AHPs4Notts

Nottingham and Nottinghamshire AHP Faculty

Delivered as part of the Clinical Placement Expansion Programme

July 2021

Leanne Horsley, Sally Knapp, Suzanne Avington

Contents

Introduction 3

Overview of recommendations 4

Methodology 5

1. Barriers introduced since the COVID-19 pandemic 7

2. Barriers relating to Higher Education Institutions (HEIs) 10

3. Practice Educator training 12

4. Barriers related to placement offering and allocation processes 15

5. Barriers related to Placement Providers 18

6. Barriers relating to students 23

Introduction

There is an urgent need to increase the number of Allied Health Professionals (AHPs) in the UK. By 2024 the NHS People plan estimates that around 27,000 more AHPs will be required, demanding a significant increase in AHP student numbers.

In September 2020, Health Education England (HEE) hosted a series of AHP workforce webinars which demonstrated that the Occupational Therapy (OT) workforce has grown in size by 11% between 2014 and 2020 to over 40,000 HCPC registrants. It is expected that the supply of Occupational Therapists will continue to grow by 2-3% per year and that demand will be in line with this growth given the requirements within the Long Term Plan, particularly in areas such as Social Care. During this workforce webinar, HEE concluded that;

"Overall, prognosis [for the profession] is reasonably positive, given history of solid growth and young age profile…however, we need further interventions to secure supply, given increasing demand."

A major limiting factor on the number of students which Higher Education Institutions (HEIs) can welcome to their training programmes comes from the number of clinical placements available to them. Locally this has been proven to be the case, with three HEIs placing OT students within the Nottingham and Nottinghamshire Integrated Care System (NNICS) reporting concerns with sourcing suitable placement numbers, a problem which, although was certainly present in previous times, was exacerbated by the COVID19 pandemic.

In depth analysis of the perceived barriers and enablers to offering clinical placement as perceived by multiple stakeholders have been explored and this information can be found in more detail in the Occupational Therapy Placement Expansion section of the '*Recovery and Expansion of quality AHP clinical placements for Physiotherapy and Occupational Therapy students within Nottinghamshire'* report.

The detail in this report focuses specifically on the barriers as perceived by practice educators (also known as clinical educators) through the use of focus groups and the recommendations from this report feed directly into the work described in the report above.

Overview of recommendations

Below is an overview of recommendations, a full description of each recommendation can be found on page 25.

- Agreement, clarity and collaboration amongst local HEIs on the content, delivery method and frequency of practice educator training sessions and practice educator updates.

- Production of bespoke educator training sessions for practice educators wanting to deliver alternative and/or contemporary placements.

- Agreement and clarity amongst placement providers and HEIs on the roles and responsibilities of the placement co-ordinator.

- Parity and agreement of processes such as placement trawls, placement offering, placement allocation and delivery of practice educator training across HEIs.

- Education Leads should be prepared to participate in higher level co-ordination of clinical placements at a system level.

- Scoping and early development of an electronic portal for placements should be commissioned.

- A system network of clinical educators for Occupational Therapists should be developed.

- Managers of Occupational Therapists should ensure that student placements remain on supervision agenda for all Occupational Therapists.

Methodology

The purpose of this project was to explore the barriers to Occupational Therapy practice educators in offering clinical placements; we conducted four focus groups from staff working in the following settings:

1. Community
2. Inpatients
3. Mental Health
4. Physical Health

Staff working in the NNICS footprint were invited to attend through communications sent from the Nottinghamshire AHP Faculty and circulated via email through trust Occupational Therapy Leads, Placement Co-ordinators and HEIs offering Occupational Therapy programmes.

In total, 25 Occupational Therapists took part in these focus groups from a wide range of clinical settings and areas; collectively representing all four of the large NHS organisations (Sherwood Forest Hospitals NHS Foundation Trust, Nottingham University Hospitals, Nottingham Citycare and Nottinghamshire Healthcare NHS Foundation Trust) and the two social care providers (Nottingham City Council and Nottinghamshire County Council). Participants reported that they took students from three local HEIs providing Occupational Therapy training programmes; The University of Derby, The University of Lincoln and Sheffield Hallam University.

The focus groups were conducted over Microsoft Teams, recorded, transcribed verbatim and then thematically analysed to identify commonalities in the perceived barriers to providing Occupational Therapy Placements. The themes and sub-themes from thematic analysis are summarised below and described in detail in the following report.

1. Barriers introduced since the COVID-19 pandemic.
   1.1 Compliance with government guidelines
   1.2 Long term changes to usual work
   1.3 Suggested solutions for overcoming COVID-19 placement barriers

2. Barriers relating to Higher Education Institutions (HEIs)
   2.1 Communication between the HEI and their students
   2.2 Communication between the HEI and the placement provider
   2.3 Barriers relating to Placement Specifications

3. Barriers relating to practice educator training
   3.1 Clarity regarding minimum standards for practice educator training
   3.2 Motivation/Incentives to attending educator training
   3.3 Barriers to completing practice educator training

4. Barriers related to placement offering and allocation processes
   - 4.1 Generating placement offers from the placement provider
   - 4.2 Appropriate student allocation to the placement area
   - 4.3 Communication regarding placement between the HEI and the placement provider
   - 4.4 On-going support from HEIs during placement

5. Barriers related to Placement Providers
   - 5.1 The role of the placement co-ordinator
   - 5.2 Clinical Educator Barriers
   - 5.3 Barriers relating to culture and attitudes
   - 5.4 Perceptions of a quality placement
   - 5.5 Suggestions for overcoming barriers

6. Barriers relating to students
   - 6.1 Barriers caused by the student as a person
   - 6.2 Student Expectation

1. Barriers introduced since the COVID-19 pandemic

Barriers introduced by the global pandemic were discussed in depth by all participants although we were encouraged to hear that there was an overall acceptance that these issues would not dissipate quickly and a realisation that it was important that placements were recommenced and continued in order to support the future workforce.

