

Longitudinal Evaluation of the Impact of Placement Development Teams on Student Support in Clinical Practice

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Abstract: *Aims:* To investigate the impact of a new structure for supporting healthcare students and mentors in practice placements (Placement Development Teams).

Introduction: The English Model National Partnership Agreement for healthcare education required Strategic Health Authorities, Higher Education Institutions and National Health Service Trusts to redesign strategies for student support. Placement Development Teams are one English University's response to this.

Materials and Methodology: This study was phase 2 of a longitudinal qualitative evaluation of Placement Development Teams. Data were collected after establishment of Placement Development Teams, and compared and contrasted with those collected prior to their implementation.

Telephone interviews were conducted with key educational stakeholders in Trusts and Strategic Health Authorities. Focus groups were conducted with third year non-medical healthcare students and first year paramedics working in 16 NHS Trusts in the south west peninsula of England.

Results: Pre-Placement Development Teams, themes from the students' data were: Supportive and unsupportive behaviour of staff; Mentor allocation; Placement allocation; Benefits of students to the placement area and Perceived control over the learning experience. Post-Placement Development Teams, the themes were Communication; Supportive and unsupportive behaviour of staff; The effect of peers on the placement experience; Knowledge and perceptions of the work of the PDTs.

From the staff data, pre-Placement Development Teams the themes were: Vision for improving student support. Post-Placement Development Teams themes from the staff data were how they provided a central point of contact for student and mentor support; and how they supported students and mentors.

Conclusion: Support of students and mentors is particularly important following the introduction of The English Model National Partnership Agreement for healthcare education. Placement Development Teams can facilitate partnership working between higher education institutions and placement providers for student support.

Keywords: Healthcare education, supporting students in practice, placement learning.

INTRODUCTION

Globally, there is a drive to improve the quality of healthcare education provision including student support and mentorship [1]. In Europe, the European Network for Quality Assurance in Higher Education (ENQA) was established to promote greater harmonization of values and good practice in higher education in relation to quality assurance [2]. In the United States, the regulatory picture is different, without central government involvement and the accreditation of higher education providers is decentralised with private, non-profit organisations designed for specific purposes [2].

In England, the annual cost of educating English non-medical healthcare staff (including nurses, midwives and allied health professionals) is approximately £4 billion; and this activity is managed in contractual relationships between Higher Education Institutions (HEIs) and Strategic Health Authorities (SHAs). The English Model National Partnership Agreement (MNPA) [3] was introduced to standardise expectations, contracts, quality assurance and costs. A national benchmark price allocates indicative costs to specific activities for each SHA in its contracts with higher education placement providers [3]. Since implementation of the MNPA [3], English HEIs have been required to re-examine arrangements for student support in clinical practice, however there is no literature on the impact of these reforms.

Placement Development Teams (PDTs) were introduced in November 2007 as a partnership between HEI providers

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in Devon, Cornwall and Somerset and their practice placement providers [4]. One university faculty of health is the major provider of regional health care education, educating undergraduate students from disciplines including nursing, midwifery, ambulance paramedicine, dietetics and physiotherapy, but not including medicine and dentistry, which have separate support arrangements. (A second university delivers education for radiography students, and these students are included in the PDTs). Sixteen NHS Trusts have contractual relationships with these two universities to deliver the practice elements of their education [4].

In response to the English National Model Contract (DH 2006) for healthcare education, our faculty introduced Placement Development Teams (PDTs) [4, 5]. PDTs comprise academic staff in partnership with practice-based staff in all placement areas (NHS Trusts and the independent sector), who work together to deliver a range of supportive activities for students and mentors in practice. These activities focus primarily on support for students and mentors in practice placement areas and include the following: mentor preparation and updates; visits to placement areas to support individuals or groups of mentors and students; quality assurance audits and action planning with placement areas; providing profession-specific advice in multidisciplinary settings. PDTs involve interdisciplinary teams supporting all learners in practice, to provide cohesive interpersonal and structural support throughout students' placement learning experience [4]. PDTs thus reflect a local response to English policy drivers; they also exist in the context of international developments concerning the importance of mentoring and student support. Most developed nations require some level of post-qualifying ward experience and appropriate preparation and support for prospective mentors. There is an emphasis on communication skills and clinical expertise as being essential in mentorship roles, and mentors should help the student to learn through effective relationships; mentors are thus simultaneously teachers and supervisors, who nurture, assess clinical practice and monitor performance [6].

