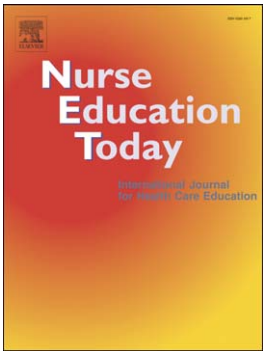
DOI:
10.1016/j.nedt.2017.04.023

Document Version
Peer reviewed version



New models to support the professional education of health visitors: A qualitative study of the role of space and place in creating 'community of learning hubs'

Sara Donetto, Mary Malone, Lynn Sayer, Glenn Robert

PII: S0260-6917(17)30099-0
DOI: doi:10.1016/j.nedt.2017.04.023
Reference: YNEDT 3537

To appear in: *Nurse Education Today*

Received date: 27 October 2016
Revised date: 9 March 2017
Accepted date: 20 April 2017

Please cite this article as: Donetto, Sara, Malone, Mary, Sayer, Lynn, Robert, Glenn, New models to support the professional education of health visitors: A qualitative study of the role of space and place in creating 'community of learning hubs', *Nurse Education Today* (2017), doi:10.1016/j.nedt.2017.04.023

NEW MODELS TO SUPPORT THE PROFESSIONAL EDUCATION OF HEALTH VISITORS: A QUALITATIVE STUDY OF THE ROLE OF SPACE AND PLACE IN CREATING 'COMMUNITY OF LEARNING HUBS'

Word count: 5147 words (including abstract and references)

Sara Donetto, Research Fellow, Florence Nightingale Faculty of Nursing & Midwifery, King's College London, sara.donetto@kcl.ac.uk (corresponding author)

Mary Malone, Head of Department of Adult Nursing, Florence Nightingale Faculty of Nursing & Midwifery, King's College London, mary.malone@kcl.ac.uk

Lynn Sayer, Lecturer - Specialist in Public Health Nursing, Florence Nightingale Faculty of Nursing & Midwifery, King's College London, lynn.sayer@kcl.ac.uk

Glenn Robert, Professor in Healthcare Quality & Innovation, Florence Nightingale Faculty of Nursing & Midwifery, King's College London, glenn.robert@kcl.ac.uk

Address for correspondence:

The Florence Nightingale Faculty of Nursing & Midwifery
King's College London
James Clerk Maxwell Building
57 Waterloo Road
London
SE1 8WA

Acknowledgements: this work was supported by funding from NHS London. A presentation based on this paper was presented at the 7th annual conference on "Critical perspectives on professional learning" in Leeds in 2015.

Conflicts of interest: None

NEW MODELS TO SUPPORT THE PROFESSIONAL EDUCATION OF HEALTH VISITORS: A QUALITATIVE STUDY OF THE ROLE OF SPACE AND PLACE IN CREATING 'COMMUNITY OF LEARNING HUBS'

ABSTRACT (289/300 words)

Background: in response to a policy-driven workforce expansion in England new models of preparing health visitors for practice have been implemented. 'Community of Learning hubs' (COLHs) are one such model, involving different possible approaches to student support in clinical practice placements (for example, 'long arm mentoring' or 'action learning set' sessions). Such models present opportunities for studying the possible effects of spatiality on the learning experiences of students and newly qualified health visitors, and on team relationships more broadly.

Objectives: to explore a 'community of learning hub' model in health visitor education and reflect on the role of space and place in the learning experience and professional identity development of student health visitors.

Design: qualitative research conducted during first year of implementation .

Settings: three 'community of learning hub' projects based in two NHS community Trusts in London during the period 2013-2015.

Participants: managers and leads (n=7), practice teachers and mentors (n=6) and newly qualified and student health visitors (n=16).

Methods: semi-structured, audio-recorded interviews analysed thematically.

Results: participants had differing views as to what constituted a 'hub' in their projects. Two themes emerged around the spaces that shape the learning experience of student and newly qualified health visitors. Firstly, a generalised need for a 'quiet place' which allows pause for reflection but also for sharing experiences and relieving common anxieties. Secondly, the role of physical

arrangements in open-plan spaces to promote access to support from more experienced practitioners.

