportunity for academics to support those responsible for assessment.

Participants in our study were very clear that they wanted greater ‘consistency’, and there was a real appetite for ‘Standardisation’ to enhance quality and reliability of practice assessment. Our proposed tools demonstrated some potential for ‘transferability’.

The ‘Purpose of assessment’ became increasingly important as our study progressed. It was evident that grading of practice – however that may be defined – needs to be part of a meaningful process, and not an end-point in itself. ‘Safe practice’ was deemed an essential component of ‘what to assess’ – but there was not always consensus on details of the latter. It was clear that ‘learning’ was a very important part of the process, and that any form of grading should clearly indicate gaps in students’ performance and provide guidance on how to improve this. Fixation on the grade itself should be avoided.

An ‘Evidence Based Model for Professional Practice Assessment’ was developed (Figure 17) to demonstrate the inter-relationship between the themes and sub-themes (Table 6) which emerged during our study. This puts the ‘Purpose of assessment’ as central, surrounded by factors which contribute to robust and reliable assessment, but mindful of the ‘Human factors’ and ‘Other factors’ which may have a negative impact.

![Figure 17: An Evidence Based Model for Professional Practice Assessment](image-url)
5.3 Recommended key principles for assessing practice

The project team recommends the following key principles for assessing practice, based on the results of this survey:

**KEY PRINCIPLES FOR ASSESSING PRACTICE**

1. Stakeholder participation is essential in the development and use of practice assessment tools (students, academics and those supporting and assessing practice);
2. The purpose of assessment needs to be understood by all stakeholders to enable achievement of learning and professional requirements, and this needs to be at the forefront of any decisions about how best to assess practice and grade (or not) performance;
3. The art of mentoring is about the development and maintenance of professional relationships in practice to enable learning;
4. The accountability of the assessor is to ensure the professional requirements are met, to ensure safe and competent practice at point of registration;
5. Any tool used needs to be as simple as possible while clearly differentiating between programme stage and levels of student performance;
6. Mentors need to differentiate between pass and fail, but also determine levels of performance to facilitate student progress and promote learning;
7. The focus needs to be on objectively assessing the student’s performance in the context of professional behaviour against set criteria, rather than a subjective judgement of the individual (i.e., criterion-referencing against the stage of the programme and professional requirements, not norm-referencing or measuring against individual expectations);
8. It is essential that knowledge, skills and attitudes are taken into account as these are all intrinsic to professional practice;
9. It is important that correct usage of words provides documentary evidence for others to objectively assess the student and determine level of performance;
10. Those contributing to the evidence need to understand the purpose of the assessment and their role in aiding decision-making;
11. Mentors (or practice and academic assessors) need to focus on feedback and feed-forward to guide the student’s progress rather than on the grade;
12. It is important to use the full range of grades or level descriptors to guide improvement or reward achievement;
13. Individual institutions need to prescribe how a grade is determined if performance falls in different categories; however failure in any aspect or component should be deemed a failure;
14. Ongoing guidance and support of those supervising and assessing students in practice is needed – this may be written, electronic or in person.

*Table 7: Key principles for assessing practice*
6. NEXT STEPS AND FUTURE CONSIDERATIONS

6.1 Practice Assessment Toolkit (Appendix 3)

The findings from our survey suggest that – following some refinement - our Lexicon Frameworks may provide some consistency in terminology relating to the assessment of levels of performance in pre-registration midwifery practice. This is currently of even greater importance due to changes in the NMC standards\textsuperscript{12, 15} and the expectation for wider professional contributions to the evidence informing decisions about progress and achievement of safe and competent practice at point of registration\textsuperscript{10, 11}. They could also be used to prepare practice assessment documentation in new curricula. Visual representation in the form of Wordles\textsuperscript{14} (see Appendix 2) may offer a more appealing alternative to individuals with relevant learning styles.

Our Rubrics, which apply the Lexicon Frameworks within the context of holistic assessment of students, have also received positive feedback. It is suggested that - following similar refinement in line with comments in the survey - these could be used as the basis for a standardised approach which could be modified to align with institutional or programme requirements and future NMC competencies for pre-registration midwifery students\textsuperscript{12, 15}. It has also been suggested that both our Lexicon Frameworks and Rubrics would have the potential to be transferable to nursing.

