Evaluation of Practice Education Facilitator Project

Commissioned and Funded by NHS Education for Scotland

Final Report

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SUPPORTING PRACTICE EDUCATION: AN EVALUATION OF THE PRACTICE EDUCATION FACILITATOR PROJECT

The Practice Education Facilitator Project is a joint initiative between the Scottish Executive Health Department (now Scottish Government Health Directorates), NHS Education for Scotland (NES), Higher Education Institutions (HEIs) and NHS Boards. This Report is based on a study commissioned by NES.

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DISCLAIMER

The views expressed in this report are those of the Research Team, and not necessarily those of the Commissioner/Funder – NHS Education for Scotland.
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MAIN MESSAGES

Impact of the PEF role on support for mentors

- Practice Education Facilitators have been well-received. The PEF is seen as a supportive and valuable addition to ensuring a quality clinical learning environment. The majority of PEFs are accessible to mentors although PEFs should maintain, and find ways to increase, their actual ‘visibility’ in their link clinical areas.

- Mentors value the support provided to them by PEFs and the increasing effectiveness of communication with HEIs which PEFs provide. In particular, they appreciate the guidance which enables them to appropriately support and deal with a ‘failing’ student.

- The NES web pages on practice education are an excellent resource. Pages should also contain up-to-date information on PEF names, geographical/clinical responsibilities and contact details to further facilitate communication.

Impact on quality of learning environment for students

- Student evaluations of their placement sites are a valuable means of maintaining and improving the clinical learning environment. Evaluations need to be fed back in a timely manner to mentors and clinicians, and where possible made specific for that clinical area. PEFs can be a conduit in supporting this feedback.

Impact on placement capacity

- Many PEFs are playing a significant part in increasing capacity in placement areas by finding ways of using existing placements differently and in helping develop new clinical placements.

Innovative practices within learning environments

- PEFs are ideally placed to impact on the ways in which mentors provide support and teaching for students through discussion with them on learning opportunities and creative ways to enable learning.

- Mentors and other clinical staff need further support in relation to their responsibilities for clinical skills acquisition. PEFs should explore ways of ensuring that students make the best use of their mentor support and clinical learning opportunities.

- Mentors are enthusiastic about their preparation and ongoing education as a mentor. It is likely that there is a small percentage of trained staff working as a mentor without appropriate preparation and updating. Innovative ways of providing mentor updates could be explored, such as e-learning or blended learning in areas which do not already provide this option.

Evaluation of models of implementation of PEF role

- Career pathways for PEFs, and their continuing professional development remain unclear for a number of PEFs, leading to concern about ‘where do I go from here?’ The work on clinical career pathways related to PEFs should continue.

- Despite a nationally agreed role specification, there is some variation in the grading of PEFs which has led to dissatisfaction for a few. This anomaly should be further investigated.

- Flexibility in the models of implementation of PEFs enables specific needs of Health Boards to be met. Consult with part-time PEFs to address any specific challenges of their role structure.

- Lead PEFs provide a focal point of support and guidance to PEFs
• PEFs appreciate supportive managers who understand the PEF role. Those positioned within Practice Development Units were very positive of this structure.

• PEFs appreciate, and benefit from, clear and structured line management.

• PEFs support mentors who are responsible for a wide range of learners and not solely at pre-registration level.

*Inter-professional learning in practice*

• Little evidence of inter-professional learning was reported.

• The concept of inter-professional learning was limited to teaching from other professionals or ‘shadowing’ other professionals.
EXECUTIVE SUMMARY

A quality clinical learning environment is essential for the effective training, education and assessment of pre-and post-registration nurses and midwives. Pivotal in this provision is the mentor who provides guidance and teaching and it is crucial that mentors receive adequate training and support in their role. In 2004 the Scottish Executive Health Department (now Scottish Government Health Directorates), NHS Education for Scotland (NES), NHS Boards and Higher Education Institutions (HEIs) initiated and supported the establishment of the Practice Education Facilitator (PEF) role whose purpose is to ensure that the student experience is of the highest quality, primarily through the support of mentors. One hundred full time equivalent PEF posts were created across Scotland and a core job specification agreed. This document reports on an evaluation of the implementation of the PEF role.

AIMS OF THE PROJECT

The overall aims of the project were to:

• Evaluate the impact of the new posts in terms of the perceived quality of support for mentors;
• Explore the impact on the quality of the clinical learning environment in terms of students’ experience;
• Identify the number of students that can be accommodated in both acute hospital and community placements;
• Identify examples of innovative practice which act as barriers/facilitators to the learning environment;
• Identify strengths and weaknesses of different models of implementation and development of posts;
• Explore inter-professional learning developments in practice.

BACKGROUND

A number of factors have been shown to impact on the quality of a clinical learning environment, including staffing levels, workload, dependency, resources, leadership, and staff attitudes. Particular issues which can relate to the PEF role include capacity for accommodating students and this is specifically linked to the availability of trained mentors. The nature of relationships with HEIs is also crucial as effective communication supports shared understanding of student learning and assessment. Much has changed since the move of nursing and midwifery education in the 1990’s from hospital based schools into higher education, and there have been challenges in keeping communication channels open and for communication to be timely to the needs of both service, education and of course the students. The last 20 years have also seen a gradual reduction in the role played by teaching and academic staff in the delivery of clinical skills teaching in clinical placement sites and there is increasing use made of simulation in areas such as clinical skills laboratories in HEIs. The acquisition of clinical skills and the assessment of clinical competency is now predominantly the province of clinical staff in the areas in which students are placed. Allocated mentors are responsible for the supervision, teaching and assessing of students, including the ‘signing off’ of competency at the end of pre-registration programmes. Mentors can have a number of additional pressures related to their own clinical responsibilities and it is vital that they receive
the support they need in order to fulfil their mentor role. A major driver for the PEF role was the recommendations of the SEHD report ‘Facing the Future’ (2001). It was against this background that the new role of the PEF was conceived and introduced across Scotland.

DESIGN

The overall design of the project was one of impact evaluation, involving both quantitative and qualitative approaches. All necessary ethical approval was sought and a favourable ethics opinion provided. NHS R&D Management approval was provided. The project was conducted in two phases. The first Phase of the project was a survey of PEFs and Phase 2 utilized case studies to explore in further depth, the impact, quality and outcomes of the PEF role. In addition, an ‘expert’ panel was also recruited to become involved in two consensus conferences, with the goal of achieving key stakeholder involvement in the research process.

The aim of the Phase 1 survey was to review the current implementation of the PEF role in Scotland. This scoping activity aimed to determine the differing roles and models of implementation of the PEF role, to identify examples of innovative practice, and to explore capacity for support and mentoring in the clinical learning environments which had a PEF in post. The response rate for this Phase was n=84 (71%). During the first consensus conference, consensus was reached on potential key criteria for the choice of case study sites for Phase 2. Six case study sites, which met the key entry criteria, were selected. Each site was within a specific geographical location such as a hospital ward/unit or community setting.

At each of the case study sites in Phase 2, data were collected through a student postal survey (n=31, 21%), a mentor postal survey (n=69, 26%), a face-to-face focus group discussion (n=31), and a telephone survey of key stakeholders (n=34, 32%). Key stakeholders included managers, students, mentors, registered nurses and midwives, and representatives from Higher Education Institutions. A second consensus conference was held in order to gather views and opinions on the implications of study findings and to facilitate the generation of potential recommendations for the future.

FINDINGS

The findings indicate that the role of the PEF has been accepted widely across Scotland and that where the role works well, it is seen as a valuable addition to the support and development of a quality clinical learning environment for pre- and post-registration students. This is particularly evident in specialist areas, where the PEF is known to the clinical staff and there are clear communication channels. There were however, some reports of mentors and other clinical staff not being aware of the PEF allocated to their area and of never seeing or hearing about them.

Early findings in this study indicated that the majority of PEFs were working at Grade G. However, there was some evidence of variation with almost 20% of PEFs positioned either below or above this grade. Later findings also indicate the feelings of some of the participants in relation to the diversity of clinical grades or Agenda for Change bands within which the PEFs are employed.

PEFs perceive they have a valuable role in supporting mentors. Mentors also feel that PEFs have the potential to be a strong support and have identified those supporting actions that work well, such as when there is a ‘failing’ student. Mentors in this study acknowledged the challenges of the role and felt they played a key part in assessing the competence of students. They were anxious to ensure that where a student was having difficulties in achieving competency, they were able to confidently provide constructive support and when this failed, they were able to identify those students who had not achieved. Mentors did not want the HEI to take over when there were
problems with a student, but to provide guidance and support for the mentor to take action when necessary.

Mentors expressed concern that clinical demands often left them without as much time as they would wish to spend alongside their students. However, students hold a very positive view of the clinical areas, the work undertaken, and environment created by the clinical staff. It was felt that PEFs had an impact on the timely allocation of mentors and on the availability of mentors adequately trained and with experience to assess students. We discovered, however, that mentor updates were not occurring for many mentors as often as they should and a small percentage had never attended mentor preparation in the first place.

Some PEFs had concerns around ways to retain their own clinical competence, particularly as their role did not involve any direct patient contact or clinical skills teaching remit. This also led them to express concerns about their future career pathways. Views varied on the extent of PEF involvement in direct clinical skills teaching with students. Some participants felt that this would be a useful addition to their responsibilities and provide support for this essential aspect of clinical education for students, although acknowledged that this was not the function of the PEF role. Those PEFs in part-time appointments who also had an appointment in clinical practice, appeared to face specific difficulties in achieving the objectives of the PEF role, most often because of the need to commit to clinical priorities when they arise, and of managing the increasing PEF workload within part-time hours. However, they did not express any concern about maintaining their clinical competence and this would appear to be an obvious advantage of part-time PEF posts.

Mentors and clinical staff were anxious to find out from students what they were doing well in relation to the students’ ability to achieve competency and also how they might improve the clinical learning environment where there were deficiencies. The ability of mentors to gain timely and specific feedback which related to their clinical area was problematic. Often it was a case of receiving a report which collated a number of placement sites, and each site being left to pick out what might, or might not, pertain to them. Additionally, this feedback report was often only distributed every few months or less.

Clear line management i.e. having one named and accessible manager, was seen as a major strength by the PEFs, and key stakeholders indicated the value of supportive managers who understood the PEF role. It appeared particularly beneficial for PEFs to be positioned within practice development units as there were shared goals with others, and line management staff were up-to-date in relation to clinical education issues.

RECOMMENDATIONS AND FURTHER RESEARCH

This report encourages the continuation and support of the PEF role. The following recommendations and suggested further research reflect the key issues and concepts identified through the lifetime of this project. These are the issues which need to be addressed in order to take forward the future development of both the PEF role and of clinical learning environments.

Impact of the PEF role on support for mentors

- Organise an annual national PEF conference to enable PEFs to present examples of their impact on the clinical learning environment.
- Maintain the good accessibility of PEFs and also explore ways to increase their actual ‘visibility’ in their link clinical areas.
• Further research the issue of the ‘failing’ student, and in particular those potential interventions to identify and provide enhanced support to students causing concern at early stage in their placement.

*Impact on quality of learning environment for students*

• Within the NES Quality Standards for Practice Placements introduce a Standard and Indicators for the feedback and action in relation to student evaluation of clinical placement sites.

• Support HEIs to provide programme and course documentation on-line and with access open to PEFs, mentors and relevant clinical staff.

• Student evaluations of their clinical placements need to be fed back in a timely manner to mentors and clinicians, and where possible made specific for that clinical area. PEFs can be a conduit in supporting this feedback.

• Provide opportunities for mentors to undertake approved mentor training and mentor updates either in e-learning or blended learning format.

*Impact on Placement Capacity*

• Disseminate best practice examples of the ways PEFs have been increasing capacity in placement areas.

• Continue the current excellent work on Clinical Education Career pathways in relation to PEFs.

*Innovative practices within learning environments*

• Mentors and other clinical staff need further support in relation to their responsibilities for clinical skills acquisition. PEFs should explore ways of ensuring that students make the best use of their mentor support and clinical learning opportunities e.g. ward-based clinical masterclasses.

• Provide innovative ways of delivering mentor updates, such as e-learning or blended learning in areas which do not already provide this option.

*Evaluation of models of implementation of the PEF role*

• Conduct a scoping exercise to review the position of PEFs in relation to pay and grading, specifically within Agenda for Change bands.

• Establish a listening event which enables key stakeholders to share views and opinions on the continuing professional development needs and future career pathways for PEFs.

• Introduce managerial supervision for PEFs in order to support the structural, organisational and leadership issues related to their day-to-day work.

• Health Boards should explore specific support which can be provided to those appointed in part-time PEF posts e.g. performance development.
• Explore ways that PEFs who have part PEF/part clinical role can add value through optimising the complementary nature of the two roles.