Phase one of our longitudinal study [4] investigated students' and staff perceptions of support activities prior to the implementation of PDTs (in late 2007). Phase two (in early 2009) had two elements: data were collected from

multi-professional healthcare student groups and PDT staff relating to the perception of PDTs support activities, and to interprofessional education. The interprofessional education element is reported elsewhere [5]. This current study is the second element of phase two and compares data on supporting students in clinical practice prior to PDTs' implementation with that gathered after implementation. It is thus a unique and innovative longitudinal study as it evaluates one HEI's structural response to the changing political drivers intended to improve partnership working and student and mentor support.

Aim

The aim of the project is to compare and contrast data from before PDTs' implementation with that gathered after their first year of operation in a longitudinal qualitative evaluation.

MATERIALS AND METHODOLOGY

Design

This longitudinal qualitative evaluation used telephone interviews and focus groups to explore student support from a staff and multi-professional student perspective. The Faculty of Health and Social Work's Human Ethics sub Committee approved the study, but the local NHS Research Ethics Committee Chair deemed the study to be service evaluation, which did not require full approval. NHS Trusts' research governance approval was given by individual trusts' research governance leads. Participants received an information sheet and gave signed consent prior to interviews, on a form which gave guarantees of confidentiality, anonymity and rights to withdraw without prejudice [4].

Sample

Forty-one students participated in the study. Two focus groups were held for both physiotherapy and adult nursing respectively and one focus group was held for podiatry and occupational therapy (n=30). Students from the disciplines of midwifery, dietetics and paramedics took part in individual telephone interviews (n=11) as they were unable to attend focus groups because they were off-site at the time of recruitment for their clinical placements [5]. Students were

Table 1. Components of the Sample

Students	Interview Methods	Total Numbers
Midwifery, dietetics and paramedics	Individual telephone interviews	11
Physiotherapy and adult nursing (two groups); podiatry and occupational therapy (one group)	Focus groups	30
		Student total = 41
Staff		
PDT academic leads	Individual telephone interviews	6
PDT practice lead	Individual telephone interviews	3
Directors of Nursing	Individual telephone interviews	3
Strategic Health Authority Manager	Individual telephone interviews	1
		Staff total = 13

recruited either face to face during lectures or *via* email using HEI programme manager distribution lists. Focus groups were run in one of four campuses that were most convenient for the students to access. Data were collected in early 2009 [5].

PDT staff who participated in stage one [4] were invited *via* email to take part in a telephone interview. The information sheet and consent forms were attached to that email. On receipt of a completed consent form, the researcher arranged a time for the interview at the convenience of the participant. Thirteen staff across six Acute Trust PDTs participated in the evaluation. These included six academic leads, three strategic leads, three

nursing directors and one SHA manager. Table 1 indicates the components of the sample.

Data Collection

Students participated *via* focus groups and interviews; telephone interviews were used to collect staff data. The questions used for the student interviews are included as Table 2, and those for the staff interviews in Table 3.

Interviews and focus groups were digitally recorded and transcribed verbatim. Data were analysed using Thematic Content Analysis [7]. For Smith [7], 'content analysis' indicates systematic procedures for extracting meaning from a body of textual material so that a large body of material

Table 2. Questions Used for the Student Interviews

<p>Questions for Phase 1 of the Study:</p> <p>We are interested in your experiences of support for you as a student in clinical practice:</p> <ol style="list-style-type: none"> 1. Could you tell me about the roles of staff who support you whilst you are on placement? (who, how do they support you?) <ol style="list-style-type: none"> a. directly (working with you) b. for the organisation where you were on placement (planning, contributing at unit/organisational level) c. liaising with the university? 2. Could you tell me about your relationship with these staff? To what extent do you feel supported? 3. How do they implement and manage student support in your current placement area? 4. Are there any benefits in having students in your current placement area? Are there any disadvantages? 5. Could you tell me about your relationship with the university? (What works well, work does not work so well, what would you like to see improved?)
<p>Additional Questions for Phase 2 of the Study:</p> <ol style="list-style-type: none"> 1. Could you tell me what you know about Placement Development Teams? 2. What is your role in relation to Placement Development Teams? 3. What do you believe that their achievements are so far? 4. Has their establishment had an impact on your support? If so how? 5. What do you believe to be the strengths of these teams? 6. How do you feel that they could be improved?

