NHS
Health Education England

RePAIR

Reducing Pre-registration Attrition and Improving Retention Report

Foreword

I am delighted to introduce this RePAIR (reducing pre-registration attrition and improving retention) Report, which is one of three outputs from this large-scale project into attrition and retention.

I feel privileged to have led the RePAIR Steering Group on behalf of Health Education England for this very important work.

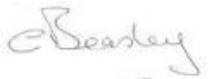
The RePAIR Steering Group was established in 2015 to respond to the DH Mandate to reduce unnecessary attrition from pre-registration healthcare programmes. Attrition has been under the spotlight for many years and whilst not all attrition should be considered negatively, unnecessary attrition does incur a significant cost to the health and care system – to universities and to healthcare providers and, importantly, it impacts on the health and wellbeing of healthcare students and those who are newly qualified.

Given the continued high profile of workforce shortages across health and social care, and the impact this has on the ability of service to deliver high quality patient care, it felt timely that attrition and retention were again subject to further scrutiny and as one of our RePAIR Community members pointed out, RePAIR provided an important opportunity (outside of the usual performance frameworks) for all stakeholders to come together to take stock and 'rekindle the conversation about attrition'.

The Spending Review and Autumn Statement 2015 announcement that health student grants would be replaced with student loans, required the Steering Group to reflect on the project's remit, given the implications for future national data collections. However, the support to continue was unanimous - built on the premise that attrition and retention is not the remit of any one stakeholder in isolation. The Steering Group recognised their collective responsibility to gain a greater understanding of why students stay or leave, a programme or during their early clinical career.

The RePAIR Project has made some significant achievements – the detailed RePAIR baseline dataset is a unique dataset and was only possible given the tremendous support from universities working in partnership with HEE. The extensive student survey has also provided detailed and valuable insight as too have the outputs from the focus groups and case study sites.

RePAIR reaffirms that attrition and retention are influenced by many different factors and it has highlighted the need for all stakeholders 'to do better' to increase their commitment to each other and to take ownership for the contribution they play in the 'journey' to reduce attrition and improve retention.



Professor Dame Christine Beasley
Chairman of RePAIR Steering Group

Professor Dame Christine Beasley

"Attrition is everyone's business – every individual or organisation providing pre-registration healthcare education or contributing to clinical placement education must ask how they can work together and with HEE to respond to the recommendations of RePAIR. RePAIR identified many examples of good practice, but equally we should remember that we can and must all do better if we are to contribute positively to the workforce challenges ahead. Undergraduates are our workforce of the future, the future of the NHS, we must cherish them to ensure our patients get the high quality of care they should expect."

Professor John Clark – Senior Responsible Officer, Regional Chief Nurse and Head of Allied Health Health Education England – Midlands and East RePAIR SRO

"RePAIR has provided a unique and fascinating insight into what motivates students to stay or leave their chosen healthcare programme. It has also been a catalyst for further work to explore some of the emerging RePAIR themes including valuing Year 2 students, the culture of care, understanding student confidence and early career choices. Although RePAIR has focussed on nursing, midwifery, and therapeutic radiography, it is exciting to consider that the principles to emerge are likely to be more far reaching. I am particularly keen to understand the relevance of the findings of RePAIR to the new models of pre-registration education and training that are being implemented across health and social care."

Professor Lisa Bayliss-Pratt, Chief Nurse, Health Education England and Interim Regional Director for Health Education England London and South East

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1. Background to the project

Student attrition from pre-registration clinical education programmes is a long-standing challenge, with resulting impact on the supply of the future workforce to provide the capacity and capability to deliver high quality patient care. As early as 1999 the then UKCC (United Kingdom Central Council for Nursing Midwifery and Health Visiting) published the findings of a large scale review of nurse education and reported high levels of attrition[1].

More recently in March 2015 the Department of Health (DH) published a refreshed mandate to Health Education England (HEE)[2], including setting out actions required to improve the quality of education and supporting healthcare students and trainees. The Reducing Pre-registration Attrition and Improving Retention project (RePAIR) was established to address the mandated requirement to reduce unnecessary attrition (**box 1**) and also identify areas of best practice in improving retention.

Box 1: HEE's refreshed mandate 2015-2016

6.19 Unnecessary attrition from training programmes can result in significant cost and impact on the health and wellbeing of students. HEE's objective is to reduce avoidable attrition from training programmes by 50% by 2017.

In the same year HEE published Raising the Bar[3] in which it was reported *that non-completion rates within pre-registration nursing programmes is, on average, in excess of 20 per cent*. This study also highlighted the financial burden to the system of educating people who fail to enter their chosen clinical career.

The pre-registration programmes deemed to be the most significant to RePAIR, in the context of the right numbers of people available to deliver the right care, are either those that have a significant whole system impact such as adult nursing and midwifery, or those that impact on vulnerable communities: children's nursing, learning disabilities nursing, mental health nursing and therapeutic radiography. The scope of RePAIR was extended to include approaches to improving retention during the first two years of employment as newly qualified practitioner turnover rates tend to be high during this period[4]. Although the focus of RePAIR is on these six programmes, and the newly qualified practitioners who graduate from them, the findings are readily transferable to other pre-registration clinical education programmes.

It is well understood that the factors that contribute to attrition are complex and that institutional, political, professional and societal issues, as well as individual student factors contribute to students leaving a healthcare course[5]. To further complicate this situation there are differing definitions of attrition and different approaches to calculating this metric, making direct comparisons very difficult.

In the 2015 government Spending Review and Autumn Statement[6], a funding reform for healthcare students was announced. The capped numbers of student places for nursing, midwifery and allied health subjects were abolished and the student grant system replaced by student loans (**box 2**).

Box 2: Grants for healthcare students removed

Grants for health students will also be replaced by loans, and the cap on the number of nurses and midwives that can go into training each year will be removed, providing up to 10,000 more nurses and other healthcare professionals for the NHS. These students will be able to receive 25% more financial support during their studies as a result.

Despite this significant change in policy there was strong support to continue the RePAIR project with the expectation that the findings would still have relevance to the healthcare sector.

2 RePAIR Context

2. Context

The current unfavourable circumstances concerning the nursing, midwifery and therapeutic radiography workforce in England indicates that RePAIR continues to be a very significant project. There are four main areas of concerns:

- Reduction in the number of applicants for these pre-registration programmes;
- Number of students leaving their course of study;
- Overall reduction in the number of these professionals per population;
- Numbers leaving the workforce.

Number of applicants

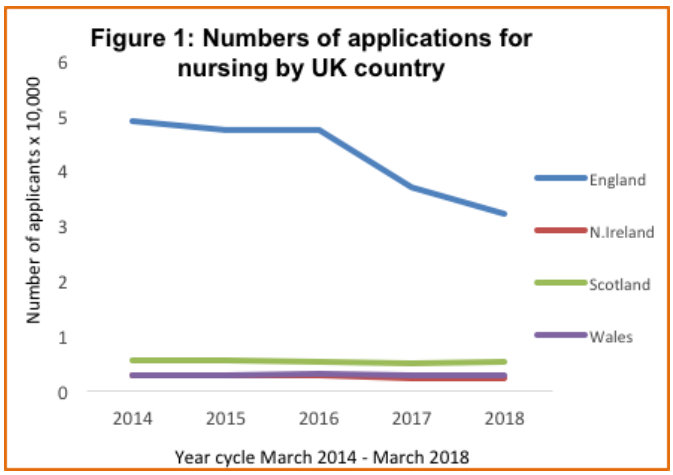
The Universities and Colleges Admissions Services (UCAS) report the data on the number of applicants to nursing programmes by UK country, although not by field of nursing. The data for midwifery and therapeutic radiography programmes are reported under subjects allied to medicine. UCAS March 2018 nursing data[7] shows a 35.1% overall reduction in the number of applications for nursing from those living in England between 2014 and 2018 (**figure 1**).

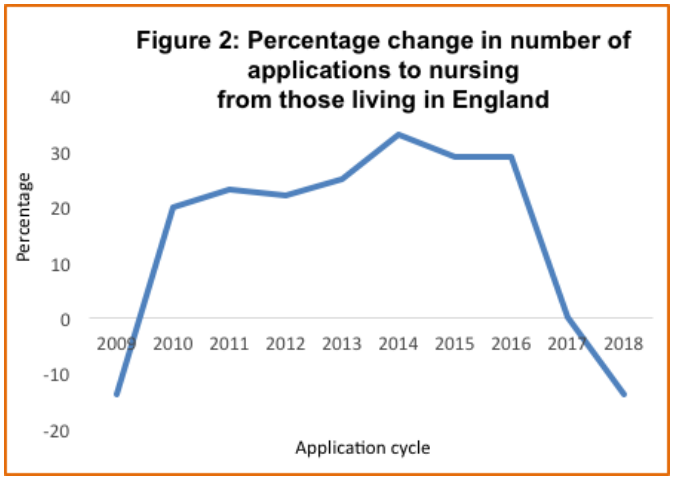
When reported by percentage change the trend over the past nine years is that the number applying for 2018 has fallen back to the 2009 value (**figure 2**). However, there has been very little change in the number applying from the other UK devolved nations over the same period. Similarly, the number of applicants for nursing programmes, to education providers in England, from UK residents, is down by 35.2%.

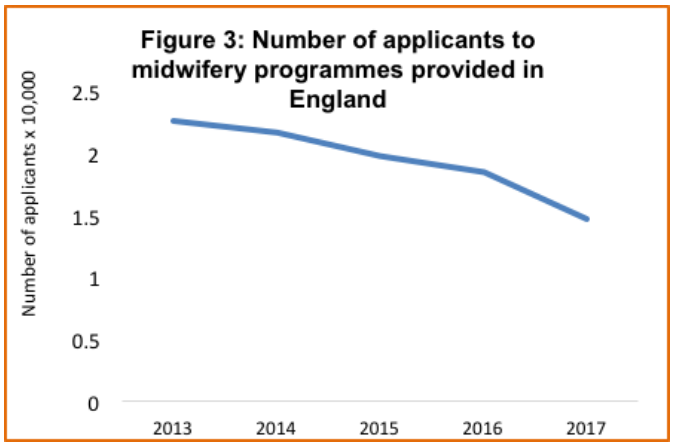
The overall UCAS records for applications to Subjects Allied to Medicine which includes nursing, midwifery and therapeutic radiography programmes reveal 81,720 fewer applicants from England during the period 2014-2018[8], a 27.5% reduction.

According to the Royal College of Midwives (RCM) there has been a 35% decrease in the number of applicants to midwifery programmes in England since 2013 (**figure 3**), with the biggest decrease in applications from those aged 21 years or over[9]. The RCM noted that *"we need urgent measures to ensure that we will have enough students willing to become midwives"*.

In September 2017, the College of Radiographers reported a significant drop in applications to therapeutic radiography pre-registration programmes both during UCAS cycle and during clearing, particularly applications from mature students.







Number of students leaving their programme of study

Currently the traditional pre-registration programmes are the main route into nursing[10], midwifery and therapeutic radiography. UCAS data published in December 2017 shows a 3% fall in the number of placed acceptances for nursing, with 585 fewer students starting nursing degrees in September 2017 compared with 2016. Similarly, therapeutic radiography programmes have reported that they are struggling to fill the places[11]. Given this trend, it is important that the focus of attention is on retaining students on these programmes.

RePAIR has sought to further understand the factors that influence a student's decision to consider leaving a programme and at what point during the course they decide to stay or leave. It is recognised that not all attrition is either bad or controllable and that some attrition is inevitable and in some circumstances desirable.

Number of professionals in the UK

The OECD (Organisation for Economic Cooperation and Development) statistics[12] show that in the UK in 2016 there were 7.91 nurses per 1000 population compared with 9.75 in 2009 and for midwives 0.48 in 2016 compared to 0.52 in 2009. The number of midwives per 1000 live births has dropped from the reported 41.29 in 2009 to 40.39 in 2015.

The latest figures from the NMC register in March 2018[13] show a reduction in the total number of registrants by 2274 when compared to 2016 (the peak number of registrants). The reductions are in nursing: nurse & midwife (1,831 fewer, a reduction of 19 per cent), and nurse (3,031 fewer, a reduction of 0.005 per cent). However, the midwifery only registrant numbers have increased over the same period by 2,584 (0.078 per cent). Over this two year period only the number of registrants in the field of children's nursing has increased. The other fields of nursing have reported a decrease in the number of registrants: learning disabilities nursing by 5.4 per cent; mental health nursing by 1.8 per cent and adult nursing by 1.4 per cent.

In 2017, in response to the NHS Cancer Workforce Plan, HEE stated that it was planning to secure a further 1,560 full-time equivalent (FTE) therapeutic radiographers by 2021. An 18 per cent increase from the 2016[14] figure.

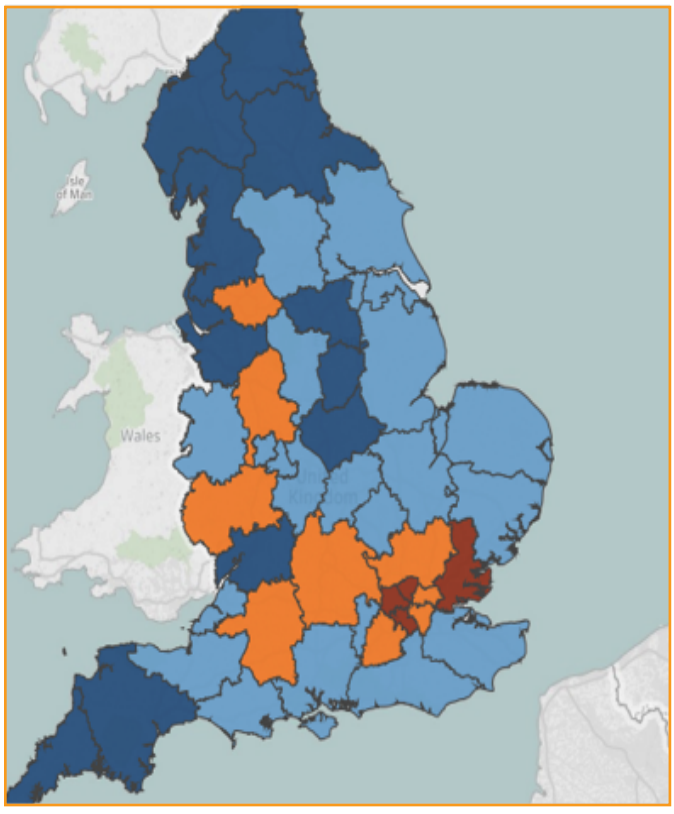
Number of professionals leaving the service

According to NHS Improvement (NHSI)[15] early career nurses leave their job to gain experience; are more geographically mobile; less tied to the NHS because of a pension and have different expectations of the workplace and career. In contrast the end of career nurses leave their job as retirement is a viable option and because of the physical and emotionally demanding nature of the work.

During the period 2011/12 to 2015/16 the rate of nurses leaving the service increased from 12.3 per cent to 16.1 per cent. The rates vary across the Sustainability and Transformation Partnerships (STPs). The lowest are in the North and Cornwall and the highest in and around London as illustrated in **figure 4**.

In September 2017 the highest percentage of advertised vacancy rates in the NHS was in the nursing and midwifery staff group and accounted for 40 per cent of the vacancy full-time equivalents[16].

Figure 4: Nurse leaver rates UK 2011/12 – 2015/2016



3 RePAIR
Existing evidence

3. Existing evidence

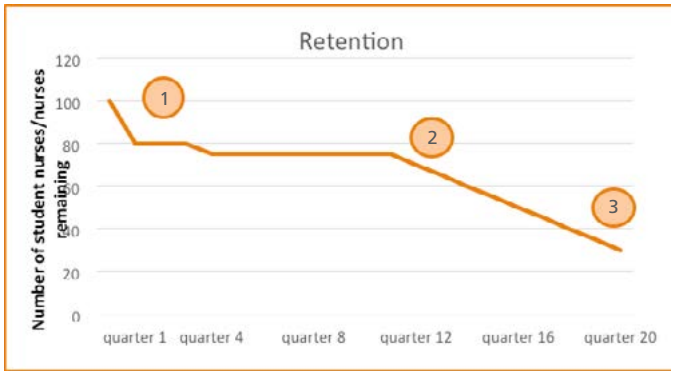
To provide an evidenced background to RePAIR, an overview of the current literature relating to the key project aims was undertaken, and is summarised in this section.

Student attrition

Fully understanding why healthcare students do not complete their programme of study on time, or at all, is recognised by HEE as a very challenging and complex issue. Two recommendations (33 & 34) from the Raising the Bar study[3] emphasised the importance of standardising the approach to collecting data on attrition and the reasons that students leave.

HEE North West's 2015 review of student nurse activity and associated costs, from enrolment to two years employment post graduation (**figure 5**) identified three key points during this period: semester one of a pre-registration programme; the end of a pre-registration course and the number of qualified practitioners still in employment after two years of working as a nurse.

Figure 5: HEE NW 2015 student and early career nurse activity data



KEY

Point 1 – this is within the first quarter or semester, with the following being the critical point: the first 12 weeks, after the first placement and Christmas (for September entries but similar timescales apply to Spring cohorts). As this attrition occurs within the first 4 months it is a relatively low cost but has the highest average level of attrition[i]. There is a small proportion who leave at the end of year 1 and before the end of the programme. However, this is less, on average, than a third of the overall level of attrition for the period up to quarter 20.

Point 2 – there is a smaller proportion of students who do not complete at the end of programme or enter employment. The cost is significantly higher than at point 1.

Point 3 – this is the number of newly qualified nurses still in employment at the end of 2 years. While data quality is patchy there is anecdotal evidence that turnover rates are high and represent a significant cost in terms of return on investment.

It is recognised how costly attrition is for students: financially, psychologically and socially[17]. There are also the costs for the education and healthcare providers and ultimately the tax payer: loss of student fees, delivering the clinical education for no reward, and the impact of the reduced pool of newly qualified practitioners. HEE estimates it costs *'approximately £78,000 to train a nurse over a three year period[3]'*.

Urwin[4] argued that factors affecting attrition are complex and that some attrition is a way of filtering out unsuitable students. Attrition is a multi-causal problem, influenced by a wide variety of factors such as personal reasons, lack of integration, lack of preparation and financial difficulties[18]. There is rarely just one reason for attrition[19]. A recent study from the Netherlands[20] reported similar findings to UK studies: the main reasons for student nurses leaving the programme strongly related to the education and training programme, most notably the lack of support from mentors and the team in the clinical placement.

In addition to non-successful progression, some of the other evidence for attrition is that factors such as family obligations, clinical model of practice (including culture) and associated lifestyle, prompt students to leave[21]. HEIs are encouraged to recruit healthcare students from a range of backgrounds, this includes mature students with caring responsibilities. A study into student radiographers who are carers, found that the main reasons for their concerns focussed around timetabling, finances, support after exam failure, understanding from the academic staff and attendance in the university and clinical placement. These researchers also found that therapeutic radiography students with carer responsibility had no significant difference in absence when compared to those with no carer responsibility[22].

Historically, much of the research has focussed on why students fail to persist on a course rather than why they succeed[23]. Increasingly the literature seeks to develop a discourse around retention rather than attrition and links retention to support from family, friends and academic staff. In 2013, Jeffreys produced the Nursing Universal Retention and Success (NURS) model and asked the retention question "why do students stay?" rather than the usual approach of asking why students leave i.e. the attrition question. The NURS model illustrates the complexity of the interplay of the multifaceted phenomenon that is nurse retention[24].

[i]This interpretation of attrition is the number of students who leave the programme, not to be confused with the RePAIR 'pure attrition'

This model is built on the fact that retention decisions are based on the interaction between the following seven variables: *'Student profile characteristics, student affective factors, academic factors, environmental factors, academic outcomes, psychological outcomes, outside surrounding factors, and professional integration factors.*

A study into what encourages students to stay[25] found a number of factors that impact on retention: student identity in the healthcare provider (HCP) organisations; fostering resilience; and the difficulties experienced in practice, including lack of support. A small study of 16 students, who had discontinued their course, highlighted the impact of negative placement experiences and concluded that this could be the tipping point[26].

A review of fifty years of research into student nurse attrition[27], concluded that in addition to the many well-established factors, the impact of policy change should be considered: policy at programme level such as progression; policy at institutional level and changes in national policy.

HEE North West commissioned Manchester Metropolitan University to undertake a two-part scoping review of the international research within nursing and midwifery[28]: part-one, the analysis of new/current interventions within higher education to reduce student nursing and midwifery attrition; part-two an analysis of post-graduate career choices and career pathways. The repeated themes from part-one were twofold: *setting realistic expectations and providing support mechanisms both on campus and within placement/clinical environments.* One such support mechanism that has been piloted is the use of a student mobile texting service[29]. The students who were engaged in this pilot project reported that the text messaging service was helpful, supportive and increased a sense of belonging to the University. However, there were some expressed concerns about the costs of reply texts.

The repeat of the PASS (Predicting and Securing Success) survey[30] found that students were positive about their experiences on the course but *'a number were dissatisfied with some aspects of their experiences - particularly in relation to initial support on campus'.* Students also reported that studying while on clinical placement is a challenge.

NHS Education for Scotland developed a student engagement process[31] *'to provide a student voice and develop a model for ongoing and enhanced engagement to inform future national work'.* The findings from this research is that it would be useful for students to understand more about national healthcare policy, particularly during their third year and during transition into employment. They also found that email was the students' preferred means of engagement.

Selecting students who are committed to their chosen profession is very important. HEE's values based recruitment framework[32] was developed to ensure that students are recruited on the *'basis that their individual values and behaviours aligned to the NHS Constitution'*[33].

According to Rodgers[34], HEIs are more concerned with recruiting to the institution rather than to the profession. Interviews are widely used, largely because they are required by the nursing and midwifery regulator. Nonetheless, this study found that there is no evidence base in the literature that interviews have a predictive validity and the effectiveness is rarely evaluated.

This overview of the literature has only highlighted two studies that makes reference to clearing and attrition[35]. In the first study the authors report that the level of commitment that an individual feels to an organisation is very important, and that students who secure a place at the first university on their application form are less likely to drop out. They went on to explain that *'those who obtained a place through 'clearing' were less likely to have their expectations met concerning institutional facilities and thus had less institutional commitment'*. In the second study[36], the authors claim that *'applying through clearing or direct to the institution appears to have a relatively weak, but significant, association with 'early-leaving' for both young and older students'*.

Others note that pre-course preparation is an important indicator of academic integration[37], as is education and social development of the student prior to enrolling[28] on a course.

The role of practice learning in student retention

Many studies make reference to the impact of the students' clinical learning environment on their decision to stay or leave a programme of study. This short section considers the role that practice learning has on student retention and the importance that national bodies place on the learning environment's support for pre-registration students.

HEE's Quality Framework[38] Domain 5 states that placements must enable learners *'to become members of the multidisciplinary team and to allow team members to make reliable judgements about their abilities, performance and progress'*.

The Nursing and Midwifery Council's new standards for education and training[39] include a set of standards for student supervision and assessment, which has a section on effective practice learning: what needs to be in place to deliver *'safe and effective learning experiences for nursing and midwifery students in practice'*. These new standards also set out the principles of student supervision and assessment, outlining the roles of the practice supervisor and practice assessor.

Accessing a sufficient number of high quality placements is a particular challenge for learning disabilities nursing[40], and *'is a real issue and cause for concern for education providers, clinicians and managers of services'*.

Attrition from pre-registration therapeutic radiography programmes continues to be a concern and students assert dissatisfaction with clinical experience as the main reason for leaving. A report, commissioned by the Society and College of Radiographers[41], sets out the expectations of the HCPs (Radiotherapy Centres), including staff responsibilities, managing bullying and harassment, and providing an opportunity for prospective students to visit prior to an offer of a place.

East Lancashire Hospitals Trust (ELHT)[42] shared, via HEE's eWIN (Workforce Information Network), the approach they had taken to reduce nursing placement attrition. ELHT reviewed the priorities of the Practice Education Facilitator team to increase the student contact, offer more local mentor[ii] support and have a consistent approach to improving education quality. Four cohorts of students were studied and the student attrition for this group was reduced from 22 per cent to 8 per cent.

According to Hamshire[26] organisations that are developing strategies to reduce attrition should focus on *'changing and improving the overall student experience of clinical placements'*. The Higher Education Funding Council for England (HEFCE), now the Office for Students, has introduced questions about placements in the National Student Survey (NSS). The student data that was available for nursing and midwifery courses in 2016 showed that the overall student satisfaction with placements ranged from 77.5 per cent to 96.2 per cent satisfaction[43].

High quality mentoring is recognised as being an important factor influencing student retention[44]. The unique relationship between the mentor/practice educator and the student also has a wider impact on the service: standards of care, staff motivation and credibility of the profession. Opportunities to mentor or buddy final year school pupils or junior students may help prepare students for future mentoring roles and help them with transition into clinical practice[45].

Transition into practice

The evidence is that newly qualified practitioners have a rollercoaster of experiences and confidence levels during their first year of employment[46]. This relates to professional self-identity; clarifying their place in the workplace hierarchy, and developing an awareness of perceived power. This scenario was described by Duchscher[47] in her 'Transition Shock' theory and represents the reaction newly qualified practitioners have, when moving from the protected environment of the university, to the demands of the contemporary clinical service. Duchscher explains that this process of adjustment is *'developmental, intellectual, sociocultural and physical'*. To mitigate against this challenge, it is suggested that HCPs should work more closely with HEIs to prepare for role transition, and that the clinical placements should enable the 'soon to graduate' students to experience the high intensity and *conflict-laden context of professional practice*.

One of the recommendations from a ten-year midwifery 'transition project'[48], was that a passport for transition, covering the period from the beginning of the final year of study to the end of the preceptorship period, should be developed.