*Interprofessional learning in practice*

• Host a national conference to share best practice in inter-professional learning activities.

• Conduct an audit of activity and outcomes in relation to strategy on inter-professional learning. Develop national priorities and an implementation plan.
MAIN REPORT

CONTEXT

In 2004 the Scottish Executive Health Department (now Scottish Government Health Directorates), NHS Education for Scotland (NES), NHS Boards and Higher Education Institutions (HEIs) initiated and supported the establishment of a new practice education role in Scotland. The Practice Education Facilitator (PEF) role was developed as part of the drive to maximise recruitment and retention of nurses and midwives in Scotland driven by the ‘Facing the Future’ agenda (Scottish Executive Department of Health 2001a). One hundred new posts were created and a core job specification agreed (NHS Education for Scotland 2004). NES have invested consistently in the development of the PEFs throughout the initial three years of funding and beyond.

The purpose of the PEF role is to:

- Maximise the number of student nurses and midwives who can be supported within clinical practice areas, in both hospital and community settings;
- Ensure that the student experience is of the highest quality and enables the greatest benefit from the individual clinical learning experience;
- Ensure support and supervision for staff engaging in continuing professional development/educational programmes which ultimately lead to practice development and improved services for patients and clients.

Practice Education Facilitators are experienced clinical staff committed to the support of staff and students in education and continuing professional development. The core job specification (NHS Education for Scotland 2004) highlights strengthening communication between HEIs, the clinical areas and Boards, enhancing the clinical learning environment and supporting the co-ordination and delivery of practice-based education. The remit of the PEF is wide-ranging and encompasses supporting the learning environment of students from pre-registration nursing and midwifery programmes, post-registration specialist and advanced practice programmes, and continuing professional development. The role also encompasses support of the education and training needs of unqualified staff and of the full range of professional groups.

In 2005 NES commissioned the University of Manchester to conduct an evaluation of the implementation of this new role in Scotland. The findings of this study are reported in this document.

This study is set in Scotland and it is important for the wider readership to note that there are differences in structure, priorities, provision and legislation for health and social care between Scotland and the other UK home countries. Scotland has a devolved Government (between 1999-2007 this was known as the Scottish Executive). Full details of the Scottish Government and health policies can be found at http://www.scotland.gov.uk. Health (and health care) is the responsibility of the Scottish Government Health Directorate (SGHD). The language of this report reflects this unique Scottish context; one notable difference is that the structure of the Scottish NHS is organised around Boards, there are 14 geographically based NHS Health Boards in Scotland and a number of National Special Health Boards. Hospital Trusts no longer exist and hospitals are managed by the acute division of the Board. GP’s and other contracted services are contracted thorough the Board and work in Community Health Partnerships (CHPs). The PEF role in Scotland, in many respects, is unique in the UK and we hope that readership from the UK and beyond will find this evaluation of the development of this innovative role contributes to the wider debates on practice education.
THE PEF ROLE

The PEF role is designed to contribute to the learning environment by providing support, educational input and development activities, and to ensure that nursing and midwifery students are given a positive and valuable learning experience during practice placements. The PEF role encompasses support for mentors and for students on all programs of education and continuing professional development. This is particularly important as it is well documented in the literature (see below) that mentors often do not feel well supported in their role and have to juggle competing demands of mentorship, teaching and assessing students with clinical workload. Difficulties are particularly marked when mentors are faced with students who are not performing to the required standards.

Since its inception the PEF role has continued to develop. Within local NHS Boards PEFs have been organised into teams, and in many areas they are led by a lead PEF introducing skill mix and a career pathway in practice education. Building on the first three year development programme, which NES provided from the outset, in January 2008 a PEF Development Toolkit was launched (NHS Education for Scotland 2008) as a web based resource to develop individuals in the PEF role. This includes sections on career management, and coaching and mentoring. Regional Practice Education Coordinators have been appointed by NES for south-east, west and north regions to support the wider infrastructure for practice education and the ongoing development of the PEF role.

In 2007 a national event was held to identify national core PEF objectives to provide consistency across the country although actions and their related timescales were developed locally to NHS Boards. The objectives for 2007-8 were to enhance capacity, quality and support in the clinical area, to develop action plans for the implementation of NMC standards to support learning and assessment in practice and the NES national approach to mentorship preparation, and to facilitate a range of learners in the clinical environment at pre-and post-registration level (NHS Education for Scotland 2007). It is anticipated that a meeting to set national objectives will be an annual event.

PRACTICE EDUCATION

A number of research and policy reports have highlighted that the quality and support for students and staff in practice placements are variable and that there are a number of challenges in providing a positive learning environment in the clinical setting (May et al. 1997; UKCC 1999; Norman et al. 2000; Scottish Executive Department of Health 2001b; Scottish Executive 2006a). Practice education in nursing and midwifery has been central to programmes of education. Student placements have changed in form from apprentice style ‘learning and working’ (Melia 1987) to the supernumerary, competence focused placements currently integral within programmes of education. Although there have been significant developments in practice placement models over the last 20 years there have been a number of concerns highlighted: those of capacity, the influence of service redesign on placements and how the various stakeholders experience practice placements.

A number of the issues relating to the quality and structure of practice placements are highlighted by Aston and Molassiotis (2003) these are; ‘practitioners having to deal with busy clinical settings combined with inadequate staffing levels, heavy workloads, insufficient continuing support, inexperience, irregular attendance of students due to clashes with academic sessions, lack of resources for training, staff misconceptions or overcrowded placements’ (Aston and Molassiotis 2003: 203). It was anticipated that these issues would be positively influenced by the introduction of PEFs (NHS Education for Scotland 2003).

One of the most significant issues that may affect placement quality is capacity. Issues of capacity in student placements are complex and it is difficult to establish robust data in this area. The final
report of The Development of Quality Standards for Practice Placements Project (NHS Education for Scotland 2003) highlights this issue. In their Scotland-wide scoping exercise, reliable data on the numbers of students requiring clinical placements at a particular point in time was difficult to find. Comparing data sets, both of numbers of students and available placements, between the different Higher Education Institutions (HEIs) was not found to be possible as a number of different systems for collecting data were present throughout Scotland (NHS Education for Scotland 2003). These limitations in the data were found at both pre-registration and post-registration education level and have been reported elsewhere (Turner 2001). The report by NHS Education Scotland (NHS Education for Scotland 2003) suggests that these issues of institutional variation in the collecting and reporting of data should be addressed, though it is not currently clear how far this process has been developed. There have been similar problems in identifying the number of mentors to support and assess student learning in practice placements, with inconsistency reported in Scotland regarding practice for the development of registers of qualified mentors (NHS Education for Scotland 2003).

In 2006 the UK Nursing and Midwifery Council (NMC) reviewed standards to support learning and assessment in practice (NMC 2006). This has introduced a number of measures to support practice education, including local registers of mentors and a triennial review of mentors (a process of appraisal to determine if mentors meet the NMC requirements to be retained on the local register). NES has built on this and developed a national approach to mentorship training and a core curriculum framework for the preparation of mentors in Scotland (NHS Education for Scotland 2006). The PEF role is seen as central to the successful implementation of these initiatives in Scotland.

Other factors related to capacity have been identified as ‘client group, bed numbers/caseload, numbers of qualified staff, skill mix, vacancy work load and patient dependency’ (NHS Education for Scotland 2003:11). Local factors such as sickness and particular local pressures must also be included in identifying capacity. Although the review of practice in Scotland did identify a number of innovative collaborative practices, many service providers had no effective infrastructure to carry out placement management. At that time no one single method of managing placements could be developed for use across the country (NHS Education for Scotland 2003).

Recruitment and retention is a key issue in capacity. This is being tackled by a number of policy developments such as ‘Facing the Future’ (Scottish Executive Department of Health 2001b) and the impact on the number and quality of student placements must be acknowledged. The relationship between staff numbers, student numbers and placement numbers is complex and often characterised by sub-optimal utilisation of resources. Whilst acknowledging the ageing profile of nurses (Buchan 1999) a clear national workforce planning strategy for Nursing and Midwifery has been developed (Scottish Government, 2007b; Scottish Executive 2006b) and increasingly robust workforce data is being collected.

Qualifying nurses are highlighted as an important resource for employers, and local initiatives are reported that encourage newly qualified nurses to take up positions at their local hospital. An assertive recruitment campaign has been successful in attracting students from a local educational establishment to stay in the locality in which they trained (Ballie et al. 2003). In this case a strong partnership was developed between the NHS organisations and the local university. Students surveyed said that their choice to stay and work locally was influenced by the convenience, familiarity, loyalty, enjoyment of clinical placements and perceived supportiveness of the Trust. This emphasises the importance of the student experience for local recruitment; if students feel supported in their clinical placements and feel valued by the Trust for their contribution, there is more incentive to stay within that Trust as qualified nurses. Mentors play a crucial part in engendering this positive environment.
In Scotland support and mentorship for newly qualified staff was strengthened in 2006 by the introduction of Flying Start. This is a national development programme for all newly qualified nurses, midwives and allied health professionals in NHS Scotland. It is a web based program of support and learning in clinical practice to ease the transition from student to qualified practitioner. PEFs are central to the support of mentors for newly qualified staff in NHS Scotland; this has had implications of the role of the PEF.

Quinn (2000) highlights the features of quality in nursing practice placements, these are, a humanistic approach to students, team spirit, management style, teaching and learning support, supernumerary status for students, good relationships with the education provider and students being able to work shifts with their mentor. These concerns are shared by midwives and Thomas (2007) highlights the importance of positive role models who are woman centred. These features of quality are challenged by pressures on qualified staff as well as increasing numbers of students. Student intakes have increased by over 25 per cent since 1996/97 and the then Scottish Executive has funded an additional 250 places in 2003 at a cost of £1.5 million (Scottish Executive 2003). The pressure on placements by increasing numbers of students is a phenomenon that is apparent across all health care professions (Huddlestone 1999).

The development of the PEF has been timely in its introduction as a means of supporting staff in their practice and thus potentially improving retention, particularly of newly registered nurses.

THE INFLUENCE OF SERVICE REDESIGN ON PLACEMENTS

Increased satisfaction and reduction of stress for qualified nursing staff is likely to improve the clinical learning environment for students. The increased throughput of patients and the reduction of bed numbers has put pressure on nursing staff (Turner 2001) and the UKCC Commission for Nursing and Midwifery Education ‘Fitness for Practice’ highlighted that clinical staff feel ‘pressurised, unappreciated and unsupported’ (UKCC 1999).

In the UK there have been significant changes in service design and implementation over the last 30 years. Studies in various countries have highlighted that re-organisation is only likely to be effective where the staff have been involved in the processes of change. The UKCC (1999) acknowledged the impact on staff of change in service delivery, including high patient turnover and ward closures and identified that low motivation and workforce issues resulting from service change can have an impact on the quality of student placements. Changes in service and education have led to difficulty for both parties being able to deal with their own problems and understand the perspective of the other (Luker et al. 1996). The impact of change in both education and service is anticipated to be a factor that will affect the student learning environment. The PEF core job description clearly identifies their role in developing relationships and understanding between service and education.

Building on Delivering for Health (Scottish Executive 2006b), Better Health, Better Care (Scottish Government, 2007a) outlines the Scottish Government’s vision for health care delivery. Better Health, Better Care outlines national priorities such as personalised care, managing long term conditions and moving towards more local delivery of care in Scotland’s communities.

These strategic documents have had an impact on workforce issues. Better Health, Better Care: Planning Tomorrow’s Workforce Today (Scottish Government, 2007b) outlines the strategic direction for the future of workforce planning in NHS Scotland. The response to the 2006 document

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1 The UKCC (United Kingdom Central Council for Nursing, Midwifery and Health Visiting) was the regulatory body for the professions prior to 2002. In 2002 the UKCC ceased to exist and its functions were taken over by a new Nursing and Midwifery Council (NMC). The English National Board was also abolished and its quality assurance function was taken on board by the NMC. The other National Boards were also abolished, but new bodies were created in each country to take over their functions e.g. NHS Education for Scotland (NES).
Delivering care, enabling health: Harnessing the nursing, midwifery and allied health professions’ (NMAHPs) contribution to implementing Delivering for Health in Scotland (Scottish Executive 2006b) was an overarching strategy for acknowledging the core values and the contribution NMAHPs can make to delivering this policy agenda. It is Delivering care, Enabling Health (Scottish Executive 2006b) that continues to articulate the NMAHP contribution to the Governments vision for health care.