Table 3. Questions Used for the Staff Interviews

<p>Questions for Phase 1 of the Study:</p> <p>We are interested in your experiences of supporting students in clinical practice:</p> <ol style="list-style-type: none"> 1. Could you tell me about your role in terms of supporting students <ol style="list-style-type: none"> a. directly (working with students) b. for the organisation (planning, contributing at unit/organisational level) c. liaising with the university as the local Higher Education Institution? 2. What kind of students do you support? (profession, stage of programme). 3. How do you implement & manage student support in your area? 4. For those working at both operational and organisational levels: Are there any benefits in having students in your placement area? Do you believe that there are any disadvantages to your placement area? 5. What do you believe are your area/organisation's strengths in terms of student support? 6. What could be improved in terms of student support in your area/organisation? 7. Could you tell me about your relationship with the university as the local Higher Education Institution? What works well, what does not work so well, what do you believe should be improved?
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can be reduced to a manageable volume. It contributes to theory building and drawing inferences in exploratory research. Content analysis can thus generate qualitative or quantitative findings; in this study, a qualitative approach to interpretation was required to address its aim, and quantification was not undertaken. In order to ensure that rigour and trustworthiness in data analysis were achieved, analysis progressed from identification of codes in transcripts to their analysis, to uncover key themes [7]. Codes were generated from the same data set by two researchers and compared. As emerging themes were consistent between the two researchers across the data sets, the remaining process was completed by one researcher until the final set of categories and themes were reached. These were then discussed and agreed within the research team, demonstrating the intercoder agreement which is key in establishing the reliability of research findings and that they are dependable and trustworthy [4, 7, 8].

RESULTS

Tables comparing these data with those from phase one [4] are presented at the beginning of the discussion section.

Findings from Students' Data

Four themes emerged from the students' data including:

- Communication.
- Supportive and unsupportive behaviour of staff.
- The effect of peers on the placement experience.
- Knowledge and perceptions of the work of the PDTs.

Communication

Communication was a core theme that ran throughout the analysis and will be outlined below with reference to communication between students, mentors and trust and HEI staff. Positive and negative aspects of communication affected all aspects of placement learning and support. The impact of communication is presented here by phase of the placement learning process: placement preparation, mentor support and placement learning. Students generally viewed communication as efficient, positively affecting their placement experience but also highlighted less effective communication in some areas.

Students valued being provided with sufficient information to prepare for placements; timely information is essential, particularly when they need to make family arrangements and book accommodation. Most students articulated that gaining information to prepare them for placements was a smooth process, but others believed that information could be communicated more effectively. Although this tended to occur only on programmes where placements were in short supply, some students had trouble in receiving timely placement information:

It's been a bit late for some people. I'm fairly flexible but [for] people with children... it's kind of got a bit too close to the actual start of the placement. [Dietetics]

Students valued having a clear point of contact in the placement areas to welcome them on their first day. Once in placements, good communication between the HEI and the

placement provider was essential so that students were supported and achieved optimal learning. Students believed that most mentors were well prepared through university and PDT courses but some students articulated that all staff in placements who had contact with students and offered support should receive perpetration for student contact, not solely allocated mentors.

Students sometimes believed that they were a conduit for communication between the HEI and mentors regarding their learning and assessment needs:

The placement I'm on at the moment, I've had to try and explain what I need to get out of it [midwifery 1], and

so I think we have to make them aware of what our learning objectives are [Midwifery 2].

Without effective communication, students could be inadequately supported by insufficiently prepared staff. Students had good relationships with mentors and other practice staff; improved informational support and mentor training provided by the PDTs overcame any negative experiences for students and raised the confidence of staff supporting them. Good quality, timely, open communication between all parties involved in practice learning, both between and within institutions ensured a range of positive benefits to students' placement learning experiences.