1.1 Compliance with Government Guidelines

Compliance with government guidelines (such as shielding and social distancing rules) were found to be some of the biggest barriers, but affected OTs working in different settings in different ways. Inpatient staff and those working in physical health settings were likely to be affected by the rules of social distancing, reporting that '*…space is a big barrier. So we're a small team with an even smaller office…we have to negotiate between us so that we don't have, we couldn't have all of the students in at the same time.'*

Those working in community and mental health settings reported that, because of social distancing guidelines, they were working in unusual ways, for example, working from home, carrying out virtual assessments or telephone advice and that there were concerns that this wasn't a suitable placement for a student for both practical and quality reasons. Working remotely caused secondary placement barriers as practice educators recognised that, where they were still able to offer a placement which incorporated these new ways of working, there was insufficient access to IT for this to become reality;

'…because we're all online now, say they need, particularly now with COVID, they need to be able to get onto teams, they need to get on system one, they need to access email…"

Participants identified there were barriers to effective communication caused by working remotely;

'*Even like, contacting each other, like, where you'd chat in the office because we're not in the office.'*

Participants also had safety concerns around the risk of students contracting COVID -19 and felt that that the risk of needing to isolate was both disruptive and affected communication whilst on placement;

'..we are currently just accepting COVID positive and COVID contact patients; I don't know whether that's got anything to do with it.'

'I've not actually worked with her yet because she'd had to isolate.'

In all cases, participants were able to articulate that, although the above barriers did not make it impossible to carry out practice placements, they felt that they created concerns around the *quality* of practice placements, something which is discussed in more detail in section 1.2 and section 5

1.2 Long term changes to usual work

Expanding on the points made in section 1.1, participants spoke about the introduction of long-term changes to their usual work with many of them suggesting that working remotely and an increase on reliance of IT were likely to become 'the new normal'. There was recognition that students needed to become part of this;

'I think everyone thought this would be over in a few months' time when we would be back to normal. Now it's sort of, it doesn't seem like that is happening, erm, we need to kind of look at how we would facilitate having students…'

Those working in mental health reflected on how induction and mandatory training processes had changed within their organisations and this had impacted student placements. Interestingly, the changes had affected placement providers differently; with some creating barriers and some providing enablers. When discussing barriers, one participant suggested that induction of employed staff was prioritised over induction of students and there was limited capacity for student induction compared to pre-pandemic. In contrast to that, we were also told that COVID-19 had made student induction less challenging;

'it's made it easier for us in some respects because they've shortened the induction…and they're running it twice a month so we've got two hits at it…security have been brilliant and they've done some bespoke training.'

Those working in the community described how remote working had led to another barrier which was unique to their area – where face-to-face visits were appropriate, practice educators and students were no longer travelling from the same base and this meant that students simply *had* to be car users. Guidance from organisations on car sharing also has huge variability, with some trusts specifying no car sharing between colleagues.

There was agreement among all participants that, because of these long term changes, many of them felt unsettled in their roles and that this had affected their ability to offer clinical placements;

'*We can't accommodate students because this isn't the right sort of placement anymore.'*

Sadly, many elaborated that this was because they felt like students would feel that the educators themselves didn't know what they were doing and this made them uncomfortable;

'*We are still really not sure what we're doing, erm, so how can we show a student what we're doing without looking incompetent?"*

1.3 Suggested solutions for overcoming COVID-19 placement barriers

The participants were able to suggest some solutions to their reported barriers. The majority of these solutions were to do with planning placements differently and using IT to support this. Suggestions included asking students to choose their case loads from a selection of team outlook diaries, utilising flexible working to reduce the footfall in office space and removing physical barriers such as creating more office space.

Community staff suggested sharing placements with inpatient staff in order to spread the workload of the students;

'*it's worked really well in the past, sort of linking in with the OTs at the hospitals too and just giving them a project to work on as well, so then if they've got to have that home time, they've got that to do also.'*

Interestingly however, all participants in the inpatient group reported space as a barrier to offering clinical placements both before and during the pandemic;

'Our office space is a hot-desking room, so there's literally two phones, er, 2 PCs and maybe 24 people in a very small space.'

Only two participants suggested use of contemporary placement models, the first being the project work discussed above, the second comment was less specific and the participant expressed her concerns with providing 'creative' placements – '*I think we could be creative potentially…but it would make the placement very, very challenging.'*

2. Barriers relating to Higher Education Institutions (HEIs)

Barriers relating to HEIs were discussed in all focus groups though not all of the themes below were discussed in each focus group. Participants who carried out placement co-ordinator roles within their organisations were understandably able to offer more depth in their responses.