It is internationally recognised how stressful the transition period is. A study undertaken in Australia[49] concluded that it is the *attitudes, behaviours, and experiences* that the newly qualified practitioners experience, at the beginning of their first post, that affect how the newly qualified practitioner responds to the transition. The authors point out the irony *'that a supposed caring and nurturing profession does not consistently afford these very qualities to its newest members'*. A review into how HEIs[50] successfully support the nursing student into first employment, recommended that a newly registered nurse should be equipped for a nursing career that is built on values for compassionate care.

[ii] *Throughout the report there are references to clinical staff who support the students in practice. There are a number of acceptable terms: mentor, practice educator, supervisor.*

A national study undertaken in Canada[51] reported that new nurses' work-life balance was overall positive. However, the authors reported that burnout continues to be a concern for this workforce. They advised that every effort should be made to prevent emotional exhaustion among novice practitioners.

The authors of a systematic review of the interventions to improve transition[52] reported that transition programmes for new graduates increase retention and improve the overall experience for the new practitioner. It was suggested that there are organisational and individual benefits where there is a smooth transition from end of the final year of study to the preceptorship period.

Preceptorship

The Department of Health[53] recognises that newly qualified practitioners are safe and competent at the beginning of preceptorship and defined preceptorship as: *'A period of structured transition for the newly registered practitioner during which time he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning.'* In 2017, CapitalNurse published its preceptorship framework[54] and set out best practice for London, with the aim of standardising the approach to preceptorship and reducing attrition during the preceptorship period. This model recommends a 12-month programme with protected time for preceptee and preceptor to enable the newly registered nurse to *'build confidence, competence, consolidate learning and build resilience'*. A study by Whitehead et al[55] also reported the need for recognition of the preceptor role and dedicated time for this role.

The Royal College of Midwives[56] (RCM) adds to this list and advises that the preceptorship period is an opportunity for newly qualified midwives to consolidate *'attitudes, values and behaviours as autonomous midwives'*. The RCM recognises there is no empirical evidence to support preceptorship, however, it suggests that this period is important for the newly qualified midwives' socialisation into the service. According to HEE[5], a *'key component of any organisation's approach to preceptorship is a policy document'*.

One example is the multi-professional preceptorship framework, published in 2018 by two Local Workforce Action Boards[58]. This framework provides an opportunity to align models of preceptorship and share preceptorship capacity and resources.

A review of healthcare preceptorship in the UK[59] reported that newly qualified practitioners believe that individualised support could improve the preceptorship outcomes and that the relationship with the preceptor is pivotal. A report of a systematic review of the literature on supporting newly qualified nurses[60] concluded that there is *'strong evidence that the newly qualified nurse benefits from a period of supported and structured preceptorship, which translates to improved recruitment and retention for the employing organisations'*.

Early career retention

There are four different generations working in the same healthcare environment. It is important to understand the effect of generational differences on workforce satisfaction and retention[61] (see Resources tab in the RePAIR toolkit **access here**). The key differences are:

- Baby Boomers (1946 -1964) are ambitious and will question everything.
- Generation X (1965 -1979) like structure and direction, work/life balance is important.
- Generation Y (1980 - 1994) expect support to achieve.
- Generation Z (1995 – 2010) are digital natives and self – directed.

Many of the newly qualified practitioners are Generation Y. Their workplace needs are illustrated below (**figure 6**).

The suggestion from the 'Mind the Gap' work[61] is that HCPs can use this framework when considering how to retain early career practitioners.

Later work by HEE: 'Narrowing the Gap'[62] points to the fact that generational typologies offer a lens through which to consider potential differences that may influence retention. Newly qualified staff do not always know where they wish to work and value the opportunity to 'rotate' through an organisation. Some organisations have enabled this to happen, whereby staff can move easily between departments without having to resign from their post or reapply for a new role[63].

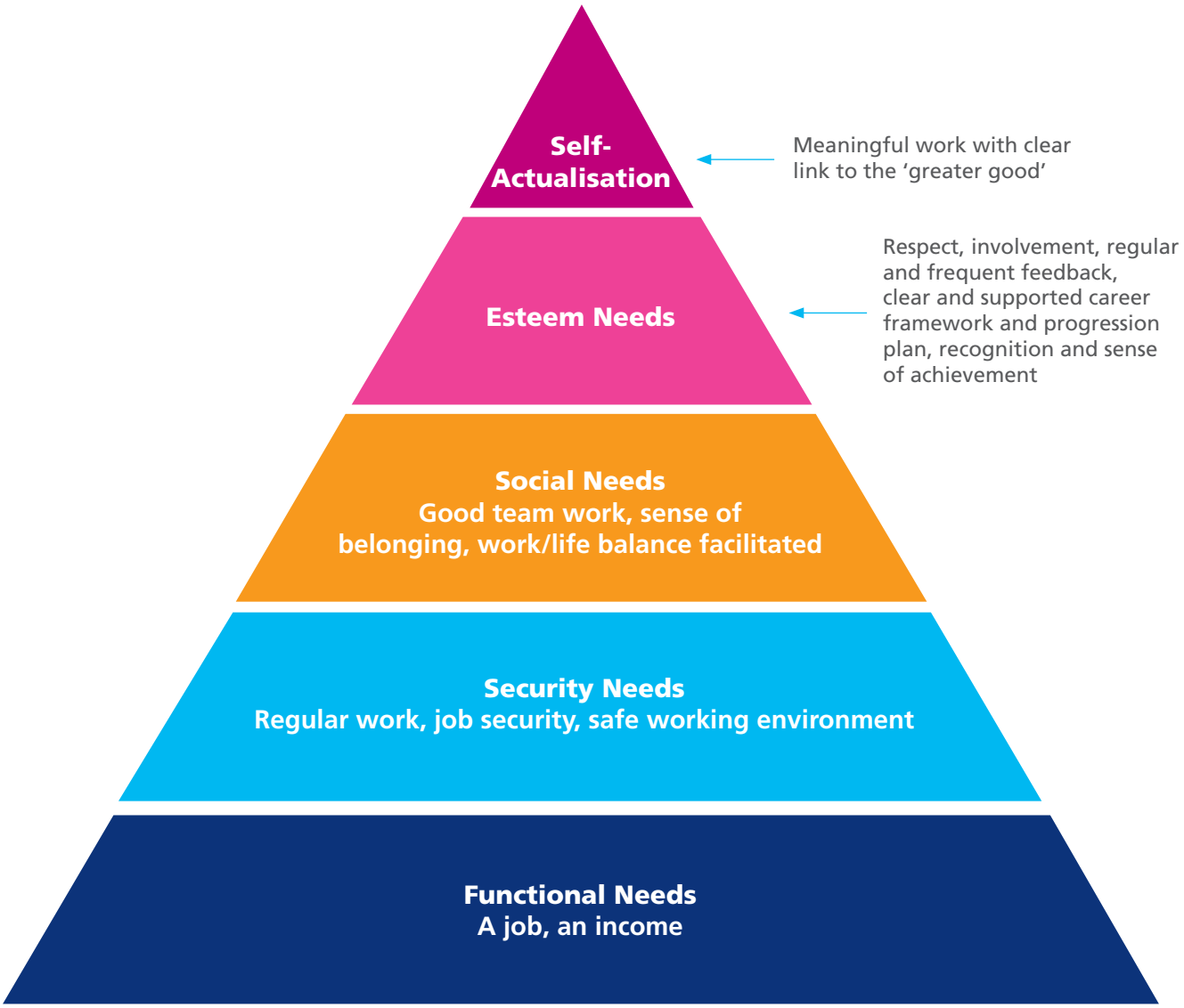


Figure 6: Maslow's hierarchy of workplace needs -Generation Y

4 RePAIR
The approach to RePAIR

4. The approach to RePAIR

In line with the mandate the agreed RePAIR project aims were to:

- Provide a standard definition for attrition and establish a baseline.
- Establish a detailed understanding of the multi-factorial aspects of attrition and retention in pre-registration education and training.
- Identify best practice and isolate the factors that are in place for retention to be optimised.
- Promote spread of identified best practice across England.
- Agree a sustainable national approach to improving pre-registration retention.

From the outset of the project it was decided that RePAIR would cover the students' journey from the period prior to them enrolling on a course, up to two years post qualifying for all programmes in scope:

- Adult nursing
- Children's nursing
- Mental health nursing
- Learning disabilities nursing
- Midwifery
- Therapeutic radiography.

4.1 The four Steps of RePAIR

For the purposes of RePAIR the student to newly qualified practitioner journey has been described in four Steps (**figure 7**):

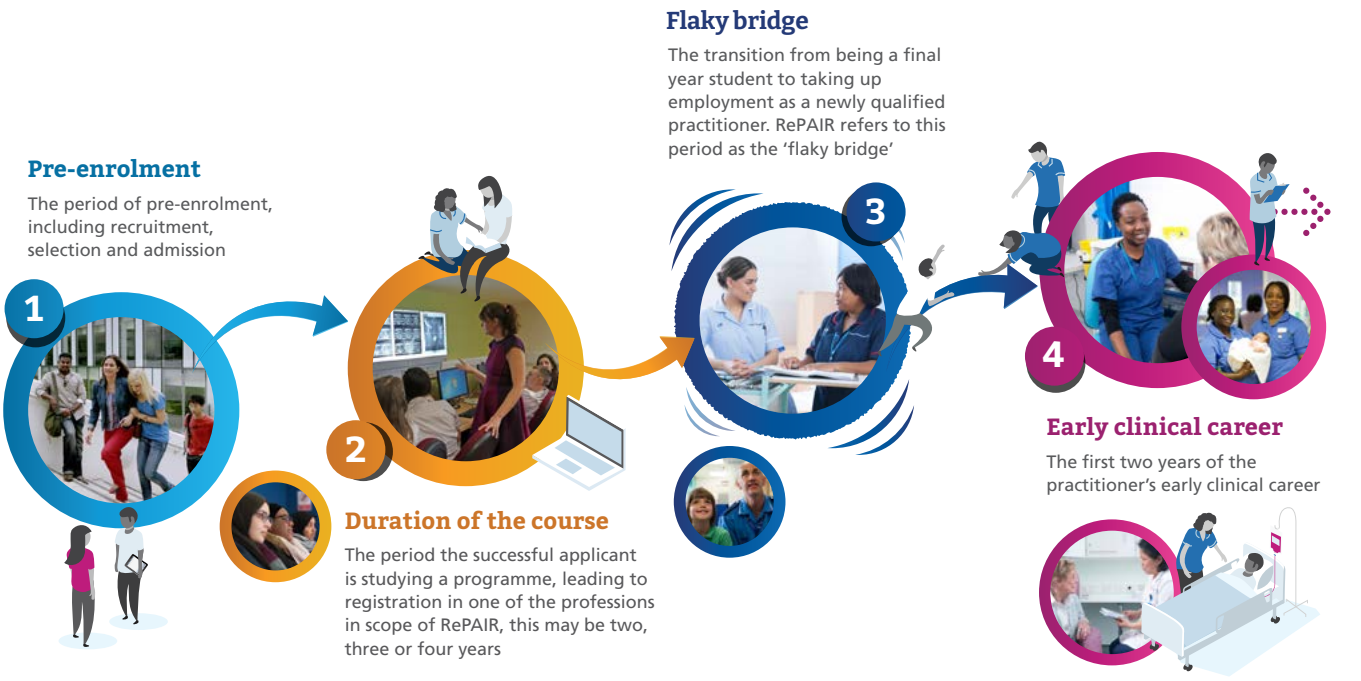
Step 1 - The period of pre-enrolment, including recruitment, selection and admission

Step 2 -The period the student is enrolled on a course that leads to registration in one of the professions in scope of RePAIR, this may be two, three or four years

Step 3 -The transition from being a final year student to taking up employment as a newly qualified practitioner. This period is known in RePAIR as the flaky bridge

Step 4 -The first two years of the practitioner's early clinical career

Figure 7: The RePAIR four Step journey



4.2 The three phases of RePAIR

The RePAIR project has been delivered over three distinct but overlapping phases:

1. Establishing the project and developing the theoretical framework;
2. Gaining an in-depth understanding of stakeholders' experience in relation to attrition and retention;
3. Identifying, developing and testing current and new interventions to improve retention.

The progress of RePAIR has been overseen by a Steering Group with initial support from an Operations Group.

4.3 RePAIR theoretical framework

As early as 1975 Vincent Tinto developed a model of student retention[64], he has since further refined this model (1993[65], 1997[66], 2012[67]). There have been various adaptations to Tinto's model e.g. Thomas[68]. Central to the Tinto model is the concept of commitment: the student's commitment to the course of study and the institution's commitment to the student.

Tinto's model provides a possible structure for examining attrition and retention. An episode of attrition should not be considered in terms of root cause analysis pointing to an isolated demographic variable that sits with either the student or the institution. Tinto's claim that attrition is a product of a student's lack of integration into the social and academic systems would suggest that retention may be best achieved through successful dialogue between the engaged student and the committed institution. Tinto's model suggests that retention is evidence of a successful relationship between student and institution, and by inference attrition is evidence of a failed relationship.

Factors affecting student commitment

Based on Tinto's original model there are the two key domains of academic and social integration. These are heavily influenced by the student's personal circumstances: prior academic qualifications, individual's attributes, family attributes (mother's education), debt and personal problems. The social integration is subject to developing a bond between the student and the HEI, and between the student and the HCP.

Factors affecting HEI commitment

Factors affecting any HEI's commitment is significantly influenced by the importance of a programme to the institution; the institutional reward (financial and status) of the programme, and the financial risks of the programme. The resources available to support the student are very significant and often reflected in the ranking e.g. staff:student ratio; research output; the type of student attracted to the programme, and the institutions commitment to widening participation.

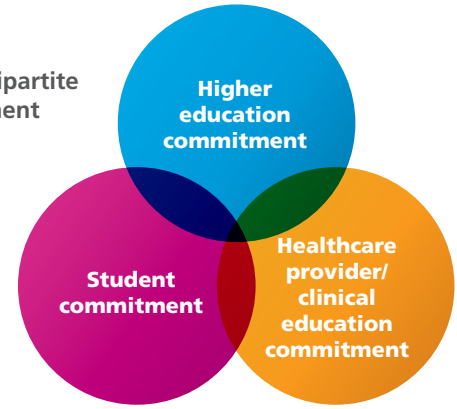
Factors affecting clinical service commitment

The approach that any HCP takes to supporting students, based in their service, will be influenced by student loyalty to the service. The capacity that any service has to dedicate to student learning significantly impacts on the student experience and the service commitment. The rewards (financial and support for service) are very important, as is the nature of the partnership with the local HEI to deliver the programme.

One of the four reasons that students who are doubters stay on a course is their personal commitment and drive to achieve[68]. For the students studying programmes in scope of RePAIR there should be a commitment to developing a culture of belonging through both HEI and HCP institutional leadership. It is important to build and maintain stakeholders' commitment[69] as evidence indicates that enhanced commitment improves retention.

The RePAIR tripartite model of commitment (**figure 8**) has been developed to enable a clearer understanding of factors that affect retention for the four fields of nursing, midwifery and therapeutic radiography. From this emerges a set of principles that are transferable to other pre-registration clinical education programmes, and potentially to other emerging routes into healthcare professions such as apprenticeships and nursing associates.

Figure 8: RePAIR tripartite model of commitment



4.4 Collecting the evidence

The mixed-methods approach to collecting the data was pragmatic and based on the premise that the findings would add to the existing knowledge base. The evidence has been collected from three different sources (**figure 9**):

- data available from Higher Education Institutions (HEIs);
- data available from stakeholders;
- evidence from the RePAIR case study sites[iii].

Understanding indicators of attrition

Defining attrition is a complex matter with different approaches in existence including those used by the Higher Education Statistics Agency (HESA), by HEE and local approaches in HEIs.

The establishment of a standard definition and baseline were key to the early work of RePAIR. A Data and Definitions Sub-Group was set up by the Steering Group, and comprised of representatives from a range of organisations that collect pre-registration student data. The purpose of this group was to discuss and recommend a standard definition of pure attrition and identify the factors that contribute to avoidable attrition.

According to the National Audit Office[18], there are two main measures of retention: completion rate and continuation rate. The former is *'the proportion of starters in a year who continue their studies until they obtain their qualification, with no more than one consecutive year out of higher education'*, and the latter is *'the proportion of an institution's intake which is enrolled in higher education in the year following their first entry to higher education'*.

In the absence of a consistently applied definition, the RePAIR Steering Group and HEE Executive supported a high level definition of ***'pure attrition' to establish the baseline and agreed that for the purposes of RePAIR pure attrition is counted as the percentage of students who did not complete within the standard pathway for that programme***. This group was also tasked with identifying existing data sources that would ultimately inform RePAIR.

Two data collection rounds were undertaken:

Round 1 – national data about the percentage of students who did not complete their course of study in the 'standard' length of the programme for students completing in academic years 2013/2014 and 2014/2015. This required accurately tracking individual student pathways using uniquely identifiable student data to eliminate any variation resulting from students transferring in and out. This was the first time that such an approach had been taken at a national level and required HEE to develop a bespoke data collection tool.

Round 2 – was on a smaller scale and involved data provided by some of the HEIs, participating in the case study sites, to gain a greater insight into completion trends.

[iii] *For the purpose of RePAIR case study sites are defined as local partner organisations that agreed to work together to advise and inform the project.*

Figure 9: Data collection sources used in the project

RePAIR

Insight into the stakeholders' experience

One of the key aims of the RePAIR project was to establish a detailed understanding of the multi-factorial aspects of attrition and retention.

An online survey was created specifically for RePAIR, based on the 2015 Predicting and Securing Success (PASS) survey produced by Manchester Metropolitan University in partnership with HEE working across the North West. Ethics approval was obtained prior to distributing the survey in October 2016. The survey was made available, through NHS Student Bursaries, to all students who were studying one of the RePAIR programmes and in receipt of an NHS bursary. The survey statements can be found in **appendix 1**. A copy of the full survey can be found in the RePAIR toolkit (**access here**).

A total of 46 meetings were held on 33 different occasions to capture a comprehensive view of stakeholders' opinions and experiences of attrition and improving retention. The majority were held in England with one in Edinburgh and one in Cardiff. Most of these meetings took the form of focus groups with either students, newly qualified practitioners or academic staff. The remainder were one to one meetings with senior policy advisors. This stakeholder engagement can be broken down as follows: 155 students, 25 newly qualified staff, 67 academics, 63 clinical educators, 7 national policy advisors. In addition, 7 representatives of professional and regulatory bodies have shared their experiences and insights into aspects of RePAIR.

Two RePAIR workshops were held to share best practice and further inform RePAIR: one was for members of the wider RePAIR Community (members of the case study sites), the other was specifically for therapeutic radiographers. The RePAIR team also attended three forums run for mentors, one forum for student midwives, and one meeting for therapeutic radiography. These events have informed the output of RePAIR.

In-depth enquiry into improving retention

To enable HEE to understand more about improving retention, the RePAIR team invited both HEIs and HCPs to apply to become case study sites to support the final stage of RePAIR. Expressions of interest were received from 44 organisations. HEE chose 17 sites, four from the North, four from Midlands and East, five from London and the South East[iv] and four from the South. One of the sites from Midlands and East withdrew at an early stage, because of impending changes in senior staff. Of the remaining 16 sites (**table 1**), 5 were HEI led and 11 HCP led.

[iv]The regional coverage used in RePAIR pre-dates HEE's regional boundary change

Table 1: Case study sites by HEE region

HEE North

1. Central Manchester NHS Foundation Trust
2. Cheshire and Wirral Partnership NHS Foundation Trust
3. County Durham and Darlington NHS Foundation Trust
4. Sheffield Hallam University

HEE London and South East

8. Barts Health NHS Trust
9. Kent Oncology Centre
10. Kingston University and St George's University of London
11. London South Bank University
12. West London Mental Health Trust

HEE Midlands and East

5. Birmingham City University
6. Derby Teaching Hospitals NHS Foundation Trust
7. James Paget University Hospital NHS Foundation Trust

HEE South

13. Oxford University Hospitals NHS Foundation Trust
14. Plymouth Hospitals NHS Trust
15. University Hospitals Southampton NHS Foundation Trust
16. University of the West of England

The name of the organisation is the one used at the start of RePAIR

RePAIR

The case study sites operated on the model illustrated in **figure 10**: each of the 16 sites had a lead site which in turn had several partner sites. This collective group formed the RePAIR Community.

A total of 18 HEIs (**figure 11**) and 25 HCPs (**figure 12**) engaged in RePAIR to: further understand stakeholders' experience in relation to attrition and retention; to identify, develop and test current and new interventions to improve retention; support the development of the RePAIR economic model and cost calculator.

An appreciative enquiry approach was adopted at the sites using the following principles:

- Learning through conversation and inquiry;
- Adult-adult shared responsibility for success;
- Challenge and support to get the "learning edge";
- Positive involvement, engagement and curiosity.

Figure 10: RePAIR case study sites model

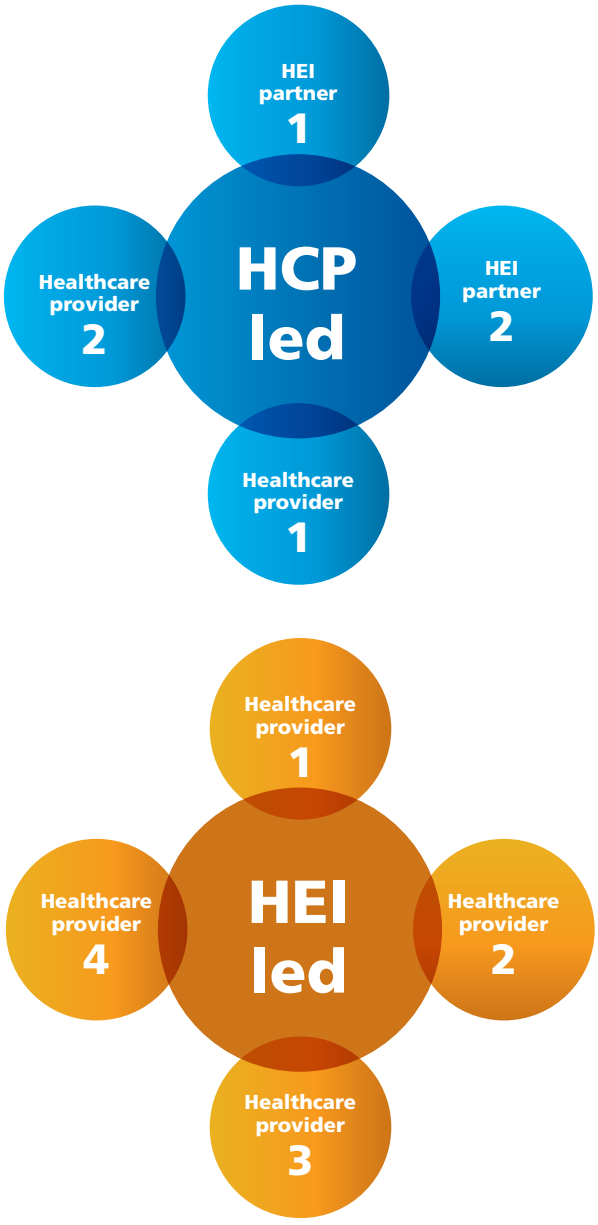
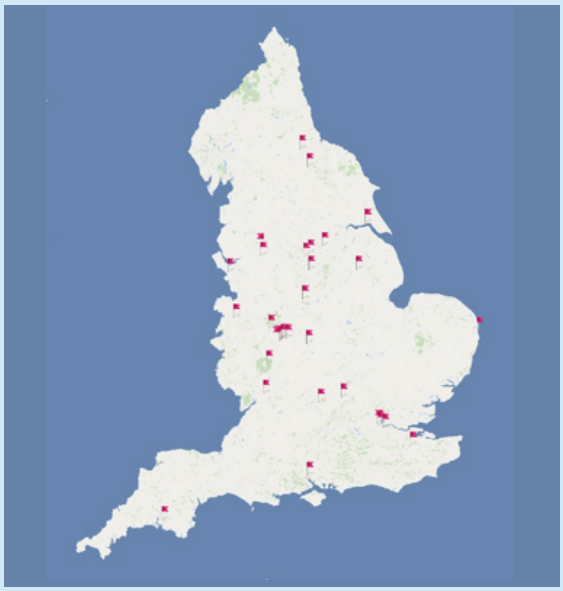


Figure 11: RePAIR education provider partners

Figure 12: RePAIR healthcare provider partners



RePAIR

RePAIR economic evaluation

HEE commissioned York Health Economics Consortium (YHEC) to carry out an economic evaluation for the RePAIR project. The economic evaluation sought to identify the costs of attrition-reducing interventions and to compare the costs of those interventions with the economic benefits. The objectives were to:

- Develop cost benefit analysis modelling to determine economic benefit from different interventions to reduce attrition;
- Conduct an analysis and summary of findings and assumptions to inform data analysis and economic modelling;
- Develop an accessible and intuitive economic modelling tool (the cost calculator) for RePAIR with an accompanying comprehensive user guide.

A pragmatic and iterative approach to the economic evaluation developed over the course of the project.

Attrition affects HEIs, that are training student nurses, midwives and therapeutic radiographers, and HCPs, that employ the newly qualified professionals. For HEIs attrition refers to the abandonment of education before completion; for HCPs it is the abandonment of employment early in the professional's career. For the purposes of the economic evaluation this has been taken to mean abandonment during the first year of employment.

HEIs and HCPs have been addressing the issues of attrition for many years and have developed various intervention programmes to tackle it. RePAIR identified four types of intervention that are in use and are designed to reduce attrition among HEIs and HCPs. These are:

- Buddying;
- Transition into practice;
- Preceptorship;
- Use of modern media.

These interventions are in place, in varying combinations, in a number of HEIs and HCPs around England participating in the RePAIR project.