Secondly, a review of community nursing was undertaken by the Scottish Executive, Visible, Accessible and Integrated Care (Scottish Executive 2006c). This report recommended the introduction of a new generic Community Nursing role which would be rolled out at four development sites in Scotland. This signals a major change in nursing services in the community and this has had an impact on the delivery of secondary care services. Supporting clinical staff in their role in supervising and assessing students during times of service change is a key component of the PEF role. PEFs have a leadership role in practice education to ensure high standards are maintained at all times.

EXTENT AND NATURE OF PARTNERSHIPS BETWEEN EDUCATION AND SERVICE

The move of nursing education into HEIs has at times put some partnerships between education and service under strain. Despite developments in curriculum there has ‘remained a cultural mismatch between HEIs and the NHS’ (Scholes et al 2004 p13). Changing relationships between service and education have been highlighted by the UKCC (1999) and Mallik and Aylott (2005). Clinical staff had to deal with larger and unfamiliar institutions that were often at a greater geographical distance from the clinical setting than traditional local nursing schools. These issues compounded with increased student intakes affected the support in practice for students that academic staff could provide (UKCC 1999; Turner 2001). After the introduction of diploma courses students were no longer rostered members of staff, and there became less of a vested interest in the education of students in comparison to the education and training of health care assistants (UKCC 1999). The large volumes of students, due to increased intakes of students at HEIs, put pressure on clinical areas that were already struggling under the pressure of high staff turnover and increased patient dependency (UKCC 1999; Finnerty et al. 2006). This has often caused tension between service and HEIs.

The UKCC (1999) suggested that joint appointments to education and service would develop collaborative working regarding the provision of clinical education. There are now many examples of this being implemented effectively in practice (NHS Education for Scotland 2003) although difficulty for link teachers in moving between education and practice has been highlighted (Ramage 2004). The UKCC also suggested the development of a model whereby an appointed practitioner supernumerary to the clinical team would take on responsibility for the learning environment (UKCC 1999). This role is similar in description to the role of the PEF.

ROLE OF THE MENTOR

Learning in the practice setting has many advantages but it has been reported that there are also limitations; the difficulty in comparing student experience, the pressure of workload for the assessor, assessment and learning in the same situation, bias towards the student if the assessor has knowledge of previous problems, difficulty in separating the role of supervisor and assessor and reluctance to fail students (Bray and Nettleton 2007; Duffy 2004).
Clinical staff who have undergone a course of preparation are currently involved in the assessment of nurses and midwives in the practice situation, but recent research has indicated that due to the shortage of staff, mentors do not all undergo mentorship and assessment training because of annual leave or sickness or because of the shortage of permanent staff (Norman et al. 2000). It is well documented (Finnerty et al. 2006, May et al. 1997; Elkan & Robinson 1995; White et al. 1993) that practice assessors feel poorly prepared for their role in teaching and assessing diploma students. The length of preparation of mentors was identified as varying throughout Scotland. Courses lasted from a few days to being an integral part of degree level post registration education (Norman et al. 2000).

Practice assessors are reluctant to assess practice negatively (Norman et al. 2000; Wood 1986; Watson and Harris 1999; Duffy 2004) and this phenomenon has been noted in other practice disciplines. Watson and Harris (1999) identified that 46% of mentors agreed with the suggestion that students were sometimes allowed to pass their placement despite their performance being unsatisfactory. The complexity of instruments, and lack of training for clinical staff in their use, played a significant part in practice assessors’ failure to fail. The emotional consequences of failing students are described using words such as ‘horrendous’, ‘traumatic’ and ‘draining’ (Duffy 2004:33). Formalising a fail in writing is identified as particularly difficult for clinical assessors (Duffy 2004).

Subjectivity of assessment is highlighted as a significant concern of students (Calman et al. 2002; Horsburgh 2001; Melia 1987). Students feel they have to ‘fit in’ to the ward environment to get a good assessment. Student nurses and midwives have highlighted that they would like to have input from the academic staff of the HEI in practice placements in order to support learning and assessment (Norman et al. 2002). However the clinical credibility of academic nursing staff has been called into question (Goorapah 1997). It was anticipated that the PEF might be able to bridge this gap between education and service.

Poor preparation of mentors is also highlighted by students who found preparation of mentors inconsistent between placements (Norman et al., 2000). Students have also highlighted that the amount of time that students work with their mentor is variable (Lloyd-Jones et al. 2001; Norman et al. 2002). Research has indicated that the benefits of mentorship to learners are related to the number of occasions on which the student and mentor work together (Lloyd-Jones et al. 2001). Recent research findings suggest that students whose named mentors were absent spent significantly less time than other students working with a qualified member of staff in giving care, so there may be a detrimental effect on the education of students whose mentor is regularly unavailable (Lloyd-Jones et al. 2001).

The 2006 NMC standards to support learning and assessment in practice (NMC 2006) aim to address these issues. A developmental framework to support learning and assessment in practice is outlined in this NMC report. This framework has implications for both pre- and post-registration (specialist, public health and advanced practice) education. Four different levels of learning support are outlined, mentor, sign-off mentor, practice teacher and teacher with the stipulated the length of preparation and competencies for each level described. This is a new way of structuring mentorship and teaching roles in practice education. As described above registers will be held of these roles and individuals will be assessed every three years. This framework will be implemented between September 2007 and late 2008 and the role of the PEF will be required to develop to accommodate these national standards and the new roles it has created.
CONTRIBUTION OF CURRENT PROJECT

The project detailed in this report utilised methods that were responsive to changes in policy and practice. By using impact evaluation, involving key stakeholders from practice, management and education and focusing on detailed case studies, the project team were able to fully understand the contextual issues that influence the introduction of a new practice education role. We have identified the strengths of the PEF role and successful models of implementation and have highlighted key recommendations from these findings.
**APPROACH**

The overall study design was that of an impact evaluation, involving both quantitative and qualitative approaches. Impact evaluation aims to answer questions about outcomes and the impact on the situation it is intending to ameliorate, in this case the effect of the implementation of the new role of the PEF on the clinical learning environment. At the commencement of the project the role of the PEF was new and therefore the design incorporated an initial scoping survey of those holding PEF posts in order to gain baseline information on the current models of implementation and demographics of those holding the post. The results also provided potentially useful trends to explore in a second phase of case studies. All ethical approval was sought and a favourable ethics opinion provided. NHS R&D Management approval was provided.

The more specific project aims were as follows:

- Evaluate the impact of the new posts in NHS Scotland in terms of the perceived quality of support for mentors;
- Explore the impact on the quality of the clinical learning environment in terms of students’ experience;
- Identify the number of students that can be accommodated in both acute hospital and community placements within NHS Scotland;
- Identify examples of innovative practice which act as barriers/facilitators to the learning environment;
- Identify strengths and weaknesses of different models of implementation and development of posts;
- Explore inter-professional learning developments in practice.

**METHODS**

The project was conducted in two consecutive phases with consensus conferences held at strategic points in order to facilitate the active involvement of key stakeholders.

**Phase 1: Survey of PEFs and first Consensus Conference**

A survey of all PEFs in post in Scotland was undertaken using a self-completion questionnaire designed by the research team. The instrument was distributed, completed and returned electronically. The survey collected demographic information and aimed to determine the differing roles and models of implementation. It also identified examples of innovative practice, and views on capacity for support and mentoring in the clinical learning environments which had a PEF in post.

A Consensus Conference was held in early 2006, the aims of which were:

- To disseminate findings from the Phase 1 survey of PEFs in Scotland;
- To facilitate the understanding of Phase 1 findings through an open discussion in small groups;
- To achieve consensus on the key criteria for Phase 2 case study sites.

The conference began by introducing participants to the project and providing them with results from the PEF survey. Small group sessions, facilitated by individual researchers, were undertaken...
to explore in further detail the potential interpretation of the findings and also to achieve consensus on the key inclusion criteria for the case study sites.

**Phase 2: Six case studies and second consensus conference**

During the first consensus conference, consensus was reached on potential key criteria for the choice of case study sites. Six sites were chosen which met the key entry criteria. Each site was within a specific geographical location such as a hospital ward/unit or a community setting and they reflected general and specialist practice.

A number of different data collection techniques were used in the sites:

- A survey of students using a questionnaire adapted from an existing instrument evaluating the clinical learning environment and supervision. This investigated the quality of the clinical learning environment in terms of students’ experience.
- A survey of mentors using a questionnaire adapted from an existing instrument. This explored mentors’ experience of, and attitudes to, clinical learning, the PEF support for mentors, and the PEF role.
- A telephone survey of key respondents using a tool devised by the research team to gauge opinion on the impact of the PEF role on the achievement of quality indicators as they related to the practice learning environment. The tool, in the form of a 30-item questionnaire related directly to relevant Standards and Indicators contained in the document “The Development of Quality Standards for Practice Placements” (NHS Education for Scotland 2003). Standards and Indicators were selected on the basis of those on which the role of the PEF could impact.
- A focus group was conducted in each site with the aim of further facilitating our understanding of the findings of the project and to consider recommendations for the future development of the PEF role and a quality clinical learning environment. Each group was facilitated by two members of the research team and the resultant discussion was audio-recorded to ease subsequent analysis.

A second Consensus Conference for the project was held in late 2007, the aims of which were:

- To disseminate key findings from Phase 2 of the project;
- To gather views and opinions on the implications of these findings through open discussion in small groups;
- To facilitate the generation of potential recommendations for the future through small group discussion and group presentation.

The conference began by presenting the participants with selected results from the case studies. Small group sessions were undertaken to discuss their views and opinions on implications and potential recommendations for the future.

**SAMPLE AND RESPONSE RATE**

**PEF survey**

The sample for this survey was the whole population of PEFs working in Scotland. One hundred and eighteen invitations to participate along with the necessary documentation were sent out to PEFs by email. The final response rate was n=84 (71%).

**First Consensus Conference**

A total of 19 participants attended the conference, including PEFs, mentors, HEI representatives, clinical managers, students and PEF co-ordinators from all regions across Scotland.
Student Survey
Students were contacted directly by key informants for each case study site and in one site students were posted the questionnaire through the placement allocations department of the HEI as well as being distributed by staff locally. One hundred and forty-eight questionnaires were sent out across the six case study sites. A total of 31 (21%) questionnaires were returned.

Mentor Survey
Each potential participant for the mentor survey was contacted directly by key informants at each case study site. A total of 265 questionnaires were administered across the six case study sites. Questionnaires were completed and returned by 69 (26%) mentors.

Telephone Survey
A snowballing technique was used to identify the potential participants for the telephone interviews. Interviews were conducted usually at the participant’s place of work. A total of one hundred and five people were invited to participate in a telephone interview and forty-six (43%) of those gave consent. Only thirty-four (32%) interviews actually took place due to repeated non response, loss of contact and annual leave of some respondents.

Focus Group Interviews
Each potential participant for the focus group interview was contacted by post or email, which included a request for information on contact points should they give consent. In order to make it easier for participants to attend, each focus group took place at a location in the case study site. A total of 31 participants took part in the 6 focus groups.

Second Consensus Conference
A total of 21 participants attended the conference, including some of those who had attended the first conference and focus groups, as well as additional key stakeholders.

TECHNIQUES OF ANALYSIS

Qualitative analysis
Qualitative data included responses from open questions in survey questionnaires and transcripts of focus groups and consensus conferences. The responses to the open questions were copied verbatim into a single document, and an interpretation placed on each response in relation to themes generated overall by the raw data. Verbatim transcripts of the tapes from the focus groups were completed as soon as possible after the interviews had been held. Content analysis was used to assist in the discovery of themes, which linked, with the main aims of the study (Strauss and Corbin 1990).

Quantitative analysis
Data from the surveys were entered either electronically by the respondent or from hard copies by the researcher. All the survey data collected in Phases 1 and 2 were entered into the SPSS package (SPSS v15.0). Data was inspected at this point to check that the data had been correctly inputted and that all values were consistent with the responses on the respective survey instruments. Descriptive statistics were produced for all the survey using SPSS.
LIMITATIONS OF THE DESIGN

The PEF role was initiated across Scotland during 2004. Phase 1 took place at an early point in the development of the role of the PEF with data collection commencing early 2005. In evaluating a new professional role over time, it is predictable that there will be developments and maturation of the role. This will need to be taken into consideration when reading this report. In particular, the PEF survey should be seen as a ‘snapshot in time’.

Response rates were variable and disappointing particularly in postal surveys. The response rate for the PEF survey was excellent and this is likely due to the high motivation of the PEFs in role at that time and their enthusiasm to convey their ideas on the role. The attendance at focus groups was satisfactory in most cases with the exception of one site where only one participant attended. The response for Phase 2 surveys in the case study sites proved disappointing in places. The samples of mentors and students were small, with the number recruited at each case study site falling well below that required for robust statistical analysis. The response rates reflect the fact that we had no contact names to identify non-responders and so were unable to send out reminder letters.

