Fisher, M. Bower, H. Chenery-Morris, S. Jackson, J. Way, S. Nurse Education in Practice, 24 (1), 99-105 (2017) doi.org/10.1016/j.nepr.2016.01.007
The published source for this article is available here: https://www.sciencedirect.com/science/article/pii/S1471595316000214?via%3Dihub

A SCOPING STUDY TO EXPLORE THE APPLICATION AND IMPACT OF GRADING PRACTICE IN PRE-REGISTRATION MIDWIFERY PROGRAMMES ACROSS THE UNITED KINGDOM

INTRODUCTION

The United Kingdom Nursing and Midwifery Council (NMC) has required all programmes leading to registration as a midwife since September 2008 to grade practice (NMC, 2009). The NMC sets the standards to be achieved, but the operationalising of these is the responsibility of the individual programme team in collaboration with clinical colleagues and subject to their Higher Educational Institution (HEI) regulations.

In March 2013, the Lead Midwives for Education United Kingdom Executive Group (LME-UK) agreed that a sub-group of experienced colleagues with a shared interest in practice assessment would undertake a national scoping activity across the HEIs where pre-registration midwifery programmes are delivered. LMEs fulfil a statutory role with direct accountability to the NMC, having oversight for all matters pertaining to midwifery education in their institution. LME-UK comprises a peer support group of senior educationalists from all 55 universities across the four countries who lead on development, delivery and management of midwifery education programmes, meeting separately from the NMC. This group enables collaborative opportunities and integration of differing health policies across the UK (LME-UK Executive Terms of Reference, 2014). The purpose of the scoping activity was to explore the range of

methods of application of the standards in relation to grading of practice, in line with the recommendation that best practice should be shared (NMC, 2006). A survey exploring assessment processes and views on the impact of grading of practice across the UK was therefore conducted through circulation of a questionnaire to the LME-UK group. No other study exploring midwifery practice assessment has been undertaken on such a broad scale. It was anticipated that a set of guiding principles to enhance consistency in grading practice may be a later outcome of the project.

BACKGROUND

The 'Standards for pre registration midwifery education' (NMC, 2009) require all universities in the UK to implement grading as a key aspect of practice based assessment in midwifery. The rationale is to place equal emphasis on practice and theory. Standard 15 (NMC, 2009, p.21) identifies that:

- "Assessment of practice, which is direct hands-on care, must be graded.
- The grades achieved must contribute to the outcome of the final academic award.
- If the assessment of clinical practice involves a variety of components and the student fails to achieve competence in one of the components, then the student must fail."

The midwifery sign-off mentor is an experienced clinician who has undertaken additional academic preparation as well as been involved in the assessment process of a midwifery student on at least three occasions (NMC, 2008). In contrast to nursing, a sign-off mentor is required for all progression points. The Nursing and Midwifery Council (2009, p.21) defines a progression point as: *"a point (or points)*

established for the purpose of making summative judgments about safe and effective practice in a programme". The responsibility of this role is therefore very evident as sign-off mentors are essentially the gatekeepers to the profession from a practice perspective. Practice assessment brings with it challenges and rewards, and the lived experience of fulfilling a role which is paramount in ascertaining a student's competence is described in both midwifery and nursing literature (Duffy, 2004; Fisher and Webb, 2008; Fisher, 2009; Fisher et al., 2011; Jervis and Tilki, 2011; Marsh et al., 2014; Rutkowski, 2007; Skingley et al., 2007). Grading adds a further dimension in that not only is competence itself determined, but a scale measuring the level of performance in practice is also required (Chenery-Morris, 2014). Maxted et al. (2004) suggests that practitioners can find separating these concepts challenging. The process of grading practice is influenced by multiple assessors in the form of individual sign-off mentors. Interpretation of the grading tools used can challenge inter and intra-assessor reliability (Donaldson and Gray, 2012; Smith, 2007). Mentors have, however, found grading tools helpful for students who were not performing well (Heaslip and Scammell, 2012).