Four of the RePAIR case study sites contributed to the economic evaluation, one from each of the HEE regions. In one region, two separate organisations, that work in close partnership, provided data on their programmes. Therefore, YHEC worked with five organisations across the four regions to gather data on the costs of the inputs to intervention programmes, or data that could be used to estimate the impact of these interventions on attrition.

Cost data
Input data was requested for each type of intervention programme that the participating organisations are running. For each intervention specific values were requested for: start-up costs, which are once-only costs incurred in the design and establishment of an intervention programme; and running costs which are incurred each year that an intervention is operational.

Benefits data
Representatives from the organisations were interviewed after the cost data had been submitted. The purpose of these interviews was threefold:

- To clarify any issues that were not clear in the data return;
- To give additional information on the interventions and how they are run;
- To provide data on the impact of their interventions in terms of whether attrition had reduced and, if so, to what extent.

Initially none of the organisations could provide data on the benefits of their intervention programmes. However, subsequently two of them provided some data which gave an indication of the impact of their interventions.

5 RePAIR Main findings

5. Main findings

The main findings of RePAIR are primarily drawn from the sources outlined in section 4:

- Understanding indicators of attrition
- Insight into the stakeholders' experience
- In-depth enquiry into improving retention

5.1 Understanding indicators of attrition

HEE, and its predecessor organisations, have historically collected attrition data as part of the contract and performance management process. Although these are generally consistent at a local office area, the processes and definitions that underpin them may vary. Given that the attrition from the six programmes in scope of RePAIR (four fields of nursing, midwifery and therapeutic radiography) may be calculated differently according to an organisation's preferred method of analysis (**see appendix 2** for different approaches), this data cannot be aggregated nationally to achieve a consistent dataset on attrition.

Pure attrition from HEIs

In the absence of a standard definition of attrition, HEE established a new and separate definition of *pure attrition*, solely for the purpose of the RePAIR project. As noted in section 4 of this report, *pure attrition* is the number of students who did not complete on time within the standard pathway for that programme, i.e. within three years for the majority of programmes. Student data for RePAIR programmes, for cohorts completing in academic years 2013/14 and 2014/15 was used to develop the attrition baseline reports for this project. All HEIs in England, which deliver these programmes, responded to the request to provide the following data based on unique student identifiers:

- **Number of starters**, i.e. the total number of students recruited to a given programme;
- **Number of non-completers**, i.e. the total number of students who withdrew or interrupted, for any reason, from the cohort to which they were recruited before the programme end date, including those who transferred out to other cohorts and programmes.

From this data the RePAIR pure attrition percentage for England was calculated, i.e. **Non-completers/ starters x 100**, as shown in **table 2**.

Except for dual qualification nursing where the numbers are very small, there was less than 5 percentage difference in attrition between the two intake years. Only for children's nursing, therapeutic radiography and dual nursing were numbers higher in 2014/15 than for 2013/14. The aggregated figure of pure attrition percentage (percentage who did not complete on time) shows that children's nursing has the lowest attrition and learning disabilities nursing the highest, and the overall percentage, across all programmes, who did not complete on time for these two years was 33.4 per cent.

Table 2 HEE national average pure attrition by programme for years 2013/14 and 2014/15

Programme, Completing Year	Starters (number)	Non-completers (number)	RePAIR Attrition % (Non-completers / Starters)
Adult nursing			
2013/14	10590	3725	35.17
2014/15	12118	3848	31.75
Aggregate	22708	7573	**33.35**
Children's nursing			
2013/14	1537	448	29.15
2014/15	1961	583	29.73
Aggregate	3498	1031	**29.47**
Dual qualification nursing			
2013/14	32	9	28.12
2014/15	59	21	35.59
Aggregate	91	30	**32.97**
Learning disabilities nursing			
2013/14	416	173	41.59
2014/15	530	197	37.17
Aggregate	946	370	**39.11**
Mental health nursing			
2013/14	2672	1003	37.54
2014/15	3222	1059	32.87
Aggregate	5894	2062	**34.98**
Midwifery			
2013/14	1827	614	33.61
2014/15	2335	675	28.91
Aggregate	4162	1289	**30.97**
Therapeutic radiography			
2013/14	202	63	31.19
2014/15	193	66	34.2
Aggregate	395	129	**32.66**

The data when further analysed by HEE region (figures 13 -18) for each of the six programmes (excluding dual qualification nursing) does not reveal, for the most part, any significant difference in attrition between the different parts of the country. However, there are some exceptions, mostly relating to London and South East:

- **Children's nursing:** London and South East and North attrition increased;
- **Learning disabilities nursing:** London and South East and North attrition increased;
- **Mental health nursing:** South attrition increased;
- **Therapeutic radiography:** London and South East attrition increased.

RePAIR

In the Spending Review and Autumn Statement 2015[6] it was announced that '*The Spending Review reforms the funding system for health students by replacing grants with student loans and abolishing the cap on the number of student places for nursing, midwifery and allied health subjects*'. Subsequently the monitoring for the health subjects affected by this reform now sits with HEFCE/Office for Students.

HESA Student Records Data – overall expected attrition after three years

Figure 13: Adult nursing pure attrition by HEE geography

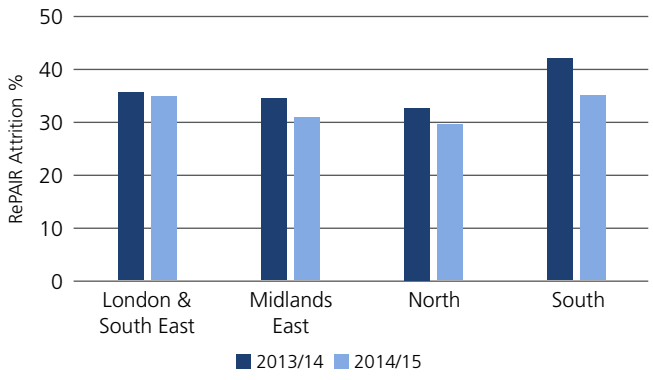


Figure 14: Chidren's nursing pure attrition by HEE geography

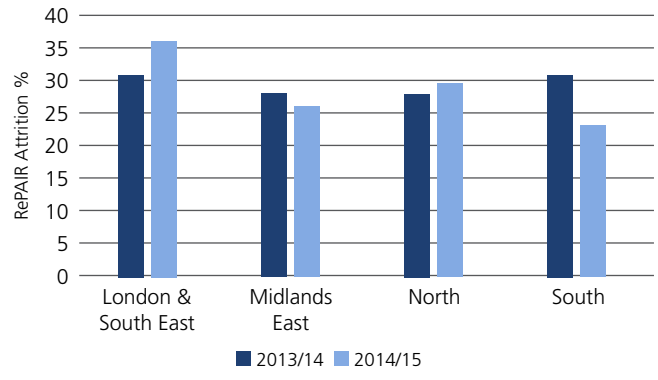


Figure 15: Learning disabilities nursing pure attrition by HEE geography

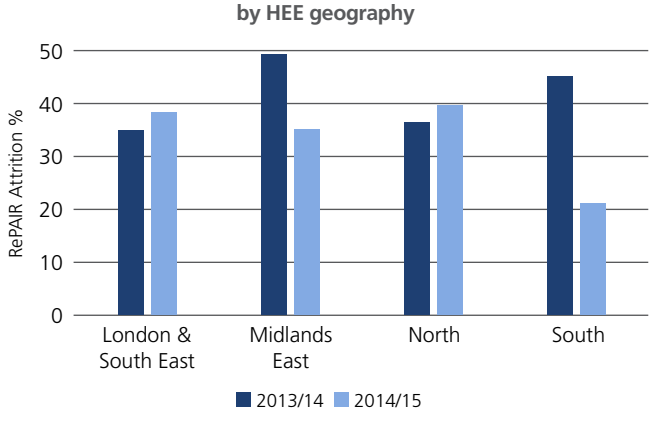


Figure 16: Mental health nursing pure attrition by HEE geography

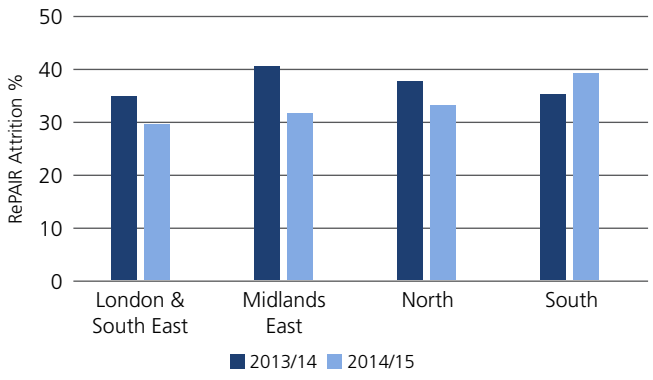


Figure 17: Midwifery pure attrition by HEE geography

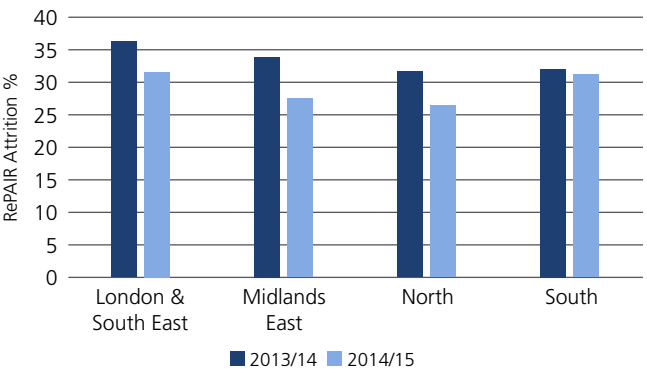
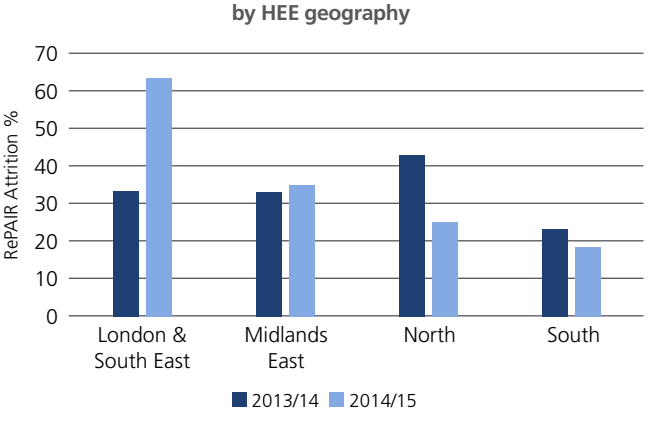


Figure 18: Therapeutic radiography pure attrition by HEE geography



RePAIR

Given that HEE no longer has a formal remit to undertake follow-up national data collections for professions affected by the reform, it undertook analysis using the HESA (Higher Education Statistics Agency) student record data. HESA collects information on all students (not just health) registered at an HEI, who follow courses leading to the award of a qualification or higher education provider credit, excluding those counted as studying wholly overseas. This data can be used to show an indicative trend of student numbers (the student population) across years. It also provides information on reasons for ending that 'instance' and the relevant academic year.

Further analysis was undertaken using a separate metric, observed expected attrition[v]. This was designed to be a high level indicative measure, based on observed trends of attrition over years of a programme. This aims to provide an indicative level of dropout expected after three years of a programme within a given cohort, on the assumption that total attrition will reflect total numbers dropping out within that timeframe.

HESA's student records dataset is nationally consistent, and pending full implementation of HESA's Data Futures programme in 2019/20, will be the mechanism through which HESA monitor and record details of student population.

However, there are a number of caveats with this data. The raw data counts the majority of records as 'unknown', and it is challenging to analyse year on year attrition within HESA's student record database, because of the number of years of data that is required for actual attrition to be reliably and properly assessed (see **appendix 3**). For the former point, we have assumed 'unknowns' do not drop out. For the latter, we have provided a crude and very high level estimate for observed expected attrition over three years of a programme. In practice, actual attrition is likely to differ, and may in fact be higher than reported here. This reflects the fact that even for programmes of three years duration, a number of students will often need longer to complete, meaning up to five to six years of data is required for accurate assessment. We therefore use observed expected attrition as an approximate assessment, in the absence of detailed cohort data.

Overall, the observed expected attrition for three years within the programmes, in scope of RePAIR, fell by approximately 40 percentage points for cohorts starting between 2009/10 and 2014/15, from 17.5 per cent to 10.5 per cent (**table 3**). Within nursing, the largest fall was in adult nursing (by 45 percentage points, from 17.5 per cent to 9.6 per cent). By contrast, observed expected attrition increased in learning disabilities nursing (by 8 percentage points, from 16.9 per cent to 18.3 percent). Observed expected attrition in therapeutic radiography fell by 57 percentage points, from 35.1 per cent to 15.1 per cent[vi].

Figure 19 on page 30 and **table 27** in **appendix 4** both show HESA's attrition trends, by year of programme, between 2009/10 and 2016/17 for the subjects in scope of RePAIR. Other than for learning disabilities nursing in year 1, there is evidence of a decrease in attrition over this period.

According to this data set, the attrition in year one, for all programmes in scope for RePAIR, is higher than in years two or three of programme. For example, in adult nursing, the attrition in year one of the programme for the 2009/10 intake was 9.7 per cent, year two 6.8 per cent, and year three 2.6 per cent. There is also consistent evidence that there has been a reduction in attrition or 'drop out' across all programmes by year of study from 2009/10 to 2016/17, except, as already noted, for learning disabilities nursing in year one, which showed a small increase in attrition from 7.4 per to 7.5 per cent[vii].

v Methodology for calculating observed expected attrition is available in appendix 3.

vi More detailed analysis is available in the appendix 4.

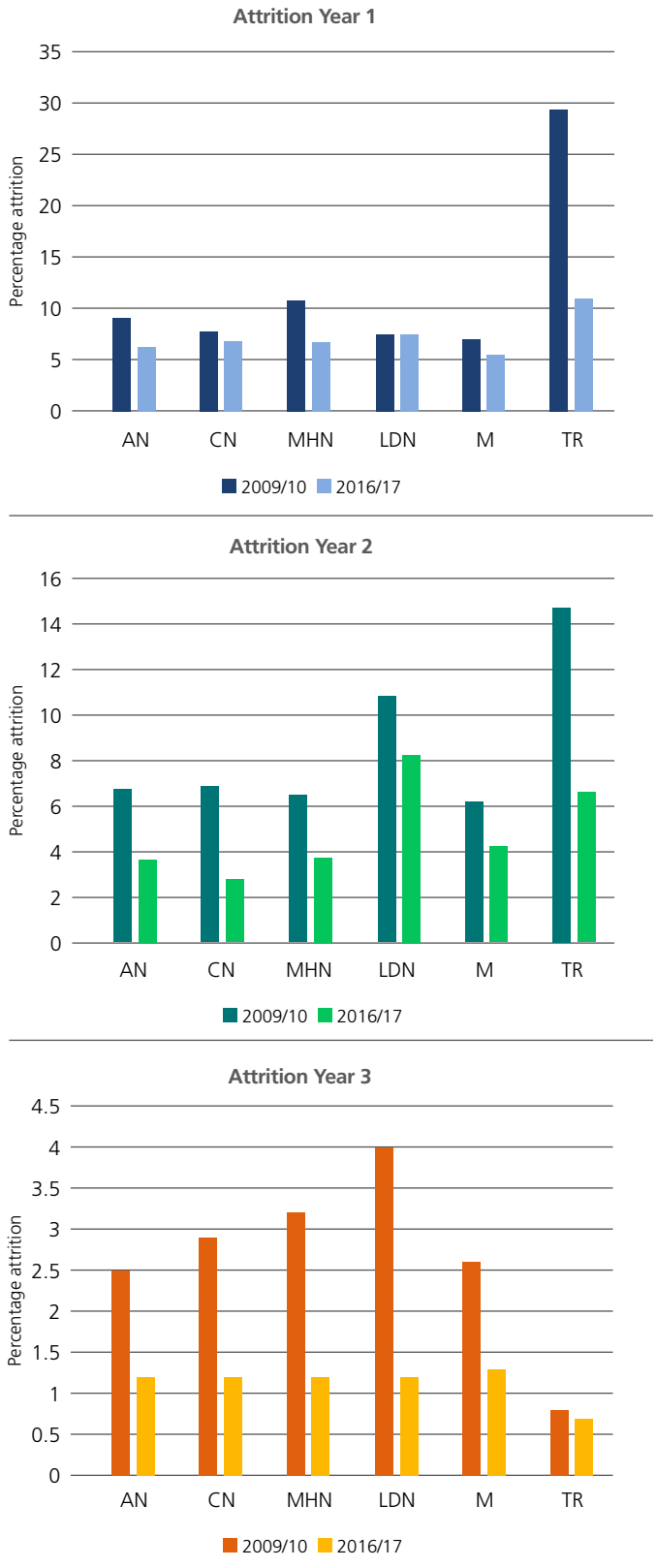
vii More detailed analysis is available in the appendix 4

Table 3: Observed expected percentage attrition by course, 2009-10 to 2014-15 cohorts

Expected attrition - Year of Programme									
Subject/Cohort	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	Trend	Average attrition	% change in expected attrition 2009-10 to 2014-15
Midwifery	15.0%	15.8%	14.2%	15.9%	12.1%	11.5%		13.6%	-23%
Nursing - adult	17.5%	16.4%	15.6%	13.6%	10.9%	9.6%		14.0%	-45%
Nursing - children	14.4%	15.5%	14.0%	13.1%	11.0%	9.9%		13.0%	-31%
Nursing - learning disability	16.9%	17.2%	19.2%	15.2%	14.8%	18.3%		16.9%	8%
Nursing - mental health	19.2%	16.3%	14.4%	13.4%	12.0%	12.9%		14.7%	-33%
Radiography - therapeutic	35.1%	28.3%	21.5%	19.7%	17.0%	15.1%		22.8%	-57%
TOTAL	**17.5%**	**16.4%**	**15.3%**	**13.6%**	**11.3%**	**10.5%**		**14.1%**	**-40%**

Source: HEE analysis of HESA student records, 2009-10 to 2016-17

Figure 19: Confirmed percentage attrition by year of programme (HESA student data intelligence)



Code: AN (Adult nursing); CN (Children's nursing); MHN (Mental health nursing); LDN (Learning disabilities nursing); M (Midwifery); TR (Therapeutic radiography)
Source: HEE analysis of HESA student records, 2009-10 to 2016-17

Accepting variation across programmes and individual years of study, these indicators reveal that percentage change improvements overall in years two and three of programme were in the region of 50 per cent across this timeframe (**table 4**).

Table 4: Average attrition by year of programme and percentage change in attrition by year of programme, 2009/10-2016/17

Year	Average % attrition 2009/10 to 2016/17 – Year of Programme	% change 2009/10 to 2016/17 – Year of Programme
1	7.3	-30.2
2	5.2	-44.2
3	2.1	-55.1

Case study data

To gather more information about the percentage of students who go on to complete their chosen course of study, the RePAIR team approached the case study sites. As previously indicated, HEIs do not use a standard format for collecting this type of information.

The following data has generously been provided by some of the partners in the HEE RePAIR case study sites to enable a greater insight into students' university and early career journeys.

Four HEIs submitted detailed data on student progression and completion for nursing and midwifery during the three year period 2012/13 to 2014/15 (**table 5**). At the time of collecting the data some of the completion information was not available and the students were recorded as having interrupted their studies.

From this small, but detailed data set, it is worth noting that the percentage of students who completed on time varied from 59 per cent (learning disabilities nursing and mental health nursing) to 70 per cent (midwifery). In keeping with the high level two thirds complete on time, the percentage that were either withdrawn, or elected to withdraw, ranged from 11 per cent (children's nursing) to 20.5 per cent (learning disabilities nursing).

The percentage that completed one year after the standard length of the course ranged from 7.5 per cent (midwifery) to 20.5 per cent (learning disabilities). Beyond this date there was very little reported variation in either the numbers that subsequently withdrew (2-3 per cent) or the number that finally completed (less than 1 per cent).

Table 5: Completion trends by course

Course	Number that started 2012/13-2014/15 incl.	Percentage that completed on time	Percentage that withdrew from the original cohort	Percentage that finally went on to complete one year later	Percentage that subsequently withdrew from later cohorts	Percentage that finally went on to complete two years later	Percentage not graduated at time of data collection
Adult nursing	**3462**	61	16	10	3	<1	9*
Children's nursing	1015	64	11	12	2	0	11*
Learning disabilities nursing	229	59	20.5	10	2	<1	7.5*
Mental health nursing	688	59	16	11.5	2	<1	10.5*
Midwifery	553	70	11.5	7.5	2	<1	8*

*Interruptions

Therefore, most students who experience an interruption complete their studies within a further 24 months of the standard pathway, a fact that is supported by the Council of Deans of Health (see Resources tab in the RePAIR toolkit access here).

Four HEIs provided information as to the reasons why students left the course. These are illustrated in **figures 20** and **21** according to whether they were deemed avoidable or unavoidable.

Figure 20: Unavoidable reasons for leaving

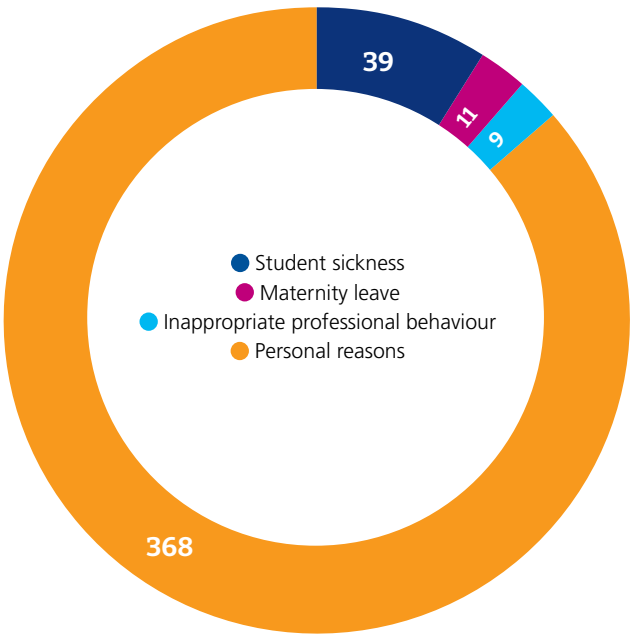
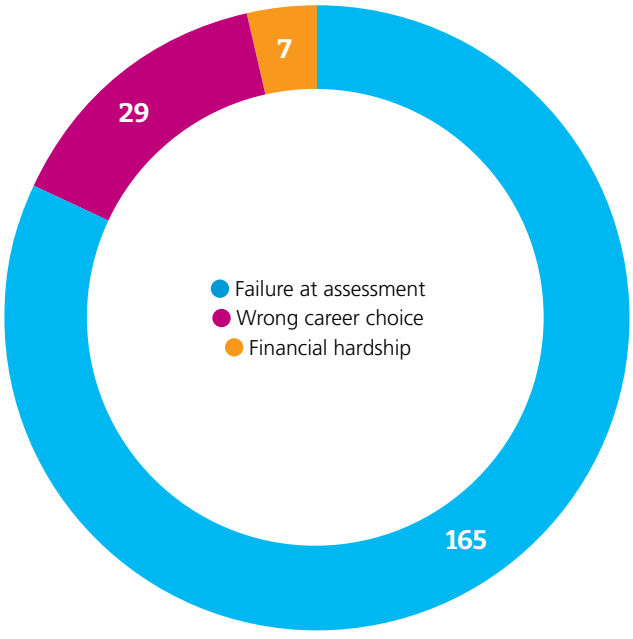


Figure 21: Avoidable reasons for leaving

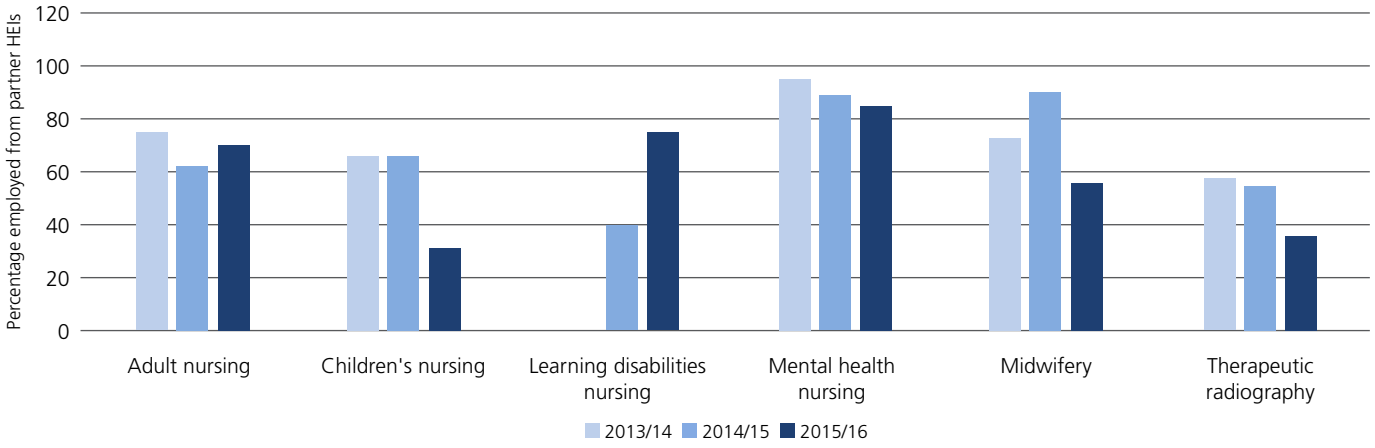


From this small data set it is shown that students primarily leave for personal reasons or failure at assessment. Historically HEE collected detailed reasons for leaving at institutional level, but the HESA dataset does not collect this level of detail as it is designed for all students not just those in health.

Six of the 13 HCPs reported that their partner HEIs provide transition into practice programmes for the students. Three of these HCPs advised that it is not available to all the students. Only six noted that they had been involved in designing these programmes. However, all 13 advised they recruit from their local HEIs, and three of them that they also proactively recruit from other HEIs.