FURTHER DETAILS

A full methodological report giving details of the methods used in the second Phase of the project is available via the NES website. Additionally, an interim report on the PEF survey is also available from the site.
FINDINGS

This evaluation project explored the role of the PEF from a number of differing perspectives. Initially our scoping activity amongst the PEFs provided much baseline information and we were also able to use this to help structure and direct later data collection which took place in six case study sites across Scotland. The sample in the overall project included a wide variety of stakeholders; clinical managers, registered nurses, registered midwives, students, mentors, representatives from HEIs and of course PEFs, Practice Education Coordinators, and lead PEFs. The findings from all parts of the study are integrated and presented here in a way which highlights the key issues related to the study objectives. Good practice examples identified from the case studies are highlighted in this section; pseudonyms are used to ensure confidentiality. Full details of the data collection instruments are contained in the methodological report which can be accessed via the NES website.

MENTORS: THEIR WORK AND THEIR SUPPORT

The mentor survey investigated placement learning from the mentors’ perspective. In particular we looked at mentors’ experience of, and attitudes to, placement learning (Table 1). The majority of the sample had been mentors for over 5 years (n=53; 82%). Although policy recommends that mentors attend an annual update many mentors reported that they had not attended one in the past two years (n=38; 55%) and 6 (9%) indicated they had never attended one. However only two mentors felt that they lacked the preparation to carry out their role. Comments were also made at focus groups in relation to mentors’ ongoing support and development. Some mentioned that updates were not happening as regularly as they would expect.

“…I think you’re supposed to get updates?”

“It will have been at least 8 years since I did the mentorship, but I’ve never had an update…”

In relation to workload, mentors often had only one pre-registration student to mentor at any one time. However, nearly a third of mentors would be expected to act as a preceptor or mentor other students at the same time, such as those undertaking CPD or SVQs. Mentors working in specialist clinical placement sites, such as primary care settings, were more likely to spend over 30 hours working alongside students than mentors working in more general placement sites. This is probably to be expected in specialist settings where students need more direct contact with mentors. However, it is important to be aware of possible existence of social desirability response bias in the use of self-report instrument (Polit & Hungler, 1999) which in this case may result in some mentors over-estimating the number of hours spent with students to be congruent with prevailing views on mentoring.
Table 1: Mentors experiences of placement learning (Mentor Survey)

<table>
<thead>
<tr>
<th>How long have you been mentoring students?</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>More than 1 year but less than 2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2-5 years</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>More than 5 years</td>
<td>53</td>
<td>82</td>
</tr>
<tr>
<td>Missing data</td>
<td>5</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How many pre-registration students are you normally expected to mentor at any one time?</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>62</td>
<td>89</td>
</tr>
<tr>
<td>1.5</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Missing data</td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Whilst mentoring a pre-reg. Student, which of the following would you expect to mentor at the same time?</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scottish Vocational Qualifications</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Pre-ceptee</td>
<td>20</td>
<td>29</td>
</tr>
<tr>
<td>Students undertaking post reg./post grad. courses</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>None of the above</td>
<td>42</td>
<td>61</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When did you last attend a mentor preparation or update course?</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than two years ago</td>
<td>25</td>
<td>36</td>
</tr>
<tr>
<td>2-5 years ago</td>
<td>26</td>
<td>38</td>
</tr>
<tr>
<td>Over 5 years ago</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>I have never attended</td>
<td>6</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you ever teach jointly in the clinical area with any of the following?</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lecturer practitioner</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Link tutors</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Link PEF</td>
<td>9</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How many hours a week do you work alongside students that you mentor in order to develop their clinical skills?</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9 hours</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>10-19 hours</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20-29 hours</td>
<td>19</td>
<td>28</td>
</tr>
<tr>
<td>30-39 hours</td>
<td>34</td>
<td>44</td>
</tr>
<tr>
<td>40-42 hours</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Missing data</td>
<td>7</td>
<td>-</td>
</tr>
</tbody>
</table>

In order to identify what mentors viewed as the most important aspects of the mentor role, we presented them with a list of 11 items and asked them to rate the three most important (Table 2). The top three most cited were supervising students (n=41; 59%), making students feel welcome in the practice setting (n=38; 55%), and planning a programme of learning for students (n=24; 35%). Least cited included, familiarising yourself with a student’s programme of study/assessments (n=8; 12%), and helping reduce stress in students (n=5; 9%). These findings were supported by discussion in focus groups where participants indicated their commitment to the supervision of students and ensuring that their learning experiences were relevant and supported the acquisition of clinical competencies. Many clinical areas reported being more pro-active since the introduction of PEFs in producing tools which support learning, such as training packages to underpin clinical situations the student met on the ward. They also found it beneficial to have the stimulation of the students’ presence.

“…I quite enjoy putting a pack together to be honest…you can become stagnant in an area you know, and you have to be involved and do something…”

“…because our students are a teaching tool for us as well. You know we do get a lot from them on how things are changing in the hospital…some of us have been on the community for years!”
Table 2: Important aspects of the mentor role (Mentor Survey)

<table>
<thead>
<tr>
<th>Aspect</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision of students undertaking clinical skills</td>
<td>41</td>
<td>59</td>
</tr>
<tr>
<td>Making students feel valued/welcome in the practice setting</td>
<td>38</td>
<td>55</td>
</tr>
<tr>
<td>Planning a programme of learning for students</td>
<td>24</td>
<td>35</td>
</tr>
<tr>
<td>Working collaboratively with students</td>
<td>23</td>
<td>33</td>
</tr>
<tr>
<td>Creating opportunities for students to learn from others</td>
<td>21</td>
<td>30</td>
</tr>
<tr>
<td>Assessing students’ practice</td>
<td>16</td>
<td>23</td>
</tr>
<tr>
<td>Providing feedback to students</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>Providing sufficient opportunity for students to reflect on experience</td>
<td>13</td>
<td>19</td>
</tr>
<tr>
<td>Familiarising yourself with students programme of study/assessments</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Helping reduce stress in students</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Familiarising yourself with students programme of study/assessments</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Helping reduce stress in students</td>
<td>5</td>
<td>9</td>
</tr>
</tbody>
</table>

It was important to identify what mentors felt were the barriers to carrying out the mentor role effectively. They were presented with a list of nine potential barriers and asked which, if any, prevented them from being effective in their mentorship role (Table 3). The findings revealed that mentors perceived the main barriers to their effectiveness were the demands of both patient care (n=28; 41%) and clinical management (n=17; 25%). This is a finding replicated in the NEWI Study (Carnwell, 2005). Only one mentor surveyed felt that they had too many students at the same time.

Table 3: Barriers to the mentorship role (Mentor Survey)

<table>
<thead>
<tr>
<th>Potential Barrier</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict of interest due to the demands of clinical care</td>
<td>28</td>
<td>41</td>
</tr>
<tr>
<td>Conflict of interest due to demands of clinical management</td>
<td>17</td>
<td>25</td>
</tr>
<tr>
<td>Lack of recognition of the demand of the role by managers</td>
<td>13</td>
<td>19</td>
</tr>
<tr>
<td>Working with the constraints of documentation</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Your lack of understanding of the pre-re curriculum</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Lack of support from clinical colleagues</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Your own lack of preparation to carry out the role</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Mentoring too many students at the same time</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Mentors reported that they would usually see their link PEF at least once every placement. However, the format of such meetings was inconsistent across the sample in that some mentors met with their link PEF on an ad-hoc basis and some mentors tended to plan their meetings. Sometimes the student was present, but not always. Despite these regular meeting, mentors reported getting most of their information about what students were taught in the HEI from the students themselves.

The mentors surveyed rated the quality of their relationship with their PEF as above average. Interestingly this was not associated with the frequency of contact between the mentor and their link PEF. Stakeholders in the telephone survey expressed the view that mentors were better supported in their role since the introduction of the PEF to their clinical areas. But in an open text question in this survey it was felt that the workload for PEFs could be high, and in some areas comments were made that they tended to take on a ‘fire fighting’ approach with low visibility in the clinical areas at times. At focus groups and consensus conferences, there were numerous examples of excellent relationships between the mentors and their link PEF. However there were exceptions to this and comment from two areas highlight a potential difficulty.

“…I know there are some mentors who are not sure who the PEF is…”
“...the PEF for our area is not easily accessible and many staff do not know who she is as she has never visited the department other than one occasion when there was a problem and we had to request a visit.”

**Good Practice Example**

Patricia and Jennifer are two PEFs who worked with their local HEI to develop an innovative toolkit that would help to support mentors in the assessment of pre-registration students. Their toolkit outlined their role, that of the mentor and described the purpose of student assessment. It also described the individual nursing programmes provided by the HEI and gave details of procedures for handling concerns about student progress. For example, a flowchart was developed to provide a guide on how to deal with student issues such as student absence. Another part of the toolkit was a checklist that mentors could use to help them to follow the guidelines set out by NHS Education for Scotland (NES) as well as the local practice standards. This toolkit is a resource that could be adopted and adapted for different practice placement areas and demonstrated the PEFs commitment to supporting mentors in practice, and having a high level of visibility in the area.

**WHERE ARE PEFs HAVING AN IMPACT?**

When we spoke to participants in focus groups and in consensus conferences, we heard numerous accounts of the value which was placed on the support and guidance provided by PEFs. Particular mention was made of mentors who could be coping with a student who was having difficulties in achieving learning objectives and clinical competencies.

“...the support in things like failing students has increased greatly since this (PEF) came into post.”

“...(PEF) has given the mentors a lot more confidence in dealing with problems that students give us.”

This is supported by findings from the early scoping survey of PEFs where nearly all the PEFs surveyed identified that they provided support for mentors to manage failing students (n=81, 96%, Table 4).

**Table 4: PEF involvement in learning opportunities (PEF Survey)**

<table>
<thead>
<tr>
<th>Type of involvement</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support mentors with failing students</td>
<td>81</td>
<td>96</td>
</tr>
<tr>
<td>Advise mentors on learning activities</td>
<td>78</td>
<td>93</td>
</tr>
<tr>
<td>Direct mentor/student to learning activities</td>
<td>63</td>
<td>75</td>
</tr>
<tr>
<td>Organising classroom style teaching in practice area</td>
<td>29</td>
<td>35</td>
</tr>
<tr>
<td>Provide classroom style teaching in practice area</td>
<td>18</td>
<td>21</td>
</tr>
<tr>
<td>Teach students specific clinical skills</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>Teach clinical skills to students who need extra support</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

The findings from the mentor survey also revealed that mentors perceived the support offered by their link PEF to be above average when they had a failing students (n=32; 46%).
In focus groups, comments were also made about the relevance and usefulness of the advice given by PEFs. Prior to the introduction of PEFs, advice was often not timely or particularly helpful.

“...you would go to your own manager and say, ‘well, I’ve got a problem with this student…and I don’t know what to do about it’. You wouldn’t maybe always get the appropriate advice or they wouldn’t always know what we should really do and then it would come back to the tutors and that could all take time as well, so I think having the PEFs there...you can rely on that...it works very well.”

“...lecturers tend to be more focussed on academic performance and less aware of clinical practice performance. The PEFs have an edge...”

The accessibility of PEFs was also valued in some areas.

“...we have had problems trying to get a hold of tutors and really by the time it’s sorted it’s far too late for the student; their placement is over!

Interestingly, the point was made that there was added value to the PEFs support, in that it could help mentors support students in a way which avoided facing failure at the end of a placement.

“...not only are they a support to us, we are also stopping students failing you know, which is very important...”