The project team is therefore in the process of developing a ‘Practice Assessment Toolkit’, drawing from the findings from this survey in making the necessary modifications. It is intended that our tools will enable versatility while following common principles of practice assessment. The content is designed to be used flexibly across programmes, and may be of particular value to teams developing practice assessment tools or those individuals providing evidence of student performance – whether the student themselves, their assessor or those contributing to the evidence towards decision-making. The tools may be used for any approach to awarding specific grades or indicating levels of performance. They are able to be adapted to current or future requirements set by the NMC and any approved education institution preferences. An overview of the proposed content can be seen in Appendix 3. On completion, the ‘Practice Assessment Toolkit’ will be uploaded to the project website, which has open access\textsuperscript{6}.

6.2 Future research

6.2.1 It is intended to evaluate use of the ‘Practice Assessment Toolkit’ and application of its constituent elements. This will be particularly valuable in light of the imminent implementation of the new NMC standards for education and associated changes in expectations of roles for those involved in assessing midwifery practice\textsuperscript{10-12, 15}.

6.2.2 It is recommended that research into the assessment of midwifery practice at masters level is undertaken. This could include the challenges and benefits, how this is defined and differentiated from undergraduate expectations and best management.
7. REFERENCES


38. Cleland, J., Knight, L., Rees, C., Tracey, S., Bond, C., 2008. Is it me or is it them? Factors that influence the passing of underperforming students. Medical Education 42, 800-809.


6. APPENDICES

Appendix 1: Documents used in survey______________________________ 58-61

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1c. Rubrics____________________________________________________ 61

Appendix 2: Examples of Wordles_________________________________ 62

Appendix 3: Proposed ‘Practice Assessment Toolkit’___________________ 63
Table 1: Categorisation according to scoring systems in midwifery across UK universities

<table>
<thead>
<tr>
<th>Undergraduate Degree Levels 4-6; SCQF Levels 7-9</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clear fail</strong> (Very poor; Poor; 0-29%; F; 6)</td>
</tr>
<tr>
<td><strong>Fail</strong> (Unsafe practice; Inadequate; 30-39%; E/F; 7; 0-7; 1-3)</td>
</tr>
<tr>
<td><strong>Pass</strong> (Satisfactory; Acceptable; 40-49%; D; 8-9; 8-10; 4-6)</td>
</tr>
<tr>
<td><strong>Good</strong> (50-59%; C; 10-11; 11-13; 2)</td>
</tr>
<tr>
<td><strong>Very good</strong> (60-69%; B; 12-13; 14-16; 7-9)</td>
</tr>
<tr>
<td><strong>Excellent</strong> (70-79/84%; A; 14-20; 17-19; 3)</td>
</tr>
<tr>
<td><strong>Outstanding</strong> (Exceptional; 80/85-100%; AA; 10-12)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Masters Level 7; SCQF Level 10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unsatisfactory</strong> (Not achieved; Fail; Unsafe practice; 45%; 0-7)</td>
</tr>
<tr>
<td><strong>Satisfactory</strong> (Adequate; Pass; 55%; 8-9)</td>
</tr>
<tr>
<td><strong>Good</strong> (Good pass; 65%; 10-11)</td>
</tr>
<tr>
<td><strong>Very good</strong> (Very good pass; 75%; 12-13)</td>
</tr>
<tr>
<td><strong>Excellent</strong> (Outstanding; Excellent pass; 85%; 14-20)</td>
</tr>
</tbody>
</table>
Appendix 1b. Documents used in survey: Lexicon Frameworks (example)

**LEXICON FRAMEWORK: LEVEL 4/ SCQF 7**

Words appearing in bold = high frequency. ‘Key words’ are those appearing in at least 6 of the 7 columns.