A maximum of four HCPs per professional group provided data about the percentage of newly qualified staff that they recruit from their partner HEIs (**figure 22**). From this small data set the following trends are noted: a higher percentage of mental health nursing students gain employment in the partner HCP and the average percentage employment for both adult nursing and mental health nursing is relatively consistent.

Figure 22: Employment trends for three year period 2013/14 -2015/16



Although all 13 HCPs advised that they run some form of preceptorship programme only eight HCPs provided data. The length of the preceptorship programmes varies from four to 18 months. Only one HCP reported that their preceptorship programme had been designed in partnership with their local HEI. **Table 6** shows that the average length of time that the newly qualified staff stay in the trust after completing the preceptorship programme varies from nine -15 months and that the percentage who left during the preceptorship programme varies from 7 per cent (midwifery) to 15 per cent (therapeutic radiography).

Table 6: Preceptees pattern of attrition

Course	Average length of time after completing the preceptorship course the newly qualified staff left (months)	Total number who took the preceptorship programme during period 2013/14-2015/16	Percentage who left during the programme (2013/14 -2014/15)
Adult nursing	13	2106	14
Children's nursing	14	395	8
Learning disabilities nursing	NA*	14	NA*
Mental health nursing	NA*	169	9
Midwifery	9	271	7
Therapeutic radiography	15	39	15

*Not available

5.2 Insight into the stakeholders' experience

This section of the findings chapter is set out according to the main stakeholder activities:

- National student survey
- Focus groups with students
- Focus groups with newly qualified practitioners
- Discussions with academics
- Discussions with clinical educators

5.2.1 The national student survey

The student survey invited responses across a range of survey statements - a copy of the survey is available via the resources tab of the RePAIR toolkit and the questions are also available in **appendix 1**.

The findings from the survey are presented as follows:

1. Profile of respondents
2. Personal reflections on the course
3. Application process
4. Introduction to the academic and placement learning
5. University-based learning
6. Placement-based learning
7. Personal circumstances
8. Future career

The findings are presented in an order that enables the reader to appreciate the positive messages before reading on to understand what the sector can do better.

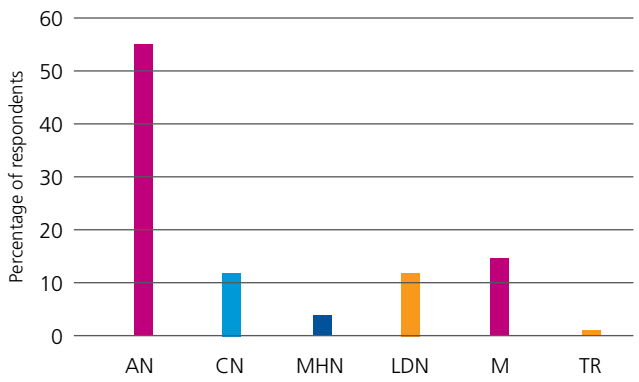
The data was primarily collected using a 4 point Likert response scale (strongly agree, agree, disagree and strongly disagree) and free text comments. The quantitative responses to the survey statements are recorded in **appendix 1**.

1. Profile of respondents to the survey

A total of 3447 students responded to the survey. The percentage of respondents by field of nursing, midwifery and therapeutic radiography is illustrated in **figure 23**. This number and spread of responses means a low margin of error (approximately 2 per cent) and a representative population. The breakdown of responses by HEE region (see footnote iii page 20), which vary in size, numbers of HEIs and numbers of students, is also representative of the total number of students in training as shown in **figure 24**.

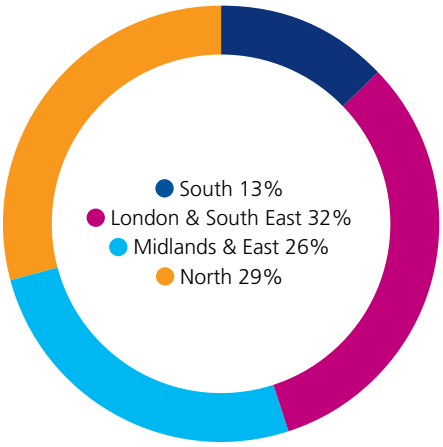
The responses by academic year of study were evenly distributed: 35 per cent year 1 students; 33 per cent year 2 students and 31per cent year 3 students. Very few respondents were supported by an HCP employer with only 6 per cent seconded from NHS employment and 2 per cent on a training contract. 58 per cent were aged between 17 and 25, and 9 per cent aged over 40 (**figure 25**).

Figure 23: Percentage of survey respondents by programme of study



Code: AN (Adult nursing); CN (Children's nursing); MHN (Mental health nursing); LDN (Learning disabilities nursing); M (Midwifery); TR (Therapeutic radiography)

Figure 24: Distribution of respondents by HEE region



91 per cent of the respondents were female, 12 per cent reported 'other language' as their first language and 10 per cent noted their national identity was not as a British Citizen with 26 per cent BAME (British English black, Asian and minority ethnic, **figure 26**).

Figure 25: Percentage of respondents by age group

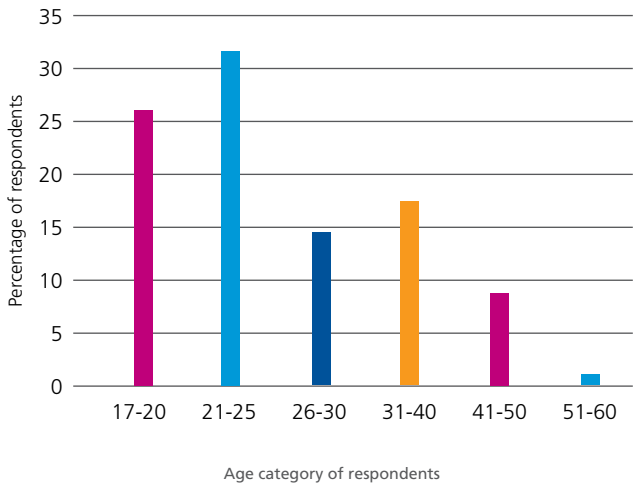


Figure 26: Respondent ethnicity

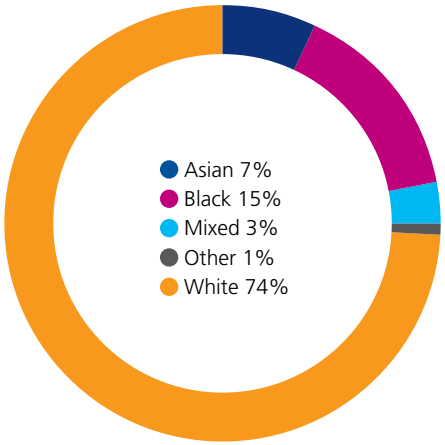


Table 7: Respondents' age, ethnicity and national identity profiles by gender

Gender	n	Age: % of respondents aged over 30	Ethnicity: % Black, Asian or Minority Ethnic (BAME)	National identity: % not from UK	National identity: % English not as first language
Male/other	**356**	47	44 [viii]	18 [ix]	20
Female	3,121	25	24	9	11
MEAN	3,477	27	26	10	12

There were some noticeable significant differences between survey respondents based on gender (**table 7**). Male respondents' were more likely to be aged over 30 (47 per cent, versus 25 per cent for women), from a BAME background (44 per cent, versus 24 per cent for women), and from outside the UK (with 20 per cent not having English as a first language and 18 per cent coming from outside the UK).

A high level breakdown of respondents' UK qualifications is listed in **table 8**. 57 per cent of the respondents advised they have at least two A-level qualifications or equivalent; 31 per cent an NVQ Level 3 or equivalent and 17 per cent hold a first degree.

Table 8: Respondents' qualification classification

Qualification group	Number of responses
2+ A-levels or equivalent	1973
Apprenticeship	95
Apprenticeship and 2+ A -Level or equivalent	47
Foreign qualifications	181
Degree	590
PhD	1
Access to Healthcare	180
NVQ Level 3 or equivalent	1055
Other	458

The range of foreign qualifications that the respondents disclosed are wide and varied and include qualifications from Africa, North America, Ireland, the Caribbean and Europe (mainly Spain and Poland).

A review of the impact of the key variables on the survey findings suggests that region had minimal effect on responses, and is not a significant explanatory factor in the results. Similarly, gender did not have a significant effect on results. This suggests that despite the demographic difference between male and female student respondents, it is not a significant explanatory factor.

[viii] *Significantly different from the mean at 1% level*
[ix] *Significantly different from the mean at 5% level*

2. Personal reflections on the course

The respondents were asked to reflect on whether the programme meets their needs and whether they knew at the start of the course what type of clinical service they wanted to work in. The responses were very positive; 86 per cent reported that the programme met their expectations, 85 per cent that it is appropriate for their learning needs and 87 per cent would recommend their course to friends or family. The first year respondents were significantly more likely to want to work in the same clinical service, as they did prior to enrolment (63 per cent). First year students were also more likely to recommend the course to family and friends (96 per cent) than third year students (80 per cent).

Just over half of all the respondents (56 per cent) stated they were clear, before enrolling on the course, what type of clinical service they wanted to work in and a similar number (52 per cent) advised that they still want to work in that clinical service.

3. Application process

The findings, relating to the application process, are mostly very positive: 91per cent considered the application process to be straight forward; 93 per cent reported that the existing students they met, at open day, were very encouraging about the course and 84 per cent found the information that the university provided was very good.

The respondents also reported that the following factors were important to them when applying for a course:

- securing a place at their university of choice (97 per cent);
- the course is delivered equally by university and HCPs (97 per cent);
- the teaching and research reputation of the university (88 per cent).

62 per cent reported that visiting a clinical placement prior to starting the course was very important. 23 per cent strongly disagreed that the social life of the university was the most important criteria when choosing a course. However, male students were more likely (42 per cent, compared to 33 per cent overall) and respondents from a BAME background, significantly more likely (30 per cent, versus 18 per cent overall), to choose a university based on the social life.

63 per cent of these respondents, all of whom were in receipt of an NHS bursary, stated that they would not have applied for the course if they had to pay course fees. When further analysed by region and age, the data revealed that 70 per cent of the students studying in London and the South East compared to 50 per cent studying in the North of England would not have applied for a course if they had to pay fees. Unsurprisingly the age of the respondents influenced their view on paying fees. The older the students the less willing they are to pay fees to study these courses: 44 per cent of the 17-20 year olds, when compared to 76 per cent of 26-30 year olds, and 78 per cent of those aged 41 and over.

The students' free text comments, about the application process, were thematically analysed and clustered into positive and negative comments. It is important to recognise, as with all surveys, respondents are more likely to comment on aspects that they view as less positive, consequently the positive comments are relatively more significant. Three positive themes emerged:

- A simple, high standard application process where decisions are made quickly encouraged prospective students to progress their application;
- Applicants are motivated by both clinical placement and HEI opportunities;
- Meeting existing students at open days is very helpful.

> ***'The most important criteria in choosing my current University were NHS Bursary, reputation, placement providers, distance from my current residence.'***
>
> **2nd year adult nursing student – Midlands and East**

There were many more comments that were less positive, these were analysed into the following themes:

- The application process was lengthy, difficult and confusing;
- Limited choice of university;
- Lack of information about the clinical sites;
- Application process did not cater well for mature students;
- Clearer assessment processes;
- More availability of pre-application clinical experience;
- Quality and quantity of the information provided could be better.

4. Introduction to academic and placement learning

The findings in response to the group of statements about the introduction to academic and placement learning were also mostly positive. 89 per cent agreed that they had sufficient information about the course, that the length of the first clinical placement was appropriate and they could feed back concerns to the university. Other positive findings included the fact that HEIs effectively actioned feedback (78 per cent) and the students reported being supported during their first clinical placement (83 per cent) with no difference in experience by region or age.

> ***'First clinical placement is a community placement. Instead I feel it would be more beneficial to undertake a 24-hour care placement to gain practical skills.***
>
> **Learning disabilities nursing student - South**

However, there were some notable concerns. Firstly, an average of 27 per cent of the respondents reported that their mentor was hardly ever on the same shift as them: 31 per cent in London and the South East to 22 per cent in the Midlands and East.

Secondly, fewer than a third of the students reported being buddied with a more senior student at the beginning of the course. When studied by region, 42 per cent of the students studying in the South reported having a buddy at the beginning of the course compared to 30 per cent in the Midlands and East. Over half of the respondents, who reported having a buddy, agreed that the 'buddy' was important in helping them to settle into the course. Worthy of note is that male students (27 per cent, versus 19 per cent overall) and respondents from a BAME background (30 per cent, versus 18 per cent overall) were significantly more likely to highlight a 'student buddy' as being key to settling in.

The concept of support from a 'buddy' attracted comment, for example: '*I think that a buddy system involving more senior students pairing with new students should be made compulsory rather than optional for nursing degrees*', third year children's nursing student.

Qualitative comments were mostly in relation to introduction to placement and ranged from really positive to concerning. Examples of really positive comments were: '*I feel I have been eased into placement gently, starting with induction and some short shifts and with lots of support*', first year children's nursing student, and '*It was amazing how the old students gave us assistance and encouraging support*', first year adult nursing student.

A less positive comment was made by a third year learning disabilities nursing student: '*personally I didn't feel prepared to embark on my first placement, maybe having a buddy or even just a chat from a more senior student would have been beneficial*', and a concerning comment by a third year adult nursing student: '*I would have liked an idea of what was expected of me on my first placement, rather than being sent in "blind"*'.

One first year student on a dual award programme noted, because they had never been to university before, the whole experience was a shock and added that '*additional practical sessions prior to commencing placement*' would have been beneficial.

The few comments about the introduction to academic learning, were similarly balanced. A third year children's nursing student explained: '*I found it useful that we had an introduction module to ease us in, however not all of its elements were necessary*' and a second year adult nursing student noted '*I felt that at the beginning of the first year it took a while to actually get into the content of the course*'. Another second year adult nursing student pointed out that '*so much thrown at you and never sure what to focus on or how in-depth. As a result, the first placement was traumatic as too much of the learning depended on the mentor*'.

One student (**box 3**) summed up many other respondents' views about introduction to academic learning.

Box 3: A student's suggestion about induction prior to enrolment

'I think that my university needs to provide a longer induction process for students. We should be welcomed to the university and introduced to buddies once we have obtained a place, not once we have obtained our grades. Students need to be welcomed into the culture of the university. Furthermore, HEIs need to encourage and allow their students to form councils, become involved in their student unions and engage with the faculty, becoming a part of the decision-making processes if they are to retain students, make them feel they have a voice and avoid poor National Student Survey feedback.'

3rd year adult nursing student

5. University-based learning

93 per cent of the respondents reported an overall positive experience with their university-based learning. 92 per cent stated that the online resources are really good, 88 per cent that the PowerPoint presentations are informative, and 85 per cent thought the course documentation is good. The students advised that the academic staff are helpful (88 per cent) and have a high teaching standard (86 per cent), also that their personal tutors are supportive (81 per cent).

From the student point of view, the area they identified as needing improvement is the organisation of the programme (68 per cent). Approximately two thirds of the students reflected on the fact that the academic workload was rather a shock at first (68 per cent) and that feedback on assessments was not helpful (31 per cent). One third noted that they sometimes struggle to complete the course work on time (35 per cent), particularly those from a BAME background who were significantly more likely to report struggling to complete work on time (45 per cent, versus 36 per cent overall).

The respondents commented extensively on their experience of university-based learning. The comments are broadly differentiated into the following themes:

5i. The university and academic staff
5ii. The course
5iii. Course related pressures
5iv. Personal tutors and student support

5i. University and academic staff

82 per cent of the written comments about university were positive. The two sets of comments below illustrate how much the students value the commitment of the university and staff to them and their programme of study:

'*I am thoroughly enjoying my time at university as a student nurse, and I think my university has exceeded my expectations and beyond.*' 3rd year adult nursing student

'*The children's nursing lecturers are so supportive and always put 110% into everything they teach us. Even in difficult times they were there to support us and get us through the tough times.'* 3rd year children's nursing student

However, not all students reported such an encouraging encounter as illustrated below:

'*At times it feels as if the university will happily sacrifice quality over the quantity of students they will pass.'* 2nd year adult nursing student

5ii. The course

There was a total of 160 students' comments, about their experiences of certain aspects of the course: the organisation (55), the lectures and seminars (52), the standard of teaching (26) and resources (27).

Most of the comments in this section, related to individual student's frustrations about how disorganised the course is and the impact it has on their studies and their overall experience (**box 4**).

Nonetheless, some students presented a more balanced account of their experience regarding how well their course was organised, as illustrated in this comment by a second year therapeutic radiography student: '*Only certain modules are disorganised. Some modules are really well structured and you know exactly what you need to do, other modules are not so*'.

The comments about the lectures ranged from the really positive: '*I like all my lectures, excellent content*' (first year adult nursing); to the mixed: '*some teaching is fantastic, but other lectures could be improved*' (second year adult nursing); to the more worrying: '*the teaching at my university has been abysmal. I came here because of the reputation; I feel totally let down*', (first year adult nursing student). Students favour the seminar and the small group learning as they offer an opportunity for debate and interaction.

Box 4: Examples of students' views about course organisation

3rd year adult nursing student - London and South East

'From first year to my third and final year my university has been very disorganised in terms of timetabling (short notice changes) and inconsistencies.'

2nd year children's nursing student - Midlands and East

'Multiple lecturers have dropped out throughout the course of our degree. This puts a lot of strain on other staff and students as everything becomes very disorganised.'

2nd year mental health nursing student - London and South East

'The programme does feel a bit disorganised. It's my second year, we are doing hardly any work and we are unable to start our assignments because they are related to practice placements. The tension is building up in anticipation of what is to come in January, when placements and assignments will all come at once. To be honest, I am dreading it.'

1st year postgraduate diploma pre-registration mental health nursing student – London and South East.

'Many of the teaching staff were unsure as to how the PGDip version of the course ran which lead to it feeling very disorganised.'

2nd year midwifery student – Midlands and East

'The timetable is disorganised, this year we have not been allocated a room correctly once!'

3rd year midwifery student London and South East

'University-based learning is often extremely disorganised with timetables not being sent through or updated until the eleventh hour. This often frustrates us and adds to the other stresses of the course.'

HEIs make it very clear, at the outset, that university education is mostly self-learning with lots of guidance. The resources available to support this education model are key to the students' commitment to the course. The students were critical of lecturers who '*read from the slides*'.

This third year adult nursing student summed up the situation on behalf of her fellow students: '*Reading from lecture slides has also caused many within my year to become disengaged from the process which I feel has affected retention because they felt like they were not being taught*'.

5iii. Course related pressures

There were 57 comments about the pressures of being on the course: workload (n=25), the personal struggle and stress (n=21), travel difficulties (n=4), financial challenges (n=4) and poor communication (n=3).

The course workload pressures are not programme specific, year specific, or HEE region specific.

> ***'The emotional and financial aspects have been a shock to the system and I have contemplated leaving the course numerous times due to having no family time.'***
>
> **3rd year midwifery student - North**

For some the workload is relentless: '*The workload is hard and feels as though it never stops*' third year adult nursing student. For others it can be a trigger to consider leaving the course: '*I nearly quit after the first week at 'uni' because of the workload. I could have really done with either less of an overload in that first week of learning or more reassurance that it was very doable*', first year therapeutic radiography student.

Some of the students reported that undertaking academic assignments while on clinical placement is very demanding (**box 5**).

Box 5: A sample of students' comments about academic workload while on placement

3rd year therapeutic radiography student - Midlands and East

'I cannot fault the lecturers, they have been brilliantly supportive and informative across the three years. However, the academic workload is overwhelming, and with all the placement hours that we have to take part in makes it extremely difficult to stay on top of the work, this is exceptionally problematic as I have to do a 100 mile round trip to my clinical site, which adds an extra 3:00 hours to my day.'

3rd year midwifery student – North

'The workload is not well staggered in 2nd and 3rd years. The demands of working full-time on placement whilst trying to complete assignments makes this more difficult.'

3rd year Learning disabilities nursing – South

'The academic workload on top of clinical placements is incredibly stressful and difficult and I do not feel academics at university realise this. I do not feel students mental health/ stress levels are taken into consideration when designing this course.'

21 students chose to comment on their personal struggle and the stress of being on the course: the competing demands of family and student life; the difficulty of understanding the science elements of the course without a science background, and the academic model that assumes adult independent learning.

Other respondents complained about the poor communication between the university and the students, the distance they are required to travel between university sites and personal financial pressures.

5iv. Personal tutors and student support

The level of student support is very important. The respondents reported a very varied experience of support ranging from '*loads of support*' (first year adult nursing student) to '*we have lost 12 of our 47 students due to the lack of support*' (second year midwifery student).

Personal tutors are particularly important and reported as central to the students' success on the course. As one third year children's nursing student explained, '*my academic advisor has been, and continues to be, fantastic, helping me to progress personally and academically. A very supportive, understanding and empathetic person*'. Unfortunately, not all students receive such good support and some have reported having many different personal tutors, tutors who are unapproachable, or worse still personal tutors who are unavailable.

> ***'Supportive, enthusiastic tutors & environments really do make a difference!***
>
> **2nd year midwifery student - North**

6. Practice-based learning

There were 17 statements in the survey about practice-based learning (**appendix 1**). The statements ranged from the clinical experience, including statements about the clinical staff; to the support from the university staff while on placement and to the location of the placement itself.

There were some very positive responses about the clinical learning experience with 85 per cent of the respondents reporting that the clinical placements are of a high quality and a good learning environment. 62 per cent stated they have enjoyed every single placement and only 12 per cent thought they had attended the first clinical placement too early. 80 per cent agreed that the staff on the ward are committed to their chosen career and 77 per cent that they felt supported while on clinical placement. However, fewer (67 per cent) agreed that the amount of thought, care and consideration that has gone into looking after students was impressive.

The students were equally divided as to whether the mentors or practice educators had time to teach them (50 per cent), and 45 per cent stated that the mentors are flexible about shift start and finish times as long as the mandated clinical hours are covered. The data showed that male students are significantly more likely to get permission, from their mentor, to adjust shift start and finish timesto allow for travelling (55 per cent, versus 45 per cent overall). It is encouraging to note that 66 per cent reported that they are respected while on placement, although, of concern is the fact that 65 per cent reported that their perception is that they are being used as 'an extra pair of hands'.

Two thirds reported that the visiting lecturer was really helpful (64 per cent) and gave them good advice (66 per cent). A quarter of the respondents noted that they are struggling to complete the practice assessment documentation (25 per cent) or are confused about the principle of the sign-off mentor (28 per cent).

Students were less complimentary about placement allocations. 47 per cent stated that placement allocation is a problem as there seems to be no consideration for where the students live. This can result in long days when the travelling time is added to the duration of the shift (63 per cent). Consequently 66 per cent would like to choose the placement location.

The importance, to the students, of the clinical placement experience is evident from the large number of qualitative comments that the students chose to make. These comments have been carefully analysed and collated as follows:

6i. Comments about the clinical placements
6ii. Comments about the mentors
6iii. Comments about HEI placement related matters

6i. Comments about the clinical placements

On balance there were fewer positive comments (102) about the clinical placements, than negative comments (156). However, 199 students wrote balanced general comments about their clinical placement experience for example: *'I struggled on my first placement, but the other two have been great - brilliant mentorship and I felt respected and part of the team'* (second year children's nursing student).

> ***'Placements are a complete lottery. Some of them are fantastic learning environments, while others are struggling to provide sufficient care let alone accommodate students.'***
>
> **3rd year mental health nursing student – London and the South East**

Students explained that clinical placements vary considerably. As one second year mental health nursing student described, '*the amount of time and energy the mentors give you and their genuine interest in your learning varies a lot*'. Some commented that all their placements have been different and that it was often down to luck whether they had a 'good' placement experience or not. Overall the community setting is better at supporting students than the acute wards, simply because of the workload. However, it was pointed out that students themselves make a difference; '*individual student's personality can make a great difference with regards to their learning experience and the extent to which they are accepted into the team*' (third year mental health nursing student). The variation in clinical placement experience that a student can have is summed up in the quote in **box 6**.

Box 6: Variation in clinical experience

'First placement was excellent and I couldn't fault it, but the second was dis-heartening, no time for students, treated as a healthcare assistant, no support at all, some nurses had no respect for me as a student and refused to let me watch or do anything! But three nurses did, so I made sure I followed them whenever possible. When qualified I will not be applying for a job at that hospital.'

2nd year adult nursing student – Midlands & East

Students based in all four regions chose to make unprompted positive comments about their clinical experience (**box 7**). The respondents really valued the clinical experience and it is clear from their comments how motivated they are by inspirational teaching and staff who are committed to facilitating learning opportunities.

Box 7: Examples of good clinical experience

2nd year mental health nursing student – North

'All my placements have been super supportive and really want to teach you as much as they can whilst giving you independence.'

3rd year adult nursing student – Midlands and East

'In my experience all four of my clinical placements so far have been excellent and have exceeded my expectations every time.'

1st year midwifery nursing student – London and South East

'The clinical placement staff were amazing and have made my experience so far amazing! I can't thank them enough for all they have done.'

3rd year adult nursing student – South

'All my placements have been great, even if I didn't think I would enjoy them before I started. They opened my eyes and I believe I will be qualifying with a great all round knowledge'.

The students were very clear about the negative aspects of clinical placements. They frequently commented on the complex and overwhelming challenges they face in the current clinical environment: staff shortages and low morale; students' learning not a priority. As one third year therapeutic radiography student explained, '*currently, it is difficult to learn much on placement, which is why some students start to feel lost and develop gaps in their knowledge, especially in the longer placement blocks, because of the lack of teaching on placement*'.