In the telephone survey of key stakeholders the impact of the PEF role on mentors’ experience of providing student support was generally rated as positive (Table 5). Over 75% of respondents felt that PEFs had a moderate or substantial impact on preparing mentors immediately prior to receiving a student and on ensuring that students receive induction to the placement on their first day of allocation (Table 5).
Table 5: Impact of the PEF role on the mentor experience with students (Telephone Survey of Stakeholders)

<table>
<thead>
<tr>
<th>What do you consider to be the level of impact of the PEF role on:</th>
<th>Level of impact</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None or little</td>
<td>Moderate or substantial</td>
</tr>
<tr>
<td>The preparation of mentors immediately prior to a student being mentored by them</td>
<td>8 (24)</td>
<td>26 (77)</td>
</tr>
<tr>
<td>The support mentors receive prior to a student being mentored by them</td>
<td>11 (32)</td>
<td>23 (68)</td>
</tr>
<tr>
<td>Conveying information on the training needs of students to mentors</td>
<td>10 (29)</td>
<td>24 (71)</td>
</tr>
<tr>
<td>The preparation of mentors to support students with specific learning needs/disabilities</td>
<td>8 (24)</td>
<td>18 (53)</td>
</tr>
<tr>
<td>Ensuring that students receive induction to the placement on their first day of allocation</td>
<td>8 (24)</td>
<td>26 (76)</td>
</tr>
<tr>
<td>Ensuring that students receive ongoing guidance and feedback from the mentor</td>
<td>12 (35)</td>
<td>21 (62)</td>
</tr>
<tr>
<td>Ensuring mentors conduct a fair and objective assessment of student performance</td>
<td>9 (27)</td>
<td>25 (74)</td>
</tr>
<tr>
<td>Supporting mentors to have freedom/authority to plan and deliver learning opportunities to meet students’ learning outcomes</td>
<td>11 (32)</td>
<td>22 (65)</td>
</tr>
<tr>
<td>The allocation of a named mentor to all students within 48 hours of commencement</td>
<td>12 (35)</td>
<td>21 (62)</td>
</tr>
</tbody>
</table>

We also asked the telephone interview respondents to rate the impact of the PEF on the actual allocation of a mentor. Despite the recommendations in the NES Quality Standards for Practice Placements (NHS Education for Scotland 2003) that each student has a named mentor within 48 hours of commencement, stakeholders reported that less than two-thirds did not receive a named mentor in this time period (Table 5).

**MAINTAINING QUALITY IN CLINICAL LEARNING ENVIRONMENTS**

In exploring the quality of the learning environment, we began by finding out students’ perceptions of their clinical placement sites using a modification of a validated instrument (Saarikoski & Leino-Kilpi 2002). The findings from the student survey demonstrated that perceptions of the learning environment were overall positive across four pre-defined aspects; the atmosphere, the leadership style of the ward manager or team leader, the nursing/midwifery care in the care giving environment, and learning in the care giving environment. As can be seen from the results in Table 6, over 70% of students felt that the environment was good for learning, staff were interested in them and learning was meaningful.

Table 6: Quality of the learning environment (Student Survey)

<table>
<thead>
<tr>
<th>How would you best describe your opinion about learning on the ward/care giving environment?</th>
<th>Response N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Disagree</td>
</tr>
<tr>
<td>Basic familiarisation was well organised</td>
<td>4 (13)</td>
</tr>
<tr>
<td>The staff were generally interested in student supervision</td>
<td>6 (16)</td>
</tr>
<tr>
<td>The staff learned to know the student by their personal name</td>
<td>1 (3)</td>
</tr>
<tr>
<td>There were sufficient meaningful learning situations on the ward/care giving environment</td>
<td>5 (16)</td>
</tr>
<tr>
<td>The learning situations were set in context of the clinical placement environment</td>
<td>3 (10)</td>
</tr>
<tr>
<td>The ward/care giving environment can be regarded as a good learning environment</td>
<td>5 (16)</td>
</tr>
</tbody>
</table>

Most students reported that they had a personal mentor relationship that worked during the placement (n=24; 80%, Table 7).
Table 7: Method of mentorship (Student Survey)

<table>
<thead>
<tr>
<th>Method</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>A mentor was named, but the relationship with this mentor did not work during the placement</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Mentor varied according to shift or place of work</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>A personal mentor was named and our relationship worked during this placement</td>
<td>24</td>
<td>80</td>
</tr>
<tr>
<td>Missing data</td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>

Students also expressed positive attitudes towards the quality of their relationship with their mentor and agreed that the feedback provided was individual (n=24; 77%, Table 8) and timely (n=20; 65%, Table 8). Stakeholders appeared to have a mixed response as to whether PEFs were having an impact on this aspect of the student experience, with 62% stating that they had a moderate or substantial impact on students receive ongoing guidance and feedback from the mentor, but 35% believing they had little or no impact (Table 5).

Table 8: Content of the supervisory relationship (Student Survey)

<table>
<thead>
<tr>
<th>Response</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Missing data</th>
</tr>
</thead>
<tbody>
<tr>
<td>The mentor showed a positive attitude towards supervision</td>
<td>4 (13)</td>
<td>-</td>
<td>27 (87)</td>
<td>-</td>
</tr>
<tr>
<td>I feel that I received individual supervision</td>
<td>6 (19)</td>
<td>1 (3)</td>
<td>24 (77)</td>
<td>-</td>
</tr>
<tr>
<td>I continuously received feedback from my mentor</td>
<td>6 (19)</td>
<td>5 (16)</td>
<td>20 (65)</td>
<td>-</td>
</tr>
<tr>
<td>Overall I am satisfied with the supervision I received</td>
<td>5 (16)</td>
<td>2 (7)</td>
<td>24 (77)</td>
<td>-</td>
</tr>
<tr>
<td>The supervision was based on a relationship of equality and promoted my learning</td>
<td>5 (16)</td>
<td>3 (10)</td>
<td>23 (74)</td>
<td>-</td>
</tr>
<tr>
<td>There was a mutual interaction in the supervisory relationship</td>
<td>4 (13)</td>
<td>2 (7)</td>
<td>25 (81)</td>
<td>-</td>
</tr>
<tr>
<td>Mutual respect and approval prevailed in the supervisory relationship</td>
<td>5 (16)</td>
<td>1 (3)</td>
<td>25 (81)</td>
<td>-</td>
</tr>
<tr>
<td>The supervisory relationship was characterised by a sense of trust</td>
<td>4 (13)</td>
<td>4 (13)</td>
<td>23 (74)</td>
<td>-</td>
</tr>
</tbody>
</table>

A major contribution to ensuring quality in clinical placement sites is the ability of the clinical staff and managers involved to receive feedback from students on their perceptions of the learning experience. With regard to the PEF involvement in this process, the early scoping survey of PEFs revealed that fewer than three-quarters of PEFs were involved in such activities as; developing student evaluation of practice placement tools (n=59, 70%), reviewing student evaluations (n=54, 64%) or providing feedback to placements after student evaluations (n=58, 69%) (Table 9).

Table 9: PEF involvement in student placements (PEF survey)

<table>
<thead>
<tr>
<th>Type of involvement</th>
<th>Yes N (%)</th>
<th>No N (%)</th>
<th>Missing data N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of student evaluation tools</td>
<td>59 (70)</td>
<td>21 (25)</td>
<td>4 (5)</td>
</tr>
<tr>
<td>Feedback to placements after student evaluations</td>
<td>58 (69)</td>
<td>24 (29)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Review of student evaluations</td>
<td>54 (64)</td>
<td>28 (33)</td>
<td>2 (2)</td>
</tr>
</tbody>
</table>

There were some positive views expressed in the telephone survey of stakeholders in relation to the PEF impact on student evaluation processes, in particular on the clarity of systems which enable students to provide feedback on the practice placement (79%, n=27) and on the impact of the PEF role on systems for acting on student feedback (74%, n= 25) (Table 10).
Table 10: PEF impact on student feedback (Telephone Survey of Stakeholders)

<table>
<thead>
<tr>
<th>What do you consider to be the level of impact of the PEF role on:</th>
<th>Level of impact N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The clarity and accessibility of systems and protocols which enable students to provide feedback on the practice placement</td>
<td>None or little Moderate or substantial Don’t know/not aware</td>
</tr>
<tr>
<td>3 (9)</td>
<td>27 (79)</td>
</tr>
<tr>
<td>Ensuring that the practice placement areas receive feedback regarding student evaluation</td>
<td>7 (21)</td>
</tr>
<tr>
<td>On the systems and protocols for acting on student feedback in relation to practice placements</td>
<td>6 (18)</td>
</tr>
<tr>
<td>The conduct of joint HEI/service provider evaluation of practice placements</td>
<td>7 (21)</td>
</tr>
</tbody>
</table>

In our focus groups, however, there were a number of contradictory views to the positive views expressed in the surveys. These specifically related to the ability of staff in clinical placement sites to receive timely and specific feedback from the students who had been allocated to them. Participants commented on a number of occasions on the delay which occurred in receiving feedback from the HEI after students had completed the evaluation of placements.

“The university document only issues the results of evaluations once a year”

“We are not supported to act on student evaluations...we have received no feedback since the end of 2005”

In one site, it would appear that they never received any written documentation.

“I think unless you asked you would never find out really how (you were doing)...”

There were also obvious difficulties faced in receiving feedback which was specific to their own clinical areas, as often the feedback which was circulated from the HEI was an aggregate of all student evaluations received over a period of time, and sometimes from differing clinical placement sites.

“...if it’s a placement that only has one or two students every now and again they wait until they’ve got I think it’s six as a minimum so they can do some analysis.”

Participants agreed that if there were small numbers then confidentiality could be a problem, but they still felt it important to explore ways of getting timely and specific feedback. Many participants did comment that they could be pro-active by approaching the students themselves when they got to the end of the placement.

“(we ask) if there’s something that we’re not doing that we should be doing, please tell us before you go...”

But there was some reservation expressed on that.

“The students are very good at giving you positive feedback as most people would be...not many people would be confident enough to give you negative feedback!”

“I feel if it’s negative feedback we probably don’t know, but it would be beneficial if they did...”
“…if we knew where we could improve our support, then I am sure student learning would improve too in the future”

**Good Practice Example**

Margaret worked part-time as a PEF and part-time in a clinical role. She was aware that nurse mentors had very little feedback from the students. At that time, practice areas were getting feedback from the HEI about once a year making it difficult to address quality issues or concerns of the students. Students tended to contact their personal tutor with any issues of major concern prior to completing their evaluation. Mentors wanted to know whether the students had found any aspect of their placement helpful or, conversely whether there were issues that the students found problematic.

Margaret worked with the local Practice Development Group to construct a feedback system that ensured clinical areas receive feedback from student evaluations as soon as possible. This involved developing a new and more detailed feedback form that students completed at the end of each placement. The new feedback forms were scrutinised by the PEF and a copy sent back to the placement areas. The PEF would telephone the placement area to discuss the student feedback with the nursing staff. The feedback forms tended to highlight organisational issues such as the learning opportunities available with, for example, the health visitor, rather than problematic issues. Mentors found this useful in planning clinical learning opportunities and activities for students.

Good quality clinical placements are those which are audited for their appropriateness for the students and for their ability in enabling students to achieve their clinical learning outcomes. In the PEF scoping survey, the PEFs were asked to indicate their type of involvement in this. Findings show that PEFs were likely to be involved in the identification of appropriate practice placements (n=79, 94%) and over 75% were involved in the audit of clinical placements, both current (n=73, 87%) and potential (n=66, 79%) (Table 11).

**Table 11: PEF involvement in placement capacity (PEF Survey)**

<table>
<thead>
<tr>
<th>Type of involvement</th>
<th>Yes N (%)</th>
<th>No N (%)</th>
<th>Missing data N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification of potential placements</td>
<td>79 (94)</td>
<td>3 (4)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Audit of current placements</td>
<td>73 (87)</td>
<td>9 (11)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Audit of potential placements</td>
<td>66 (79)</td>
<td>16 (19)</td>
<td>2 (2)</td>
</tr>
</tbody>
</table>

**BUILDING CAPACITY FOR STUDENT PLACEMENTS**

Over 80% of PEFs in the scoping survey perceived that capacity in their clinical areas was affected by availability of trained mentors (n=72, 86%) or numbers of qualified staff (n=71, 85%) (Table 12).

**Table 12: Factors perceived to affect capacity (PEF Survey)**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Yes N (%)</th>
<th>No N (%)</th>
<th>Don't know N (%)</th>
<th>Missing data N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of mentors</td>
<td>72 (86)</td>
<td>8 (10)</td>
<td>-</td>
<td>4 (5)</td>
</tr>
<tr>
<td>Number of qualified staff</td>
<td>71 (85)</td>
<td>7 (8)</td>
<td>1 (1.2)</td>
<td>5 (6)</td>
</tr>
<tr>
<td>Workload</td>
<td>65 (77)</td>
<td>14 (17)</td>
<td>1 (1.2)</td>
<td>4 (5)</td>
</tr>
<tr>
<td>Numbers of students</td>
<td>65 (77)</td>
<td>13 (16)</td>
<td>-</td>
<td>6 (7)</td>
</tr>
<tr>
<td>Unfilled vacancies</td>
<td>64 (76)</td>
<td>15 (18)</td>
<td>-</td>
<td>5 (6)</td>
</tr>
<tr>
<td>Staff sickness</td>
<td>62 (74)</td>
<td>17 (20)</td>
<td>-</td>
<td>5 (6)</td>
</tr>
<tr>
<td>Staff recruitment difficulties</td>
<td>60 (71)</td>
<td>18 (21)</td>
<td>-</td>
<td>6 (7)</td>
</tr>
<tr>
<td>Staff turnover</td>
<td>48 (57)</td>
<td>27 (32)</td>
<td>2 (2)</td>
<td>7 (8)</td>
</tr>
<tr>
<td>Patient dependency</td>
<td>44 (52)</td>
<td>30 (36)</td>
<td>-</td>
<td>10 (12)</td>
</tr>
<tr>
<td>Complementary staffing</td>
<td>41 (49)</td>
<td>31 (37)</td>
<td>2 (2)</td>
<td>10 (12)</td>
</tr>
</tbody>
</table>
Building capacity involves not only the availability of mentors and clinical staff, but the identification of new clinical placement sites, the ability of clinical areas to increase the numbers of students they can accept, and finding ways of using these existing placements differently. Stakeholders in the telephone survey showed that they perceived PEFs playing a significant part in these initiatives, with the majority believing PEFs have found ways of using existing placements differently (n=23; 67%), and in developing new clinical placements (n=23; 68%) (Table 13).