Conclusions: attention to spatiality can shed light on important aspects of teaching and learning practices, and on the professional identities these practices shape and support. New configurations of time and space as part of educational initiatives can surface new insights into existing practices and learning models.

Highlights

- little research has been conducted into the role of spatiality in nurse education
- three 'community of learning hub' projects aimed to support health visiting learning
- need for a 'quiet place' for reflection as well as sharing experiences
- physical arrangements need to enable access to experienced practitioners
- spatiality can help explore how professional education practices shape professional identities

INTRODUCTION

Analyses of space as not merely the "arena in which social life unfolds, but rather as a medium through which social relationships are produced and reproduced" (Gregory & Urry, 1985, p.3) have been relatively scarce in higher education research (Edwards & Clarke, 2002). Although, over the last two decades, a substantial body of research has emerged that applies geographical thinking to nursing enquiry (Andrews, 2006, 2016), there has been little analysis of the role of spatiality in nurse education (e.g. Gray, 2003; Brodie et al., 2005; Andrews et al., 2005, 2006). In this paper, we explore a learning support initiative in health visitor education and reflect on the role of space and place in the learning experience and professional development of student health visitors.

Health visitors are Specialist Community Public Health Nurses (SCPHNs) with a varied and complex role which includes leading and supporting interventions aimed at improving the health and social outcomes of children aged 0-5 years. Student health visitors access their post-registration programme having previously qualified as either nurses or midwives. Qualification courses are usually delivered over 52 weeks (NMC, 2006) and include both university and practice-based learning. Traditionally, practice placements follow a model of preparation for practice where one student is assigned one qualified practice teacher (an experienced health visitor who has undertaken further training to supervise students) for the duration of the programme. However, more recently, in response to the Coalition government's drive to dramatically increase the number of health visitors in post by 2015 and re-frame the vision for health visiting services (Department of Health, 2011), other models have been tested. In particular, in view of the dramatic increase in student numbers caused by the policy-driven workforce expansion, long-arm mentoring approaches have been implemented, with one practice teacher being responsible for a variable number of students, each supported by a mentor (usually a qualified health visitor who has undertaken some mentoring training) (for more detail, see Devlin & Mitcheson, 2013; see also Figure 1).

{Insert} Figure 1 - Models of health visitor practice learning

With the aim to ensure good learning experiences for the considerably larger and growing student body, in 2012 NHS London invited applications for funding to support local initiatives which would enhance health visitor learning. King's College London was awarded funds to pilot a 'hub-and-spoke' model for supporting health visiting students in their practice placements at two participating NHS trusts. The model draws upon the theoretical underpinnings of Lave and Wenger's (1991) 'communities of practice' and seeks to establish 'Community of Learning hubs' (COLHs) for the professional learning of health visitors. It does so primarily by facilitating organisational rearrangements which enable one experienced practice teacher in each COLH to dedicate protected (40% full-time equivalent caseload-free) time to supervising and coordinating learning not only for health visiting students but also newly qualified health visitors, practice teachers and mentors. The way in which the model was implemented in each trust and the activities it included were left to the expertise and local knowledge of service managers and senior practice teachers. The two participating London NHS trusts implemented three community of learning hubs projects, two in one trust – which we called the Oak and Pine projects, and one - the Sycamore project - in another. The projects started in November 2013 and ended in October 2015. Our evaluation explored the views of managers, educators, project leads, students and newly qualified practitioners on their experiences of the COLH projects during the first year of implementation.

Like Edwards and Usher, we find that the "relative lack of interest in space" in higher education research "becomes even more surprising when one considers the extensive use of spatial metaphors in the discussion of education and pedagogy" (2003, p.1). In view of the marked spatial connotations of 'hub' metaphors, and indeed of 'communities of practice' models for learning, in this paper we

focus on some possible effects of spatiality on the learning experiences of student and newly qualified health visitors and on team relationships more broadly.