I had a good experience because there was plenty of communication and I felt as though... there were opportunities for me if I needed them. [Dietetics].

Email is kind of quick and easy and often get a quick response [from lecturers] so that's all been good. [Paramedicine].

She [mentor] always replies to every email... if I need her advice she's always willing to meet up with me and she's really good. [Paramedicine].

Students stated that staff from university and placement areas were approachable thus enabling them to ask for support:

Very passionate about what they're doing, they're approachable; you can go up and ask them stuff. [Podiatry].

Students viewed direct communication between themselves and staff as vital in ensuring appropriate placement support. As students worked with many different practice staff, to ensure continuity of support and assessment placement staff must communicate effectively about their experience of working with them:

I know that they all got together to discuss the feedback from [my work], and then they all got together towards the end to discuss the final feedback from the whole placement. [Dietetics].

Although students generally viewed communication as effective, some students believed that their placement experience could have been enhanced if communication had been more open and efficient. In isolated incidences where

communication was perceived as inefficient, students viewed this as being most lacking between the HEI and the individual mentors:

There doesn't seem to be any communication... I'd even say that there is no correlation between mentors and the university at all and that is their biggest downfall in communications. [Adult Nursing].

Therefore, for students, adequate support whilst on placement required clear, timely, effective communication between themselves and their staff mentors, and also between the HEI and placement areas to ensure that practice staff are sufficiently informed to provide such support.

Mentor Support

Supportive and Unsupportive Behaviour of Staff

Students believed they well were supported in their placement learning by staff from PDT and practice. Although sometimes requiring directed support, but students valued being able to direct their own learning if they can access support when needed:

There's a lot of self-directed learning in some placements...the support is there though, whatever I need to ask then there's always someone there to answer the question as long as it's not too busy. [Paramedicine].

Paramedicine students particularly emphasised the importance of autonomy in their learning and assessment. All students valued the opportunity to work on a supernumerary basis (contributing to the placement area rather than a member of the workforce). However, some students perceived that this boundary was confused by some practice staff who placed pressure on students when workloads were high and expectations of responsibility heightened.

The Effect of Peers on the Placement Experience

Student numbers in placements varied according to its size. Most students recognised peer support, usually emotional support through discussions of their experiences during break times:

When we were together in the hospital there were ten of us which is a fifth of the course, and [in] our lunchtime just to offload with each other was brilliant [others agree] [Physiotherapy].

Students provided each other with support by discussing issues and being physically present in the same placement areas; by working together, the positive effects of fellow students can impact directly on students' learning:

While there are other students there, you're still getting involved, so it's really good having that support from your peers, and you can learn a lot from each other. What they've been achieving on their placement gives you an idea of what you need to be doing. [Paramedicine].

Being observed by a student from another profession can aid in the consolidation of learning:

I was doing a delivery and there was a paramedic student with me and they have to observe so many deliveries...it's quite nice because it makes you realise how much you do know and the fact that you've learnt things, you can talk things through with them. [Midwifery].

In contrast, some experiences led students to hold opposing views of the value of learning alongside their peers; having too many students learning alongside them could be problematic when there were not enough patients for the number of students:

Five of us all turned up and there wasn't enough [to do]...because we're limited in what we can do and I think we were getting in the way because we're all in the same area and it was just too many people. [Paramedicine].

Achieving learning objectives is a prime aim for students on placement and in professions such as midwifery, students must complete a specified number of procedures, so fellow students can obstruct achieving these objectives:

At the moment I'm doing ok, but I've got a set number of deliveries I have to do to qualify and if they've got a labouring woman and they've got [another] student with them I lose out on that delivery, which can be awkward. [Midwifery].

Knowledge and Implementation of the Work of Placement Development Teams

Students' knowledge of PDTs was varied: participating students from professions such as Adult Nursing and Physiotherapy had greater knowledge than others. Adult Nursing students perceived that they had benefitted from PDT support during their placements and in response to specific events:

I feel supported by the PDT. [Adult nursing].