The current drive to increase the number of students in training can result in students being 'sent' to placements that only offer very limited learning opportunity, or situations where there are too many students and not enough mentors to support them. 20 respondents conveyed their concern that they are worried about being a burden or a nuisance to already busy clinical staff. For example: a second year adult nursing student observed: '*I often found that some members of senior clinical staff see students as a burden and often react quite rudely to them*'; and a third year midwifery student commented: '*It was clear the students were seen as a bit of a nuisance and something the clinical staff didn't have time for*'.

> ***'We are used as an extra pair of hands which is understandable, Patients come first, but I felt my learning was put on the back burner.'***
>
> **1st year adult nursing student – North**

More than 120 students commented on the fact that they are used as extra staff, often in the role of a healthcare assistant. Not all students think this a bad thing and some recognise the experience this gives them, as one second year therapeutic radiography student explained: '*Although I agree we are an extra set of hands, this is sometimes in a good way and makes me feel like a valued member of the team*'. However, the majority who commented do not agree with this sentiment and some found it very worrying, as a third year learning disabilities student nurse explained, '*At times I was used as an extra pair of hands when short staffed and this caused anxiety as I did not always feel I had the knowledge required*'

Some students commented on the fact that they are told by the university staff that they are supernumerary as they not employed by the HCPs, nonetheless, they are told informally by the staff to take clinical responsibility for a patient.

A third year mental health nursing student explained that in their trust '*they are never supernumerary. I've provided specialist nursing care to patients so many times whilst being a student*'.

> ***'It is very dependent on where you are placed but, there is sometimes a culture out there that students are there to do all the little jobs the staff don't want to do: "This patient needs escorting where's the student? they can do it". This leads to the view that students do all the jobs that no one else can be bothered to do or they're just happy to get us out of the way for a while, we sometimes feel like a burden.'***
>
> **2nd year adult nursing student – Midlands and East**

Other respondents expressed concern about losing valuable clinical learning time. A second year adult nursing student shared her experience and stated '*I was never supernumerary on one 7-week placement. These placements were neither a learning experience nor a pleasant experience. I was deprived of proper breaks and used as free labour*'.

The impact of the relentless clinical workload on the staff did not go unnoticed and students reported some staff actively discouraging them from continuing to pursue a healthcare career. An example of the type of conversations that students recounted is in **box 8**

> ***The teams in which we are placed are in demand and this means that teaching students is not a priority.'***
>
> **3rd year learning disabilities nursing student – North**

> ***'Staff morale is low, which impacts on our learning experience.'***
>
> **3rd year children's nursing student - North**

Box 8: Example of how demotivated some clinical staff are

'I frequently come across colleagues who absolutely love what they do but, are so tired and drained due to poor staffing and poor pay that they are leaving the profession. Recently a nurse said to me "I love what I do but, if my daughter wants to do nursing I will not let her because the job is too stressful now, with little pay to show for all that stress". I couldn't help but agree partly with her. She also said to me "it's not too late for you to change your mind. If I were you and I knew what I know now I would leave and find another career". It saddens me that many vital people are being pushed out of the career.'

2nd year adult nursing student – Midlands & East

6ii. Comments about the mentors

A total of 200 students chose to write comments about mentors: the importance of mentors; the extent to which they help or hinder the student's learning and the mentor's commitment to supporting the students as summed up in **box 9** on the next page. A first year student midwife explained that '*mentors make or break your experience*'. However, not all mentors realise the impact they have on the students.

Box 9: Importance of mentors' commitment to student learning

'Placement experience depends on where you are placed and who your mentor is. If they are willing to teach, and you can build a respectful, trusting relationship which can help a student develop so much. However, if a mentor and ward staff aren't welcoming it can prove detrimental to your experience and confidence!'

3rd year adult nursing student – London and the South East

72 students reported positive experiences of working with their mentors: their mentors were very supportive, they teach them a great deal and were well informed about the course. A representative sample is illustrated in **table 9.**

Table 9: Examples of students' positive experience of working with mentors

Comment	Student Group	Region
'I have had some very positive experiences - some mentors have been fantastic and I have felt part of the team.'	2nd year midwifery student	North
'All of my mentors have been well educated on what is expected of students throughout different levels of training and therefore have helped me achieve all of my competencies. My placement educators have always given prompt replies when I have emailed them with any issues.'	3rd year mental health nursing	North
'The mentors I have had have been very supportive and eager to share their knowledge with me.'	3rd year mental health nursing student	Midlands & East
'I have been lucky enough to have superb mentors who are worth their weight in gold and taught me heaps.'	2nd year adult nursing student	Midlands & East
'Some mentors try their very best to help teach you and support you.'	2nd year midwifery	London & South East
'The majority of the time my mentors have been amazing.'	3rd year children's nursing student	London & South East
'All my placements have been super supportive and really want to teach you as much as they can whilst giving you independence.'	2nd year mental health nursing student	South
'I have had very positive experiences and have had excellent mentors.'	3rd year midwifery student	South

An almost matched number (n=67) reported disappointing experiences when working with mentors. It is important to note that 51 per cent of these negative comments (n=33) were from students on adult nursing programmes and 30 per cent (n= 20) were from midwifery students. Given that 55 per cent of the survey respondents were adult nursing students and 14 per cent were midwifery students this finding suggests that midwifery students have a more disappointing experience when working with their mentors than the other groups in RePAIR. The percentage regional responses are well matched to the overall survey regional responses suggesting that there are no regional differences in terms of students' negative encounters with mentors. A representative sample of negative comments about working with mentors is illustrated in **table 10**.

Table 10: Examples of students' negative experience of working with mentors

Comment	Student Group	Region
'Many mentors clearly do not want to be mentors. They're busy and they don't want the hassle.'	Adult nursing	London & South East
'Some mentors are the nastiest of bullies.'	Midwifery	London & South East
'They leave your books until the day you finish and then complain about completing them. Some mentors really don't have a clue what to do with students.'	Mental health nursing	Midlands & East
'I find the mentors are not happy in the profession and complain the majority of the time. I have also been actively encouraged to not become a midwife. My first placement in a hospital setting was very negative and the staff went out of the way to belittle me.'	Midwifery	Midlands & East
'When I tried to talk to my mentor she said "you are a 2nd year and you need to find your own opportunities to learn".'	Adult nursing	North
'As the nursing role has expanded, mentors have struggled to teach, particularly in areas where there is more than one student or there is a high levels of sickness.'	Learning disabilities nursing	North
'Mentors make you feel like a nuisance.'	Midwifery	South
'I have seen mentors out in practice not interested in educating students.'	Adult nursing	South

Students are very concerned that the mentors simply do not have time, in a busy clinical setting, to spend with students and that often they both have to stay, after the shift has finished, to go through the practice assessment document. **They repeatedly requested protected time for the mentor to teach them.** Several (n=41) chose to comment on the practice assessment documentation (PAD) and pointed out that the volume of work associated with the PAD exacerbates an already difficult situation, either because the mentors are not familiar with the particular PAD or because the sign-off mentor is not available.

6iii Comments about HEI placement related matters

110 students reported that they have never been visited by a tutor or link lecturer while they have been on a clinical placement, as one third year adult nursing student explained '*I have never had a visit from a visiting lecturer while on placement*'.

Figure 27: Percentage of students not visited by tutors by region

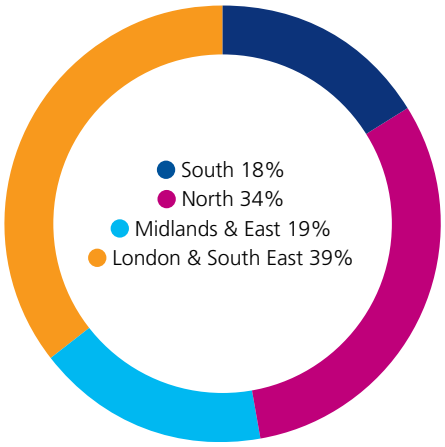


Figure 28: Percentage of students not visited by course tutor by programme

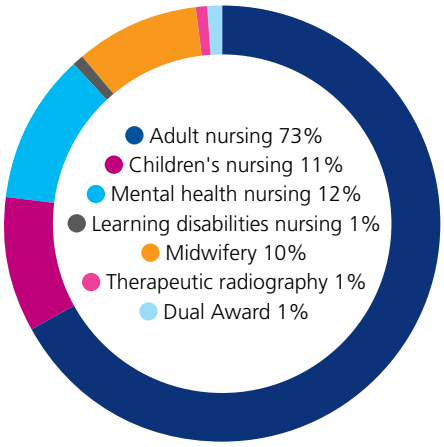


Figure 27 illustrates that the region has no impact on whether the students are visited in practice. However, given that 55 per cent of the respondents, to the student survey, were from adult nursing and 66 per cent of these comments (n=73) were from adult nursing students (**figure 28**), then a relatively higher percentage of adult nursing students reported not being visited by somebody from the university while on placement.

The comments about whether the students are supported by the university staff, if they have a problem while they are in clinical placement, were balanced between positive comments stating that they knew they could contact the university if they had any concerns; and comments asking for more support from the university while on placement for example: '*support from the university is poor during most placements*' (third year adult nursing student from Midlands and East).

There were 41 comments recorded about placement allocation. Students understand that they do not get a choice as to where they are allocated,

> ***'Staff most definitely do not have enough time for students due to their large workload.'***
>
> **2nd year therapeutic radiographer student - North**

although, as noted on page 40, 66 per cent would like to have this opportunity. However, they noted that the organisation of placements could be improved, particularly giving the students sufficient notice to be able to organise their personal lives; acknowledging those who already have extensive experience in an area, and providing support for those students who will be isolated from fellow students and family members while on placement. The comment in **box 10** summarises these views. Worthy of consideration by the clinical placement allocation team, is whether the safety of a student is at risk, particularly during the winter, especially if their mentor is not willing to be flexible about the shift start time.

Out of the 42 comments about travelling to placement, five noted travelling to placement was not a problem. The rest explained how difficult it was getting to some of their allocated clinical placements. Mostly because of the long distance between where they live and where the placement is located, resulting in a very long day and considerable associated travel costs.

Box 10: A student's view of placement allocation

'The students do not have a choice over where they are placed. However, I feel that as many students have an idea of where they would like to work when they qualify they should be given the opportunity to experience that environment before they commit to a job there. I agree that the first placement was too early, and too long. The longer placement would have been better in the 2nd block as students can spend longer consolidating their experience from previous placement. Logistically there seems to be little consideration of travel arrangements and childcare considerations for working mums. There seems to be the thought process of 'you'll find a way' regardless of how much strain that puts on family support structures as in 'real life working' childcare doesn't shift from 9-5 blocks to shift patterns. This has been a major stumbling block throughout the course.'

3rd year adult nursing student – Midlands & East

In some HEIs they have an agreement with the students that the time to travel between where they live and the clinical placement is no more than 90 minutes. Unfortunately, this does not always seem to be managed, as one student children's nurse explained '*I had to travel 6 hours to placement which left me emotionally and mentally drained*'.

7. Personal circumstances

The respondents were asked to consider their experience of being on the course. **96 per cent of the respondents agreed that they had made the correct decision to enrol on the course and an equal number noted that they carried on with the course simply because of the end goal.** 89 per cent reported being well supported in developing their career, although mostly through the friendships they had made (87 per cent) and the support of their family (84 per cent). With very little money, students stated that paying upfront for travel to placement is a struggle (85 per cent) and they are concerned about getting into increasing debt (73 per cent). 40 per cent advised that they were quite unprepared for the amount of work they have to do and for many this is in addition to the time spent caring for family members (37 per cent).

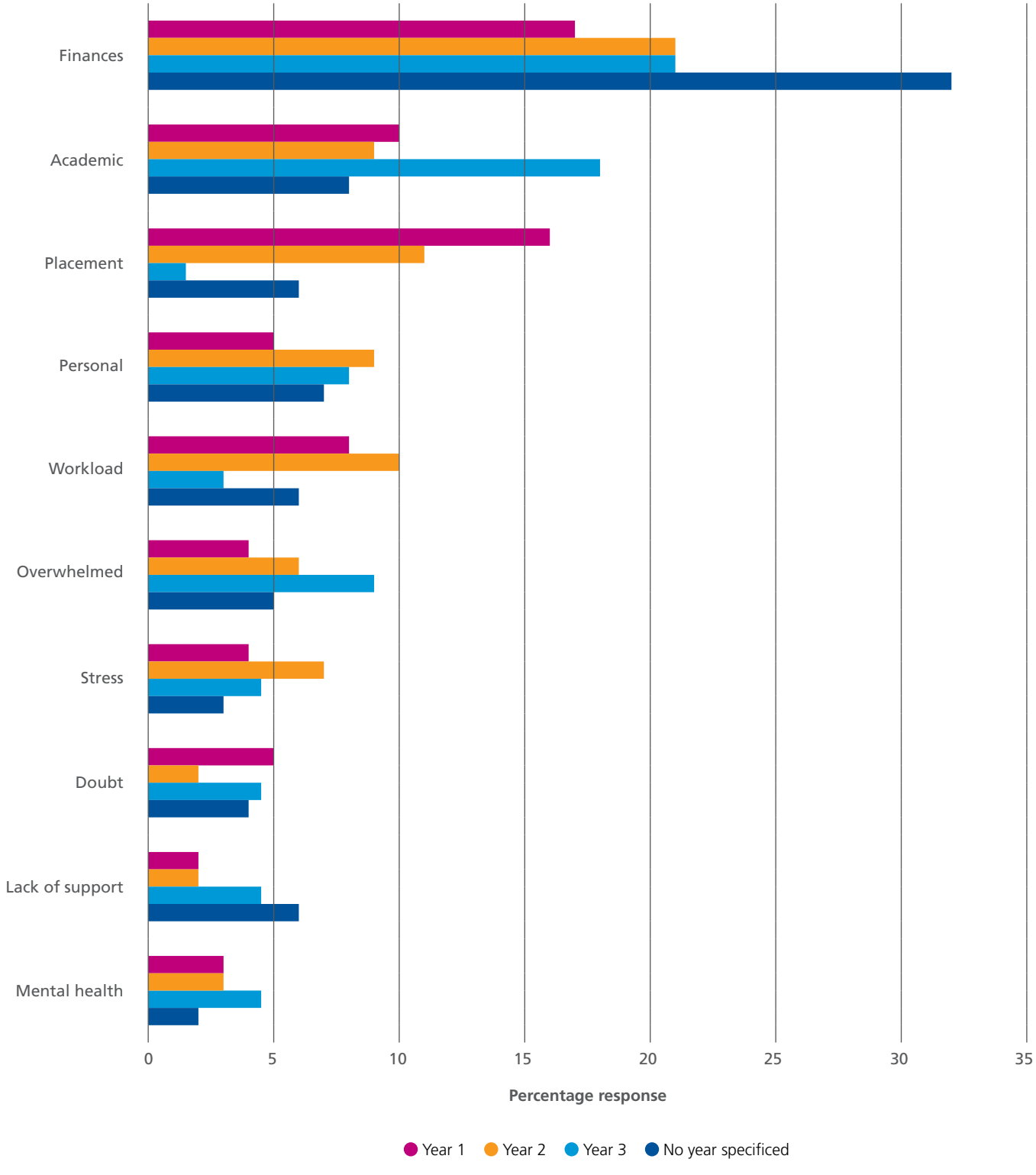
The students were asked if they felt like a student, irrespective of whether they were in the university or the clinical placement. Interestingly 80 per cent reported that they feel like a student while on the university campus and while in placement, 65 per cent reported feeling like a trainee/apprentice while in a placement-based learning setting and 42 per cent like a trainee/apprentice in the university setting. This is an important finding as it reminds the sector that these students have a dual role.

41 per cent acknowledged they had thought about leaving the course. Only 18 per cent of the first year students had considered leaving by the time they completed the survey which was at the end of their first term. However, by the time students were in the middle of their course (year 2) this had increased to 48 per cent, and by the middle of their final year to 56 per cent. 41 per cent of female students reported that they had considered leaving their course compared to 33 per cent of male students. There was no significant age difference for those who had considered leaving their course or not. The results by age group were:

- 17-20: 38 per cent;
- 31-40: 36 per cent;
- 21-25: 45 per cent;
- 41-50: 35 per cent;
- 26-30: 43 per cent;
- 51-60: 37 per cent.

Students who advised they had considered leaving the course provided more detail as to when and why. The reasons for leaving were thematically analysed by year. Unfortunately, not all the students specified at what stage in their course they considered leaving, these responses have been grouped under 'no year specified'. The top ten reasons why the students contemplated leaving the course are illustrated in **figure 29**, and discussed below. For further information, see **appendix 5**.

Figure 29: Top ten reasons why students considered leaving the course



i. Top ten reasons why students consider leaving their course

a) Finances

This is by far the most significant concern for students in all years of study (**table 11**). Unlike other university programmes, healthcare programmes tend to have more weeks of academic contact time. Many explained that they are not able to earn enough, or indeed any, money while they are a student and are either getting increasingly into debt, or are reluctantly dependent on others to support them. Many noted the financial challenges associated with reimbursement of costs relating to clinical placements e.g. travel and parking. They also pointed out that working shifts meant they struggled to find part-time paid employment.

Table 11: Examples of students' financial challenges

Year 1	Year 2	Year 3	No year specified
'Financially it is difficult to survive so I need to work part-time as well to top up my bursary.'	*'Finance is tight and having to pay to get to placement I think is hard on the students. We get the money reimbursed though it takes ages to come back into your account.'*	*'After three years in the university, I have to leave for a job.'*	*'During placement it is so hard financially. Money is a huge problem. I do not get enough bursary to live on so have to work. That is really hard whilst on placement.'*
I'm scared about my finances and I don't think I will be able to continue to support myself financially.'	*'I get significantly less money from loans/grants than students in my situation on non-NHS funded courses. This means I am required to work to fund my living expenses as my parents are unable to support me financially.'*	*'I am on less money now than I was studying at college on income support. I really need help wherever I can get it - so extra loans from university and hardship funds.'*	*'While on placements when I am unable to work. Money is a massive struggle and hospital car parks that cost £8 a day make things harder.'*

b) Academic concerns

The students recorded a variety of academic concerns, examples in **table 12**. The comments ranged from not being sufficiently academically challenging to being much harder than expected, particularly in year 2. Students complained about disorganisation and poor standard of lecturing.

Table 12: Examples of students' academic concerns

Year 1	Year 2	Year 3	No year specified
'I found the lectures to be irrelevant and focused heavily on adult nursing which was very frustrating. As a mental health nurse, myself and my peers felt neglected and many of us questioned our motivation to stay on the course.'	*'In the second year, the work load was very hard to manage and the level of academic writing went up to a level that was even harder than first year and that was very unexpected and demotivating.'*	*'The stress of passing the maths exam and applying for jobs make third year a lot more stressful and was thinking about quitting quite a lot.'*	*'The university is of a very poor standard. The lecturers regularly lack knowledge. The course is not stretching; it is too easy.'*
'The course is not as academically rigorous as I expected. I asked about extra reading/research and my tutor advised me not to bother because it's skills that are important leaving me feel like I was wasting my time/doing nothing.'	*'Lecturers talk about how hard second year is and it seems like they try to talk you out of coming back.'*	*'Taught sessions continuously running until 7pm.'*	*'Disorganisation of the course.'*

c) Placement experiences

The majority of comments that referred to experience while on clinical placement, as a reason for thinking about leaving the course were linked to year one experience. Students find year one placements particularly challenging, especially if they have little or no clinical or academic support during this time. However, it is not just first year students who report negative placement experiences and lack of support as illustrated in **table 13**.

Table 13: Examples of students' reported negative experience while on placement

Year 1	Year 2	Year 3	No year specified
'After several complaints and constant moaning I managed to move placement site and I am now much happier. Out of the 16 students that started at my old placement site there are 9 left which says it all really.'	*'Being on a placement where you are not made welcome and going straight from year 1 placement to year 2 placement definitely affected me.'*	*'Very bad placement, treated with no respect, being an extra pair of hands and made to feel like a burden when asking questions.'*	*'We're just thrown into placement and as I had no previous healthcare experience I felt so lost and continue to feel this way with each placement.'*
'After my first placement, even though I passed, I felt that I couldn't face another placement like that. I felt like I was being tested and examined and not supported or guided. It's not fair for a student to feel like this, the nurses should help us.'	*'I had a difficult placement and an unsupportive mentor. I lost my motivation while on placement and found it difficult to continue on the course.'*	*'Beginning of third year - very high expectations - when asking for advice or explanations this seemed as inappropriate as, "You will be qualified soon so you should know this".'*	*'Because of changes to working hours and the expectations on midwives, lack of breaks etc. I was finding the practice area a negative place to be.'*

d) Personal reasons

Students frequently cite personal reasons for leaving the course (**table 14**). They explained that sick relatives, guilt of not being at home for the children and demands on other family members are the main factors that led to them thinking it would be better if they left the course.

Table 14: Examples of personal reasons that led students to consider leaving the course

Year 1	Year 2	Year 3	No year specified
'I was going through a rough patch in my personal life.'	*'My husband worked 7 days per week to support the family and I was very concerned about his health.'*	*'My husband was diagnosed with terminal cancer. It was very hard, having to look after him and undertaking an intense course at the same time.'*	*'I've considered leaving on a few occasions through guilt of not seeing my young daughter and being placed so far away from her.'*
'balancing having a family.'	*'A change in my personal circumstances.'*	*'Home life suffered.'*	*'I took a leave of absence due to my ill health and family ill health.'*

e) Workload

Students report that they are not prepared for the workload (**table 15**). For many, particularly Year 2 students, the shock of the relentless workload is leading them to question whether they should stay on the course.

Table 15: Examples of workload challenges

Year 1	Year 2	Year 3	No year specified
'The demands of the course in first year, were more than I ever imagined.'	*'The workload was huge at the end of second year and we were on placement for most of it. I felt worn out and felt like I needed a break.'*	*'Deadlines were staggered one after another and so it felt never ending.'*	*'I have considered leaving the course many times due to the high workload both during practice and at university the course is very intense.'*
'Shock of workload.'	*'Heavy workload and feeling I wasn't keeping up made me question if I could continue into the third year.'*	*'Too much work to do with only one day off.'*	*'The demand of the course all the material is online and I feel constantly behind.'*

f) Overwhelmed

Woven throughout the explanations as to why students considered leaving the course is the concept of feeling overwhelmed by it all. Overwhelmed by the combination of academic assignments while in clinical placement; the level of responsibility in the clinical area; and the difference in academic levels between the years of study, as shown in **table 16**.

Table 16: Examples of students feeling overwhelmed

Year 1	Year 2	Year 3	No year specified
'I felt like leaving the course as the university gave me a lot of information and I felt overwhelmed that I wouldn't be able to complete the course.'	*'I felt overwhelmed by negative comments made by staff when out on placement.'*	*'I felt totally overwhelmed by the workload and also the increased level of responsibility in the clinical area.'*	*'The realisation of the amount of responsibility you have is overwhelming.'*
'Overwhelmed with placement and academic assignments.'	*'Such a jump from year 1 to year 2. It was too much to handle.'*	*'Studies have become very overwhelming and little support from university.'*	*'At times the academic workload combined with the required hours on placement are overwhelming'.*

g) Stress

Students frequently mentioned the fact that they are feeling the stress of being on the course. The reported stressors are normally multiple as shown in the Year 2 example (**table 17**). Year 2 is reportedly a more stressful year of study than other years of the course.

Table 17: Examples of students feeling stressed

Year 1	Year 2	Year 3	No year specified
'Due to stress from the long shifts and intense work.'	*'Cumulative stress reached a peak when multiple essay hand-ins coincided with practice documentation hand-in, the practical exam and a bad placement experience.'*	*'I am super stressed and I sometimes wonder whether the worry and stress is worth it!'*	*'The main ones being that the course is so stressful.'*
'I was nervous about if I was writing the essays the correct way and if I was going to fail. I was very stressed and seriously questioned if this course was the right decision for me.'	*'Because of stress of so many assignments that felt "undoable" along with full time placement and financial issues.'*	*'The amount of stress from this course has been phenomenal.'*	*'High levels of stress put on the students.'*

h) Doubting their ability or choice of career

According to the percentage response from the survey, students in Year 1 and Year 3 are more likely to be doubting their ability or choice of career than those in Year 2. Although the causes of doubt appear to be the same irrespective of the year of study (**table 18**).

Table 18: Examples of students doubting their ability

Year 1	Year 2	Year 3	No year specified
'Doubts about becoming a radiographer.'	*'Don't know if I am suited to being a nurse.'*	*'Doubting my own passion, debating if the job is worth the stress.'*	*'I considered leaving the course due to questioning my abilities.'*
'I think that midwifery is a very challenging career and constantly doubt that I am resilient enough to complete the course.'	*'I didn't think I was good enough to continue and the course is going so fast.'*	*'I'm terrified of graduation because I don't feel like an experienced nurse.'*	*'I doubted if working for the NHS was the right choice.'*

i) Lack of support

Students of all years of study report lack of support both in the university and in the clinical placement. The evidence from this sample is that lack of support is more of a concern for final year students (**table 19**).

Table 19: Examples of lack of student support

Year 1	Year 2	Year 3	No year specified
'There was hardly any support, the staff made me feel uncomfortable and I felt like my practice educator didn't want to support me.' *'I didn't feel I was supported and mainly felt like I was alone.'*	*'I had thought about stepping off the course for a year due to the lack of support within university.'* *'I felt poorly supported in placement and demoralised.'*	*'Lack of university support.'* *'There seems to be less support and guidance.'*	*'Due to the lack of support and guidance from my mentors on placement and tutors at the university.'* *'The lack of support from both university and placement provider is key to the feeling that I don't wish to continue.'*

j) Mental health challenges and depression

It is unsurprising that students comment on their personal mental health challenges including depression. Students who suffer from depression reported that the pressures of the course made the condition worse (**table 20**).