Table 13: Impact of the PEF role on capacity (Telephone Survey of Stakeholders)

<table>
<thead>
<tr>
<th></th>
<th>Response</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEFs have been instrumental in finding ways of using existing</td>
<td>Disagree</td>
<td>Neither agree nor disagree</td>
</tr>
<tr>
<td>clinical placements differently to the advantage of student</td>
<td>3 (9)</td>
<td>4 (12)</td>
</tr>
<tr>
<td>learning</td>
<td></td>
<td>23 (67)</td>
</tr>
<tr>
<td>Mentors are better supported in their role since the introduction</td>
<td>5 (15)</td>
<td>2 (16)</td>
</tr>
<tr>
<td>of the PEF to their clinical area</td>
<td></td>
<td>26 (79)</td>
</tr>
<tr>
<td>PEFs have played a significant part in developing new clinical</td>
<td>4 (12)</td>
<td>Neither agree nor disagree</td>
</tr>
<tr>
<td>placements</td>
<td></td>
<td>4 (12)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>23 (68)</td>
</tr>
</tbody>
</table>

In the PEF scoping survey, we asked PEFs to briefly describe one innovative approach being taken to maximise the number of students who can be supported in their practice area. These ideas, however, were limited to identifying new placements, use of team or co-mentoring, use of pathways and hubs, or an on-site mentoring programme. They were also asked in a free text question to describe how their role affects capacity. Their responses indicate a number of approaches.

“Sometimes it is the perception of staff that is my biggest challenge. If they perceive they can’t support any more students….hopefully with support and making the areas aware of how others cope, then there will be a change in attitude in the future.”

“I try to encourage clinical areas to plan ahead by providing schedules detailing when to expect students a year in advance.”

Participants in focus groups were able to describe initiatives which involved using different areas for short experiences for their students and in this way not only enhancing their learning, but relieving them of one-to-one supervision when this might be problematic.

“No the treatment rooms are a placement (for students)and that’s something the PEFs have been very proactive in introducing.”

In the PEF survey, the support that PEFs provide for mentors was also felt to have an effect.

“My role has influenced a general increase in number of students agreed, as mentors feel better supported and informed.”

“I have become involved in ensuring the number of trained mentors is increased within clinical areas to ensure maximum student capacities can be achieved.”

Problems with capacity were also discussed in the focus groups and it was evident that PEFs were able to support staff in clinical areas where they may be having a spell of difficulty in continuing to take their usual numbers of students or where there were changes in staffing or patient dependency which might mean a reduction in capacity.
“(The PEF) is there for all sorts of queries…if you have a staffing problem, it’s not fair for students to come in to that learning environment when there is nobody around to facilitate them.”

“Demands are changing all the time but it’s about saying how do you make that decision, so from a capacity point of view the PEFs are then asked to help with that decision making.”

**Good Practice Example**

Frankie, a PEF in a specialist area, was described by one of the mentors as a really creative person. The mentor had felt that her clinical learning environment did a really good job, but the hub and spoke model had become somewhat stale, certainly for the mentors. They had been using the same places and the same practitioners in the spokes for well over 2 years. They discussed with Frankie ways that they might refresh their approach, and together they identified some very different spoke sites, which could support students in meeting their learning outcomes in a more exciting way. This entailed some different spoke visits, and some different professional practitioners which they might not have thought of if Frankie hadn’t encouraged them to think a bit more laterally.

**HOW ARE CLINICAL AREAS AND PEFs HELPING STUDENTS LEARN?**

One of the main aims of the PEF role is that of supporting and facilitating the mentor to carry out their mentoring role effectively. In this report, we have already presented findings related to the support of the mentor and the mentor role, but it is also important to look more broadly at this issue which includes the PEF role in the availability of learning opportunities and supporting student learning.

When we asked PEFs to indicate how learning needs were assessed and whether or not they were involved in this, the most frequent approach was informally with mentors throughout the placement (n=74; 88%, Table 14) and this was also the type of assessment in which most PEFs were likely to be involved (n=47; 56%, Table 14). Learning contracts were also used, and more often negotiated through the mentors (n= 73, 86%) than through academic staff at the HEI (n=29; 34%, Table 14).

**Table 14: Ways of assessing learning needs in PEFs’ clinical areas (PEF Survey)**

<table>
<thead>
<tr>
<th>Type of assessment</th>
<th>Assessment of learning needs</th>
<th>PEF involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (%)</td>
<td>No (%)</td>
</tr>
<tr>
<td>Informally with mentors</td>
<td>74 (88)</td>
<td>4 (5)</td>
</tr>
<tr>
<td>Learning contracts with mentors</td>
<td>73 (87)</td>
<td>6 (7)</td>
</tr>
<tr>
<td>PP outcomes prescribed by HEI</td>
<td>71 (85)</td>
<td>7 (8)</td>
</tr>
<tr>
<td>Clinical skills booklet/inventory</td>
<td>60 (71)</td>
<td>17 (20)</td>
</tr>
<tr>
<td>Learning contracts with HEI</td>
<td>29 (35)</td>
<td>34 (41)</td>
</tr>
</tbody>
</table>

Stakeholders in the telephone survey indicated their belief that the PEF role had a positive impact on aspects of student learning (Table 15). There was also thought to be a moderate or substantial impact on ensuring access to range of teaching and learning resources for the student (n=28; 82%), and on the range of opportunities being made available to support achievement of learning outcomes (n=27; 79%).
Table 15: Impact of the PEF role on student learning (Telephone Survey of Key Stakeholders)

<table>
<thead>
<tr>
<th>What do you consider to be the level of impact of the PEF role on:</th>
<th>Level of impact N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None or little</td>
</tr>
<tr>
<td>The access to a range of teaching and learning resources for the student</td>
<td>6 (17)</td>
</tr>
<tr>
<td>Students receiving a fair and objective assessment</td>
<td>8 (24)</td>
</tr>
<tr>
<td>The adequate availability in the practice placement of mentors who have appropriate education/training to assess students</td>
<td>8 (24)</td>
</tr>
<tr>
<td>The adequate availability in the practice placement of mentors who have appropriate experience to assess students</td>
<td>12 (35)</td>
</tr>
<tr>
<td>Students gaining experience as part of a multi-professional team</td>
<td>11 (32)</td>
</tr>
<tr>
<td>The range of opportunities available to students in order to support their achievement of learning outcomes</td>
<td>6 (18)</td>
</tr>
<tr>
<td>On the team approach to the support of students, where this is appropriate</td>
<td>5 (15)</td>
</tr>
</tbody>
</table>

The views on the impact of PEFs relating to students gaining experience as part of a multi-professional team were mixed, with 32% (n=11) stating it was either little or none, but 65% (n=22) believing PEFs had a moderate or substantial impact. The availability of inter-professional learning was explored in the focus groups. The views expressed overall tended to demonstrate that there was hardly any inter-professional learning occurring in practice placement settings. The comments focused on such things as other professionals teaching the students, or students shadowing other professionals to gain insight into what their role entailed.

“…the consultants do a weekly teaching session here…”

“We’ve had teaching sessions on equipment and pharmacies, talks on drug administration…”

“We try to get the students to go with her for an afternoon (occupational therapist)”

We did not hear any specific examples of students from differing professions or disciplines learning together in practice, other than in the sense of being taught by other health professions or shadowing others.

In the initial PEF scoping survey, PEFs were asked in what ways they were involved in identifying appropriate learning opportunities in the practice placements (Table 4). Over 75% (n=78; 93%) were involved in advising mentors on appropriate student learning activities. Many PEFs reported being involved in indirect ways regarding learning, with 75% (n=63) directing the mentor or student to learning activities. A small number, however, were involved in teaching specific clinical skills (n=12; 17%) or in providing clinical skills teaching to students who needed extra support (n=7; 8%).

It is of interest to note the responses of mentors in the survey when they were asked for their view on the three most and three least important aspects of the PEF role (Table 16). In the most important category, the items on teaching students specific clinical skills (n=17; 25%) and teaching clinical skills (n=17; 25%) featured relatively high, but this was equally divided amongst those who thought it was not important with responses from n=27 (39%) and n=10 (15%) respectively. It is also valuable to note that during interviews mentors generally appeared to have a clear understanding of the role of the PEF, and often acknowledged that although clinical skills teaching was not included in their role specification, some mentors appreciated that support when offered.
In the first consensus conference, it was also clear that there was a division of opinion on the reasons for these differing opinions. We therefore explored this further in the focus groups.

There was acknowledgement that teaching students clinical skills could be time intensive particularly if the student required additional support to what was expected, but there was a general level of unease about students being taken away from the clinical situation and the mentor.

“…if you’ve got a student who can do it first time, that’s great, but if you’ve got someone that takes time to show them for them to get it right it does take up a lot of your time and I may be happy with someone coming in…not necessarily a PEF, but someone!”

“I don’t think coming in and taking students away…would make them any better…because it’s about being with the mentor within the clinical area…”

There were concerns that PEFs would not have appropriate competence for skills teaching if they were covering a number of varying clinical areas, and that it would also be difficult for all PEFs to keep up-to-date and that there would not be enough of them to provide this role.

“How would you (PEF) be able to take on that role and keep yourself up-to-date, as well as doing all these other things…”
“I feel if the PEFs were to take on the old clinical teachers’ role that would be depriving the nurses of quite a lot…I don’t think it’s a PEF’s role, but I think there’s certainly a role there…”

“I think that role is big enough and meaty enough without having clinical teaching, but I definitely think there’s a role for clinical teaching to be more supported…whether that means going back to the clinical teacher?”

As can be seen from the preceding quotes, there were many opinions expressed about there being a need for support for clinical skills teaching. This was also expressed in focus groups from specialist areas and disciplines, but it was generally acknowledged that this was not within the role specification of the PEF.

“When they were taking them (clinical teachers) away out the system, we all complained.”

“OK, we did get rid of the clinical teacher role, but the PEF wasn’t specifically brought in to actually do that role.”

Mentors appear committed to ensuring that students acquire competence in clinical skills and this is reinforced by results from the mentor survey which indicate that the supervision of students undertaking clinical skills was the highest rated aspect of the mentor role (Table 2).

## MODELS OF IMPLEMENTATION OF THE PEF ROLE ACROSS SCOTLAND

Many differing models of implementation were evident both from responses in survey questionnaires and from focus groups and consensus conferences. There were obvious differences in that PEFs could be ‘generic’, that is, attached to a number of different clinical units, where others were of a more specialist nature such as based in primary care, or within a specific discipline such as mental health. The types of students allocated to the placement areas for which PEFs had a responsibility also varied in number and level (Tables 17 and 18). For example in the PEF scoping survey PEFs were asked to indicate which types of students were placed in their clinical areas. Nearly all PEFs (n=79, 94%) had educational responsibilities for Diploma students. However, less than half had educational responsibilities for postgraduate students (n=39, 46%) or for SPQ students (n=33, 39%). Most types of other learners were newly qualified staff (n=52, 62%) and staff who were returning to practice (n=48, 57%).

<table>
<thead>
<tr>
<th>Type of students</th>
<th>Number of PEFs</th>
<th>% of PEFs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diploma</td>
<td>79</td>
<td>94</td>
</tr>
<tr>
<td>Healthcare</td>
<td>65</td>
<td>77</td>
</tr>
<tr>
<td>Undergraduate</td>
<td>60</td>
<td>71</td>
</tr>
<tr>
<td>CPD</td>
<td>60</td>
<td>71</td>
</tr>
<tr>
<td>Post graduate</td>
<td>39</td>
<td>46</td>
</tr>
<tr>
<td>SPQ</td>
<td>33</td>
<td>39</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 17: Types of students placed in PEFs’ clinical areas (PEF Survey)
Table 18: Other types of learners in PEFs clinical areas (PEF Survey)

<table>
<thead>
<tr>
<th>Type of learners</th>
<th>Number of PEFs</th>
<th>% of PEFs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preceptorship/newly qualified</td>
<td>52</td>
<td>62</td>
</tr>
<tr>
<td>Return to practice</td>
<td>48</td>
<td>57</td>
</tr>
<tr>
<td>Vocational qualifications</td>
<td>45</td>
<td>54</td>
</tr>
<tr>
<td>Clinical updates</td>
<td>42</td>
<td>50</td>
</tr>
<tr>
<td>Induction</td>
<td>37</td>
<td>44</td>
</tr>
<tr>
<td>Adaptation</td>
<td>33</td>
<td>39</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

PEFs also identified a number of limitations to the structure of their role and these are illustrated in Table 19.