2.1 Communication between the HEI and their students

Although there were certainly examples of providing flexibility for students during placements, there was also a feeling amongst the groups that the level of flexibility possible during clinical placement is over-communicated to students and this can bring additional barriers to offering placements and affect rapport between practice educators and students. Many reported difficult negotiations with their students about placement hours;

'*We've had students come in and say, 'well I want this day off and I want that day off'…I'm sounding like we should be being dictorial, I don't mean it like that, but they're not clear enough about where the boundaries of the placement are'*

Sadly, some comments made suggested that these perceptions were affecting their attitudes towards academics working at HEIs – '*I don't know whether the uni have got a real grasp on what's the true situation is out in the real world.'*

Those working in mental health and physical health did not offer opinions on this matter.

2.2 Communication between the HEI and the placement provider

Practice educators discussed three key points within this subtheme; the role of the placement co-ordinator, the impact when students are allocated without a pre-liminary conversation about their additional needs and frustrations when placement offers are not utilised.

Practice educators unanimously agreed that the role of placement co-ordinator simplified the communication required in offering placements to universities.

Many practice educators had experience of supporting students who had additional needs which they felt were challenging and hadn't been communicated prior to the placement starting or attending their pre-placement visit/conversation. All reflected that they were disappointed with this and felt that improved communication from the HEI would have allowed them to prepare more thoroughly and support the student more effectively;

'*..it's frustrating that the university didn't make her needs clear…we would have still offered it…but we would have given her a different supervisor. So that's a shame.'*

'…a very similar experience in that I had a student where it was an extra placement and they had specific needs…it turned out that the main day we were running our patient programmes was the one day that she couldn't come in because of her health needs. So she missed out. And again, if we'd have known that beforehand maybe we would have approached it a bit differently."

A final key concern was placements that are offered but not utilised by HEIs. Practice educators were unclear on the reasons behind this, given the apparent desperation for practice placements, but some participants were able to suggest reasons; those working in physical health suggested that there is an oversupply of physical health placements when HEIs really require mental health placements. Sadly, participants admitted that it would make them less likely to make placement offers again in the future;

'*What's the point? If they're not (using them) I mean, you know if you have one that's not taken up then the next one you just go 'oh well, fair enough' but if it happens a lot you do think…what is the point in continually offering if we're not the sort of placement that is needed. I think that feedback of 'thank you very much but we've been really lucky this year, having lots of physical placement offers therefore we won't be taking you up on it'…something would be nice to keep you motivated I suppose.'*

2.3 Barriers relating to Placement Specifications

Participants described that placement specifications (placement length, level of student, marking criteria etc.) did influence the ability to offer placements both positively and negatively. When considering the responses collectively, it's clear that there is no one single placement specification which would fit all clinical areas.

Placement length was a key factor with participants recognising that Occupational Therapy placements can be quite long. There was discussion in each focus group about whether this introduces barriers and it was clear that it was a difficulty for some and an enabler for others.

'…the students I have in low secure forensic settings, in private settings and not in the NHS…they were there for 10 weeks, had it been 3,4, or 5 weeks it wouldn't have worked because it's not enough time to get hold of what they are meant to be doing or learning.'

'*…in my role now, because I'm pretty much doing one thing, erm, shorter placements would be fine and then I could get more people (students) through too!*'

There was also a suggestion that longer placements were less suitable for virtual placements; '*seven weeks was long enough to have a virtual placement for but to do it for 10-12 weeks would be just torture.'*

3. Barriers related to practice educator training

All participants discussed practice educator training although there were very mixed perceptions on its purpose and its delivery and this is not surprising given the variability in participant's reported experiences. Participants had attended a range of practice educator training sessions both with local HEIs and with those located out of area, some had completed their educator training a number of years ago, others' very recently – some simply had received no formal educator training.

3.1 Clarity regarding minimum standards for practice educator training

Participants reported many issues with practice educator training for Occupational Therapists. One of the biggest issues was around the uncertainty of what the course was called – '*…they introduced APPLE accreditation, I don't even know if it's still a thing? I think they call it L'APPLE now.'*

There was confusion around the word 'accreditation' with many participants referencing it regularly and others identifying that the practice educator training course is not accredited and perhaps this made it less attractive as a course; '*I think they've stopped the APPLE and because of that the L'APPLE that's out now is not accredited.'*

Participants were unclear about whether completion of the educator training was a pre-requisite of supporting a student on placement and felt that each HEI held a different perspective on this;

'I think there's very mixed messages. So certainly [University A] say 'it's nice to have but it's not a pre-requisite', [University B] say 'No, no, you must do it' and [University C] I think are a little bit more on the fence. So although they've kind of got their local APPLE they don't really have a consistent…idea of how it should be used.'