METHODS

Between July and October 2014, we carried out 29 individual semi-structured interviews with managers and leads (n=7), practice teachers and mentors (n=6) and newly qualified and student health visitors (n=16) involved in the Community of Learning 'hub' projects supported by King's College London (a breakdown of interviews by project is provided in Table 1). Interviews were carried out by SD, who is an experienced interviewer as well as a researcher with experience of the health visiting setting but a complete outsider to the COLH initiative. They lasted approximately between 20 and 80 minutes and aimed to explore people's understandings of and involvement with the initiative, their experiences of providing and/or receiving learning support, and their views on the key benefits and challenges of the initiative. They were transcribed verbatim and analysed thematically. All members of the research team coded a sample of 5 transcripts. Emerging codes and categories were discussed at two team meetings and a coding framework generated to guide further coding. SD coded all transcripts using and expanding the agreed coding framework. Coding was carried out both manually and in NVivo-10 to aid data management. Ethical approval was obtained by the King's College London Psychiatry, Nursing and Midwifery Research Ethics Sub-committee prior to data generation. All names used for projects and participants in this paper are pseudonyms; data extracts have been edited to ensure confidentiality.

{insert} Table 1 - Interviews

The three community of learning 'hubs'

Two NHS trusts took part in the initiative to pilot a COLH to support health visitor learning in practice. One trust implemented the project (Sycamore COLH) in one London borough, the other trust ran two parallel COLH projects (Oak and Pine), one in each of two London boroughs and covering approximately half its geographical area. The three projects were different in many respects; their main characteristics, including the organisation of physical space (which varied greatly due to local circumstances) are summarised in Table 2.

{insert} Table 2 - Characteristics of the three COLH projects

RESULTS

Participants in our study had different views about what counted as a hub in their COLH projects. For the heads of children's services at both trusts, the essence of having a 'hub' was that all students, regardless of specific placement, would have access to a senior practice teacher as a point of reference for support. For project leads Tanya (Oak COLH) and Nadine (Pine COLH) as well as mentor Eleanor (Pine COLH), the definition encompassed the place in which the educational support was available, as well as the wider concept of supporting students and newly qualified practitioners in their learning. However, for the students affiliated with the Pine COLH who were aware of the existence of a 'hub' room, referring to the hub usually meant referring to a specific room a few doors away from their main health visiting office.

Where no dedicated room was available, students were less clear about what counted as a hub. Regardless of where the emphasis was placed in terms of who or what functioned as a hub in

connecting people and activities aimed at supporting health visitors' learning, our analysis highlighted that – in different ways in each of the projects – spatiality had an important role to play. The physical space often identified as the hub in the Pine project, the instability of similar designated spaces in the Oak project, and the physical coming together in monthly 'supervision' encounters in the Sycamore delineated this role more clearly.

The Pine hub room: a designated space to 'get away' to reflect, learn, and share experiences

The Pine project was the only one where a room was clearly identified as a 'protected' space for students (see figures 2 and 3). It was interesting that whilst educators described this room as a space that was often used by students to reflect, study, and get together to discuss their practice, the students we interviewed did not report using the room very much. Project lead Nadine explained the function of the room:

> *So I think what it actually offers students is a place where they can go in a group and meet up themselves without me being there. This is their space as such. so I think for them it offers them that opportunity, that peer support, and that sharing of information, because quite often when I come in here they have been sharing information, you know, sharing experience of alternative practice.* (Nadine, project lead, Pine)

{insert} Figures 2 and 3 - the 'hub' room at the Pine project

Students overall liked the fact that a room was available, and some appreciated the fact that some resources (mainly journals) were kept in it, and could see the potential of improving the space with a steadier desk and a computer with internet access. However, they also found themselves seldom using the room. Student Madeleine, also from the Pine project and based at the 'hub' health centre,

found that the room was a good space for reflection, although in practice it was difficult for students to find the time to sit in it and think about their experiences as student practitioners. Madeleine's comments on the lack of time to use the 'hub' were echoed by other students based at the same health centre, whilst for Rosemary, who was based elsewhere, accessing the hub was not easy enough to become a regular undertaking:

> *Well, that's the thing I was going to say about the hub. I come here when there's teaching sessions on, but other than that, generally I don't, because it takes about 10-15 minutes to get here and then get back, and it's just easier for me to get the train [home] from there. So, generally I do my sort of reflection at the end of the day with my mentor at [our base]. I don't really come here that often.* (Rosemary, student, Pine)

Student Chloe did not find the room very conducive to studying or reflecting on learning and practice:

> *To be honest, I don't think it's necessary. I mean, it's nice to have, it kind of feels like a staff room. That's how I see it. It's more like if I was going to have my lunch, I'd come and sit in here. But it's not really, I would definitely not study in here, on the broken table, and I would never sit on this chair, with the table so low, to study. Neither would I sit up there with the foetus looking at me.* (Chloe, student, Pine)

Chloe also felt that the layout of the room was not ideal for seminar-like sessions and Louise found that it did not afford enough privacy for supervision. However, student Lucy found that the room was very helpful at the beginning of the placement, when students who had just started and felt uneasy about the new environment could meet and offer each other some support:

> *…it was a good feeling to know that we've got this room that we can come to, as students. That it belongs to us. We felt, like, initially, in the first few days, when we didn't really know the other people in the office, it was quite nice to be able to come out here and just give each other moral support and get away from it all. Which is why we used to make time for lunch quite regularly as students, you know, 'cause it was sort of our hideaway place, and that was quite nice in the first few days.* (Lucy, student, Pine)

Irrespective of the extent to which the room was used by student health visitors, the very fact that it existed and was available at all times seemed to have a significant symbolic value for learners and educators alike. In several descriptions, the hub room was a safe haven, a place that offered refuge when students needed to 'get away' from the busy environment of the main office and/or the emotional demands of practice. Whether or not students actually used the room to this effect was relatively unimportant, as long as the place was perceived to offer the possibility for temporary withdrawal. Mentor Eleanor pointed at the anxieties that the practice learning could involve for students:

> *It's a useful space, as well, for them – the hub – where they can come away from the hustle and bustle of the health visiting room and they can come here together and they can reflect together and talk out amongst themselves what's happening. That has happened, actually, where [the COL lead] has gotten them together and they just said what was going well for them and what wasn't and what they would like to happen, and that was fed back to us as mentors and acted upon. So, from that point of view, it's really useful. Because then the student isn't left thinking, 'Oh, I have nowhere to take my anxieties and if I'm not – if I feel I'm not achieving, where do I take it?' There's somewhere for them to take it.* (Eleanor, mentor, Pine)

Even though the actual use of the room by students seemed limited, its function as a 'hideaway place' appeared important and may have the potential to affect the way in which students deal with the anxieties of entering the unfamiliar workplace in which they are meant to develop their professional identity. As we go on to illustrate below, the role of a space for reflection and peer support was important even when such space was far less stable or not at all identified as a 'hub'.

The Oak and Sycamore hubs: unstable and flexible spaces for reflection and learning

Student Rebekah, from the Oak project, explained that project lead Tanya had tried to organise a space but students had drifted due to the intensity of the academic programme. She explained how students affiliated with the project had used a library room in one of the bases and found it useful to meet there to bounce ideas off each other (see figures 4 & 5).

{insert} Figures 4 & 5 – Prospective 'hub' room at Oak

However, after the early days students were just too busy to meet again in the same way. Despite the lack of time, Rebekah also said that "it would have been nice" to have an allocated space within the workplace to "reflect on what's working and what's not working" – again highlighting the potential need for a designated space for reflection regardless of the frequency with which it is used.