National Health Service (NHS) Education for Scotland (NES, 2008) noted that the ange and breadth of practice assessments are diverse in contrast to greater similarity in theoretical modules. Gray and Donaldson (2009) recommended that ongoing evaluation and monitoring of grading processes should be undertaken, which is further supported by Heaslip and Scammell (2012) and Bennett and McGowan (2014).

PROJECT DESIGN

This descriptive survey sought to ascertain the varying practice assessment methods, tools and views across the full range of pre-registration midwifery programmes in the UK. This particular approach was used in order to elicit in-depth details of the range of methods HEIs currently use when applying the NMC standards (2009) within the constraints of the individual institutional regulations across the four countries. The intention was to identify any perceived impact on degree classification and the experience of those involved in grading practice. This may help realise the contributory factors and impact of any inconsistencies in grading practice. As the LME-UK group had itself initiated this scoping activity as an internal evaluation and no other participants were involved, no ethical approval was required.

In order to elicit the information, three key areas were explored through circulation of a questionnaire: 1) the process of grading practice; 2) the impact of grading of practice on mark profiles; 3) clinicians' views on grading of practice. A questionnaire was circulated electronically via the professional network following an initial introduction to the planned activity at an LME-UK meeting (see *Table 1*). Colleagues were also invited to share the practice assessment tools used in their institutions.

1. For each year of the course/programme for both the long and the short courses/programmes:
    a. When do you ‘Grade practice’?
    b. How do you ‘Grade practice’?
    c. What weighting is given to ‘Grading of practice’?
2. Has there been any observable alteration to students’ mark profiles since ‘Grading of practice’ was mandatory? (e.g.: higher, lower, no difference)
3. From Annual Monitoring of the course/ programme, how do clinicians view ‘Grading of practice’?

Table 1: Grading of practice scoping questionnaire

Subsequent rounds of requests for feedback were undertaken in person at LME meetings or electronically. A 73% response rate was achieved, totalling 40 of 55 universities and reflecting the whole geographic spread of HEIs providing pre-registration midwifery education across the UK (see *Table 2)*.

Country	***Number of HEIs***	***Number of Respondents***
England	*47*	*34*
Scotland	*3*	*3*
Wales	*4*	*2*
Northern Ireland	*1*	*1*
TOTAL	*55*	***40 = 73%***

Table 2: Profile of respondents

FINDINGS

The data was compiled onto a spreadsheet, categorised according to the questions and relevant institutions which were subsequently anonymised. The project team divided the questions for initial thematic analysis which was then cross-checked by the rest of the team. A brief summary follows presentation of each section in the findings.

1. The process of grading practice

Practice placements where grading took place included community, labour suite, antenatal, postnatal and caseload holding. A combination of both formative and summative grading was used in most HEIs. Findings from the specific questions are categorised below:

a) When do you 'Grade practice'?

The survey comprised only an open question, leaving respondents to use free text to explain their processes. Quantitative data were therefore not available, but four themes were identified to reflect the differing approaches: (i) Twice a year; (ii) End of year; (iii) Variety throughout the year; (iv) Clinical practice modules. :

(i) Twice a year:

If grading took place twice a year it was generally at the end of a six-month period or semester. In some instances a formative assessment was undertaken after the first six months and a summative after the second. In some cases each semester had a

summative assessment with occasionally an average of the two grades used as the final mark.

(ii) End of the year:

Although in all cases grading took place at the end of the year in this theme, some may also have taken place at the end of specific placements. All grades were reviewed at the end of the year and could be increased if further experience had been gained. In one case practice was assessed as pass/fail using competence measured against the five core midwifery Essential Skills Clusters (NMC, 2009) and a grade was then awarded for overall performance at the end of the year.

(iii) Variety throughout the year:

Not all HEIs graded practice each year of the programme, whilst others undertook formative or summative assessment after every practice placement.

(iv) Clinical practice modules:

In many institutions discrete modules were allocated to practice, with at least one being included in each year of the programme. As described earlier, frequency varied and practice was not always a summative component of the module assessment in either year one or two. Summative assessment did, however, take place in all final year practice modules across all universities.

b) How do you 'Grade practice'?