Table 19: Limitations of structure as perceived by PEFs (PEF Survey)

<table>
<thead>
<tr>
<th>Limitations of structure</th>
<th>Number of responses</th>
<th>% of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources</td>
<td>39</td>
<td>46</td>
</tr>
<tr>
<td>Lack of management</td>
<td>35</td>
<td>42</td>
</tr>
<tr>
<td>Part-time post</td>
<td>34</td>
<td>41</td>
</tr>
<tr>
<td>Geographical spread</td>
<td>33</td>
<td>29</td>
</tr>
<tr>
<td>Poor communication</td>
<td>21</td>
<td>25</td>
</tr>
<tr>
<td>Conflict with HEI</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>Not linked to own speciality</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

Availability of resources and lack of clear management featured highly, some of which were described in the following terms:

“…line management arrangements appears to vary across the Health Board (sic) ranging from laissez-faire to being quite prescriptive”

“…lack of development support from manager”

“…fragmented line management structure”

Participants from focus groups and consensus conferences also highlighted the value in having a clear management structure, and having line managers who understood the PEF role. Being positioned within Practice Development Units was also reported as very beneficial by PEFs at focus groups.

Another limitation of the structure of the post reported on over 40% of responses (n=34; 41%, Table 19) was the part-time status of some PEFs. In focus groups some concern was expressed at the volume of work of the PEFs and the difficulties in achieving the aims of the role if it were a part-time post. Most participants explained this in terms of growing recognition of the potential of the role and the consequent greater demands for support.

“(I am) part-time…and the increase in workload is enormous from where we started and the demand for support from the PEF is a lot greater than it was initially.”

“…probably because it’s taken that length of time to raise awareness of the role so that…people are utilising it better, but certainly from a part-time point of view it is very, very difficult to sustain that support and we definitely need full-time people in there…”

Some also expressed the view that part-time did not really work for them.
“The organisation of our PEF does not work well as she is only available part-time...”

The structures of all PEF posts involve linked HEIs and the initial PEF scoping survey indicated that 18 (22%) PEFs were linking with three or more institutions (Table 20).

Table 20: Number of HEI links held by individual PEFs (PEF Survey)

<table>
<thead>
<tr>
<th>Number of links</th>
<th>Number of PEFs</th>
<th>% of PEFs</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>37</td>
<td>44</td>
</tr>
<tr>
<td>Two</td>
<td>29</td>
<td>35</td>
</tr>
<tr>
<td>Three</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Four</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Some PEFs expressed the view that they had conflict with the HEIs (n=13; 16%, Table 19), describing these in free-text questions as:

“…lack of clarity from others (organisation and HEI) about role”

“(PEFs) need defined role in HEI”

“(PEFs) not being included in the HEI in that the HEI have felt threatened by our presence and the PEF role”

On the positive side, when PEFs in the survey were asked about the strengths of the structure, many identified clinical credibility, team-working opportunities and strength of line management as pertinent to them (Table 21). Some of the PEFs gave more than one example within a theme, for example clinical credibility and so the results represent the number of times an item was themed under the heading of clinical credibility, rather than the number of PEFs who described this particular strength.

Table 21: Strengths of structure as perceived by PEFs (PEF Survey)

<table>
<thead>
<tr>
<th>Strengths of structure</th>
<th>Number of responses</th>
<th>% of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical credibility</td>
<td>46</td>
<td>59</td>
</tr>
<tr>
<td>Team working opportunities</td>
<td>48</td>
<td>57</td>
</tr>
<tr>
<td>Line management</td>
<td>37</td>
<td>44</td>
</tr>
<tr>
<td>Autonomy</td>
<td>32</td>
<td>38</td>
</tr>
<tr>
<td>Located on-site</td>
<td>24</td>
<td>29</td>
</tr>
<tr>
<td>Linked to Practice Development Unit</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Working in own speciality</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Full-time post</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>21</td>
</tr>
</tbody>
</table>

ADDITIONAL DATA

The results from this evaluation project provide a broad range of information, including demographic details which are not presented here in full. Readers, who wish to access additional results from surveys, or wish to see the actual data collection tools, are directed to the Methodological Report which can be accessed via the NES website.
IMPLICATIONS

The findings indicate that the role of the PEF has been accepted widely across Scotland and that where the role works well, it is seen as a valuable addition to the support and development of a quality clinical learning environment for pre- and post-registration students.

Given the main purposes of the role of the PEF\(^2\), the audience for this evaluation project is likely to encompass all healthcare personnel who have involvement and/or interest in the education and training of nurses and midwives, particularly in Scotland. When the role was initially conceived, it was hoped that the PEFs would have a positive impact on maximising the number of student nurses and midwives who could be supported within clinical practice; the report may therefore also be of interest to those dealing with the allocation of students to clinical practice settings. The implications of the findings are presented in respect of these different stakeholders and it is hoped that this will help focus the busy clinician or manager. Where time permits the reader, there are likely to be points of interest in all sections.

PRACTICE EDUCATION FACILITATORS

Specifically:

- Develop the PEF role in the support of mentors specifically in relation to the clinical skills acquisition of students
- PEFs should further develop their work with managers and HEIs in developing innovative learning opportunities in the clinical learning environment to ensure students acquire optimum clinical skills competency e.g. simulation, support of ward-based clinical masterclasses
- Explore ways to broaden involvement in student learning and assessment which does not necessarily mean direct contact with students, but supportive initiatives with mentors and clinicians, including preparing students to make best use of mentor support and the learning opportunities available to them in practice settings.
- Engage pro-actively with stakeholders such as NES, on providing clarity and structure for the career progression of PEFs.
- Where needed, clarify and advertise the communication channels between mentors and PEFs which should include PEF names and contact points.
- Explore ways to increase ‘visibility’ of PEFs such as through periodic visits or other forms of contact with the clinical area(s), particularly where PEFs are covering large geographical areas.
- Build on the current involvement of PEFs in mentor updates and explore further innovative strategies in this involvement e.g. critical case analysis of student support.
- PEFs could further support the practice element of mentor preparation in collaboration with HEIs.
- Networking nationally can provide opportunities to share best practice and trigger ideas for innovative ways in which PEF role and responsibilities can be achieved.

Evidence and Rationale

\(^2\)Maximise the number of student nurses and midwives who can be supported within clinical practice.
- Ensure that the student experience is of the highest quality and enables the greatest benefit from the individual clinical learning experience.
- Ensure support and supervision for staff engaging in Continuing Professional Development (CPD)/educational programmes.
The survey of PEFs had a positive response in terms of sample size with a total of n=84 (71%) PEFs returning completed questionnaires. The PEFs were also actively involved in focus groups within the majority of case study sites and in both consensus conferences. Their enthusiasm and commitment to the role was evident during the project, both by the care taken in their responses in both qualitative and quantitative elements of data collection, and by the time taken to communicate with the research team to clarify aspects of the PEF role and to ensure that where possible they supported our understanding of structures and models of its implementation.

The findings indicate that PEFs perceive they have a valuable role in supporting mentors. Mentors also feel that PEFs have the potential to be a strong support and have identified those supporting actions that work well, such as when there is a ‘failing’ student. This is a heartening result given the concern over the past few years on the need to provide guidance and support for mentors and assessors in this position (Duffy 2003).

In focus groups and consensus conferences it was acknowledged that direct clinical skills teaching was not part of the PEF role, although some participants had experienced PEFs being involved in this field. It would appear that mentors and other clinical staff would appreciate further support in relation to their responsibilities for clinical skills acquisition, and it PEFs could explore more creative ways of ensuring that students can make the best use of their mentor support and clinical learning opportunities. It would be unconstructive to encourage PEFs to become directly involved in clinical skills teaching as it is not in their role specification and furthermore they may face the same criticism as those which confronted the clinical teacher role in the past i.e. not having a specific patient caseload and, more importantly, does not provide direct support for mentors (Rowan and Barber 2000; Drennan 2002). There is, however, a need to consider the future clinical career pathway of the PEF, particularly for those in full-time posts who may wish to return to practice. Often we heard the phrase, “So what does a PEF do next...”. Our PEF survey indicated that over 70% saw the PEF role as a way to achieve a career in practice based education, and less than 40% would like to continue working in the PEF role in the future. It would appear that the career pathway of the PEF is unclear for many despite the current national and NES initiatives on clinical career pathways.

It can be challenging to convey the full scope of a new role to those most likely to find it useful, particularly when that role is implemented at a national level. The findings indicate that in a number of clinical areas, the PEF is seen as a supportive and valuable addition to ensuring a quality clinical learning environment. This is particularly evident in specialist areas, where the PEF is known to the clinical staff and there are clear communication channels. There were however, some reports in focus groups of mentors and other clinical staff not being aware of the PEF allocated to their area and of never seeing them or hearing about them. This situation was not prevalent, but where it did exist, the views on the PEF role were negative and there was little confidence in the value of the role. Finding ways to increase ‘visibility’ even if a physical presence in a clinical area is not possible on a frequent basis, would ameliorate this problem. One example may be through involvement in mentor training and updating as this would introduce the scope of the PEF role to new mentors and maintain a PEF profile in the minds of those experienced mentors.

**MENTORS**

*Specifically:*

- In addition to other guidance, mentors could consider contacting PEFs at an early stage if there are concerns with a student’s clinical competency.
- PEFs can be a useful support for mentors if the situation of a failing student arises.
- Mentors value and appreciate regular updates and information about the role of the PEF.
• With other stakeholders explore cost-effective and time-effective ways of training new mentors and providing mentor updates.
• PEFs can be a valuable link between mentors and the HEI.
• Mentors should work alongside PEFs to explore how students can achieve appropriate clinical skills competency in the practice setting.

Evidence and Rationale

The response rate to the mentor survey was somewhat disappointing (n=69, 26%) although we acknowledge that response rates for postal questionnaires are generally low. However, mentors were also involved in the telephone interviews, and participated in the focus groups and two consensus conferences.

Findings from the student survey indicate that students hold a very positive view of the clinical areas, the work undertaken, and environment created by the clinical staff. Given that the mentors felt that making students welcome was one of the top two most important factors of their role, it is likely that this has contributed to this student view. Assessment responsibilities had somewhat less emphasis in the view of the mentors in our survey, and this has been reflected in other quantitative studies (Cameron-Jones & O’Hara 1996), but our discussions in focus groups and consensus conferences provided a broader and richer background to this aspect of the role.

Mentors play a vital role in the support and assessment of students (Whitehead & Bailey 2006; Papp et al. 2003) and are pivotal in ensuring a quality learning environment for the students allocated to their areas. Mentors in this study acknowledged the challenges of the role but also felt they played a key part in assessing the competence of students. They were anxious to ensure that where a student was having difficulties in achieving competency, they were able to confidently provide constructive support and when this failed, they were able to identify those students who had not achieved. We heard numerous accounts of where the PEF role worked well in supporting mentors with ‘failing students’ and emphasis was placed on the value of HEI representatives and the clinical areas working closely together in identifying students causing concern at an early stage in their placement.

Our telephone survey indicated that there was a very positive view of the impact of PEFs on the timely allocation of mentors and on the availability of mentors adequately trained and with experience to assess students. Taking on the role of mentor, however, can lead to overload (Whitehead & Bailey 2006) and mentors in this study expressed concern that clinical demands often left them without as much time as they would wish to spend alongside their students. This finding appears contradictory in light of the responses in the mentor survey which indicated that just over 50% of mentors spend over 60% of the students’ placement time working with their student. This could be partly explained by social desirability response bias in the use of a self-report instrument (Polit & Hungler, 1999) which in this case may result in some mentors over estimating the number of hours spent with students to be congruent with prevailing views on effective mentoring. Alternatively, these responses can reflect the greater period of time that mentors spend with their students within community and specialist placements.