I spent hours on the phone to her and she was great and then the same person happened to be in another placement of mine in my second year as a staff nurse and PDT person. [Adult Nursing].

There's two things that stick in my mind with this university: when I needed compassionate [leave] away from practice it was sorted, it wasn't an issue, and then in the next [placement] I had an issue in practice and that was sorted as well. [Adult Nursing].

Other students were unsure who they should contact for support:

If I was on placement even now in the hospital I wouldn't know where to find [individual's name] and I'd have to...I'm not sure how I'd get hold of her. [Adult Nursing].

When the researcher explained the PDTs' roles students were positive in their responses, with ideas about potential functions:

PDTs would be useful for... supporting you in ways like with paperwork or with anything if you weren't quite sure of how to do something. [Physiotherapy].

PDTs within trust [should do] something a bit more strategically. I know some of my friends, they were down in [place name], they had sessions where they go over reflective writing, things like that. [Physiotherapy].

Although some students were not well-informed about PDTs, this reflected not a failure to provide information but the methods used to inform students. They suggested that this information be provided more personally rather than via email or through notices on the web-based 'student portal'.

Half an hour where you get everybody together and say 'I'm here, this is my office, this is my job', a couple of slides and just say 'this is how it's going and this is how we're getting on and this is where you fit in if you need to get hold of me'. [Adult Nursing]

Findings from Placement Development Team staff data

The two themes emerged from the staff data were

- Central point of contact.
- Direct provision of support.

Central Point of Contact

PDT leads view themselves as the central point of communication for Trust staff and students; participants described three essential attributes that facilitate it: geographical location; team profile, and joint working between the Trust and the HEI.

First, locating PDTs and a 0.5 Full Time Equivalent (FTE) HEI academic in the Trusts was viewed as vital to these teams' success:

I think by having somebody based locally, that seems to have been hugely important for people.

Participants' physical presence aided communication between mentors, students, Trust and HEI and assisted with team working between HEI and Trust staff:

It means I'm able to bounce ideas. I'm treated as a member of staff

Second, disseminating the PDTs' roles and responsibilities raised their profile so that individuals requiring support were aware of the teams' roles. This high profile needed constant work to maintain as new staff and students entered the Trusts and as support services offered by the PDTs evolved.

I don't like to stand still and when I feel the profile is dropping a little bit, it feels like you're going backwards sometimes.

PDT profiles were maintained by 'walking the wards' to meet and respond to students and staff and via the PDT newsletter. Staff provided examples of assertive approaches to ensuring that PDT activity is known within Trusts:

We go to every meeting that we're invited to and we muscle our way into those we're not invited to.

Where teams were successful in promoting and maintaining their PDT's profile there was an increase in staff (rather than students) approaching them, particularly mentors:

The profile of the PDT is much higher so that we're getting a lot more people dropping in to our office.

It's great that the ward managers are contacting me because, quite rightly, they have something to say when it's not going right.

Third, all but one of the academic leads interviewed worked 0.5 FTE in their Trust PDT role and 0.5 FTE in the HEI as lecturers or in placement development; and this link with the HEI mediates Academic Leads' success in supporting students, mentors and Trusts: it is their understanding of the HEI that enables Academic Leads to support staff and students by signposting them to appropriate individuals or services.

I suppose because I've got the network in the university. I know who to ask.

As a tangible example of how this link worked, participants highlighted mentors' concerns about students not attending placements, a situation which could be easily clarified as a result of the PDT's HEI-Trust link:

Their learning experience is in the placements, [it's] better if [placement staff] know that every Monday they're not going to be there, or whatever, so there's some clarity been brought to the situation.

I think it's really good and helpful for students to know that the university and practice talk to each other.

PDT enabled this support structure to be the central contact point and line of communication between the two institutions. Participants were clear that maintaining their role was ongoing and that continual communication across placement areas is vital to ensure parity across the Trusts:

It is still bumpy; I'm still getting calls from placements where a student pitches up and they don't know anything about them so it's not completely brilliant.