The qualitative responses to this open question were categorised in a grid using terms such as mentors, grading tool, summative or formative point and types of grades. These themes were then adjusted to reflect an emerging alliteration according to six 'Ps' – (i) **P**eople, (ii) **P**rocess, (iii)**P**oint in course, (iv) **P**ackage, (v) **P**ass marks and (vi) **P**ortfolio. This is reminiscent of themes identified in an earlier

multiprofessional study on assessing practice (Fisher et al., 2011) – process, preparation, purpose, placement, people and professional persona.

(i) People:

Clinical and university based midwives were involved in the process of grading practice across all HEIs, with clinical staff comprising mentors, midwives or sign-off mentors. Academics were referred to as lecturer, link lecturer, personal tutor or teacher, midwife teacher or university lecturer. In one university a supervisor of midwives was involved in the process. Only a couple of responses specifically stated the student's contribution to their practice assessment.

(ii) Process:

A range of processes in awarding grades were described. These included sign-off mentor only grades, sign-off mentor assessment of competence and provision of qualitative feedback which was subsequently graded by academics, clinicians marked and lecturers moderated, or a clinical educational meeting was arranged for moderation. A tripartite meeting (or triad) involving the student, sign-off mentor and lecturer was mentioned by seven universities. This could be face-to-face or over the telephone. On some occasions grading was undertaken at this meeting while in others marks had already been awarded prior to the discussion. In some institutions it was unclear whether the grade was actually derived from practice or from a written piece of work to complement this. Student self-assessments formed part of the process in some programmes.

(iii) Point in course:

Continuous assessment was mentioned by several respondents. Practice was commonly graded in the final week of placement, although a range of assessment points were used across the UK, as identified earlier. One respondent mentioned

intermediate and final, but these terms were not qualified. One explicitly stated that assessment was at levels five and six only (i.e.: years two and three).

(iv) Package:

The framework or tool used in practice assessment varied across HEIs. The most frequent terms describing tools included criteria, scoring tool, criterion referencing, percentages and aggregate scores. Some tools had up to 20 descriptors with five possible grades. Criteria assessed included both clinical skills and concept-based components, with knowledge, skills, attitudes, communication, co-operation, team work, reflection, problem solving and self-awareness being cited. One HEI specifically mentioned the close relationship between the NMC Essential Skills Clusters (NMC, 2009) and the assessment tool. Others commented on continuous assessment, signing of learning outcomes and NMC Domains (NMC, 2009). Some programmes used published frameworks such as Benner's 'Novice to expert' (1984) or Steinaker and Bell's 'Experiential taxonomy' (1979). Others devised their own framework, incorporating the '6Cs' (Department of Health, 2012). Two cited common assessment documents used in their region.

(v) Pass marks:

In compliance with NMC requirements, all HEIs ensured that if one element of practice did not pass, the whole assessment was deemed a fail and had to be achieved at second attempt (NMC, 2009). Pass marks were defined as 'D', 40%, 50% or a simple pass/refer. One rubric indicated a choice of grades within a band. Descriptive measures ranged from refer to excellent with up to five or six available scores, or A-F and AA-F. Several respondents stated that the academics undertook a formulaic calculation to convert these descriptive terms to numeric marks.

(vi) Portfolio:

Not all of the institutions used a grade which was derived only from direct assessment of practice in the placement. Other modes of assessment included portfolios or reflective accounts, caseload reports, viva voce and Objective Structured Clinical Examinations (OSCEs) such as hand washing and administration of medicines. One university incorporated ward and medicine management assessments in the clinical environment as part of the practice grade. As little as 10% of the grade could arise from clinical practice only; in this institution a portfolio and viva voce made up 90% of the practice grade. One tool had four elements marked by the mentor (contributing to 50% of the assessment) with another marked by mentor and lecturer comprising the second half. Another university determined achievement of practice competencies through confirmation by the sign-off mentor, with the portfolio itself comprising 100% of the practice grade.

c) What weighting is given to 'Grading of practice'?