As discussed earlier, the Sycamore project involved a smaller community of practitioners, educators and learners, and it focused on supporting newly qualified health visitors in view of the anxieties that the early stages of working as an independent practitioner after the university links are severed may entail. The regular monthly Action Learning Set or 'supervision' sessions held as part of the COLH project took place in a meeting room removed from practitioners' bases. Newly qualified health visitors and the project lead facilitating the sessions usually met in the same room but

changes of venue had occurred when the habitual room had been unavailable. This was a rather plain board meeting room with a rectangular table and approximately 12-14 chairs, big windows, and no decorations or information material on any of the walls. Although the 'supervision' sessions part of the Sycamore project did not have any correspondence with the activities at the Pine and Oak projects, like the hub room they were meant to enable the containment and management of learners' anxieties in a safe and protected space, as manager April explained:

> *I think we, you know, when we start the set, inevitably we end up asking, myself and [Ella, the project lead] end up answering lots of questions in order to quell people's anxiety. And then, as the group develops and they build up trust, you can ask people to be a little bit more reflective and, you know, participate actively because, you know, that's where the learning and the growth and development comes from. With the practice teachers, we run a similar group.* (April, manager, Sycamore)

When asked about what she thought the COLH model offered learners that a normal placement did not, April stressed:

> *I think it offers the emotional containment and managing anxiety. I think that's really key.* (April, manager, Sycamore)

Newly qualified health visitors also talked about the supervision sessions as a chance to share their worries and concerns from practice. Bridget explains:

> *So we meet once a month and it's kind of governed by how the group wants it to go. […] We just talk about what we're worried about, any particular cases, anything like that, and then we just sort of chat through it and there'll either be [the project lead] or [the clinical lead] there,*

who is there to sort of take the group and to give their opinion on what we bring.(Bridget, newly qual HV, Sycamore)

Bridget's colleague Anne also found the sessions useful and important, and emphasised the way in which they could support learning at any stage of one's career:

I missed one 'cause I was on annual leave, but on the whole I find it really, really important, groups such as that, 'cause it gives you an opportunity to discuss any concerns or the processes and the organisational processes… […]I suppose there is structure; it's more informal structure, though, so it's just more a group discussion or a two hours to air any concerns and thoughts and, I suppose, to learn from one another. […] I don't think you ever do know everything. It doesn't matter how long you've been practising. So it's always good to discuss it and then you'll learn from others… (Anne, newly qual HV, Sycamore)

<u>The health visiting office – visibility and support</u>

As well as illustrating the actual and potential function of the COLH – irrespective of what this was actually called in each of the projects - our data also highlighted, by contrast, the functions served by the spatial arrangements of the open-plan health visiting office. Mentor Maura, above, mentioned how the office can be 'crazy.' The image of a very busy, noisy, and crowded work environment appeared in several descriptions referring to a large office. Where offices were smaller, they might not be as hectic, but they can still be limited in the space they can offer students.

It's a big team with, the health visiting team […]. So it[the open-plan office] gives easy access to what other people do and how it all works so it's been really good, been really great. The down side is you can hear everything and hear everybody so it's hard to concentrate sometimes and it

can be quite noisy you know and you're trying to do something, trying to concentrate and so that's been the downside of being in a large office with many people. (Dionne, student, Pine)

Students who were based in GP surgeries may not have suffered noisy environments, but they still described the limitations of insufficient space to accommodate students adequately and to provide for time away from one's desk – like Chloe below:

Where I am, we just have our office, where we do everything, so all the work, your lunch break – unless you go out. You can – there's nowhere else to go, so you sit there and have lunch. You can just turn your chair so you're not facing your computer. That's about it. (Chloe, student, Pine)

Despite these limitations, the co-location with other team members was seen as very helpful, and not only by students. Project lead Nadine underlined the effects physical 'visibility' had on her ability to support other educators:

…because I'm here I'm always visible which means that actually, you know, I'm always available. And sometimes when I may be busy and tied up, because I'm seen and I'm here and I'm always available… so there are advantages to that and disadvantages. However, because I'm easily accessible and always available I think the mentors appreciate that. And, you know, so, I am here. I am in that open plan office, I'm sitting in with them, I am part of the team. I'm not, you know, somewhere in some lofty tower as the senior practitioner not being hands on. I am here, I am part of the team. I'm just like them. (Nadine, project lead, Pine)