Table 20: Examples of students' mental health challenges

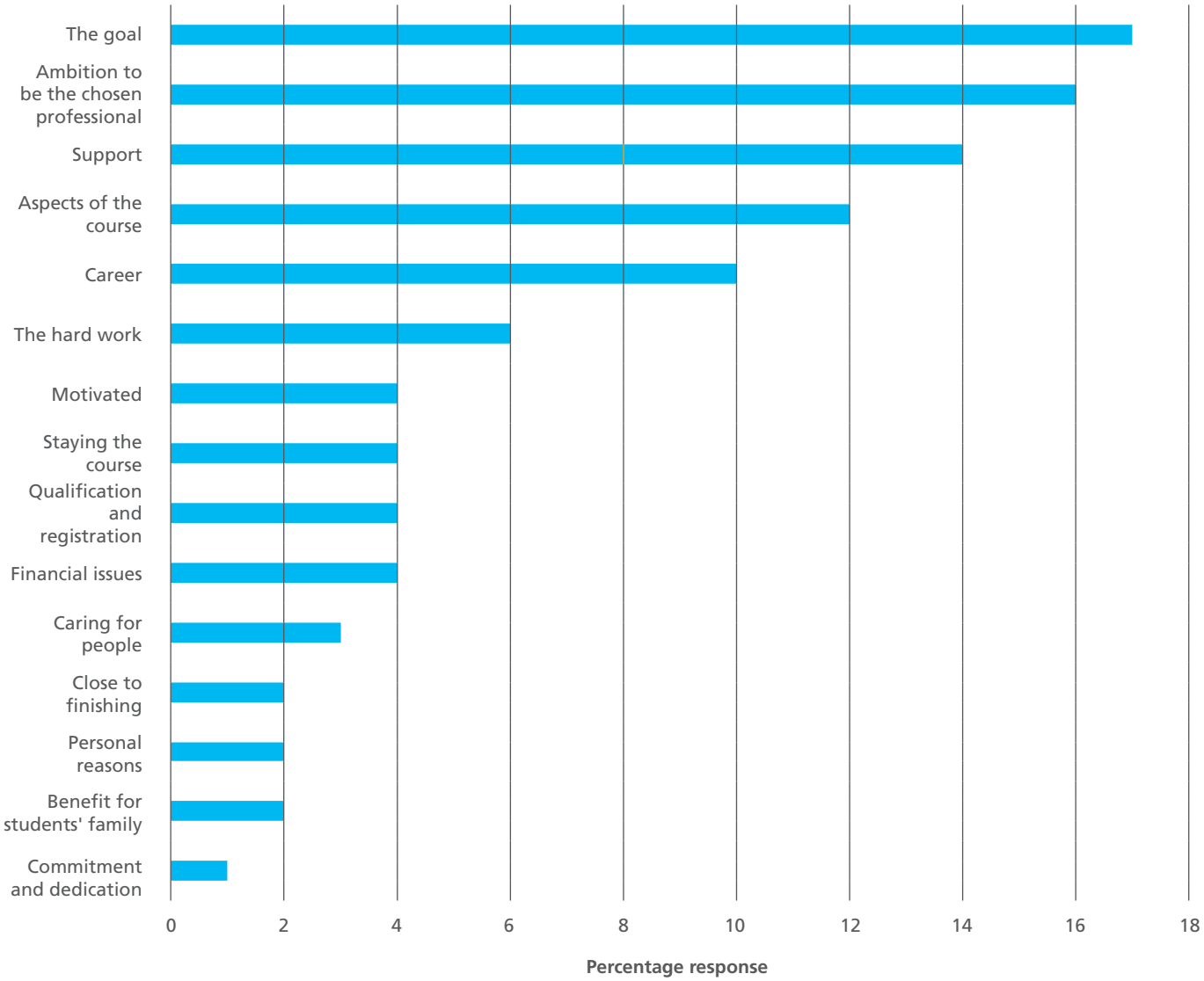
Year 1	Year 2	Year 3	No year specified
'The belittling behaviour that embarrasses you takes a mental and emotional toll and makes you begin to believe that you are incompetent for your role.' *'I was very down, my mentor had not been supportive, I was depressed and unhappy with the care I had seen.'*	*'I was diagnosed with severe depression and all I could think about was leaving the course. I am still struggling now but I think about the end.'* *'I suffer with depression and this course has made it so much worse.'*	*'I developed debilitating anxiety attacks and had to take two years of sick leave. I am now returning to the course with strong reservations about my suitability for the job.'* *'Due to personal circumstances of suffering with anxiety, I have found the course hard at times and have thought about leaving.'*	*'Health reasons - I had to take 18 months out because of poor mental health and wasn't sure I would be resilient enough to return.'* *'Feeling incredibly anxious about the future. and mental health issues.'*

The other reasons, for considering leaving, that students listed include: travel to clinical placement (distance and time taken); a negative student – mentor experience; struggling with demands of the course alongside personal problems; juggling competing demands of course and home life; feeling homesick or very lonely; being subjected to bullying; being treated like an unpaid healthcare assistant; thinking they were following the wrong career and childcare considerations.

ii. Reasons why students have NEVER considered leaving the course

About half of the respondents provided a total of 3130 comments about why they have not considered leaving the course. The responses are clustered into 15 themes as shown below (**figure 30**). The overriding reason students have not considered leaving their chosen course is simply their goal of becoming a nurse, or midwife, or therapeutic radiographer.

Figure 30: Top ten reasons why students have not considered leaving the course



The respondents acknowledge how hard the course is and that without the help from friends and family it would not be possible to continue. They note the personal sacrifice and hope that in the future it will benefit their family as well as themselves.

The graduation and professional registration are important to the students and they report a sense of pride in the anticipation of this future achievement.

The respondents shared their concern about the financial cost of being on the course and the debt they have built up and would not want this to be for nothing.

Many reported enjoying the course and being highly motivated by the opportunity to have a professional career.

> *'The end goal of making a change for people with learning disabilities.'*
>
> **3rd year learning disabilities nursing student – Midlands and East**

8. Future career

When asked to comment on their future career plans only 28 per cent of the respondents suggested it was too early to say. **A staggering 97 per cent reported that they intend to pursue a career in their chosen profession within the next three years.** 93 per cent noted that they are aware of the employment opportunities and 78 per cent that they are confident in being fully prepared for employment at the point of qualifying. It is worth noting that when analysed by year of study, only 67 per cent of the third year respondents thought they would be fully prepared whereas, the first year respondents were much more confident at 92 per cent.

5.2.2 Focus groups with students

Early on in Phase 2 of the project, 155[x] students from across the country took part in focus groups to share their insight into being a student, on one of the six programmes in RePAIR. Their comments have been recorded, analysed and are presented below under the first three Steps of RePAIR.

Step 1 - Pre-enrolment

Just over one quarter of this sample of students (26 per cent) already hold a first degree prior to applying for their chosen course. When looking specifically at the therapeutic radiography sample this rises to 65 per cent. Many of these students chose their programme of study, either because they had family members who had experienced a related clinical condition, or in the case of midwifery and children's nurses they had always wanted to work with children and small babies, or they simply wanted to make a difference. For some students it has felt like a marathon waiting to get onto a course while they achieved the necessary entry qualifications. These individuals should be commended for their commitment to their chosen career.

Because of family responsibilities students do not always have a choice as to where they can apply to study, or they prefer to live close to home. Only one student mentioned that they had applied to a specific university to enable them to gain clinical experience in a particular partner hospital.

It is important that the marketing recruitment messages are clear and help the prospective student understand what their 'training' experience will be like. This is extremely important for those applying for therapeutic radiography. Although prospective therapeutic radiography students are required to spend at least one day in a clinical department, prior to an interview, not all applicants do so and consequently these people are not ready for the clinical experience. One therapeutic radiography student explained: *'when you look at the university website it is all pretty and everything, but there is no information about what to expect. One of my fellow students left early on in the course because she was not expecting to see severely ill patients and patients who are likely to be dead in a few days'*.

The students had little or no recollection of the university keeping in contact with them, during the pre-enrolment period, other than routine administrative emails. **If the HEIs do have a 'keeping warm policy' then it is not evident to the students.** Students who go several months without any contact from the course team, start to question whether they have made the correct career decision or chosen the right HEI for them.

Step 2 - Duration of the course

It was very evident from talking to the students just how important the clinical practice experience is and that no other clinical skills development opportunities match that experience. Several commented that the clinical component of their course is either too short or not sufficiently well planned, resulting in the risk of students lacking in confidence to carry out basic clinical nursing procedures.

Some students reported feeling like a traditional student for the first few months that they are in university, but that quickly changes when they go into practice. Others, explained that they do not feel like traditional undergraduates at all and they do not feel part of the university, as they spend relatively little time in the university and prefer to introduce themselves as 'student nurses'.

[x]42 adult nursing students, 12 children's nursing students, 26 learning disabilities nursing students, 7 mental health nursing students, 37 midwifery students, 31 therapeutic radiography students.

The importance of the first clinical placement should not be underestimated, as students have high expectations and put much pressure on themselves to achieve and some did not feel prepared. This sample reported differing experiences of their first clinical placement. Some reported having a really good first placement: *'I think I was lucky with my first placement because I had a good mentor and it was an amazing ward'*; others reported being disappointed with their first placement experience, or struggling with their emotions: *'I just assumed that all the patients on the stroke rehab ward would get better and they don't. I was missing my family so much, as I had only just started the course, it was just so difficult'*.

The support from the mentor, practice educator and clinical staff must not be undervalued, as one second year mental health student explained: *'The mentor has the biggest impact together with the leadership on the ward. Some are star mentors and I have learnt a lot from all the staff'*. Support for students while they are in the clinical setting is more structured and evident while they are in their first year of study. However, the support is not consistent and on some wards the mentors really understand that they are there to support the students learning and to create a 'mindful learning environment', and conversely the students contend that on other wards the staff just do the mentorship to get their promotion. It was appreciated that the mentors themselves are under pressure and should have appropriate support. For some students it is the whole learning environment and the wider team that are important. As one mental health nursing student advised: *'placement is the best bit. I gain a lot from interaction with medics'*. For specialist courses such as learning disabilities nursing it is important that the general ward staff are aware that these students have been through the same core training as other nurses and that they have an increased knowledge and skill in looking after patients with learning disabilities.

Students recognise that they can make a difference and if they demonstrate commitment to their chosen profession and confidence in their own abilities then the mentors are more likely to trust them to get on with the task. The interaction with the mentors influences the way students feel about the placement, *'the mentors make a massive difference and if I had had a mentor who didn't inspire me in year one I would probably have left. I do not enjoy the academic, the clinical is so important'* (midwifery student).

Some students recognise how busy the clinical departments are and how little time the staff have for the students, they do not blame the staff, but rather the system-wide lack of support for their mentors or clinical tutors. Nonetheless, they recognise that sometimes they get support in the departments, for their academic work as well as their clinical work. How accepting the clinical area is of students varies by profession and location. For example, in some radiotherapy departments the students reported not being invited into the staff room, and if they are the students report feeling awkward and not welcome. It is important that students are socialised into the clinical setting and feel part of a team from an early stage.

Some students advise that there is support while they are in the clinical setting but they do not always know how to access it, and others commented that if they do report a problem they are not always supported: *'so I didn't report the problem until the end of the placement as I was worried about losing this clinical experience'* (second year adult nursing student). However, a children's nursing student advised that *'I asked to swap my mentor in year one and the university was very supportive, it was an easy process'*. This student went on to explain that the mentor was a very good clinical nurse but that she did not treat the students very well.

A few students commented on how little they are valued, as a student group, by their university. They advised that the large scale lectures are a waste of time, as most students talk their way through the lecture, showing no respect for the lecturer or fellow students who want to learn. The students prefer the education model whereby they have small academic groups and spend some time in a clinical setting early in the course. There is a view that at certain times during the year the lecturers give the students self-directed learning simply to fill the timetable slot. A group of second year nursing students reported being very demotivated, as they are only required to attend the university two days per week during the academic period in semester two. They went on to explain that when they do go into university: *'we attend the lectures really hopeful that we will be stimulated by the lecturer as the topic is really important. The lecture, which may last for 90 mins, can be very motivating and then we are told to go and do group work for three hours to create a poster which we will not get anything from'*. As one year two adult nursing student explained, *'I come to the uni to learn from people who know more than I do'*.

It is important that academic staff explain the value of exercises that encourage team building so they are not readily dismissed by students, who may have different expectations, and see them as irrelevant.

There is recognition that the pieces of the 'puzzle', that will go on to offer the student the necessary knowledge and skills to develop the competencies required of a newly qualified practitioner in their chosen profession, start to come together in year two of their programme. The students recognise that the learning curve in year two is very steep. As one third year student explained *'it is a really, really big jump from first year to second year. In first year you hear a lot. "Oh you are on your first year, you are not meant to know everything. You are on your first year, don't worry about it" and then when you come back in to practice as a second year that never gets mentioned again'*.

> ***'In the second year you really start to think, actually I am a nurse. We do find that a lot of students wobble in second year as they do not have the confidence to say yes I can do that. In addition, we are put on a clinical rota and the academic assignments can be really difficult.'***
>
> **3rd year adult nursing student**

A group of children's nursing students reported that they have many different placements during year two, heavy academic workload while on placement and no time to earn extra money, and it can be really difficult to manage the stress levels. In addition, as the students progress from year one to year two they are treated more like one of the team, irrespective of the clinical experience they have to date. A group of midwifery students had been warned how demanding year two would be and advised it is up to the individual student as to *'whether they are strong enough to cope'*.

Some second year students reported not being given the opportunity to gain placement experience in many clinical specialist areas, limiting skills development opportunities. Or they are rostered into areas where they are only allowed to observe, which is frustrating at a time when they should be developing their clinical confidence and competence.

Very few students reported that their university operates a robust buddy scheme. RePAIR has uncovered a very good scheme that is bespoke to a children's nursing course but not currently offered to the students on the other healthcare courses run by the same faculty. In this model a first year student is buddied with a second year student, also in that placement, and the second year student teaches the first year student 'agreed' basic clinical skills. The third year students teach the first year students how to undertake a literature search, and the third year students are assessed on this activity. As one of this group explained *'I still have my buddy I really like her, we meet up four or five times each year and this is facilitated by the university'*. The remainder of the students either reported that there is no buddy scheme at all or the scheme simply didn't work. The students advised that they would like a formal scheme and believe that it would help them cope with the pressures of the course.

It is very difficult to obtain accurate data from previous students as to why they have left the course. This sample of students were asked to comment on attrition from their course and if they knew why any of their fellow students had left. They pointed out that as the course is so demanding students will only stay if they really want to complete the course. They also noted that as these are vocational courses *'the clinical is key and the most significant factor that will influence a student to stay is the placement experience'*.

Some adult nursing and midwifery students reported that many of their cohort had left and that *'once students start to leave, the others who are thinking about leaving decide it is OK to leave, it sort of becomes infectious'*. They requested that the system become more flexible and accommodate students who have family commitments: sick relatives or young children. A group of learning disabilities nursing students advised that 25 per cent of their cohort had left by the end of year two, with twice as many leaving in year two than year one. They explained that some had failed their academic assignment and others had left for personal reasons. According to a children's nursing student: *'23 per cent left their cohort: the first year students did not like the clinical and the second year students failed their assignments'*.

Students chose to share their concerns about financial pressures. A very important point was raised by a group of learning disabilities nursing students, who advised that they are only reimbursed 28p per mile, rather than 45p that other staff can claim which is thought to be discriminatory. Therapeutic radiography students studying in the North advised that they could not manage without the bursary. Healthcare programmes have very long terms or semesters, this means that students have limited holiday periods, and therefore, unlike other students, they have little or no opportunity to earn any money. In addition, healthcare students are sometimes required to pay two lots of accommodation costs: university accommodation fees and the rent for accommodation close to a remote clinical training site.

It is thought that students who come directly from school are more likely to acknowledge that everybody else pays student fees so they will not question paying fees to train as a healthcare professional. However, if we start to look at students who are more mature and who have lifelong commitments the cost of training becomes more challenging. This situation has been borne out by this student sample, who advised that with a previous degree they do not qualify for a loan so all they have to live on is the student bursary and any work they can find.

Step 3 – Flaky bridge

> ***'I would like to stay but I have heard their preceptorship package isn't the best one to go to.'***
>
> **2nd year adult nursing student**

Some students are ready for the challenge of being a newly qualified practitioner and want to know when the posts are going to be advertised and how soon they can apply. Others reported that they felt scared at the prospect and wanted to refresh some of their skills. It is important that the students are given opportunities to take responsibility, under supervision, towards the end of their course to help them develop confidence in their abilities.

Students are aware that some trusts take very few of the students they train and so they need to start to look for jobs elsewhere. Whereas other trusts offer all students a chance to apply for posts.

Students report that the design of the preceptorship programme is a major factor when choosing where they want to work.

5.2.3 Focus groups with newly qualified staff

25 newly qualified staff reflected on their journey from being a final year student to becoming a newly qualified practitioner. Their comments have been recorded, analysed and are presented below under Steps 3 and 4 of RePAIR.

Step 3 – Flaky bridge

Only three of these preceptees reported the transition from being a final year student to a newly qualified practitioner as very straightforward. This small group reported a good culture in the hospital where they had chosen to work and knew, from their student experience at that site, that they would be well supported throughout the preceptorship period.

The stage at which the participants had decided where they wanted to work ranged from very early on in their training, when they had asked for exposure to that clinical area while working 'on the Trust Bank', to not having any idea where they wanted to work and just taking any post that was on offer. Most of them thought that being asked to think about where you want to work at the end of year two is too early as the clinical experience in year three helps you decide.

On reflection, the preceptees acknowledged that the approach a trust takes to employing students who have gained their clinical experience in that organisation is very important. They welcomed receiving an invitation to apply for a post and being formally interviewed, as from their point of view this demonstrated organisational commitment to the student and the post.

> ***'Didn't know where I wanted to work until the last year and it was down to my interest in the field. 'Uni' just allocated placements that is the way it worked. I had no experience in Oncology before my first day here'.***
>
> **Newly qualified practitioner**

How confident the preceptees had felt coming up to qualification was dependent on where they had trained, and their clinical placement experience, particularly towards the end of the course. Some felt really confident, others less so, as one explained: *'as a student, during the last placement you know what you are doing and then you become a qualified nurse and think I have no idea what to do'*. Others commented that they were not sure they were ready to take on the responsibilities expected of them and were very worried about being left in charge, as the perceived gap from being a final year student to a newly qualified practitioner was vast. A particular concern for those approaching a first clinical post is night duty; when it will happen and what responsibility they will be given.

Step 4 – Early clinical career

There is no standardised approach to preceptorship and the preceptees reported very different experiences during their early clinical career. However, they all agreed that the preceptorship programme and the support they get during this period is important. Some preceptees reported that their colleagues are very supportive and are willing to teach and nurture them throughout their early clinical career.

One option to address the fact that many newly qualified practitioners are unclear as to where they want to work is to offer, during preceptorship, an option to take part in a clinical rotation programme (**box 11**).

Box 11: Example of a rotational preceptorship model

The newly qualified nurse rotates every three months to a different clinical area for a 12-month period. At the end of this period they can choose, in discussion with a department lead, where they have a substantive post, subject to availability.

How much preceptees know about any particular preceptorship programme varies. Some preceptees explained that they know about the programme and that it is very clear what they are expected to achieve during the given period. However, others explained that they were not at all clear as to what they had to do, nor the length of the programme.

> ***'When I started my job I was supported in every way. I really enjoy what I do. At the end of every month I look back and think whether I have made a difference to these patients lives.'***
>
> **Newly qualified practitioner**

Even within an organisation the preceptorship model can vary and the approach determined at department level. This means some preceptees in a trust have monthly meetings with their preceptor to sign off the competencies, while others have little opportunity to meet with their preceptors, because of the preceptors' clinical demands. Worryingly, some preceptees suggested they are fast-tracked through the preceptorship programmes to meet service demands.

It is important that trusts do not oversell their preceptorship programme as the preceptees expectations will not be matched by reality and they then may opt to leave during the preceptorship programme.

A constant criticism made by the preceptees is that they are asked to demonstrate skills that were signed off when they were a student. They do recognise that newly qualified practitioners, who trained at another clinical site, may need to assure the staff that they are competent to do a task, but that should not dictate that preceptees who trained at a partner university should have to demonstrate these skills for a second time.

According to the preceptees the preceptorship programmes can be very demanding and very stressful and feel like a fourth year of study, with excessive paperwork, which is not what they were expecting. However, for some, a well structured, fully supported, two-part accredited preceptorship programme works very well. They value the work that the education team has put in to designing a preceptorship programme, which enables them to progress from being fully supported on day one, to remote supervision, as they transition through the programme. In part two of the programme they are encouraged to develop their mentoring skills and support a part one preceptee. They welcome the opportunity to seek accreditation for the modules of study to give them advanced standing towards a postgraduate award.

The pressures in the clinical service can dictate the approach that an HCP takes towards their newly qualified staff. Very often the pressures in the service and the staff shortages mean that the service is left with no choice but to expect the preceptees to 'step up' to take more responsibility. This can result in the newly qualified member of staff feeling extremely anxious, worrying that the patients are not safe and then resigning from their post. Other preceptees reported that they do not know until they arrive on shift where they are going to be working. They alleged that other staff are leaving the trust because of this uncertainty, *'nobody wants to come in to work not knowing where they are going to end up working'*.

5.2.4 Discussions with academic staff

67 staff employed in the university sector: associate deans, programme leads, and tutors engaged in focus group discussions to inform the output of RePAIR. The transcripts of the discussions have been analysed and collated under the Steps of RePAIR. Unsurprisingly, most of their comments relate to Step 2: Duration of the course.

Step 1 - Pre-enrolment

The university staff recognise that it is important to consider retention throughout the whole student journey and that avoidable attrition begins with a sensible recruitment and selection strategy. **Managing potential students' expectations from the outset, is only achieved by including scheduled 'current students' sessions during open days.** The student ambassadors give a more realistic view of the course and explain how the programmes are run, how far they will have to travel to placements and the academic demands of the course. Despite this approach, the admissions tutors advise that people still get through the interview process without having a clear understanding of what the course, or indeed the profession entails. They also note how difficult it is to: *'predict at interview whether or not somebody is going to successfully complete the course'*.

The first stage of the selection process for therapeutic radiography students takes place in the clinical department. The Society and College of Radiographers strongly recommends that all prospective therapeutic radiography students spend at least one day in a radiotherapy department. The staff in the clinical departments assess the prospective students, before the students are formally interviewed, as to their suitability for the course. This process places considerable demand on the clinical departments but nonetheless, the majority of potential therapeutic radiography students do get this opportunity. The reason for taking this approach is partly to give the students a lived clinical experience and partly to reduce attrition during or after the first clinical placement. If the clinical departments deem the prospective candidate unsuitable, the HEIs will not progress the application.

Amongst this sample of educators, multiple mini interviews is the preferred selection process (as recommended in HEE's Values Based Recruitment Framework[32]). This involves service users, final year students, colleagues from service as well as university lecturers in the selection process. Some courses are significantly over subscribed and the course leaders are in a fortunate position of actively testing the prospective students' knowledge of their chosen profession and their commitment to working in this field. Tutors from mental health nursing courses pointed out that they must assess for resilience, as increasingly applicants to their courses declare personal experiences of mental health challenges. These course teams make reasonable adjustments for these students and report being more concerned *'about those who don't disclose their mental health history than those who do'*. The academic staff noted that Clinical Practice Educators and Professional Development Facilitators, who support students in the clinical practice settings, have an important role in engaging with the local community and helping to recruit students.

It can be several months between the time the students are offered a place and the start of the course. It is very important that HEIs have a formal process by which they keep in regular contact with these pre-enrolment students. The course team could usefully review the approach that medical schools and other non-healthcare faculties take to proactively engage with students during the pre-enrolment period, where first year students are tasked with making contact, either by phone or social media, with pre-enrolment students.

One university has produced a set of student led videos about studying nursing, which are made available to all healthcare students once they have been offered a place on the course at that university (see Resources tab in the RePAIR toolkit **access here**).

Pre-emptive sessions with the pre-enrolment students to go through the detail of the programme are becoming more popular, particularly for cohorts of mature students, as this gives them time to make personal and childcare arrangements if necessary.

Understanding recruitment and selection from Generation Y and Generation Z applicants is important. These generations are increasingly familiar with digital and electronic technology and academics *'need to understand the current generation of 18 year olds and particularly how they seek support'*. A children's nurse tutor commented that applicants, particularly the younger applicants *'don't understand the level of stress that they might experience doing a children's nursing course, because they don't appreciate what it is like to work with sick children and their families'*.

With an expansion of student numbers, HEIs that have not previously recruited through clearing, have had to do so to secure the required numbers of students. One university reported poor outcomes for students recruited though clearing. The staff advised that the students had struggled because they had insufficient time to prepare properly. A course leader suggested: '*it is not the clearing process that is at fault, but the fact that the students do not have time to demonstrate and understand their level of commitment to their chosen programme, and similarly the university doesn't have time to demonstrate to the student how important it is that they are clear about the chosen course and their career intentions*'. Some tutors reported that a number of excellent students are recruited through clearing and some of their better students have opted to only apply through clearing.

The admissions tutors agreed that the system should *'divert more resource and more staff time to the admissions process'*.

Step 2 – Duration of the course

In addition to the correct selection of students, the university staff recognise that there are many causes of attrition. They assert that helping the students to feel part of a community, that has a purpose and a vision, is key to improving retention. At the centre of this approach is the partnership between the university and the clinical service.

> ***'After much thought I have arrived at the conclusion that we really need to look at the collaborative relationship between the HEI and the practice partners. I feel very strongly that the relationship between the university and their clinical partners is absolutely critical to the students' experience.'***
>
> **Therapeutic radiography Course Leader**

Some of the established clinical placements report no longer having the capacity to provide quality learning environments, and the course leaders recognise that it is their responsibility to work with clinical colleagues, to review the placement quality and capacity.