Some participants reported that employing organisations held different opinions on whether the training was mandatory;

'O*bviously I'd heard of APPLE when I came to the trust. Erm, I'd never completed it, I'd done, kind of dipped into it but never actually done the assignment. Erm, it was never a pre-requisite at the trust I as in previously. So when I started here…and everyone was saying 'You have to do the L'APPLE' erm, I was a bit confused.'*

There was also anger from some participants that their colleagues would use their own lack of educator training as an acceptable reason for not offering placements;

'…that has been quite a big barrier in stopping people from wanting to take a student, and it seems quite, like a valid (reason) maybe for those people, aaaah I don't want to say the wrong thing here! Those people that maybe haven't got as much motivation to take a student maybe are saying, 'oh I haven't done my APPLE training – I can't', that might sound unfair, I don't mean it to be unfair, but it's what we've seen in our team."

'We have had people kind of ducking out of it by almost saying 'I've not done my training, I can't have a student.'

3.2 Motivation/Incentives to attending educator training

Opinions on the perceived importance and the quality of the training were variable and influenced motivation to engage with training opportunities. Some participants really valued the educator training and others held opposing opinions.

'*I think people feel the like they need to go on that training, to feel like they've got the confidence to take a student. Erm, which I understand you know…if doing that piece of training is gonna give, erm, the clinicians, er, encouragement and the support to be able to feel like they're in a position to support the student through their placement, they that's great…'*

'(it was) really well put together, but not necessarily particularly useful for an experience educator especially…'

A powerful influencing factor for offering placements (and therefore attending practice educator training as a perceived mandatory requirement) was financial gain. Those staff that were educators before the introduction to agenda for change were able to remember a time when they received financial incentives for placements and felt this was a good motivator;

'People [used to be] paid to have students, erm, and obviously I know when agenda for change came in it was supposed to be included in our pay, it was certainly given to the trusts…It's certainly something that's brought up in conversation with my colleagues. And they said "well actually if I was paid I wouldn't mind doing the work at home" "and I wouldn't feel so aggrieved to be spending this time". Erm, and I think you know, I suppose people, people feel sort of like, you know, putting extra in without really getting an awful lot back for themselves if that makes sense. I know that sounds a bit selfish but it is something that is a, a barrier. People are putting extra time in in what is already a busy time for them, erm, you know, and not feeling that they're being erm, rewarded for doing that.'

3.3 Barriers to completing practice educator training

The sub-themes previously discussed within this section undoubtedly outline some large barriers to completing practice educator training. The additional barriers discussed within this section outline the experiences of those participants who have engaged with the educator training; reported experiences were also mixed but most participants agreed that the process felt lengthy and it was difficult to achieve 'completion', requiring a large amount of commitment.

Most participants reported a two stage process to the training, with attendance at a training day followed by varying forms of follow-up 'assessment'. The initial training day was reported to be varied in that it could be one or two days training and was delivered face-to-face, online (in response to the COVID19 pandemic) or self-lead using electronic resources.

The follow-up assessment stage was most often completed with an assignment (of varying lengths), sometimes by presentation and most rarely in viva format.

There was a general opinion that the first stage of the training was good and there were positive comments about the accessibility of the course now many HEIs have switched to online delivery.

'I did it (the L'APPLE update) in the Autumn, and actually, I thought it was very good, so it was all online and there were some videos to watch and then some kind of exercises – some thinking exercises .I found it really good actually.'

However, the opinion of the second stage of the educator training was much different; educators agreed that this was time consuming and felt unnecessarily lengthy;

'*…and then having to write this silly, 3000-word essay afterwards.'*

'…just not had the time to do it, not had the time to do it at home. Erm, I've tried a couple of times and it's just never materialised.'

'*I've gone to the training days or the refresher updates about three times, and never actually completed it.'*

It was a perception of the more experienced participants that if their 'accreditation' had expired they'd need to complete the course again and their previous experiences made them reluctant to engage with the course again;

'*I did it a long time ago and I did the essay for the first time and then I had a student and the educator was like 'Oh, your APPLEs out of date, we'll do a viva' and I was literally like 'Oh no!''*

'If you're experienced in having students, erm, and sort of, going through the renewal process, its ongoing, ongoing and ongoing, that you think – if I've already had loads of students, do I need to like, write an essay too?'

However, one participant did comment that she had completed her 're-validation' recently and the process had been much more streamlined;

'*I think I wrote four or five pages prior to the recent re-accreditation and (now) it's just simpler and it was bullet points.'*

4. Barriers related to placement offering and allocation processes

As discussed previously, all participants recognised that all the process of offering placements to HEIs through to students arriving and successfully completing the placement came with challenges. They described different key points within this process; generating the placement offer from the placement provider, appropriate student allocation to the placement area, communication regarding the placement between HEI and placement provider and on-going support from HEIs during the placement.

4.1 Generating placement offers from the placement provider

There was a small amount of discussion around this point from the participants and the discussion that did take place was mainly from those in placement co-ordination roles. The timing of placement offers was felt to be important - it was preferred that offers were made in advance, as last minute offers were more difficult to plan for and co-ordinate, however, there were also significant challenges in offering too early.

'*…the communication from (the HEIs) at the minute are very much 'we need offers, we need offers, come on, offer..' erm, I know historically there has been problems with people offering too late and that that's kind of caused problems..but actually, the reality at the moment is, how far ahead can you plan? So, I know ideally they want your whole year of offers but I don't, I don't think that's reality for most.'*

'I guess we need to know a cut-off point…I might be able to take another student, kind of, with the support of a long-armed educator, but it's gonna take a bit of time to organise and is it gonna be, kind of, too late by the time I get everything organised?'