Direct Provision of Support

As well as maintaining direct contact by visiting wards, further support mechanisms include induction programmes and packs, email contacts, and study and drop-in sessions for students. Students only attended sessions when there was an issue to which the PDT could provide a response rather than maintaining regular contact to avoid such situations arising. In order for this to work effectively there needs to be a change in student and staff perceptions of support seeking:

I'm questioning the culture where if students accesses support they are seen as failing... because by the time students get to me there

tend to be significant issues to deal with, which is quite interesting because we want to be there for general student support as well.

Participants prepared staff through mentor updates. PDTs had worked hard to ensure that Trust staff were aware of these updates' importance. PDTs were at various stages in negotiations about delivering updates and aimed to collaborate through established processes:

We're trying to work with the matrons and sisters to see how we can do that and us being on those steering committees is helping us to move those things forward.

You can't get mentors to study days; it's the same problems that you get on every programme trying to get people out of practice when they're frantic.

The challenges to be addressed were staff release; clarity regarding the purpose of placement learning; and preparing staff across the professions.

First, clinical pressures and restrictions on staff release to attend mentor updates or sessions for 'sign-off mentors' pose challenges in successfully preparing mentors. PDTs initiated modes of delivery to enable updates without time off the wards, including taking updates to mentors at shift handovers rather than mentors attending designated sessions, using electronic and poster presentations and display boards on wards.

Second, there is a discrepancy between the HEI's understanding of placement learning and that of some mentors:

There has been something missing in this organisation about mentors realising practice placements are meant to be [about] developing clinical skills.

Third, PDT leads support students and staff across the professions within their Trusts and participants listed a range of professions with whom they worked to a greater or lesser extent.

DISCUSSION

Table 4 shows how adult nursing students' data from phase 1 prior to PDTs' establishment compares to data from this second phase of the study from multi-professional students after PDTs' implementation. This comparison indicates whether themes were enduring between phases one and two, and whether new themes emerged.

'Communication' emerged as important for good placement experience, being implicit in students' discussions

pre-PDTs and explicit post-PDTs. Students believed that their placement preparation could be improved by more timely allocations, but were unaware of the organisational context: during the study period many of the local acute sector NHS Trusts were undergoing ward and department re-organisations, amalgamations and closures.

Students identified that PDT staff helped with communication issues and supported them: communication is noted as problematic and a significant disquiet for students elsewhere in the literature, particularly surrounding the amount of communication received on topics including allocations, the curriculum and students' learning outcomes [9]. Poor communication is an important factor in students' leaving their programmes [10]. Also, placement students easily identify examples of best and worst communication practices [11]. Students' concerns in this study were about communication between the HEI and placement staff, rather than between themselves and individual PDT staff and mentors. Students had an understanding of PDTs, and gave examples of support and communication PDT staff offered. Thus, although not perfect, PDTs made a difference to students by addressing their learning needs and through their communication. PDTs had put in place structures in all 16 NHS Trusts for mentor preparation, support and updating and so PDT staff communicated extensively with mentors as well as students. Even so, some students did not equate PDT activity with effective communication by the HEI, possibly because PDT staff are embedded in their placement organisations and perceived as being 'placement' staff rather than 'HEI' staff, even though they worked 0.5 FTE each in the Trusts and the University. From one perspective, there is more work to do in the 'marketing' PDT activity as a partnership between HEI and placement areas; from another, it is interesting that PDT staff had so successfully assimilated in the host organisation that students were identified them as 'Trust' staff.

Supportive and unsupportive behaviour amongst placement staff was a common theme at both points in our longitudinal study. Supportive behaviour before PDTs was about staff providing tangible, facilitative and emotional support. Supportive behaviour was still valued after PDTs were implemented but the most important aspect concerned autonomous learning. It is difficult to know why this had changed but it may reflect that such comments come from students on the paramedic programme, which has an emphasis on autonomy. Unsupportive behaviour prior to PDTs concerned negative attitudes of staff towards learners, whilst post-PDTs it was discussed as students not being able to work independently when they perceived that their supernumerary status was not fully being fully recognised. Whilst there might be many local clinical and operational

Table 4. Comparison of Student Data on Support Activities Pre-and Post-PDT Implementation