Newly qualified health visitor Frances (Sycamore project) and practice teacher Megan (Oak project) reported their approach to support-seeking. For both, physical proximity was a significant factor in feeling supported:

> *We are less than ten, with the team manager, and then we've got community nursery nurse, as well, in our team, and we've got Ella [project lead] as the supervisor there as well. […] …which is really good for me because the rest of the girls down there [in the supervision group], they're from different teams, so they can talk to [Ella] on the phone, and I get to have her next door to me. Next seat, yeah.* (Frances, newly qual HV, Sycamore)

> *I think I can go to any of them [for support], but [the project lead] and I we used to be in the same office. So it's more likely that you go to the person you know than the others.*(Megan, practice teacher, Oak)

DISCUSSION

In discussing the data presented above, we focus on two themes that stand out from students', practitioners', educators' and managers' discourses around the spaces that shape the learning experience of student and newly qualified health visitors: firstly, a generalised need for a 'quiet place,' which allows pause for reflection but also for sharing experiences and relieving common anxieties; and secondly the role of physical arrangements in open-plan spaces to promote access to support from more experienced practitioners.

In his work on practice placements in pre-registration nurse education (2003), Gray explores the possible effects of spatiality on the emerging professional identities of student nurses and suggests we examine spatial experience as having three dimensions: proximity – referring to any relationship of distance; mobility – the possibility of action over distance; and possession – the relationship

between personal and collective experiences of spatiality determined by the power relations permeating space. In discussing our findings, we use these dimensions to think about spatiality in health visitor learning.

When we looked at the forms of proximity with which students seemed most concerned in their accounts of their experiences of the community of learning hub, we found that they often referred to their proximity to a 'quiet space' to get away, reflect, and/or share experiences with peers, and with proximity to experienced practitioners who can guide and support learning. (In data we have not reported in this paper students also referred to their proximity to learning experiences, when they talked about the 'hub' lead organising alternative practice visits and other group sessions for them).

Reflecting on proximity allowed us to identify participants' references to mobility. These highlighted that students need to do a lot of overcoming distance in different ways: they are 'out' on practice placement as part of their academic programme; they go out on visits with their mentor or practice teacher when on placement; and –in some cases – they also go out and shadow other health professionals' practices on alternative practice placements. This 'high mobility' inherent in the structure of practice placements contrasted with students' resistance to acting over distance when it came to seeking support for their learning. In such circumstances, students seemed to appreciate the immediacy of advice from more experienced practitioners who were physically near or immediately available at any time over the telephone. In Gray's (2003) work, mobility is associated with the 'autonomous professional' self-image of nursing. This self-image is very strong in health visiting also, and indeed seems to go hand-in-hand with the mobility that is required of practitioners in moving between different places of work – the office, the home of the families they visit, the clinics, the children's centres. We suggest that a focus on mobility in health visitor learning highlights a tension between the autonomous professional self-image of student health visitors and the 'community' dimension of the learning support they find useful – i.e. easy to access and based on

relationships with peers and experienced practitioners of choice. More specifically, we propose that the 'high' mobility required by the professional socialisation process, which contributes to shape the 'autonomous professional' dimension of practitioners' identity, needs to be counterbalanced by a learning environment - *within* the practice placement – requiring 'low' mobility. That is, a learning environment which offers immediate access to guidance and advice as well as time and space for reflective and constructive peer support.

With regard to Gray's (2003) final dimension of 'possession', our analysis highlights the need for learning spaces in the workplace to accommodate students' experience in a way that does not make them feel alienated or excluded. Although student health visitors are supernumerary, and might therefore expect having to adapt to constrained work-spaces, physical spaces that make them feel valued members of teams and enabled to 'do their work' are likely to facilitate the development of a professional identity which values professional autonomy but is also aligned with a community of practice.