This was again an open question, and general categorisation of qualitative responses took place. At least 50% of the practice module/s in the majority of programmes comprised grading of practice, but this attracted a variable number of credits. Between 10 and 60 of the 120 academic credits were awarded each year for practice across the UK, with some institutions increasing the credits incrementally as the years progressed, such as 20 in year one and 60 in year three. Some extremely complex calculations were used.

In summary, a significant lack of parity in the process of grading practice was demonstrated across UK pre-registration midwifery programmes. Although all

institutions met Standard 15 of the NMC requirements for grading of practice (2009), there was a wide variation in approach. Timing included differing interpretations of 'progression points'. A range of modes of assessment attracting practice grades were described, and weighting was variable. There were notable differences in the assessment of observed practice in clinical settings and the extent to which this contributed to the overall practice grades. Although a sign-off mentor was always part of the practice assessment process, a number of other contributors were cited. A diversity of frameworks or assessment tools were used, however commonalities in clinical skills and concept-based components as outcomes were noted.

2. **The impact of 'Grading of practice' on mark profiles**

Quantitative responses were sought to the question about whether there had been any observable alteration to students' mark profiles since grading of practice became mandatory, with options being provided. The results are shown in *Figure 1*. The six respondents (15%) who said they were unable to comment explained that this was either because grading had been undertaken for over 10 years in their institution so it was not possible to make comparisons with previous academic profiles, or that grading had only recently been introduced. Half of the respondents (n=20) stated that students' mark profiles were higher since practice had been graded. Fourteen (35%) stated that no difference was evident. Of note, no respondents said the profiles had decreased.

Figure 1: Alterations to students' mark profiles

Themes which emerged in the qualitative responses to this question were categorised into: a) Degree classification; b) Correlation between practice and academic modules; c) Grading profile; d) Increased confidence; e) Moderating influences; f) Contributory factors.

a) Degree classification:

The general view was that the positive impact on degree classification was acceptable and to be expected as a minimum of 50% of the programme was practice-based. It was suggested that academic module profiles were often close to the next grading band and the practice module/s tipped them over into the next category as they often fell in the 70%+ bracket.

b) Correlation between practice and academic modules:

Generally students who were academic high-achievers also gained high marks for practice. There were, however, exceptions to this: one cited a band difference (higher) for weaker students and another noted that some students who were less able academically but known to perform at a high standard in practice achieved grades reflecting this. The resultant altered profile was considered to recognise the importance of practice.

c) Grading profile:

The full range of grades was now seen and a more normal distribution curve was noted in a number of HEIs. One respondent stated that the profile of marks achieved by individual students for the various practice assessment criteria showed variations which indicated that sign-off mentors were thoughtful about grades awarded, and that the range of grades across the cohort was reassuring of the process in placements across the region. However, one respondent stated that students did not always feel their achievements in practice were reflected in the grade awarded, thinking this should be higher. They also perceived a variation in the grading process between different mentors and personal tutors in their institution.

d) Increased confidence:

Nearly all respondents noted that as sign-off mentors became more familiar with the process and the assessment tool became more refined, they appeared more appreciative of the implications of giving higher grades and reserved these for 'exceptional' students. This increased confidence also resulted in enhanced decisiveness in constructive referral.

e) Moderating influences:

Factors identified which appeared to enhance the 'moderation' of inflated grades and rigour of assessment included:

- Careful wording of grading frameworks or criteria;
- Support from academics at implementation of a new assessment tool or process;

- Formative grading opportunities which provided a benchmark for subsequent summative grading activities and also enabled new sign-off mentors to practise these skills;
- In institutions where this was used, tripartite (or 'triad') discussions involving an academic, the sign-off mentor and student were valued as a moderation process, ensuring that grading aligned with the sign-off mentor's qualitative (written or verbal) evaluation of the student's performance;
- In institutions where other components in addition to pure clinically-based practice assessment were included, respondents considered that this helped mediate grade inflation yet maintained the focus on accredited practice.

f) Contributory factors:

Two respondents noted that other initiatives could have resulted in the apparent improvement in profiles and awards over the past few years, such as a change to degree pathways and recruitment practices. This included the requirement for higher academic achievements for entry to many of the programmes, reflected in increased UCAS points (the UK Universities and Colleges Admissions Service rating system). It was also suggested that students' improved uptake of and responsiveness to formative feedback and feed-forward in theory and practice could contribute to increased marks.