A clinical department, that is under increasing pressure to deliver a service, sometimes struggles to commit, in a timely manner, to providing a suitable clinical experience for students. As one adult nursing tutor recommended: *'we have to do this bit better, we are losing students because they do not know until the last minute about their clinical placement and they are worried that they will not be able to organise childcare'*.

> ***'We have got a student who is going out to placement next week and is still waiting to hear who the community mentor is because they can't decide between them who is going to do it. And for that nurse, actually sorting out the mentor is not that high a priority.'***
>
> **Adult nursing link tutor**

Box 12: Example of best practice of placement management

'One of the clinical placement facilitators of a large community healthcare provider is an administrator by background. The service provider took the decision to employ an experienced administrator in this role rather than a nurse. The rationale being that an administrator is proficient in the use of different databases, is familiar with spreadsheets and understands the importance of record keeping and auditing the information. This placement facilitator manages all the placements and keeps very good records. She is also very good at communicating with everybody: students, clinical staff, link tutors, a totally reliable system.'

Course leader, pre-registration nursing

One university reported providing their adult students with a three year clinical placement rota at the start of the course. Tutors, at other HEIs, have argued this is too difficult because of the uncertainty of placement opportunities because of changes in the clinical service. Other HEIs give the students an indication of the type of placement they will attend: *"so over the three years you will do a medical, surgical, community, complex care placement"*. The staff recognise that placement allocation and practice education support is a huge commitment for the clinical service and some question whether the levels of resourcing are adequate. **Box 12** illustrates an example of a successful approach that a large community healthcare provider has taken, to ensure the students know about their clinical placements, well in advance of the start of that placement.

The academic staff commented that the service would like to encourage students to develop a sense of 'belonging' and commitment to their organisation. They recognise how difficult this is to achieve, when the students are on placement for such short periods of time. One children's nursing tutor explained they have addressed this challenge by *'implementing a "base placement" system for the students' final year. The students are allocated to one site for a whole year, and from that site they do shorter placements. This means that effectively over that year they will spend 23 weeks in one organisation. According to the tutor: 'The students really like this as they become part of the team and feel valued'*.

The course tutors understand the importance of reliable support for students, while they are in clinical placement. They testified that where there are named clinical tutors, employed by the service, the overall experience for the students is better. They were particularly complimentary about the Practice Education Facilitator (PEF) model (see RePAIR toolkit evidence of best practice tab **access here**). PEFs support the clinical practice educators and mentors and are employed to focus on the learning environment and to ensure capability, quality and multi-professional learning in the clinical setting. PEFs are especially helpful in the smaller professions such as therapeutic radiography, and in parts of the country where students gain their clinical experience remote from the university. Unfortunately, these posts are not available across the country and some students do not get this level of support.

The tutors repeatedly noted their concerns about the funding constraints and the risk to these posts, with many of them currently under threat.

> ***'We are in a position at the moment where one of our trust partners is unable to locate the money within its service and therefore we don't have a substantive clinical practice facilitator. We have seen a huge difference in the experience of the students. This is not because people aren't working hard in that organisation, but you need somebody who is specifically appointed to take on that role.'***
>
> **Programme Leader, Midwifery**

They reported that it is often very difficult to identify how the student tariff money is used in the trusts. Seemingly, some HCPs recognise the importance of a robust support system for students and allocate the tariff directly to the education department, others do not. One university advised that they fund a number of practice facilitators employed in their partner trusts. Some are employed full-time in the larger sites, and others two days a week where there are fewer students in training. The course leader reported: *'we have university funded practice facilitators working in the clinical sites to provide first hand support for the students and the clinical staff. This works very well'*. The demands on the clinical practice facilitators is considerable and many of them support mentors and preceptors as well as students.

Frequently, the difficulty of getting student feedback about their clinical placement experience was commented on by clinical staff. Although academic staff allege that they ask students to complete placement evaluations they advised that their clinical colleagues report *"we haven't had any feedback for a while"*.

Gaining an in-depth understanding of the students' experience in clinical placement, is recognised by the tutors as being central to reducing attrition. It is well understood that students have a different placement experience at different stages of the course and in different settings. One nurse tutor explained that they have *'just introduced the concept of practice consolidation, a forum where academic staff (course leaders and module leaders) can listen to what students have to say. We also invite one of our local Health Education England colleagues to attend. The plan is to include our practice partners in the future'*. This initiative is important because it fills the void created by the removal of contract performance.

The academic staff noted that different generations reacted differently in the clinical setting. They observed that the *'way young people deal with stress is very different to how we would traditionally have expected them to'*. It is important, that where there is an ageing mentor population, the academic staff are aware of this tension and provide greater support to both students and mentors. A mental health nursing tutor explained that the younger students '*experience a lot of reality shock when they are out in clinical placement. The environment in which mental health nursing students are currently having to learn is hugely challenging*'.

The tutors recognised that these challenges are having an impact on student retention. It is very testing for the academic staff to provide a contemporary curriculum that encourages reflection, alongside a very aggressive professional socialisation process which is reactive. This is an issue for younger students and a concern for academic staff who are unsure as to how to address this matter.

Academic staff working in the field of children's nursing reported an additional set of issues: the students are mostly young female school leavers and not representative of the population they care for. They usually have very little life experience and find it difficult to support families, under enormous stress, who are from diverse backgrounds.

Attrition in learning disabilities nursing is higher than in the other fields of nursing. This is made worse by the shortage of suitable placements. The tutors advised that the established approach needs to be reviewed and a different placement model implemented. They explained how important it is for them to be mindful of the learning environment that the students experience and that where possible the tutors should spend some time in the placements prior to them being approved.

Tutors commented on the university personal tutor model, but recognised that students also turn to fellow students and clinical colleagues for help. Particularly those who will not make an assessment judgement on them. The staff acknowledge that they should further consider the students' journey and to value and respect the students' needs, outside the course, as well as within the programme. One group of tutors reported strengthening their personal tutor model. In this new approach the personal tutors support the students to develop some resilience and independence and ultimately resolve their own challenges. The hope is that there will be less of a confidence dip in year two students and that they will maintain their levels of enthusiasm and commitment to the course. There was criticism of the levels of student commitment, whereby some hardly ever turn up for lectures and seem unaware of the university attendance regulation. One learning disabilities tutor reported that they had set up practice interviews with clinical colleagues and only one third of the students turned up. Other tutors reported setting up processes to engage with the non-attenders early on and to ascertain their reasons for staying away.

The approach that the university sector takes to organising formal buddying schemes is very varied. For example, there is a PALs (Peer Assisted Learning) model (**box 13**) which is not profession specific

Box 13: A Peer Assisted Learning model

The principle is that the second year students support the first year students. The academic staff arrange for the second year students to meet the new first year students within the first two weeks of the start of academic year. All students are actively encouraged to join in and reasonable adjustments are made to accommodate specific requests. The tutors report the PALs scheme is like 'marmite', some of the students are really engaged and others think it is a complete waste of time. The second year student is the 'coach' and they make a note in their clinical record of the meetings between them and the first year student. As one of the tutors explained: 'this model is purely a support structure not about helping the first years to 'write an essay'.

Another example is a 'student mentoring model', whereby, a small group of second and third year adult and children's nursing students form a small team to mentor a group of first year students. This provides an opportunity for first year students to ask some key questions, for example: how do I get to a clinical site on a Sunday?

The most well-established buddying scheme, reported during the focus groups, is in children's nursing (also see section 5.2.2 Step 2). This innovative scheme was established six years ago and includes both peer learning and peer teaching and all cohorts of students. The children's nursing academic team organise 'buddy triads'. When the first year students start they are allocated a second year buddy who already has a third year buddy, so they work in small buddy families. The staff explained that they try really hard to buddy them with somebody who is in the same clinical setting, so that the new student already knows somebody when they go to their first clinical placement. Sometimes it is possible for two buddy families to join up. At least twice a year the university team organises a 'buddy lunch' for all the buddies, as one of the tutors explained *'it is a bit chaotic but everybody enjoys it'*.

The approach this team has taken to peer teaching is very formal; the second year students teach first year students about reflection and use their own examples of reflection, and the third year students teach the first year students about carrying out a literature search. The academic staff are convinced that this model of buddying reduces attrition, as it is frequently cited in students' testimonials. The students note that *"the buddy family supported them and they felt less anxious than students on other healthcare courses"*. The tutors were surprised to find that the second and third year students reported benefiting from the scheme as well and reported that it enabled them to consolidate some of their learning, support others and show first year students what they know. The evidence that this scheme works is that their NSS (National Student Satisfaction) score went up to 100 per cent when this scheme was fully operational.

The educators were agreed about the importance of recognising the impact of the mentor on a student's experience. One university reported holding an annual mentor conference for nursing and midwifery mentors, which is very well attended. Mentors from all the clinical partners come together to share good practice. The students vote for the best mentor of the year and the winner is presented with their award at the conference.

In some HEIs the prime responsibility of the link lecturer is to support the mentor and the secondary responsibility is to support the students. One midwifery course leader explained that she monitors the level of training of the mentors in the clinical placements and claimed that *'I will not allow our students to go into environments where the mentors are not trained and up to date and able to fully support the student's journey through that placement'*.

Some educators expressed concern about the commitment of the mentors to support the students. One tutor advised that her current research is into midwifery student retention, and in her study the key factor that '*comes up time and time again is the influence of the mentor*'.

The educators noted that some students, particularly year two students should not have been passed by their mentor. The tutors put this down to 'failing to fail' a student. The university staff suggest that introducing a simple grading system that is formative in year one and summative in years two and three is one way to help the mentors make an objective assessment of the students.

Step 3 – Flaky bridge

The tutors recognise that once the students start year three they suddenly realise that they will soon be registered practitioners and *'for some students this is quite scary'*. The educators noted that at the point of registration the newly qualified staff are experts in normal care in their profession. As one midwifery tutor explained; *'this requires a student midwife, at the end of their programme of study, to demonstrate competence in caring for women with medical, surgical and gynaecological needs'*.

One therapeutic radiography education team, together with their clinical partners run a two hour final clinical observed assessment. The tutors observed that this model of assessment helps the qualifying student secure a job. When they pass this final assessment they are deemed practice ready, an ideal scenario for student and service.

Increasingly the university sector is running academic modules that support the students in preparing for the transition from being a final year student to a newly qualified practitioner. One tutor described how, as part of their transition into practice module, they run an employability session which potential employers attend. This event is reported to be very successful because it gives the students an opportunity to ask questions and for employers to explain what they are looking for in a newly qualified practitioner, how they expect the final year student to behave while on placement and what skills they are expecting them to demonstrate.

The tutors discussed that at a time when there are more posts available than there are qualifying students it is important that trusts look after the final year students. One adult nursing tutor explained that one of their large teaching hospitals offers the students a job early in the third year. This ties the students into the trust but also gives the student that sense of belonging and security going 'across the flaky bridge'.

Other students look for support from the newly qualified staff, who trained in the same university. They let the third year students know of job vacancies and tell them about the preceptorship programme, how well they are supported and what to expect from a new job.

Step 4 – Early clinical career

Very few educators commented on the students early clinical career. Those who did were themselves relatively recently qualified. The main comment related to the behaviour of the Y generation of newly qualified practitioners. They explained that when these students qualify they want a very different early career experience to those from previous generations. In particular graduates who start their course at 18 years old, want to focus on their careers until they are about 30 years old. Unlike previous generations these newly qualified staff do not want to 'get stuck' in just one place. They want to build up their confidence and skills and then move on. As one tutor questioned: *'how good are the universities at making sure the service knows what the new group of 21 year olds want in comparison to a group of 35 year olds, who will behave very differently?'*.

There was also some discussion amongst a group of mental health nursing and learning disabilities nursing tutors that the preceptorship programme could possibly have a negative impact on newly qualified staff's confidence. They explained that at the point of registration the students are deemed competent to practice. The 'next moment' they are being told they are not able to perform some of the basic tasks, and that it will take another six to 12 months and further demonstration of skills acquisition before they are no longer supervised.

5.2.5 Clinical Educators' insights

Clinical educators play a vital role in supporting students on practice placements. 63 clinical educators representing a range of different roles, including those who primarily support pre-registration students to those who co-ordinate all trust non-medical clinical education activities attended focus group discussions. This sample included clinical educators from all programmes in RePAIR, all four regions in England and a range of HCPs. As in earlier sections (5.2.2-5.2.4) the transcripts from the discussions have been analysed and collated according to the four Steps of RePAIR.

Step 1 - Pre-enrolment

The clinical educators value the partnership with their local education provider. Nonetheless, they stressed the importance of strengthening the partnership between them, especially in relation to recruitment and selection of students. Their view is that clinical educators should be more involved from the very start of the student's journey. The expressed concern is that the sector could further improve this step, by collectively acknowledging that the clinician's view, as to the students' suitability to enrol on a course, is as valid as the academics. One clinical educator from a large teaching hospital urged the HEIs to increase the level of engagement of the clinical service at all stages of the selection and recruitment process. They explained that their colleagues are sometimes frustrated by the current process: *'the clinicians get disinterested and think "why should I bother with recruitment I am not allowed to influence the choice; my decisions do not count"'*. The perceived dissonance between what the staff in the university are looking for (academic potential), versus what the clinical service needs (quiet, incredibly thoughtful, caring and resilient people), if not addressed at selection, may result in dissatisfaction and lack of engagement on behalf of the clinical educators. As one practice educator explained *'we have lost those wonderful, amazing people who have the capacity to care for people under immense stress, it appears that the academic side is more important than the patients themselves. Being a good academic will not necessarily mean you will make a good nurse'*.

Managing students' expectations during the recruitment process is essential if retention is to be improved. There needs to be clear and realistic expectations around:

- Where the students will go on placement;
- The level of technology and computerisation within the modern healthcare service;
- How flexible and parent/carer friendly the course will be.

As one supervisor explained the expectations of the new generation of students are much higher than previous generations of students but *'at the end of the day the basic job is still the basic job, which is that if a patient wants to go to the toilet, the practitioner (whoever they are) will have to take them to the toilet'*.

The staff reported, understandably, that the approach taken at recruitment fairs tends to be market driven and promotes the 'glossy' side of the course and career, rather than the reality of caring for an increasingly elderly population with multiple clinical problems.

One aspect of the discussions about managing students' expectations centred around the type of care experience a prospective student has prior to applying to university. Therapeutic radiography has a formal process whereby, most applicants will have spent time in a radiotherapy department and been 'signed off' by clinical colleagues as suitable to apply for a course. Although the HEIs do require prospective students to demonstrate care experience the nature of this experience can be so varied that an applicant may have had no exposure to the type of work they will be doing as a healthcare student. One clinical educator who trained in Canada pointed out that many of the universities in Canada, that run healthcare programmes, require the prospective student to demonstrate that they have completed a set number of hours in a clinical setting: either as a hospital volunteer or some other type of clinical care work. This approach is in line with students applying to study medicine or veterinary science in England.

The clinical educators noted that local recruitment is good for the service as it is more likely to provide a pipeline of newly qualified staff. However, they recognise that many HEIs actively recruit from a larger pool to secure viable cohorts.

The change in student funding was an important topic for this group. Many of them were concerned as to whether the service could deliver against the promises that the HEIs might make to self-funding students, who may have different expectations from previous generations. The clinical educators working in the smaller professions: therapeutic radiography and learning disabilities nursing were particularly exercised by these changes and were calling for these groups to be made a special case.

Step 2 – Duration of the course

An important insight, from discussions with the clinical educators, was what can be done to strengthen the resilience of the students while on the course (**box 14**).

It is important that the students feel they are part of the clinical team, that they are valued, and that the clinical staff reflect on how best to support the younger generation of students. The clinical educators recognise that students who are referred to as 'the student', or students who are not expected, nor welcomed, into the clinical setting may report a negative experience, irrespective of the clinical learning opportunities. They understand that they are responsible for ensuring the students have a really high quality experience while they are with them, and they recognise that the clinical experience impacts significantly on student retention. A therapeutic radiography clinical educator described an ideal commitment model where the students are integrated into the team as an equal member of staff, the students are expected to work the same shifts as the staff, to work alongside the radiographers, attend staff meetings and are welcome to attend staff development sessions.

> ***'Apart from anything else to me a good placement is indicative of the quality of patient care'.***
>
> **Member of a quality placement team at a large teaching hospital**

According to the clinical educators, providing the optimum clinical learning environment, requires a well-resourced clinical education workforce. Without this the clinical education component of the course is at risk, as one clinical educator explained: *'the clinicians don't see students as a priority and the tutors in the university don't always necessarily see the placements as a priority, without the funding to support our role, clinical education is nobody's responsibility'*.

Caring for patients is the priority of any healthcare provider, consequently without protected supervision time staff often find it difficult to support students. They reported carrying out student assessments in their own time, after work, often after a long 12-hour shift. One trust reported implementing a new system whereby part of the clinical educator's role is to cover for the mentor while they tutor the student or attend their own education and training update.

Box 14: Change in students' values as they progress through the course

'We see students at the beginning of the programme who demonstrate tremendous enthusiasm and have lots of new ideas. They have really strong values about how they would like to work and sadly we see these values change as they progress through training'.

Professional education and training lead

Not everybody who is eligible to be a mentor wants to be one. Just because an individual is told to be a mentor doesn't mean they are going to be good at it. As a lead mentor explained: *not everybody is a good mentor. It doesn't mean that they are not a good nurse it just means that some people don't have that ability to share their knowledge'*.

Some mentors reported that they have no choice as to whether they are a mentor and for those who work in hospitals that have multiple education provider partners, supporting students can feel like a burden.

The amount of paperwork/electronic assessment reports that the mentors have to complete is considered extensive. The clinical educators requested *'less wordy **standardised documentation** with clear guidance and better worked examples to give the mentors confidence in their judgement'*.

> ***'We have two universities who have different sets of paperwork so the mentors have got a lot more work to do here because they have to have an understanding of both sets of paperwork as well as all the different processes, it is hard for the guys out on the ward'.***
>
> **Clinical Practice Educator**

> ***'I would bang the drum in support, if there was any chance we could have a standardised practice assessment document, as this would make our lives a lot easier.'***
>
> **Lead clinical mentor**

> ***'Recently we had a third year student who was struggling clinically and we had to ask the university tutor to help us. It is such a shame that she has reached her third year of training and the problem has only just been picked up.'***
>
> **Lead training mentor**

Clinical educators may mentor students as well as supervise preceptees. It is possible that they will be working with students from different HEIs and preceptees with different pre-registration competencies. They agreed that it would help enormously if any of the process could be standardised. They commented on the London model which has a well-established standardised pre-registration practice assessment document.

The **role of the mentor** to support and develop the student is not always fully understood nor appreciated by mentor or student. As an experienced clinical nurse educator explained: *'it is joined up work between your mentor and the student, but it takes as much commitment from the student as it does from the mentor'*. If the students turn up without having completed their part of the documentation it can be very frustrating for mentor and student, and it puts extra strain on their relationship.

The mentors stated that they really value feedback from the student but are disheartened by comments from students like: *"my mentor never taught me anything, I never worked with my mentor"*. The mentors explained that students' understanding is often based on incorrect expectations and that when asked if the mentor had taught them anything the students compared it to formal teaching rather than learning in the practice setting. The clinical educators reported that they respond to negative feedback from students and cited an example from a practice placement quality assurance process. On this occasion they took a tripartite approach: student/mentor/tutor and put in place an action plan for that placement area to further support mentors and students.

Some mentors are reluctant to take on the perceived additional responsibility of being a sign-off[xi] mentor. The clinical educators commented that they are not sure why this should be a problem and pointed out that mentors should not be signing off a student's clinical assessment if they are not confident in the student's ability. It is very important that students who are struggling with their clinical work are identified as early as possible, rather than letting them progress on the course without some intervention to support them. Allegedly some second year students progress to year three, who should not have progressed clinically, the problem is then deferred to the third year and the sign-off mentors have to address any shortfall in competence. The clinical educators noted that the clinical assessment for year two students can be less straight forward than for first and third year students and what the second year students need to learn is often very varied. This is particularly difficult for mentors who support students from a number of different education providers.

The clinical educators recognise that year two students may not have as much support as first and third year students and that *'it would probably help the system if they did'*.

The mentors referred to the allocation of student placements as a 'lottery'. One mentor in an acute setting gave a specific example of a third year student on her first placement in that year. This student had spent the whole of year two in a community setting. The mentor explained that her colleagues' expectations of a third year student are high and they expected this student to perform like any student who has continued to gain clinical experience in the acute setting throughout their course. As a result, this student was heavily criticised by the staff and the mentor advised that *'it wasn't the student's fault but the staff simply wouldn't give her a chance'*.

[xi] Sign-off mentor is the mentor who has met additional criteria and makes the final assessment of practice and confirms that the student has achieved the proficiencies to enter the register.

Ensuring that the clinical educators know which students are coming to their site and when the placements are scheduled is very important. They fully recognise that students who have family commitments need to know in plenty of time where they are to be placed so they can make the necessary arrangements. They commented on how awkward they feel if a student *'turns up'* on placement and they were not expecting them. One clinical educator explained: *'I try not to make them more anxious and say something like if you come in on this day we will sort out a mentor for you'*.

The mentors reported that sometimes there is a mismatch between what the students expect and what some of the tutors think is happening in a particular clinical placement, and what is 'actually going on'. For example, many community based teams have moved to 100 per cent agile working. When the students 'turn up' on day one they are surprised to find there is nowhere for them to put their belongings and that they have to carry everything with them. One mentor pointed out that *'it is really important that the tutors know what practice actually looks like now, and for some placements all they have is a laptop and a phone'*.

There was some criticism over how the tutors, who are the link between the HCPs and the HEIs, manage their time. They reported having confidence that some tutors will visit the students when they are in clinical placements, and will know all the staff, but there are others they have less confidence in. As one sign-off mentor explained: *'I think increased visibility helps mitigate against problems, some universities do it better than others'*.

One of the HEIs is reported to have developed an electronic placement allocation system that the staff in the clinical setting can access as well. The university has arranged for one of the tutors to work with the clinical staff to ensure they know how to operate this system. The clinical educators reported that longer clinical placements are better for helping the students to build their confidence and resilience. They advised it takes about two weeks for a student to adapt to the new clinical setting. Where the placement model is for multiple short clinical placements the students have just started to settle into the department routine before they are *'moved on'* again. In addition, short placements of say four weeks are difficult for the mentor to make a judgement on a student's clinical competence. A balance has to be found between giving the students a suitable range of clinical experience versus enabling the students to build confidence in their ability. Students that present the system with 'issues' get disproportionately more attention than the rest. The clinical educators acknowledged that they should proactively seek to support the students who are *'just making the grade to help them successfully complete the course'*.

Another pressure on this workforce results from the decisions that the HEIs make about the number of intakes. If a university decides to have just one intake this results in a concentration of students requiring supervision at a specific time of the year, whereas multiple intakes spreads the supervision and assessment load.

Step 3 – Flaky bridge

The clinical educators reported that third year students frequently discuss their career options but they do not always know where they want to work. They suggested that one way to help these students is to offer them a rotation as part of their first post.

They observed how anxious the students are at the end of their third year. As one practice educator illustrated: *'I think they have a panic attack about this time of the year, it is the academic pressures as well as the employment uncertainty'*.

A lead midwifery educator expressed concern about how little time the students get to consolidate their learning and that many final year students have that overwhelming feeling that once they are a newly qualified practitioner they will be solely accountable. She explained that *'for three years every decision they have made has been discussed and countersigned and suddenly they will be behind a closed door with the possibility of being left alone to get on with it'*. The midwifery clinical educators recalled the time when final year students were remotely supervised while they took responsibility for the labour ward or a normal delivery. These scenarios were referred to as 'a confidence case', they went on to question whether in fact *'we currently hold the students' hands too tightly and then all of a sudden let them go'*.

The clinical educators welcome the opportunity to talk to the third year students about transition into practice. They also advised that where possible the trusts will try and accommodate the students' last clinical placement request, especially if they have already secured a job in that organisation. They understand that these activities help to reduce the anxiety level for students approaching the 'flaky bridge'.

Recruiting the best final year students is very important for the HCPs and in some parts of the country it is very competitive. Some trusts that 'spot' a potential 'star', even if they are a year one student, will keep in touch with them throughout the rest of the course in the hope that once they qualify this student will elect to work for them.

Step 4 – Early clinical career

Clinical educators acknowledge that preceptorship is very complex and a key influencing factor for those applying for their first post.

> ***'Preceptorship is the golden nugget in your flaky bridge.'***
>
> **Education and training development lead**

There are multiple models of preceptorship. The models are largely trust led and in some cases there is more than one preceptorship programme in an organisation, as one practice educator explained *'in the emergency department they do a different preceptorship to the rest of the trust'*. The length of the reported preceptorship programmes varies from a minimum of six months to a maximum of 12 months. The clinical educators explained that not all preceptees can complete within the standard time and consequently they extend the preceptorship time to accommodate the learning needs of the preceptee. No-one advised that their preceptorship programme had been designed in partnership with the local education provider. One clinical educator thought this was an essential part of the process of developing the programme and stated that: *'it is hard enough doing three years training without making it difficult for them when they come into the job'* and another suggested that the final year of the degree *'should lead more seamlessly into'* the first part of a preceptorship programme.

They reported that increasingly trusts are recognising that they need to be more flexible and more responsive to the varying needs of the newly qualified practitioner, particularly in organisations that recruit from different parts of the country.