We also found it interesting that practice teachers felt the most removed from the COLH support. The practice teachers we interviewed had heard of the initiative but had taken little interest in what it offered. Whilst the data illustrated above shows how mentors, as inexperienced teachers/tutors, were often anxious about their new role and actively sought the support of the COLH lead, established practice teachers appreciated their work but did not really access the support for themselves. We therefore also propose that our data says something about the traditional one-to-one student-practice teacher model of learning for health visitors more broadly. Some of the senior practitioners reported having been worried about and relieved by the absence of open resistance from practice teachers, were the advice or support from a COLH lead to be perceived as an intrusion in one's practice as an established teacher. One project lead explained how experienced practice teachers can be 'very protective' of their students, another one explained how her role in this

project had made her reflect on the insularity of her previous teaching practice and made her develop a dimension of advocacy for students as part of her educator identity. The distributed model of support offered by the COLH as opposed to the traditional one-to-one model resonates with Gray's (2003) dimension of possession where the practice teacher's protectiveness of their student contrasts with the multiple forms of supportive relationships within the COLH.

We suggest that health visitor education should consider complementing the traditional one-to-one model of practice learning with more distributed understandings of learner support. These should incorporate the promotion of support networks for practitioners across all levels of seniority in and out of formal teaching roles. Our findings resonate with Devlin and Mitcheson's recommendations from their evaluation of different models of practice-based teaching and learning for health visitors in the East of England. In particular, their call for: "a re-examination of the culture and challenges that reside in practice placements and means to ensure optimal practice based learning that offer students a supportive clinical expert, working in close proximity"; and "a re-examination of the preparation of practice teachers and mentors, including practice teaching curricula and regulatory standards that give greater prominence to the affective aspects of practice learning considered fundamental to professional achievement" (2013, p.6).

A limitation of our study is the difficulty of contextualising our findings in an institutional environment that continually shifts and transforms. As the COLH projects were an educational initiative largely limited in space and time, it is problematic to move our argument forward by replicating our research approach. Also, the fundamental differences presented by the three projects examined made it particularly challenging to distil overarching threads in students' and educators' approaches and perspectives. This sort of challenge is, to an extent, inherent to qualitative research and does not affect the theoretical generalisability of findings; however, whilst it

can suggest useful leads for further research, it does constrain the scope of recommendations for policy and practice.

CONCLUSION

By examining the role of spatial experiences in three pilot 'community of learning hub' projects supporting health visitor learning, this paper highlights how attention to spatiality can shed light on important aspects of teaching and learning practices in professional education more broadly and on the professional identities these practices shape and support. Our study also shows how new configurations of time and space as part of educational initiatives can give us new insights into existing practices and learning models. We found Gray's analytical dimensions of proximity, mobility, and possession a useful starting point to examine in more depth the spatial experience of teachers and learners in the health professions.