In summary, the majority of respondents noted an increase in or maintenance of academic profiles since grading of practice was introduced. It was clear that these changes were generally welcomed by the academics, who considered that the increased emphasis on practice was a positive development. It was evident that as the grading process had become embedded, so sign-off mentor confidence had

grown – and this was further enhanced by clear frameworks and processes. The importance of academics supporting sign-off mentors in their role in order to ensure a level of intra and inter-assessor reliability was highlighted, and a range of approaches was taken to address this. Some alternative influences were suggested which may have also contributed to the apparent increase in the majority of mark profiles.

3. Clinicians' views on grading of practice

Respondents were asked to draw on their experiences from internal quality monitoring processes and other interactions with clinicians in order to determine their perceptions of grading of practice. Qualitative responses were themed: a) Being valued; b) Specificity; c) Partnerships; d) Challenges.

a) Being valued:

Nearly all respondents said that clinicians were positive about grading of practice and comfortable with the process. Reasons included especially:

- The value this gave to practice and its minimum 50% contribution to the programme;
- The opportunity to reward and value students who excelled in practice, contributing to their degree classification;
- The value this gave to the sign-off mentors as contributors to the assessment process and their role as professional gatekeepers.

b) Specificity:

Clinicians were not keen on a pass/fail system and preferred the awarding of grades, considering this to be more robust; those who had experienced assessment of

students prior to the implementation of grading were particularly vocal. Sign-off mentors felt grading acknowledged good practice across different domains and highlighted strengths and weaknesses in a way that was comparable. They saw grading as essential to properly reflect a student's capabilities. They also liked the fact that students received instant feedback about their performance. Those who had experienced poorly achieving or failing students were positive about the assessment document enabling them to pin-point areas of weakness and make clearer decisions through having to award a specific grade. It was evident from the majority of the HEI responses that as clinicians became more confident in the process, so did their appreciation of grading.

c) Partnerships:

Academic staff or link lecturers were considered very important to the assessment process. Their role included clarification of issues, support of sign-off mentors to make their decisions, moderation at tripartite meetings (where these occurred), or provision of general guidance at mentor updates and ad hoc encounters. Grading workshops were seen as very useful. Academics and clinicians appreciated collaborative partnerships and clinicians were positive about being consulted. There was a willingness of academics to modify assessment tools following clinician feedback regarding clarity. In one institution, clinicians had appreciated their workload being taken into account when they expressed a wish not to grade practice themselves – instead qualitative comments were awarded a mark by academics. This consultation was also reported to have been commended by the NMC at validation events. Not all clinicians were equally enthusiastic about their increased role, however. One respondent commented that mixed opinions had been expressed by sign-off mentors about recent changes to the programme whereby they were now

required to undertake grading which had previously been performed by an academic and supervisor of midwives.

d) Challenges:

Challenges to clinicians and the grading process included:

- Time to complete documentation or undertake the grading process was considered a major factor.
- Tripartite meetings (triads) were resource-intensive although beneficial.
- Objectivity could be difficult – some sign-off mentors became too 'close' to students. Some found grading challenging as they felt this was a judgement on an individual rather than appreciating it was the student's performance which was being assessed.
- Some sign-off mentors were reluctant to award higher grades early in the course and needed guidance from academics to differentiate between criteria associated with different stages of the programme and to use the full range of grades. One respondent said that concern not to over-inflate grades could result in the opposite outcome. Lecturers worked hard with sign-off mentors to explain the concept of a normative curve.
- Some sign-off mentors still found it difficult to fail students. Students were noted to be very competitive.
- Some mentors found it difficult to provide face-to-face feedback and phrased comments differently in written and verbal forms – this could result in a discrepancy between qualitative comments and grades awarded.
- Clinicians in one area had been concerned about the move to an electronic portfolio, although another HEI said that the advantage of grading being electronic was that it was auditable.