The number of placements that participants were expected to offer was also discussed. Again, there was variability between participants and across clinical settings. Some participants described that there was a '*minimum requirement'* to have *'one student a year'* and there was a thought that this guideline came from the Royal College of Occupational Therapists (RCOT) but there were also comments to suggest that this was not the reality;

'*..So it's, kind of just down to individuals to take a student, nobody is monitoring if you haven't had one.'*

'…and I've had no follow up at all with regards to the fact I haven't had a student for two years."

'It's just like, well, how many of us can actually say if that if we're actually only having a student in the team, sort of, once every three years..that we're actually performing to that aspect of the job description.'

In relation to the above, one participant was able to recognise that this was a big contributor to the current placement shortfall – '*that's why they end up like now where they've got a mass amount of placements which they haven't filled.'*

Participants were able to recognise the benefit of placement co-ordinators in ensuring equitable division of students amongst teams, providing additional support to Occupational Therapy Practice Educators, communicating with HEIs and ultimately generating more placements;

'I do think having it coordinated better…is probably better, the sort of equitable division of students, and there would probably be more placements offered.'

4.2 Appropriate student allocation to the placement area

There was discussion around the challenges of student placement related to that of the COVID-19 pandemic (i.e., where to place clinically vulnerable students) which has been outlined previously in theme 1. Other barriers were common and overlapped with previous sub-themes, such as students needing to be car users for community placement allocation and the location of placements in relation to the student's residence.

Two additional key points were highlighted; the importance of the pre-placement visit and the complexities of offering placements specifically in mental health settings.

Some participants felt that the pre-placement visit was integral to providing a successful placement. These opinions were strong and participants were incredibly passionate about its purpose;

'*It's about leaving anxieties on both sides and I think it's quite a nurturing thing to do and a big part of our profession.'*

Participants from mental health settings describe additional barriers around student allocation from HEIs. Mainly this is linked to the previously discussed need for additional trust-specific mandatory training sessions for students placed in these areas. Participants commented that is it almost impossible for HEIs to change the named allocated student closer to the placement time as the new individual won't have received this training in time for their placement;

'*…we need to know who our student is as soon as possible, to try and get them to do the training before they start the placement. Especially with short placements, if a placement's 6 weeks and they have to wait three weeks to do their training then they've missed half of it just waiting to go on the wards.'*

Placement co-ordinators expressed that, although they understood the need for parity in the timing of release of placement information to students, they were concerned because they had previously successfully negotiated some flexibility with this to allow for the mandatory training and this had been lost due to staffing changes within academic teams/ HEI placement teams;

'*We did have an agreement…pre-COVID that we got the early, the students for our (areas), they were released early and it was, maybe 6 or 7 weeks early, but I think we've lost all that now…I think we're going to struggle.'*

4.3 Communication regarding placement between the HEI and the placement provider

Participants reported difficulties in trying to communicate with HEIs, although they agreed that the role of the placement co-ordinator did facilitate this. Those without access to placement co-

ordinators reported logistical and practical issues such as; having access to the correct portals, being included on the correct mailing lists and understanding the time frames around offering placements. However, not all participants reported that this role was as effective;

'*..our key port of call and prompter is [named]…but they've got a million jobs to do so, I do think they don't always remind us as much as they could…'*

Some participants reflected that they had experienced communication difficulties when trying to set up placements in new clinical areas or when trying to adapt to changes to placements, such as adjustments to placement length. They described that the purpose of communicating with HEIs was to get reassurance that '*this is going to be a suitable placement'* and they felt that '*one of the barriers is just to try and, kind of, get understanding from the universities about what they want us to provide.'*

4.4 On-going support from HEIs during placement

There were mixed opinions on how well practice educators were supported whilst actively supervising students on placement. Most educators reflected that the majority of their support comes from their colleagues and there was a preference for this colleague to be an occupational therapist specifically. Lone working OTs did feel isolated when hosting students on placement and this was a barrier to offering placements;

'*Although in some ways it's a good thing…it also has it's… the flipside of it is that they (the student) could be horrific at the same time, when you haven't got the support of another OT.'*

'I've got a fantastic MDT, don't get me wrong, but not having another OT to kind of bounce off and to say 'well what do you think' was really, really hard.'

Practice educators recognised that some issues needed to be escalated to HEIs for support but those with experience of this reported variable experiences;

'*I'm not sure they really took our concerns to heart, it felt like they just wanted to get the placement done.'*

'I rang the university and they were really good, they talked me through it step-by-step what I needed to do with the student in order to support her with this issue…yeah it was, it was very helpful and it was quite stressful at the time but, as I say, they kind of just almost held my hand through it and it was great, it was a great learning experience for me as well.'

5. Barriers related to Placement Providers

Participants identified a range of 'in-house' barriers; some of these have been briefly mentioned before in other themes, such as the role of the placement co-ordinator. This demonstrates further the level of complexity of the communication channels required when organising and executing clinical placements. Other barriers could be fitted mainly into the following categories: barriers relating to clinical educators, practical barriers and barriers related to culture or attitudes. There was in depth discussion about what is needed for a placement to be 'quality' and participants were able to offer suggestions for overcoming some of the barriers outlined.