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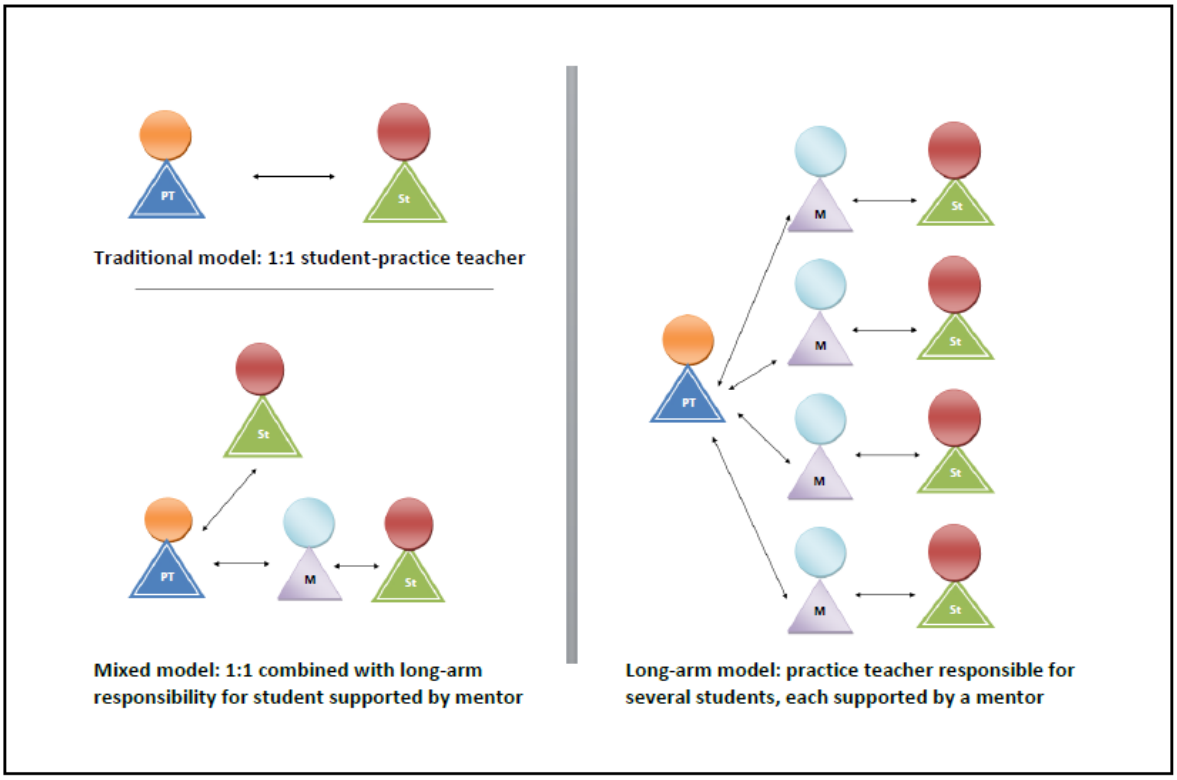
Table 1 - Interviews

Interviewees	Pine and Oak COLHs		Sycamore COLH
Head of children's services	1		1
Manager	1		1
	Pine COLH	**Oak COLH**	
Project lead	1	1	1
Practice teacher	1	2	-
Mentor	2	1	-
Newly qualified HV	2	-	5
Students	7	2	n/a
Total	29		

Table 2 - Characteristics of the three COLH projects

	Pine COLH project	Oak COLH project	Sycamore COLH project
Primary focus	Student health visitors and mentors	Student health visitors and mentors	Newly qualified health visitors and practice teachers/mentors
Catchment	Sub-section of London borough 1 (geographically divided in half for the purpose of the project)	Sub-section of London borough 2 (geographically divided in half for the purpose of the project)	London borough 3
Number of students (intakes Sep13 – Aug14)	12	7	3
Number of Newly qualified HVs	>10	5-10	5-10
Learning model	Project lead as 'troubleshooter' and coordinating additional sessions Mix of 1:1 student-practice teacher and long-arm mentoring model (project lead is senior practice teacher long-arming 6-7 students supported by a mentor)	Project lead as 'troubleshooter' and coordinating additional sessions Mix of 1:1 student-practice teacher and long-arm mentoring model (project lead is senior practice teacher long-arming 6-7 students supported by a mentor)	Project lead as 'troubleshooter' and facilitating monthly Action Learning Set sessions (known by newly qualified health visitors as supervision sessions)
Physical space	Dedicated 'hub' room for the sole use of students (health visitors and other nursing students) in the large health centre where the project lead is based (Figures 2&3)	Room for meetings and additional sessions booked as required (plans for a dedicated space to be shared with other professionals – see Figures 4&5))	Meeting room for Action Learning Set ('supervision') sessions booked regularly, usually same room same venue
Project lead	Senior Practice Teacher Nadine	Senior Practice Teacher Tanya	Senior Practice Teacher Ella
Local manager	Melanie		April
Head of children's services	Selina		Simon

Figure 1 - Models of health visitor practice learning



PT = practice teacher; M = mentor; St = Student

Figure 2 - the 'hub' room at the Pine project (photos taken by participants)

Figure 3 - the 'hub' room at the Pine project (photos taken by participants)

Figure 4 - Prospective 'hub' room at the Oak project (photo by SD)

Figure 5 - Prospective 'hub' room at the Oak project (photo by SD)