Student Data Prior to PDTs [4]	Student Data Post-PDT Implementation
<ul style="list-style-type: none"> • Supportive and unsupportive behaviour of staff. • Mentor allocation. • Placement allocation. • Benefits of students to the placement area. • Perceived control over the learning experience. 	<ul style="list-style-type: none"> • Communication • Supportive and unsupportive behaviour of staff • The effect of peers on the placement experience • Knowledge and perceptions of the work of the PDTs

reasons why a student may perceive that their supernumerary status was occasionally not honoured (and these issues are always fully investigated at a senior level when they occur), it has been reported [12-15] using the validated Clinical Learning Environment Inventory), that students' perceptions of their placements' culture and learning climate influences their learning outcomes, with those most satisfied achieving the best learning outcomes. A supportive clinical learning environment is crucially important for optimum learning and conversely, poor experiences of ward culture and mentors adversely affects students' perceptions of their careers [16].

We did not measure students' perceptions of the clinical learning environment, but they indicated that communication and the quality of mentoring received were important: mentors help students to learn in clinical practice and formatively and summatively assess their placement learning [6]. The importance of mentoring arose in the data pre- and post-PDTs: initially this concerned how important mentoring was for good practice learning [17, 18], being the single most important relationship a student can have for clinical practice learning [19]. Post-PDTs some students acknowledged that they had good support from mentors but believed that communication between the HEI and the individual mentors could be improved. This might be because students were unaware of the number of mentor updates and support sessions in existence as a result of PDT activity in our study's 16 Trusts.

Mentoring has long been recognised as a complex and skilled activity, requiring educational preparation, support and recognition [6, 20], although there are concerns about the extent to which mentors find the role stressful and receive adequate preparation for it, and this has an impact on students' assessment and learning experiences [21]. Watson [21] advocates greater emphasis and resources being given to mentor preparation, and a higher visibility of HEI staff for this purpose. Our study did not include interviews with mentors to assess this from their perspective, but PDT leaders in their data articulated that mentor preparation and support were crucial aspects of their activity.

A further enduring student concern pre- and post-PDTs was the issue of student numbers and their impact on learning. Support from peers was discussed pre- and post-implementation as valuable and important and is consistent with other studies' findings [22, 23]; but when there were 'too many' students, they could not get adequate access to patient care to learn effectively. Student numbers have been expanded over the last decade in the UK as a result of government policy [24, 25], and this can have an adverse impact on placements' ability to support students and facilitate their practice learning [26-30]. It is significant that this is still an issue one year after the implementation of

PDTs and that it affects professions other than nursing, but is not something that PDTs can control, only seek to mitigate. As noted previously [4], these findings will be of interest nationally and internationally where student numbers are being expanded as they indicate that this expansion is not without impact on the quality of placement learning.

Overall, students' data pre- and post-PDTs shows broadly similar concerns (support, communication and mentoring), with some changes in emphasis and awareness of the role of PDTs.

Table 5 shows how staff data from phase 1 prior to PDTs compares with data from this phase of the study after PDTs' implementation.

Staff data showed more striking longitudinal development: prior to PDTs, stakeholders' themes were their vision of support services; their aspiration to provide proactive rather than reactive support; an understanding of barriers to good support; and a sense that they wanted to bridge the HEI-Trust gap. After PDTs' implementation they talked about being a central point of contact and providing direct support for students, and now they spoke from the position of having actually carried out these roles; this is to be expected as they had now enacted the role.

Being a central point of contact involved three facets: their location as staff with substantive roles within the Trusts meant they had ongoing relationships with other Trust staff. This allowed them continually to disseminate PDT activity in their areas, meaning that they were a real link between HEI and Trusts; they gave tangible examples of how they provided direct support. This concerned directly supporting individual learners from the many professions in their areas; their assimilation was so effective, we argue, that it caused issues with students identifying them as Trust rather than HEI staff.