In summary, responses to this question were largely positive about the feedback received from clinicians regarding grading of practice. Most described an increased satisfaction in the specificity of assessment since grading had been introduced. It was clear that mentors took their role very seriously. They felt valued for the contribution they made to the process and benefitted from partnership-working. Challenges reflected those documented in the wider literature about practice assessment.

DISCUSSION

As the purpose of the project was a scoping activity to elicit in-depth detail of the application of the NMC (2009) standards relating to grading of practice, quantitative data were considered of lesser importance and free text in response to open questions was encouraged. Therefore, although some quantitative data were produced, these were generally only used as a guide in relation to whether findings were unique to an institution or more wide-spread. No attempts were made to draw any within-group comparisons. The project group was more interested in establishing patterns of similarity or variance and ascertaining the possible causes and impact of inconsistencies through examining the emerging themes from the qualitative responses.

Key findings around timing, modes and academic weighting given to practice assessment demonstrated widespread variation in application of the NMC standards

to pre-registration midwifery programmes across the UK. Similarly, the extent to which clinicians were involved and the emphasis given to the contribution of directly observed practice to the overall practice grade and therefore academic profile showed notable differences. Although all institutions complied with the core principles of Standard 15 (NMC 2009), the wide variations in interpretation caused some concern. These were reflected in another published scoping exercise in nursing (Mallik and McGowan, 2007). The scale of this midwifery survey has, however, provided new information relating to the extent of these discrepancies.

The benefits and challenges of aspects of the assessment process such as the role of reflection, portfolios, observations and tripartite meetings in a range of professions are well documented in the wider literature (Doughty et al., 2007; Fisher and Webb, 2008; Fisher et al., 2011; Smith, 2007), and this study provided further evidence to support this. The findings also concur with the literature that support from academics is needed to enable those assessing practice to fulfil their role (Bennett and McGowan, 2014; Black et al., 2013; Fisher and Webb, 2008; Fisher 2009; Gainsbury, 2010; Heaslip and Scamell, 2012). This is essential in order to avoid 'failure to fail' which continues to be an issue particularly in the nursing literature (Black et al., 2013; Duffy, 2004; Jervis and Tilki, 2011; Rutkowski, 2007). This project identified, however, that mentors become more confident in grading practice and using the full range of marks available as they gain experience – particularly when supported by academics. Although opinions are divided as to the academic's role in grading practice since they do not usually witness the student's performance (Passmore and Chenery-Morris, 2014), their role in tripartite or triad meetings may fulfil a combination of valuable educational and psychosocial support. Of note, many

of the respondents stated that clinicians indicated that they found the grading process helpful in discerning levels of performance and particularly pinpointing those students who were not achieving. This is an encouraging aspect of the requirement to grade practice in midwifery.

Whilst a range of assessment tools were used, all programmes incorporated a combination of concept-based and practical skills assessment. The importance of assessing all these criteria is supported in the wider literature and across health professions (Fisher et al., 2011; McLean et al, 2005; McLean 2012; Nicholls and Webb, 2006). It is, however, important that there is parity in the measures used to assess competence at point of registration, or inter-assessor reliability and validity is compromised and the consistency of decision-making is put into question.

This study found that there appeared to have been a positive skew in the profile of midwifery students' marks and therefore degree classification since grading of practice became mandatory. This was a finding which has not previously been reported on such a wide scale. Whether – as suggested by some respondents – this is a good thing as it emphasises the importance of practice, or whether it may reflect challenges of inter and intra-assessor reliability due to the range of individuals involved in the process is open to debate. A systematic literature review of grading in a range of professional practices also raised the issue of grade inflation (Gray and Donaldson, 2009). They found that this could be attributed to pressure by students, leniency of mentors, inadequate understanding of the impact of grading, a close student-mentor relationship and efficacy of the tool. Their later paper (Donaldson and Gray, 2012) offered ways to reduce this, such as development of a common

practice assessment tool. This is particularly the case where HEIs share placements as differences can cause confusion and increased workload for those supporting students in practice. Separate to this project but happening at a similar time, funding was agreed by three UK Local Education and Training Boards to develop a common midwifery practice assessment tool between eight universities and their practice partners in London (Gillman, 2014). This initiative was in response to a request from the local Trusts after the successful implementation of a PAN London nursing practice assessment document in 2014. Similar work had previously been undertaken in 2008 across six sites in the Yorkshire and Humber region of England, where a common practice assessment tool had been implemented and evaluated in midwifery. A Scottish tool is also being proposed.