<table>
<thead>
<tr>
<th>Nouns</th>
<th>CLEAR FAIL</th>
<th>FAIL</th>
<th>PASS</th>
<th>GOOD</th>
<th>VERY GOOD</th>
<th>EXCELLENT</th>
<th>OUTSTANDING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowledge</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>evident(ce) insight knowledge theory(ethical) information understand(ing)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>knowledge evident(ce) theory(ethical) information understand(ing) awareness instruction</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>knowledge evident(ce) theory(ethical) information understand(ing) awareness knowledge</td>
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<td></td>
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<tr>
<td>knowledge evident(ce) theory(ethical) information understand(ing) awareness knowledge</td>
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<td>knowledge evident(ce) theory(ethical) information understand(ing) awareness knowledge</td>
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<td></td>
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<tr>
<td>knowledge evident(ce) theory(ethical) information understand(ing) awareness knowledge</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>knowledge evident(ce) theory(ethical) information understand(ing) awareness knowledge</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

| Skills | | | | | | | |
| practice(able) ability skill care | | | | | | | |
| practice(able) ability skill care | | | | | | | |
| practice(able) ability skill care | | | | | | | |
| practice(able) ability skill care | | | | | | | |
| practice(able) ability skill care | | | | | | | |
| practice(able) ability skill care | | | | | | | |
| practice(able) ability skill care | | | | | | | |

| Attitudes | | | | | | | |
| behaviour appreciation compassion manner | | | | | | | |
| behaviour appreciation compassion manner | | | | | | | |
| behaviour appreciation compassion manner | | | | | | | |
| behaviour appreciation compassion manner | | | | | | | |
| behaviour appreciation compassion manner | | | | | | | |
| behaviour appreciation compassion manner | | | | | | | |
| behaviour appreciation compassion manner | | | | | | | |

| Other nouns | | | | | | | |
| woman feedback family student colleague NMC time(s)/ly guidance level supervision workload standard require(ment) | | | | | | | |
| woman feedback family student colleague NMC time(s)/ly guidance level supervision workload standard require(ment) | | | | | | | |
| woman feedback family student colleague NMC time(s)/ly guidance level supervision workload standard require(ment) | | | | | | | |
| woman feedback family student colleague NMC time(s)/ly guidance level supervision workload standard require(ment) | | | | | | | |
| woman feedback family student colleague NMC time(s)/ly guidance level supervision workload standard require(ment) | | | | | | | |
| woman feedback family student colleague NMC time(s)/ly guidance level supervision workload standard require(ment) | | | | | | | |
| woman feedback family student colleague NMC time(s)/ly guidance level supervision workload standard require(ment) | | | | | | | |

| Adjectives | | | | | | | |
| unable poor insufficient professional(s) ineffective effective(ly) appropriate(ly) ineffective appropriate(ly) inappropriate(ly) inconsistent | | | | | | | |
| unable poor insufficient professional(s) ineffective effective(ly) appropriate(ly) inconsistent | | | | | | | |
| unable poor insufficient professional(s) ineffective effective(ly) appropriate(ly) inconsistent | | | | | | | |
| unable poor insufficient professional(s) ineffective effective(ly) appropriate(ly) inconsistent | | | | | | | |
| unable poor insufficient professional(s) ineffective effective(ly) appropriate(ly) inconsistent | | | | | | | |
| unable poor insufficient professional(s) ineffective effective(ly) appropriate(ly) inconsistent | | | | | | | |
| unable poor insufficient professional(s) ineffective effective(ly) appropriate(ly) inconsistent | | | | | | | |

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<table>
<thead>
<tr>
<th>Nouns</th>
<th>Adverbs</th>
<th>Verbs</th>
<th>Prepositions</th>
</tr>
</thead>
<tbody>
<tr>
<td>clinical, individual, own</td>
<td>adequate, very</td>
<td>demonstrate, apply, make</td>
<td>between, to, on, around</td>
</tr>
<tr>
<td>own, clear, direct, very, normal, high, kind</td>
<td>usual, well</td>
<td>provide, communicate, link, show, demonstrate</td>
<td>toward, between, overall</td>
</tr>
<tr>
<td>clear, direct, very</td>
<td>consistent</td>
<td>respond, respond, respond, respond</td>
<td>always</td>
</tr>
<tr>
<td>current, inadequate, next</td>
<td>relevant, close</td>
<td>promote, manage, fail, expect</td>
<td>consistent</td>
</tr>
<tr>
<td>next, relevant, significant</td>
<td>acceptable</td>
<td>recognise, plan, change</td>
<td>record, keep, identify</td>
</tr>
<tr>
<td>significant</td>
<td>close</td>
<td>perform, manage, fail, expect</td>
<td>recognise, plan, change</td>
</tr>
<tr>
<td>very</td>
<td>relevant</td>
<td>perform, manage, fail, expect</td>
<td>promote, manage, fail, expect</td>
</tr>
<tr>
<td>adequate</td>
<td>consistent</td>
<td>plan, change</td>
<td>develop, participate</td>
</tr>
<tr>
<td>high</td>
<td>relevant</td>
<td>perform, manage, fail, expect</td>
<td>develop, participate</td>
</tr>
<tr>
<td>adequate</td>
<td>good</td>
<td>manage, perform</td>
<td>provide, com</td>
</tr>
<tr>
<td>high</td>
<td>confident</td>
<td>manage, perform</td>
<td>provide, com</td>
</tr>
<tr>
<td>adequate</td>
<td>responsive</td>
<td>perform, manage, fail, expect</td>
<td>provide, com</td>
</tr>
<tr>
<td>close</td>
<td>relevant</td>
<td>perform, manage, fail, expect</td>
<td>provide, com</td>
</tr>
</tbody>
</table>