5.1 The role of the placement co-ordinator

The presence of a formal student co-ordinator was variable across organisations with some organisations having a named individual and others not. There was a strong feeling that the presence of a placement co-ordinator removed barriers for clinical placements from practice educators;

'*We don't have an OT placement co-ordinator. We don't have a link and I think that is a bit of a barrier…historically, when I worked in more acute services, it was just an expectation, so students just came through, it was, that was how it was, so, there wasn't really an option really it felt like. But that was okay because you had all of the resources to support the management of that. There was somebody coordinating the arrangement of the student placements, then they had the student training opportunities, education, it was, it just felt more coordinated and probably a better experience for the students.'*

It was felt that one of the most important roles of the placement co-ordinator was to help 'set the placement up':

'The whole practicalities of getting a student set up so, I'm imagining going through, like, the new starter erm, for IT and for, kind of, access and things like that…yeah, I guess it's having maybe a bit of a streamlined process and are there things that can be, kind of, sped up.'

In settings such as community services it is apparent that this is much more difficult to achieve. This was demonstrated nicely, not through a direct report from a participant, but when a placement co-ordinator in a focus group realised that a clinical educator from her trust was on the call and hadn't received her information;

'*it's interesting what you said about not having the dates, I've sent out the dates for the one coming up in March, so I'm just really interested that you haven't received that, so that kind of helps me in my job, making sure those communications are going out to people but I think that massively highlights a big barrier.'*

Where there was a named individual, the roles and responsibilities of that individual, and the time allocated to do the role was often variable, with some co-ordinators in the focus group identifying that they were allocated no additional resource to carry out the role;

'*Well, we have a student co-ordinator, but I don't know if she actually has allocated time. We used to have her full time as student co-ordinator, erm, student professional practice officer, but that role as you know, went.'*

Other co-ordinators suggested a lack of direction and supervision within the role;

'I've taken that on as my role [role of coordinator] but this is as far as I have got. So I've just been trying to get to grips with what is happening and, just trying to get on with it and what's going on.'

5.2 Clinical Educator Barriers

It was evident from all focus groups that there were barriers to offering placements which were related to clinical educators themselves. These were related to staff working less than full time hours, reported more frequently in the community and mental health focus groups, and workforce fatigue, which was reported more highly in the inpatient and physical health groups.

Part time working or working 'unusual' hours was felt to be a barrier. There was a lack of consensus amongst participants about whether having a part-time practice educator affected placement experience for students but it remained a concern. This concern was exacerbated if the practice educator was a lone OT working within a multi-disciplinary team;

'I can foresee issues around my hours…I'm the only OT, there aren't any other OTs in the team to support them as well if you're not there, which is going to be very difficult.'

There was recognition that sharing clinical educators was a reasonable solution and that this may offer benefits to students;

'I mean more generally in our team, most, we're all sort of part time or work funny hours. So, you've kind of, we also have to share students amongst us, which is, which is fine as that can be good for students to have different mod, different people so they're not trying to be little mini mes. That they can get their own kind of identity a little.'

Adding additional pressure to an already fatigued workforce was mentioned many times, demonstrating that clinical educators felt that students were something additional to their normal working weeks;

'I think the other barrier I consider a lot is, people are very tired at the moment because we've kept going, erm, we have worked really intensely on the wards and just trying not to overload.'

Words such as '*burn out'* were used frequently with one participant suggesting '*having more than one student a year would start to push us towards, kind of, placement fatigue'.*

Other barriers were discussed, such as time taken away from having students whilst settling into new roles, with one participant identifying that she hadn't had a student for approximately five years '*just to moving around. Changing jobs.*'

5.2 Practical Barriers

The main practical barriers discussed were location in terms of proximity of placement to the HEI, with educators recognising that some of their bases were very rural and it was difficult for students to travel to them.

One participant discussed OT students in the context of a multi-disciplinary team where other professions were also supporting students on placement;

'…the physios do seem to be a bit more organised than us, so their students tend to come through fairly regularly, so then we're, we run short on space.'

Other practical barriers were related to social distancing caused as consequence of COVID19 and have been discussed elsewhere in this report.

5.3 Barriers relating to culture and attitudes

With the exception of the inpatient group, all focus groups discussed organisational/departmental culture as a potential barrier (or enabler) to occupational therapy placements.

The consensus was that where placements were not discussed as part of '*day-to-day'* work, barriers were created;

'I think, for me, coming into the trust, erm, from another trust; I have noticed that, because I was the lone OT within my service, students weren't even mentioned. It's, kind of, not part of my supervision, it's not, kind of, part of the day-to-day discussion really with, kind of, my manager. Erm, and it's only really because, historically I've always taken students I just, kind of, always see it as part of the core role really.'

There was also a suggestion that this was increasingly challenging in community services;

'maybe there is a culture, like a cultural barrier in terms of, I think as an organisation we don't have culture that fosters us to offer and have a student community within, community based services. I think some of that is because we are community-based, erm, so I think in terms of even coming together as a group of OT's, that's a real challenge, erm, erm, and having sort of a joined up approach to student placements that's not something we've necessarily got in place.'