Although the design of this study was largely qualitative and statistical significance cannot therefore be defined, the inconsistencies in interpretation and application of the NMC (2009) standards are unequivocal. Although some diversity is inevitable as the structures of curricula will differ, programme teams will have a unique ethos and university regulations will vary, it could be argued that a move towards greater equity of assessment would be good practice. It is therefore intended that a set of core principles and common grading matrix will be developed by the LME-UK group, drawing on the findings from this scoping activity. Work is already underway to refine these. As the NMC standards are currently being reviewed and the opportunity will therefore arise for teams to incorporate these principles into newly validated programmes, it is hoped that parity of practice assessment processes will thus be enhanced. **CONCLUSIONS**

The LME-UK group benefits from opportunities for collaboration and sharing of projects which are perhaps unique due to the network of midwifery educationalists and institutions across the four countries. This facilitates dissemination of ‘best practice’. This scoping activity was therefore important as it enabled a nationwide evaluation of methods, tools and views currently used to grade practice in midwifery

programmes. The value of undertaking such a widely representative project cannot be underestimated.

There is the opportunity for findings of this study to be embraced by the key educationalists and professional regulators who are in a position to have a significant impact on future midwifery programmes. Ongoing efforts to address some of the inconsistencies highlighted in this study will promote greater parity in the application of professional standards across the four countries in the UK. This will enhance reliability in assessment of competence of future registrants, better fulfilling the partnership responsibilities between clinicians and academics to be gatekeepers to the profession and thereby promoting protection of the public.

[word count 5004]

CONFLICT OF INTEREST STATEMENT

None of the authors has any financial or personal conflict of interest with other people or organisations which could bias this work.

REFERENCES

Benner, P., 1984. From novice to expert: Excellence and power in clinical nursing practice. Addison-Wesley, Menlo Park.

Bennett, M., McGowan, B., 2014. Assessment matters-mentors need support in their role. British Journal of Nursing 23 (9), 454-458.

Black, S., Curzio, J., Terry, L., 2013. Failing a student nurse: A new horizon for moral courage. Nursing Ethics 21 (2), 234-238.

Chenery-Morris, S., 2010. Grading midwifery practice: a discourse analysis. Evidence Based Midwifery 8(4), 122-127.

Department of Health, 2012. Compassion in Practice: Nursing, Midwifery and Care Staff – our vision and strategy. [Online], Available: http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf [8 March 2015].

Donaldson, J. and Gray, M., 2012. Systematic review of grading practice: is there evidence of grade inflation? Nurse Education in Practice 12(2), 101-114.

Doughty, R., Harris, T. and McLean, M., 2007. Tripartite assessment of learners during practice placements in midwifery pre registration programmes. Education and Training 49(3), 227-235.

Duffy, K., 2004. Failing students: a qualitative study of factors that influence the decisions regarding assessment of students' competence in practice. Nursing and Midwifery Council, London.

Fisher, M. and Webb, C., 2008. What do midwifery mentors need? Priorities and impact of experience and qualification. Learning in Health and Social Care 8(1). [Online], Available: http://onlinelibrary.wiley.com/doi/10.1111/j.1473-6861.2008.00193.x/pdf [8 March 2015].

Fisher, M., 2009. How can midwifery sign-off mentors be supported in their role? An evidence-based discussion of the challenges facing clinicians, managers and academics. MIDIRS Midwifery Digest 19(3), 319-324.

Fisher, M., Proctor-Childs, T., Callaghan, L., Stone, A., Snell, K. and Craig, L., 2011. Assessment of Professional Practice: Perceptions and Principles, in: Wergers, C.E. (Ed), Nursing Students and their Concerns, pp.1-36. Nova Science Publishers, New York. [Online], Available: https://www.novapublishers.com/catalog/product_info.php?products_id=22965 [8 March 2015].