Key words: show, document, demonstrate, develop, respond, learn, reflect, perform, communicate, lack, need, apply, manage, provide, record, work

Key words: consistent, always, overall, usual, well, further

Key words: between, to, on, around

Key words: toward, between, overall
### RUBRIC: L4 (SCQF 7) – Bold = high frequency, plain = medium frequency (others in Lexicon Framework), italic = ‘grammar words’ (not included in spreadsheet)

<table>
<thead>
<tr>
<th>CLEAR FAIL</th>
<th>FAIL</th>
<th>PASS</th>
<th>GOOD</th>
<th>VERY GOOD</th>
<th>EXCELLENT</th>
<th>OUTSTANDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>Inadequate knowledge of theory.</td>
<td>Shows evidence of limited underpinning theoretical knowledge.</td>
<td>Accurate knowledge and good understanding of underpinning theory.</td>
<td>Shows evidence of very good theoretical knowledge and understanding.</td>
<td>Excellent knowledge of theory consistently informs practice.</td>
<td>Comprehensive knowledge is consistently applied to practice.</td>
</tr>
<tr>
<td>Skills</td>
<td>Demonstrates very limited ability in basic clinical skills.</td>
<td>Able to demonstrate basic clinical skills and safe practice.</td>
<td>Demonstrates development of good clinical skills and safe practice.</td>
<td>Demonstrates safe and confident skills in clinical practice.</td>
<td>Consistently demonstrates excellent ability in clinical skills.</td>
<td>Consistently demonstrates outstanding clinical skills and excellent care.</td>
</tr>
<tr>
<td>Attitude</td>
<td>Student lacks insight into own professional behaviour and development.</td>
<td>Student demonstrates inadequate awareness of professional behaviour.</td>
<td>Student demonstrates adequate understanding of professional behaviour.</td>
<td>Student demonstrates good understanding of appropriate professional behaviour.</td>
<td>Student demonstrates very appropriate professional behaviour and self-awareness.</td>
<td>Student demonstrates exceptional insight into personal professional behaviour.</td>
</tr>
<tr>
<td>UNDER</td>
<td>Does not achieve all the NMC standards/requirements</td>
<td>Does not achieve all the NMC standards/requirements</td>
<td>Achieves all the NMC standards/requirements well</td>
<td>Very good achievement of all the NMC standards/requirements well</td>
<td>Excellent achievement of all the NMC standards/requirements</td>
<td>Outstanding achievement of all the NMC standards/requirements</td>
</tr>
<tr>
<td>DIRECT</td>
<td>Supervision:</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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Appendix 2: Examples of Wordles

Level 4 (SCQF 7) PASS

Level 5 (SCQF 8) OUTSTANDING

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Appendix 3: Proposed ‘Practice Assessment Toolkit’

This will be uploaded to the project website when the Lexicon Frameworks and Rubrics have been refined in accordance with findings from the survey: https://www.plymouth.ac.uk/research/national-grading-of-practice-in-pre-registration-midwifery-project

The Practice Assessment Toolkit will be subject to copyright, but may be used freely provided the authors are acknowledged and the toolkit cited as specified.

Proposed contents:

1. Introduction
2. Background (including model)
3. How to use this toolkit (including explanation of how each element complements or feeds into the other elements or local tools)
4. Categorisation of levels of performance
5. Wordles (optional alternative format of terminology in Lexicon)
6. Lexicon Frameworks (refinements based on survey responses)
7. Rubrics (refinements based on survey responses)