Individual attitudes were also felt to be important, with those that felt that having students on placement with them was a positive thing, were more likely to offer student placements.

5.4 Perceptions of a quality placement

During the focus groups many participants commented on how different factors affected '*the quality of placements'*. The quality of placements was thought to be affected by both long standing concerns and new concerns, introduced as a result of COVID-19 but overall, there was a feeling that placements were unsuitable unless they achieved a certain level of 'quality', of which the definition was subjective.

Key points discussed by participants were; that remote and virtual working which was felt to be inferior to face-to-face placements and therefore reduced the quality of the experience;

'So, from my point of view or the thing that I've been concerned about is, erm, not enough patient contact time really, not enough chance to actually interact with patients and do the things that a therapist does. Erm, and yeah, a lot more of that can be done by a video and call than people thought but I think, kind of, remains, there's a, sort of, lack of interaction concern. So a lot of it is about time, the face-to-face time that you would normally expect within the allotted hours.'

In addition to reduced clinical contact time, it was suggested that working in this way had also affected participant**s'** ability to build a relationship with their students;

'I've wanted to make her feel, like, supported and comfortable and stuff so it has been challenging because I've not really met her yet so I don't know really what she's like yet.'

Having enough time to supervise and nurture students to acceptable standard was important for practice educators and it was felt that juggling the conflicting priorities of the working day made this difficult to achieve;

'So, it's trying to dedicate the time that the students need to be able to learn and develop on placement but also to be able to do the work that needs to be done and support the other staff on the team.'

It was proposed by a small number of individuals that a quality placement was one which focused on introducing the reality of working within health and social care;

'…it's still beneficial to have students at this point because actually I think, erm, Sometimes students need to see the reality of what's going on.'

5.5 Suggestions for overcoming barriers

Participants were able to offer solutions to some of the barriers discussed above. Commonly proposed solutions were; sharing students between two or more educators, sharing students across placement areas, using technology as a replacement to face-to-face working and allowing flexibility in working hours to accommodate the needs of students.

Some solutions were more innovative; one participant identified that occupational therapists are well placed for innovation;

'You can try and be flexible where you can, but I think maybe as OT [more so] because we are flexible for routine and occupation, it's one of our cores.'

An example of innovation to increase placement capacity was shared within the mental health focus group;

'The two we've got at the moment are both doing, they're splitting the week between them and I think we've seen the really good side of that working brilliantly.'

It was identified that barriers were not only practical and suggestions to overcome some of the cultural barriers were made;

'So, from my point of view it's been making sure people are taking them in a timely way and, and, kind of, the rule of thumb was always, you take one student a year. Erm, so it's just keeping on

top of that and also, sort of, keeping placements on every meeting agenda that I go to and encouraging people.'

6. Barriers relating to students

Participants identified some barriers to offering placements which are caused by students. Broadly speaking, these were related to either the student and their personal circumstances or the student's expectations of the placement.

6.1 Barriers caused by the student as a person

Participants were able to identify factors which affected their ability to offer placements to certain students. Unsurprisingly some of these were simple barriers, such as struggling to host placements in remote areas away from city based universities where many students don't drive.

Some other individual barriers were discussed; such as needing to accommodate health needs or providing flexibility to placement hours to accommodate family commitments for example. Participants were generally happy to accommodate these situations but many of them reflected that the number of students requiring these placement adaptations had increased more recently, some had even suggested reasons for this;

'*I don't know if it is because they're paying for university now [and want] to get specific things out of the placement.'*

Participants felt that the pre-placement visit, which is typical for occupational therapy placements, was key to reducing and removing some of these barriers. Participants in all focus groups agreed with this and seem to be passionate about it.

'*you know, it is, it's about leaving anxieties on both sides and I think it's quite a nurturing thing to do and big part of our profession really.'*

Lastly, the programme and level of study that students came from was important for clinical educators, although there was no agreement on which was more preferable, with some saying third year students or pre-registration master's degree were preferable and others commenting that they preferred less experienced students from the first or second year of undergraduate routes;

'We don't generally offer placements to first-year students, we generally go for the MSc and third years, which again is a bit of a barrier because, there's lots of [students that are] missing out on those first couple of years, erm, but like I…that's sort of just a coping thing that we've put in, a strategy that we put in as a team to make it a bit more manageable.'

'I would tend to take a first or second year students, one for the length of time of the placement but also…because ours [clinical placement area] is so hands-on and so it takes time to learn those handling skills,[the placement] is more observational, so it's, less pressure on the student.'

There was recognition that level of study was not the only influential factor, with participants commenting that factors such as learning styles and preference for clinical areas will also impact placement performance.

Participants that had previously difficult interactions with students were far more likely to let this impact their willingness to offer further placements for students;

'Certainly for myself and the team I was with before, when I had my last student, erm, the student was a complete and utter absolute nightmare. Erm, and erm, it just caused so much upset in the whole department, erm, it took so much time, erm, communicating with University, it was taking hours and hours that I was sat at home doing things, erm, the amount of tears is that was shed over it and I just thought do you know what, it's not worth it, it's not worth the pressure and all the upset, and you know as a whole department it affected everybody this, this student, you know, came in with lies, erm, playing one team member off another team member off another team member and it was, it was horrible. And I think that's put a lot of us off.'.