Gainsbury, S., 2010. Mentors admit to passing bad students. Nursing Times 106 (16), 1-3.

Gillman, L., 2014. Grading clinical practice in midwifery, the opportunities and challenges. Maternity, Mother and Baby: Caring through the Science and Art of Midwifery Conference, London.

Gray, M. A. and Donaldson, J., 2009. Exploring issues in the use of grading in

practice; literature review. Edinburgh Napier University, Edinburgh.

Heaslip, V. and Scammell, J.M.E., 2012. Failing underperforming students: The role of grading in practice assessment. Nurse Education in Practice 12(2), 95-100.

Jervis, A. and Tilki, M., 2011. Why are nurse mentors failing to fail student nurses who do not meet clinical performance standards? British Journal of Nursing 20, 582-587.

Lead Midwives for Education United Kingdom Executive Group, 2014. Terms of Reference. LME-UK Executive.

Mallik, M. and McGowan, B., 2007. Issues in practice based learning in nursing in the United Kingdom and the Republic of Ireland: Results from a multi professional scoping exercise. Nurse Education Today 27(1), 52-59.

Marsh, S., Cooper, K., Jordan, G., Merrett, S., Scammell, J. and Clark, V., Accessed 4/8/14. Assessment of Students in Health and Social Care: Managing Failing Students in Practice, Making Practice Based Learning Work Project. [Online], Available: http://cw.routledge.com/textbooks/9780415537902/data/learning/5_Assessment%20of%20Students%20in%20Health%20and%20Social%20Care.pdf [8 March 2015].

Maxted, M., Grant, J., Wooding, K. and Norcini, J., 2004. Assessing Healthcare Students in Practice Placements: An overview of the Literature.

Association for the Study of Medical Education (ASME), Edinburgh.

McLean, C., 2012. The yellow brick road: A values based curriculum model. Nurse Education in Practice 12(3), 159-163.

McLean, C., Monger, E. and Lally, I., 2005. Assessment of practice using the National Health Service Knowledge and Skills Framework. Nursing in Critical Care 10(3), 136-142.

National Health Service Education for Scotland, 2008. Nursing and Midwifery in Scotland; being fit for practice. NHS Education for Scotland, Edinburgh.

Nicholls, L. and Webb, C., 2006. What makes a good midwife? An integrative review of methodologically-diverse research. Journal of Advanced Nursing 56(4), 414-429.

Nursing and Midwifery Council, 2006. NMC consultation on a review of pre-registration midwifery education. Nursing and Midwifery Council, London. [Online] Available: http://www.nmc-uk.org/Documents/Consultations/NMC%20Consultation%20-%20pre-registraition%20midwifery%20education%20-%20final%20report.pdf [8 March 2015].

Nursing and Midwifery Council, 2008. Standards to support learning and assessment in practice. Nursing and Midwifery Council, London. [Online], Available: http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Standards-to-support-learning-assessment.pdf [8 March 2015].

Nursing and Midwifery Council, 2009. Standards for pre-registration midwifery education. Nursing and Midwifery Council, London. [Online], Available: http://www.nmc-uk.org/Documents/NMC Publications/nmcStandardsforPre_RegistrationMidwiferyEducation.pdf [8 March 2015].

Passmore, H. and Chenery-Morris, S., 2014. Exploring the value of the tripartite assessment. Nurse Education in Practice 14 Issue 1, 92-97.

Rutkowski, K., 2007. Failure to fail: assessing nursing students' competence during practice placements. Nursing Standard 22, 35-40.

Skingley, A., Arnott, J., Greaves, J. and Nabb, J., 2007. Supporting practice teachers to identify failing students. British Journal of Community Nursing 12 (1), 28-32.

Smith, J., 2007. Assessing and grading students' clinical practice: midwives' lived experience. Evidence Based Midwifery 5 (4), 112-118.

Steinaker, N.W. and Bell, M.R., 1979. The Experiential Taxonomy: a new approach to teaching and learning. Academic Press, London.