The mentor survey also indicated that mentor updates were not occurring for many mentors as often as they should. The NMC has published guidelines for mentors (NMC 2006) which require future mentors to have undertaken a minimum 10-day preparation programme and guarantee more supervision time with students. Additionally, there is the requirement for a ‘sign-off’ mentor who will be responsible for assessing and agreeing that the student has met all of the Registration entry requirements. All midwifery mentors will be required to meet the additional criteria to be a sign-off
Each mentor will be reviewed every three years in order to ensure that only those who continue to meet the mentor requirements remain on the local register of mentors. In light of these developments it is worrying that our results indicate not only that mentor updates may not be as frequent as they should for some mentors, but that 6 (9%) report never having attended mentor preparation in the first place. Participants in focus groups expressed acceptance of other forms of mentor education, such as on-line or blended learning, should they become available.

NHS EDUCATION FOR SCOTLAND

Specifically:

- Strengthen role clarity by reviewing the core job description of the PEF, particularly in light of findings from this current study, but also to reflect the needs and priorities of various Health Boards and the natural evolution of the PEF.
- Confirm where there is disparity in relation to the role of the PEF and explore ways to address this when needed.
- There is a need to progress speedily towards providing clarity and structures for the future educational needs of PEF and their career progression.
- Ensure clear links to PEF information via the Practice Education section of the NES website and that the pages are up-to-date, particularly with the names and contact details of PEFs.
- NES should, through annual reporting, provide an overview of numbers of PEFs employed at Band 6 and 7.

Evidence and Rationale

Recent consultation events have proposed national core objectives for the PEF during 2007/08 and NES indicate that this should ensure consistency in what PEFs are setting out to achieve during this time. Evaluation of the impact PEFs are having in relation to these objectives would reassure NES that the specific needs and priorities of various NHS Boards are being met, particularly given the potential variation in the development and organisation of the role in certain areas, for example in remote and rural settings. NES plan to set new and updated objectives for the PEF at an event in March 2008, and it would be useful to explore if any barriers to the achievement of the 2007 objectives have been encountered. Particularly whether organisational structures, such as part-time status or remote and rural based PEFs, are as effective in fulfilling current and new objectives.

Findings from focus groups and consensus conferences highlighted worries over career pathways for PEFs. Some of the full time PEFs in our sample had some concern around ways to retain clinical competence, particularly as their role did not involve any direct patient contact or clinical skills teaching remit. It is heartening to see the general guidance provided on the NES Practice Education website and to recent initiatives such as the Stakeholder Consultation Event on Clinical Education Career Pathways held in October 2007. This event aimed to engage stakeholders in the development of Clinical Education Career Pathways in Scotland as part of the Modernising Nursing Careers Agenda (SEHD 2006a). At this latter event delegates proposed that the PEF was placed at Senior Practitioner (level 6) in the National Career Framework levels and a pathway within clinical education was indicated. The NES Clinical Education Careers work is likely to support both succession planning and sustainability of the PEF role. The consultation work on this issue continues and it will be essential that future proposals clarify the ways in which PEFs with varying

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3 All midwifery mentors will have met sign off mentor additional criteria as part of their mentor preparation programme (NMC 2006)

career plans can be accommodated i.e. those wishing a future full time educational pathway and those wishing to return to practice or combine education with practice.

Some clinicians and managers within focus groups expressed difficulties in knowing which PEF was allocated to their clinical area. Currently there is no up-to-date list of PEF names and contact details kept on the NES website. The site is currently being updated in a number of very useful ways, and it would certainly be a useful addition to have this information for clinical areas.

Results from the PEF survey indicated that the majority of PEFs were working at Grade G (This phase of the study was completed before the full implementation of Agenda for Change). However, there was some evidence of variation with almost 20% of PEFs positioned either below or above this grade. This data was collected at an early point in the establishment of the posts, and there have been ongoing developments in relation to decisions about individual Agenda for Change banding positions. It is of interest to note, however, that the second Consensus Conference highlighted the feelings of some of the participants in relation to the diversity of clinical grades or Agenda for Change bands within which the PEFs were employed. Given the nationally agreed role specification for PEFs, it would be useful to scope and establish whether this diversity of pay grading still exists and to explore the reasons for this, as it would appear that it has led to some dissatisfaction.

HIGHER EDUCATION INSTITUTIONS

Specifically:

- Consider reviewing strategies to enable student evaluations fed back to clinical placement sites to be timely and specific to the clinical area concerned.
- PEFs appreciate a clearly defined role in their links and presence with HEIs.
- Have clear documented procedures for clinical placement sites and clinical staff to follow in cases where students cause concern early in their clinical studies.
- Ensure that the form and content of student programmes is made available to mentors and that this information is updated when necessary.
- Consider PEF involvement, where time permits, in Programme Committee membership within HEIs thus enabling their input into ways to increase student allocation capacity.

Evidence and Rationale

Data from HEIs came primarily through academic staff attendance at focus groups and consensus conferences. Although the numbers were small, we gained a deal of data from other data collection events, which proved pertinent to the interests of those working in HEIs.

Cope et al. (2000) noted that students emphasise the central nature of clinical placements in the goal of becoming clinically competent registrants and that the “contribution of the expert (mentor)” is at its most effective when the mentor is able to situate knowledge in authentic contexts i.e. a clinical environment. In our study, we heard many examples of mentors and clinical staff anxious to find out from students what they, in clinical learning environments, were doing well in relation to the students’ ability to achieve competency and also how they might improve the clinical learning environment where there were deficiencies. Mentors are encouraged to seek evaluative feedback from students at the end of their practice placement (RCN 2002). However, in many of our case study sites we found that the ability of mentors to gain timely and specific feedback which related to their clinical area was problematic. Often it was a case of receiving a report which collated a number of placement sites, and each site being left to pick out what might, or might not, pertain to them. Additionally, this feedback report was often only distributed every few months or less. Our participants acknowledged the difficulties of confidentiality when a placement perhaps only
received few students and at specific times of year, but they felt that some way could be found to provide more specific feedback to them.

Mentors were overwhelmingly clear in their view that they did not want the HEI to take over when there were problems with a student, but to provide guidance and support for the mentor to take action when necessary. Skingley *et al.* (2005) urge HEIs and practice teachers to work together in identifying students who cause concern early on in their education. It would seem practical and logical to involve the PEF in all stages of identification and support of students who are struggling. Although in a minority, our findings did indicate that some PEFs remained dissatisfied with their link with HEIs, with just over 15% of PEFs in the Phase 1 survey finding some conflict in the relationship. Given the importance of a collaborative approach to managing the ‘failing’ student, it would seem essential that ways are found to support HEIs in understanding the PEF role and the value of the PEF as a conduit with clinical colleagues.

Stakeholders in the telephone survey were very positive in their views on the impact of the PEFs in the identification and development of new and appropriate clinical placement sites. Similarly in the focus groups, we heard a number of examples of how clinical staff were supported in looking creatively at where students could be placed to support the achievement of learning objectives. These were, in the main, in health or social care settings, and there could be scope for HEI staff to work closely with PEFs to identify potentially ‘alternative’ settings where there is good potential for further support to achieve learning outcomes, particularly in community settings. Kirkham *et al.* (2005) in their North American study suggest, for example, community centres, church groups and children’s residential camps provide rich learning experiences.

**HEALTH BOARDS**

*Specifically:*

- Work alongside other stakeholders e.g. NES and HEIs, to explore the optimum model of implementation of the PEF role, including managerial structures and the efficacy of part-time PEFs.
- Explore ways that PEFs who have part PEF/part clinical role can add value through optimising the complementary nature of the two roles.
- Consult with part-time PEFs to address any specific challenges of the structure of their role.
- Provide support to part-time PEFs which will help them fulfil their PEF role effectively.
- Continue to have a voice in the recruitment and appointments of future PEFs.
- PEFs appreciate clear and structured line management.

*Evidence and Rationale*

A number of clinical managers attended our focus groups, consensus conferences, and responded in the telephone survey. They were overwhelmingly in support of the value of the PEF role and in particular in the support and guidance afforded by the PEFs to mentors. Along with other participants they acknowledged the particular difficulties of part-time PEFs, particularly where the other ‘part’ of their role was as a clinician in the same clinical area. A number recognised that where clinical pressures arose, there was always the danger of ‘encroaching’ on PEF time. It is acknowledged that a role with two differing role specifications, differing responsibilities and potentially differing line management structures is vulnerable at a number of levels (*Ogilvie et al.* 2004). This includes the challenges of role evolution which is particularly pertinent in the case of a new role such as the PEF. When setting up such roles, there is a need for top-level managerial support and understanding of the potential of the role (*Ogilvie et al.* 2004). The models for part
time posts should be carefully considered and the expectations for such posts should be realistic. Managers should continue to have a strong presence and involvement in NES consultations around the PEF role.

There will be a natural turnover of PEFs in role, either through moving forward on a career pathway or through natural wastage. We noticed with interest the ‘added value’ of the PEF when participants spoke of the strategic initiatives in which they were involved, and the advanced level of ‘people’ skills they required for the many interpersonal challenges they faced as the role bedded down in practice. In new and complex appointments, Fowler et al. (2007) comment on the need to appoint those who can cope with a degree of uncertainty and who look on challenges as opportunities rather than issues on which to complain. As PEFs are replaced, it will be crucial for managers to play an active part in their recruitment and appointment in order that those of an optimum calibre are attracted to the post and can play a full part in the strategic developments in clinical education.

When we explored the differing models of implementation of the PEF role, clear line management was seen as a major strength by nearly 45% of PEFs in the Phase 1 survey, with open responses indicating that a fragmented line management structure was a severe barrier to achieving optimum performance in the role. This finding was reinforced in focus group discussion, where participants indicated the value of supportive managers who understood the PEF role. Examples of structural benefits included being well-positioned within practice development units as there were shared goals with others and line management was up-to-date in relation to clinical education issues. It is useful for an agreed management structure to be in place on the appointment of any PEF.

Additionally, our findings indicated that those PEFs in part-time appointments can face specific difficulties in achieving the objectives of the PEF role, most often because of the need to commit to clinical priorities when they arise amongst those mentors who also hold a part time clinical appointment. Those with part-time clinical responsibilities, however, did not express any concern about maintaining their clinical competence and this would appear to be an obvious advantage of part-time PEF posts.
RECOMMENDATIONS AND FURTHER RESEARCH

The following recommendations and suggested further research reflect the key issues and concepts identified through the lifetime of this project. These are the issues which need to be addressed in order to take forward the future development of both the PEF role and of clinical learning environments.

Impact of the PEF role on support for mentors

- Organise an annual national PEF conference to enable PEFs to present examples of their impact on the clinical learning environment.

- Maintain the good accessibility of PEFs and also explore ways to increase their actual ‘visibility’ in their link clinical areas.

- Further research the issue of the ‘failing’ student, and in particular those potential interventions to identify and provide enhanced support to students causing concern at an early stage in their placement.

Impact on quality of learning environment for students

- Within the NES Quality Standards for Practice Placements introduce a Standard and Indicators for the feedback and action in relation to student evaluation of clinical placement sites.

- Support HEIs to provide programme and course documentation on-line and with access open to PEFs, mentors and relevant clinical staff.

- Student evaluations of their clinical placements need to be fed back in a timely manner to mentors and clinicians, and where possible made specific for that clinical area. PEFs can be a conduit in supporting this feedback.

- Provide opportunities for mentors to undertake approved mentor training and mentor updates either in e-learning or blended learning format.

Impact on Placement Capacity

- Disseminate best practice examples of the ways PEFs have been increasing capacity in placement areas.

- Continue the current excellent work on Clinical Education Career pathways in relation to PEFs.

Innovative practices within learning environments

- Mentors and other clinical staff need further support in relation to their responsibilities for clinical skills acquisition. PEFs should explore ways of ensuring that students make the best use of their mentor support and clinical learning opportunities e.g. ward-based clinical masterclasses.
• Provide innovative ways of delivering mentor updates, such as e-learning or blended learning in areas which do not already provide this option.

_Evaluation of models of implementation of the PEF role_

• Conduct a scoping exercise to review the position of PEFs in relation to pay and grading, specifically within Agenda for Change bands.

• Establish a listening event which enables key stakeholders to share views and opinions on the continuing professional development needs and future career pathways for PEFs.

• Introduce managerial supervision for PEFs in order to support the structural, organisational and leadership issues related to their day-to-day work.

• Health Boards should explore specific support which can be provided to those appointed in part-time PEF posts e.g. performance development.

• Explore ways that PEFs who have part PEF/part clinical role can add value through optimising the complementary nature of the two roles.

_Interprofessional learning in practice_

• Host a national conference to share best practice in inter-professional learning activities.

• Conduct an audit of activity and outcomes in relation to strategy on inter-professional learning. Develop national priorities and an implementation plan.
REFERENCES


Scottish Executive Health Department (2006b) *Delivering Care, Enabling Health: Harnessing the Nursing, Midwifery and Allied Health Professions’ Contribution to Implementing Delivering for Health in Scotland*. Scottish Executive: Edinburgh. 


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