'*If you've had a bad one than the next time you'll be like "oohhh I've got capacity to have a good student but I don't have the capacity to have a bad one" but obviously, you don't, you don't know what you're gonna get. A good student can actually be an asset and can actually help you, but if you've got a bad one then you just like, actually like I can't cope with that with everything else that's, that's going on'*

6.2 Student Expectation

Participants reported that student's expectations of their placements were often not aligned to the real-life possibility of clinical placements. Primarily this was around the flexibility available to students in terms of working hours although there were comments that the expectations of the work itself were also a barrier;

'So, they're not probably seeing what they think they're going to see…and you just have to sort of keep going over that with them.. you see the staff getting burnt out, the students getting frustrated, there's definitely something around managing expectations.'

Balancing student expectation with the expectations for the marking criteria placements was also a challenge for clinical educators;

'So then trying to obviously support them to learn and try different areas and also trying to help them realise that they need to need the time on a specific team to meet their objectives and trying to balance that was really difficult.'

As discussed before, participants felt that the pre-placement visit was crucial in avoiding these issues and setting expectations and this was something which participants were very passionate about.

Recommendations

- Agreement, clarity and collaboration amongst local HEIs on the content, delivery method and frequency of practice educator training sessions and practice educator updates – it is clear from these focus groups that the removal of the APPLE course previously delivered by RCOT and the introduction of a local APPLE (L'APPLE) delivered by HEIs has caused confusion. Although there is commitment from HEIs to deliver educator training in collaboration, this feels disjointed and difficult to access and understand for Occupational Therapists, but staff do regard the training as essential. Care should be taken to reintroduce practice educator training and updates in a way which avoids labour intensive work from busy clinicians, is easy to access and is useful for delivery of modern placements.

- Production of bespoke educator training sessions for practice educators wanting to deliver alternative and/or contemporary placements. Occupational Therapists are very creative professionals and within these focus groups were able to offer solutions and ideas for overcoming barriers to placements however, they often lack the confidence to set these up and deliver them in practice. Bespoke sessions to provide skills and confidence in providing contemporary placements and/or alternative supervision models for Occupational Therapy students would help to empower clinicians to turn these ideas into action.

- Agreement and clarity amongst placement providers and HEIs on the roles and responsibilities of the placement co-ordinator. Ensuring that individuals holding this position are supported using appropriate training and coaching/supervision models and are held accountable to both the number and quality of clinical placements within their organisation through their line managers and training, education and development departments.

- Parity and agreement of processes such as placement trawls, placement offering, placement allocation and delivery of practice educator training across HEIs would remove barriers and reduce inefficiencies for clinical educators, placement coordinators and placement teams at HEIs. Currently, placement providers are required to navigate complex processes which lack clarity and are individual to HEIs in order to host placements and it is clear from these focus groups that this is a process which impacts the number of occupational therapy placements offered to HEIs.

- Education Leads should be prepared to participate in higher level co-ordination of clinical placements at a system level and utilise approaches such as Fair Share Models and cross-site placement offers in order to utilise current untapped capacity. This would require sharing of Occupational Therapy workforce and placement data to groups such as the AHP Faculty and the AHP Cabinet/Council with a level of transparency that will drive forward change and improvement.

- Scoping and early development of an electronic portal for placements should be commissioned in order to share information related to Occupational Therapy placements and clinical educators across the ICS and avoid placement loss through the inability to share

unused placements. Development of this kind of platform in the future would mean that the sharing of placement dates, offering of placement opportunities and placement allocation could also be standardised.

- A system network of clinical educators for Occupational Therapists should be developed – this will provide support particularly to OTs who are lone workers and often feel disconnected from their colleagues and therefore less able to offer clinical placements. A network of practice would link OTs with those with similar/related roles thus creating additional placement opportunities and building confidence amongst clinical educators.

- Managers of Occupational Therapists should ensure that student placements remain on supervision agenda for all Occupational Therapists in order to guarantee a highly skilled and capable future workforce. A theme amongst the focus groups was that many Occupational Therapists are not directly line managed by other Occupational Therapists and this means that student placements are not discussed as part of business as usual, re-establishing and maintaining these conversations is an integral part of future workforce supply.

Conclusions

It is clear from the focus groups that the barriers to offering clinical placements, as perceived by both clinical educators and placement co-ordinators, are complex and multi-faceted. The barriers are both caused by the COVID-19 pandemic and historical and any effort to reduce these barriers in order to increase the number of high - quality Occupational Therapy placements will require joined-up working across the ICS and from all stakeholders involved in the placement planning, allocation and provision process.

The focus groups described in this document were completed as a single aspect of a much bigger Clinical Placement Expansion Project (CPEP) and the recommendations of this work in its entirety can be found in the full report '*Recovery and expansion of quality AHP clinical placements for Physiotherapy and Occupational Therapy students within Nottinghamshire.'*

References

NHS England. (2019) *The NHS Long Term Plan* NHS Long Term Plan » The NHS Long Term Plan

Health Education England (2020) *AHP Workforce Webinar 1: Occupational Therapy, Podiatry and Art Therapy* AHP workforce webinar 1: Occupational Therapy, Podiatry and Art Therapy - YouTube