A more substantial role concerned preparing mentors through updates and dissemination of information around the Trusts. It is here that the staff data contrasts most strongly with that of some students: whilst some students believed that communication was satisfactory between HEIs and mentors, others believed that it could be improved. PDT staff, however, gave myriad examples of how they were in fact carrying out this communication 'on the ground' and were in fact delivering many multiples of sessions and activities for mentor preparation and updating. This dichotomy may be explained by the fact that students are often not in Trusts for extended periods, going between placement areas in the community, independent sector, and other hospitals, and so may not pick up fully on activities such as those of the PDT staff. However, if students are not fully experiencing the role of PDTs, work still needs to be done on dissemination and publicising their activities. One

Table 5. Comparison of Staff Data on Support Activities Pre-and Post-PDT Implementation

Staff Data Prior to PDTs [4]	Staff Themes Post-PDT Implementation
<ul style="list-style-type: none"> • Vision of support services. • Proactive versus reactive support. • Barriers to achieving proactive support. • Bridging the gap between HEIs and the Trusts. 	<ul style="list-style-type: none"> • Central point of contact • Direct provision of support

development that will help with facilitating communication is an on-line electronic resource, which is 'going live' in 2010/2011. This will include an extensive data base of placement and allocation information, which is regularly updated by HEI and Trust staff, and is constantly available to mentors, ward managers and students.

PDT staff have in place structures of support that address many of the students' requirements and concerns; they are addressing students' needs for local support and mentor preparation on a daily basis. The structures created by PDTs also address the need to invest more resources and give a higher profile to the mentoring role [18] to support mentors more effectively [31]. We were not able to quantify it in our study but PDT activity seems to address a need expressed elsewhere in the literature concerning recruitment and retention. There maybe some positive impact on recruitment and retention of students in clinical areas [10, 31, 32] as students with positive mentoring experiences evaluate their clinical learning well [19] and those with poor experiences leave [16].

Although there is an international dimension to it [6], mentor preparation is particularly an issue in the UK. Here, the regulatory body (the Nursing and Midwifery Council) [33] has introduced new standards for practice learning, including 'sign-off mentors' (already well-established in midwifery), who take final responsibility at ward level for indicating that a student should be admitted to the professional register. These sign-off mentors require extra preparation and support in order to be effective, and this is also the responsibility of the PDTs.

LIMITATIONS

This is a qualitative evaluation, albeit one that takes place in one English region; it is bound up with the local context but is of interest and relevance to others nationally and internationally who are redesigning their structures for student support and considering mentoring [6]. One issue is that the student comparisons pre- and post-PDTs are between adult nursing students (pre), and adult nursing students and other non-medical healthcare professional students (post). Having illustrated the issues of student support with our largest student population of adult nursing students before PDTs [4], we then implemented PDTs as a multi-professional initiative impacting on interprofessional education [5] and wanted to examine whether similar issues were in evidence amongst the non-medical healthcare professional students who form the rest of our faculty and are in the same placement areas. PDT staff were in many cases the same staff as those who responded to the initial interviews, which is perhaps why they have greater clarity and contrast in their data concerning the impact of PDTs.

CONCLUSIONS

This longitudinal evaluation of the impact of PDTs has indicated that our efforts to improve student support for multi-professional healthcare students have had some successes. Similar issues exist for students concerning communication, support and mentoring; however, these data reveal that whilst students did not necessarily equate PDTs with HEI communication, they had awareness of, and

exposure to, their work, and could give tangible examples of supportive PDT activities.

Staff gave a different perspective, indicating that they were now embedded in and part of the placement organisation team, and were working hard to improve mentors' preparation and support. This is a necessary achievement given the NMC requirements concerning mentor preparation and 'sign-off' mentoring, and the impact that good mentoring can have on students' placement learning, recruitment and retention [10,16,19, 31, 32].

From this study we recommend that more be done by PDT clinical and academic leads to make clear that PDT activity is a shared responsibility between the HEI and the placement providers. Whilst communication channels between HEI staff and individual mentors exist in the form of the mentor updates and the support PDTs deliver in clinical practice settings, students are not necessarily aware of this and so it needs to be made more visible to them at orientation and induction events. Our on-line placement data base should help in this objective.

As a substantial and important PDT activity is the preparation and support of mentors [33], further research is necessary on the views of mentors, the effectiveness of their preparation and support, and the issues and challenges they face in this region and nationally. This is particularly important in light of the need for sign-off mentors, which have only recently been introduced across nursing professions in the UK by the NMC.

AUTHORSHIP

Study Design: GRW, LC, EW, LM, VH.

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