The clinical educators maintain that they have to deliver a preceptorship programme that addresses the skills that their trust requires of the newly qualified practitioner, even if this means that the preceptee will be repeating skills previously signed off by staff in that trust. They argue, that while they may be confident in the competencies of a newly qualified practitioner who trained at a partner university, this is not the same for staff they recruit from other parts of the country. Some preceptorship leads are trying to address this conundrum and offer a more personalised preceptorship programme. An example of such an approach taken by a midwifery preceptorship lead is illustrated in **box 15**. This midwife advises that their retention has improved since they introduced this model and that she has heard anecdotally that *'the word on social media is that this is one of the best preceptorship programmes because of the support structure that the preceptees have during the first 12 months'*.

One clinical educator, who works in a large teaching hospital, pointed out: *'we should also focus our attention on retention of the newly qualified practitioners and the level of support for them'*. She explained that the preceptees in her Trust openly state: *"if I don't get the support that I need here then I will take my skills elsewhere"*.

Box 15: Individualised preceptorship programme

'We review our preceptorship programme every year based on the feedback that we are getting from our current preceptees. We have regular sessions with the preceptees and have quite honest conversations with them about what works and what doesn't work and then we will change accordingly. So this year, for the first time ever, have individualised preceptorship packages for each preceptee. This has been quite a challenge in terms of rostering but I guess because we are looking to meet their individual needs, as such, it makes for a happier midwife.'

Midwifery Preceptorship Lead

> ***'We could do better; we could look to develop a formal preceptorship training programme.'***
>
> **Lead nurse for education**

It was recognised that the preceptors themselves do not always have enough dedicated time or support to enable them, in turn, to help the preceptees, particularly if they have to mentor students as well. Even in organisations where the preceptors have protected time on the rota, to meet with the preceptee and review the preceptorship document, they have to be flexible and responsive to service needs, which will always take priority. The lack of formal training to be a preceptor was an expressed concern. No-one in this sample reported attending a formal preceptorship programme, they advised that normally they would shadow an experienced preceptor. However, they agreed it is something that should be considered. An example of the approach that one lead for education takes to support their preceptors is shown in **box 16**.

Box 16: Support for preceptors

'To build confidence in my team I personally try to come round to the wards on a regular basis, enquire about people and enquire about the situation both of the preceptors and preceptees, so I have got reassurance. If there was a need for our preceptors to be supported then I would do that. However, most of our preceptors have been on a mentorship programme anyway so they are very used to supporting learners.'

Lead nurse for education

Organisations should aim to find a preceptorship model that works well for both preceptees and preceptors. An example of such a model, that was initially signalled by a preceptee and commended by the preceptors is a Band 5 competency booklet which is colour coded according to when the competencies need to be completed. For example, the competencies that need to be signed off within the first three months are coded red, those that need to be signed off between three to six months are coded amber and the rest are green. At a glance preceptee and preceptor can see what key competencies are outstanding. The lead preceptor explained: '*all the preceptees are required to complete all the competencies and normally they do, although I am not going to pretend it all goes perfectly every time'*. This same organisation ensures that the preceptees have a clinical management study day a month and allocates time during this day for the preceptees to meet their peers and to reflect on their experience as a preceptee.

Three of the clinical educators (from different clinical sites) questioned whether the preceptorship programme is really needed and argued that other professionals qualify as 'fit for practice'. Although they observed that having preceptorship programmes at all suggests this is not the case. They argued that with the many different models of entry into nursing the purpose of any preceptorship should be reviewed so the programme is fit for purpose. Other clinical educators questioned whether we should be discussing 18-month preceptorship programmes at all because of the demands on the clinical service and that surely the root cause is the design of the pre-registration programme and whether there is sufficient focus on building resilience throughout the course.

A lead midwife commented on her experience recruiting midwives trained in Ireland and that the *'difference in confidence was quite extraordinary'*. This is attributed to the 'good grounding' provided by the 'supernumerary year', that these newly qualified midwives experience. This midwife recognised this is not possible in England and although *'we try, we allocate a preceptor, we support them as much as we can, we simply cannot shield the newly qualified midwives from a very busy shift, being short staffed and all the things that come with the reality of working'*.

5.3 In-depth enquiry into improving retention

Teams from the 16 case study sites generously gave their time to support RePAIR. As mentioned on page 22 there were a total of 18 HEIs and 25 HCPs that supported HEE to form 'the RePAIR Community'; engage through a model of appreciative enquiry (page 22 and **figure 31**), and share examples of best practice.

Figure 31: Model of appreciative enquiry

The RePAIR teams, from the local case study sites, met with representatives from the HEE project team over a period of 15 months. A maximum of seven meetings at each site were held during this time, most of which were face to face.

In addition,120 representatives from the RePAIR Community and HEE attended a workshop. Many of the emerging findings, at that time, from the nursing and midwifery discussions did not directly apply to therapeutic radiography. Therefore, a group of therapeutic radiographers from the case study sites were invited to a second workshop. The case study sites also supported some of the focus groups reported in section 5.2.

Findings from the case study sites are presented as follows:

- Examples of interventions to improve retention
- Workshops
- RePAIR Community networks

5.3.1 Examples of interventions to improve retention

Throughout the RePAIR project the team found many examples of interventions that had already led to improved retention or were deemed likely to sustain or improve retention. There are 26 examples illustrated in the pages below. The first ten were uncovered during the face to face case study site meetings. They are detailed in the 'Evidence of best practice' section of the toolkit (**access here**) and outlined in **table 21** below. The remainder (examples A-P) were provided in response to HEE's request to all RePAIR case study sites to share examples of local initiatives that support retention.

Examples A and C below are in the public domain, D is available as a podcast in the RePAIR toolkit Resources. The remainder were submitted not as an attributable example of best practice but to illustrate good practice principles and ideas that could be replicated relatively simply, as part of the project. The first example covers all four Steps of RePAIR the remainder are clustered by RePAIR Step.

Table 21: List of examples of best practice of improving retention programmes

RePAIR step	Title of intervention	Intervention programme
Step 1 Pre-enrolment	Scott Medical and Healthcare College	A small specialist studio school in Plymouth, established to prepare young people ready to work in the health and social care sectors.
	Pre-degree work experience	A model of recruiting people with little or no care experience into vacant healthcare assistant posts, with a guarantee that once they have successfully completed the six month Pre-Degree Work Experience they transfer onto an adult nursing degree course.
	Recruitment of students to therapeutic radiography	An innovative approach, to student recruitment, taken by the UK's largest provider of therapeutic radiography education.
Step 2 Duration of the course	Collaborative learning in practice (CLiP)	A model of recruiting people with little or no care experience into vacant healthcare assistant posts, with a guarantee that once they have successfully completed the six month Pre-Degree Work Experience they transfer onto an adult nursing degree course.
	Support for year two therapeutic radiography students	A bespoke academic programme to support Year 2 therapeutic radiography students.
	The Nightingale programme	A Trust nurse-led programme designed to improve recruitment, retention and staff well-being.
	Impact of the culture of care on the student learning environment	A university-led approach to understanding the culture of care in the students' learning environment.
	North West Practice Education Facilitator (PEF) model	A model of supporting high quality learning environments and continuing professional development of staff.
	Multiple models of education and training in therapeutic radiography	An HCP's approach to managing multiple student training pathways that led to improved staff recruitment.
Step 3 Early clinical career	Preceptorship	A two-phase accredited preceptorship programme resulting in improved retention of newly qualified staff.

RePAIR

A. Partnership between an HEI School of Nursing and Midwifery and a local HCP

The commitment to nurse and midwifery education and training by both HEI and HCP is central to RePAIR's theoretical framework. In 2017 Oxford Brookes University launched the Oxford School of Nursing and Midwifery, https://www.brookes.ac.uk/osnm/. The partners to this innovative development are:

- Oxford Brookes University,
- Oxford University Hospitals NHS Foundation Trust
- Oxford Health NHS Foundation Trust

These three organisations have come together under the umbrella of the Oxford Academic Health Science Centre (AHSC) to support education, clinical practice and research across the nursing, midwifery and allied health professions.

It is anticipated that this new development will increase recruitment to the pre-registration programmes and qualified staff posts, and improve retention.

RePAIR Step 1 - Pre-enrolment

The two examples below relate to the period from student application to enrolment on a course.

B. Recruitment, Selection and Marketing

Promoting the course and managing prospective students' expectations of the course is one of the biggest challenges for HEIs, which are under pressure to fill places.

One university has introduced a DVD of a group of their students discussing the programme, their experiences of being on the programme and the realities of being in practice. The HEI has reported that the DVD has been positively received.

The placement circuit, travel and shift patterns are reinforced during the interview day presentation, to enable candidates to understand how placements are organised and the expectations placed upon them.

C. Keeping prospective students warm

The qualitative evidence collected from the focus groups with students (section 5.2.2), highlighted the doubt that many prospective students experience, about whether they have made the correct decision to accept an offer of a course.

The students at Oxford Brookes University have produced a series of short videos called 'What's it like to study nursing'. These videos can be accessed by students who have accepted a place and are waiting for the course to start, for some this can be many months. The students who contributed to the focus groups have reported that *'these videos are very helpful and encouraging'*. The eight videos (**table 22**) can be **accessed here**.

Table 22: Examples of 'keeping warm' videos

Study Tips - Students' tips for studying and dealing with their timetables.	**Making Mistakes on Placement** - Nursing students talk openly about making mistakes on placement.
Male Nurses - Breaking down the gender stereotypes: students discuss what life is like for male nurses.	**Is age a Concern?** - Whether you're fresh out of college or returning to study later in life, nursing is open to all. Students reflect on the benefits and challenges of choosing when and how to enter the profession.
Work-life Balance - As dedicated as student nurses need to be, it's important to ensure it doesn't totally eclipse other aspects of life. Whether it's looking after children or playing sports, students discuss how they fit everything in.	**Money Matters** - You don't need to come from a wealthy background to study nursing. Students discuss how they live and earn whilst on the course.
First Day on Placement - Any first day in a new role can be nerve-wracking, but especially with the first clinical placement. Students talk through their experiences of that moment.	**Night Shifts** - Shift work is a large part of being a nurse, the students here discuss the good and bad sides of night shifts.

RePAIR Step 2 - Duration of the course

The examples below relate to aspects of supporting students while they are on the course. The concept of a buddy scheme drew comment in the survey, so it is unsurprising to find that a number of HEIs have implemented or are in the process of implementing buddy schemes.

D. Buddy schemes

Two different buddy schemes, that relate solely to students, are shown below. A further model is set out under Step 3.

i. Mental health nursing - student buddying scheme

Newly introduced as part of RePAIR, a student led buddy scheme based on supervision support to help the students engage in the scheme. The sample included three groups of students and the student experience was evaluated, out of the 150 students involved in the pilot 22 per cent returned the survey. The students were strategically linked by placement area. The tutor who supported the scheme contacted the students via email.

For detail about the scheme, and lessons learnt from the pilot, **access here**.

ii. Student to student support model

A volunteer group of first, second and third year student ambassadors, originally established to promote nursing as a career to school children, and welcome prospective nursing students into the university, has developed into a society for students which organises social events, for example: coffee evenings and the Great North Run. They have established an anonymous email system to enable direct contact between them and any student seeking confidential support.

They reported finding that students *'don't like to approach lecturers but they are quite happy to approach peers'*. The society members are easily identified by students who may wish to ask them for help or advice.

In 2017, this model was formalised and now third year students have a named person to buddy. The importance of this role is illustrated in the **box 17**.

Box 17: A third year student nurse offers support for a first year student nurse who is overwhelmed by being away from home

'I support an 18 year old first year student nurse who is training a long way from home. She is very homesick and doesn't fit in, she is a "fish out of water". She didn't know what she was doing and decided to leave the course a few months after starting. The university contacted me to explain the situation and that the first year student would need a lot of support. The first year agreed to "give it a go". She has rung me every day since and most days in tears. It is the first time she has been away from home and doesn't have any confidence. It is also the first time she has ever had a job, there are so many firsts for her that she is overwhelmed. Unfortunately, she had a very bad experience in her first placement, with a very unsupportive mentor, which didn't help her confidence. Yet this young lady turned up on my doorstep two weeks ago. I had to peel her off the ceiling because she passed first year and she had done it. I didn't think she would get through but she has and she loves nursing and she has signed up to be a mentor for first years. She asked me if I will continue to be her mentor when I start in my new job and of course I said that is fine and she has my number.'

E. Retention Officer

An HEI has appointed a retention officer who is available to support all the students. They are introduced to students during the induction period. Following a period of sickness or other absence the officer invites the student to a meeting with them, to discuss any support they might need. This is a confidential service and, with the student's permission, they will follow up support strategies to facilitate the student's progression. According to the university that reported this initiative the approach works well.

F. Preparation for Practice

HEIs invest a great deal of time in preparing students for their first clinical placement. This is very important, as the evidence is that the highest attrition rate happens during or just after the students' first clinical placement.

One HEI explained how they support the mentors to effectively support the students, when they are in practice:

- Workshops with mentors who come into the University prior to the students' first placement to explore and address any anxieties and discuss the mentorship role.
- The mentor website includes video clips of students talking about what makes a good mentor to help mentors understand what it feels like to be a student.

The student evaluations are positive.

G. Developing resilience

Nursing, midwifery and therapeutic radiography pre-registration courses are mentally, physically and emotionally demanding. Helping students to develop resilience is increasingly becoming part of the pre-registration curriculum for these courses. An HEI explained that resilience–mindfulness (to help students understand how resilient they are) is included in the initial induction period. In addition, personal and leadership development is included throughout the programme, including action planning and a focus on strategies to develop personal effectiveness and resilience. Students evaluate this approach to developing resilience very positively.

H. Mindful placements

In 2009 an HEI appointed a disability lead, whose specialist interest is in ensuring that the practice placement is appropriately prepared to support a student with a protected characteristic. This member of staff writes the action plans for these students when they go into practice, which is sent to the practice manager. The students understand that the disability lead ***'will not do it for them, will not do anything to them, only be with them'***. This approach has really resonated with students with a disability, because they understand that the lead is either 'shoulder to shoulder' with them, or only a couple of steps behind them, to catch them if they fall. The idea of the action plan is to minimise the risk of these students having a problem in placement and to ensure that reasonable adjustments have been considered.

This model led to the concept of mindful placements. For example, if a student has a visual impairment and struggles to drive in the dark, they will not be allocated a placement remote from where they live.

A key objective of this initiative was to reduce the number of times that disability, inclusion, accessibility etc. was cited as an issue in fitness to practice referrals. Since the implementation of 'mindful placements' there have been no referrals to fitness to practice based on these issues.

RePAIR Step 3 - Flaky bridge

The four examples in this section relate to the period of the student journey that straddles the final year of study and the first year as a newly qualified practitioner.

I. Development of a buddy scheme to support final year students

One HCP case study site decided to explore, with final year nursing students, what a buddy scheme between final year students and newly qualified staff would look like. Three groups of final year students and newly qualified practitioners, based on different sites of the same trust, were invited to a meeting to discuss what a buddy scheme might look like. They were asked to consider the following:

- What do you think the aim of a buddy scheme should be?
- How should the buddy scheme be organised?
- What benefits can you see from having a 'buddy?'
- What is the best way of communicating with each other?

The aim of the proposed buddy scheme

It was agreed that a buddy scheme should be informal and should offer support for both third year students and newly qualified staff. The system should promote confidence in both groups and specifically help with the transition from being a final year student to a newly qualified practitioner.

Proposed approach to organising a buddy scheme

An informal system with drop in sessions. However, the trust should formally recognise that it is a component of a preceptees role and a development opportunity for those who wish to engage, and allocate time accordingly. Clear ground rules including parameters and recognising the importance of confidentiality. Preferably with a small group, although options for one to one discussions is preferred. It is important that this is integrated into induction and not an 'add on' for those who are struggling.

The perceived benefits of having a buddy scheme

The perceived benefits of having a buddy, from a student's perspective are reported as follows:

- Support for transition from final year of study to first year as a newly qualified practitioner;
- Strengthened confidence in knowledge and skills;
- Help with deciding where to work and preparing for first post;
- Help to dispel myths about being a newly qualified practitioner;
- Support during the period between no longer being a student and becoming a registrant
- Build resilience, and positive mental and emotional well-being, in both students and newly qualified staff;
- A 'go to person' for the most basic queries;
- A support network with newly qualified staff who are passionate about their role.

The newly qualified staff also reported benefits, for themselves, of being a 'buddy', such as developing leadership skills, passing on their experiences of humanistic approaches to patient care and maintaining links with the university.

Communication between buddies

It was unanimous that the initial meetings **must be face to face** with some protected time. The preferred model was reported to be drop-in sessions and action learning sets every other month. Social media to be used as a backup

J. Candidate Communications Toolkit

To maintain the recruitment edge in a highly competitive environment, it is important that HCPs maintain good communication, with prospective new members of staff who have been offered a post.

A large teaching hospital has developed a Candidate Communication Toolkit for use by the resourcing team and the recruitment managers. This toolkit is a step-by-step guide about 'what to do, when to do it, what to say and how to engage and communicate with the candidate in a vibrant and inspiring way' from the time when this trust receives an application from a prospective new member of staff to the day they commence work in that organisation.

The newly recruited staff have commented on how personal this approach is and that they really appreciated being treated as individuals whose application was important to the Trust.

K. Keeping prospective new staff 'warm' event

A trust holds a 'keeping warm' event when all newly qualified nurses and allied health professionals, who have been offered a post, are invited to the trust prior to starting work. At this event managers meet the new staff who will be working on their wards or in their departments. This is a good opportunity for potential new staff to network with each other, develop new friendships and gain support from each other, something that they can build on in practice.

L. Regional recruitment drive

The evidence from RePAIR is that students, on a traditional three-year undergraduate pre-registration programme, start to plan for their first job at the end of year two, beginning of year three.

A group of local trusts worked together to co-ordinate advertising vacant posts, suitable for newly qualified nurses. These trusts committed to the following:

- Releasing the advertisement for these posts on the same day;
- Employing all student nurses, who have had at least one clinical placement in their trust, on successful completion of their course;
- Where possible offer the newly qualified nurse a job in their preferred clinical area or negotiate a suitable alternative.

This approach is very popular with the students and has resulted in a reduction in unfilled posts.

RePAIR Step 4 Early clinical career

M. Preceptorship facilitator

The first 12 months, for any newly qualified member of staff, is the period during which they further develop the knowledge and skills, that they have gained throughout their pre-registration period, to become a confident, competent and accountable member of a multi-professional team[70].

A large teaching hospital recognised that new registrants benefit from additional support during this period and introduced the role of a preceptorship facilitator, to assist newly qualified staff enrolled on the trust's structured mandatory multi-professional preceptorship programme.

The introduction of this role as part of an already existing successful initiative, has reduced the attrition rate of preceptees, during the two year period (2016-2017), from 17 per cent to 4 per cent.

N. West London Mental Health NHS Trust and the Capital Nurse Foundation Programme

West London Mental Health Foundation Trust is a partner to HEE's North West London Capital Nurse Foundation Programme. In this programme newly qualified staff embark on a six monthly rotation and move clinical placements three times during the 18-month period. This programme runs alongside the Trust's 12-month preceptorship programme to help the newly qualified nurse gain clinical experience in a variety of settings to help them make an informed career choice. The nurses on this programme are allocated a 'Super-Mentor', who meets with them quarterly over the 18-month period.

They are also issued with a welcome pack

O. Legacy mentor in midwifery community service

Experienced staff who are retiring may be interested in changing their roles and reducing their number of working hours. A trust introduced a legacy midwifery mentor post based on the Canadian Legacy Mentor model[71]. A dedicated 'retire and return' Band 7 midwife who was formerly lead midwife in the community, was employed on a part-time contract (15 hours per week) primarily, although not exclusively, to support the preceptorship midwives when they rotate into the community setting.

This level of support has been highly rated by the preceptee midwives (more information can be accessed here).

P. 'Super-Buddy' and buddy system in midwifery

One trust reported that all their preceptee midwives are allocated a 'Super-Buddy' midwife for the first two weeks of any placement. The super-buddy shares a caseload with the preceptee and works alongside them. This helps build the confidence and the competence of the preceptee midwife, who is not scheduled to work night or weekend shifts during this period.

After the initial two weeks in any area the preceptee midwives are then allocated a buddy who supports them on every shift. This arrangement is in place for the 16-month preceptorship programme.

Anecdotally, this two-level buddy support scheme has been favourably received by the preceptees.

5.3.2 Workshops

103 members from the RePAIR 16 case study sites attended a workshop to share their RePAIR related activities, network and learn from each other and HEE's RePAIR team. The workshop participants illustrated key messages: improve support, 'step-up' transition from student to newly qualified activity and improve communication as shown in **figure 32**. The presentations and discussions were captured by a graphic artist (**figure 33**).

Following the RePAIR Community Workshop, a therapeutic radiography only workshop was held, which brought together representatives from the RePAIR case study sites, the Society and College of Radiographers and the HEE RePAIR team. The purpose of this workshop was to inform policy on best practice for the retention of therapeutic radiography students and early career therapeutic radiographers, towards and beyond registration and preceptorship.

Fig 32: Illustration created by workshop participants

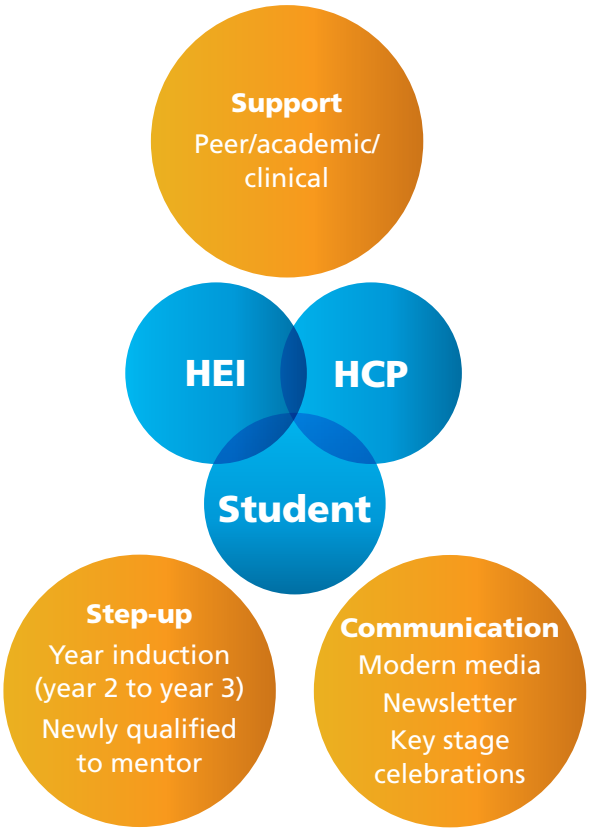
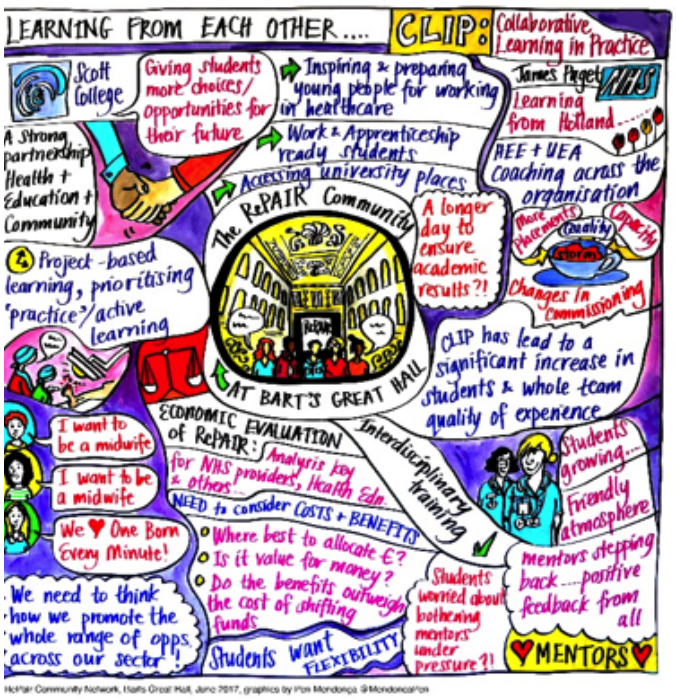


Figure 33: Graphic illustrations depicting the presentations and discussions at the RePAIR Community workshop



5.3.3 RePAIR Community Networks

Two informal RePAIR Community networks were established: preceptorship and therapeutic radiography, to inform RePAIR and continue beyond the lifespan of this project. The approach to setting up the networks was very different. The preceptorship network relied on email and the therapeutic radiography network used NHS networks.

The preceptorship network primarily considered the optimum length of a preceptorship course and shared examples of best practice. The emerging consensus, from this group, was that the minimum length of any preceptorship programme should be 12 months.

Three different models that the preceptorship network shared are set out below.

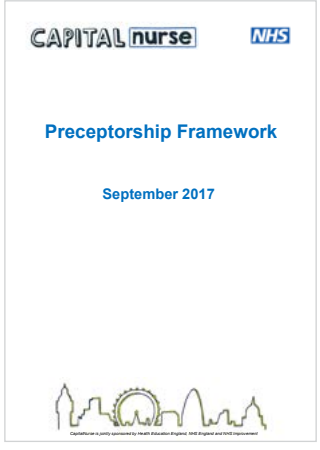
1. Derby Teaching Hospitals preceptorship model

This model reinforces the RePAIR commitment framework and aims to demonstrate HCP commitment to the newly qualified staff and help build their confidence during this period. They have also introduced a green lanyard, for easy identification of somebody who is newly qualified. The Trust has made a video about their preceptorship programme which can be **accessed here**).

2. CapitalNurse preceptorship programme

The CapitalNurse programme, funded by HEE has four main workstreams:

- Training
- Recruitment
- Retention
- Productivity



Under the retention workstream CapitalNurse has developed a preceptorship framework to standardise best practice across the capital.

Further information can be accessed here: https://www.hee.nhs.uk/our-work/capitalnurse/workstreams/preceptorship

3. Oxford University Hospitals Foundation programme

The Trust has developed a multi-professional (nurses, midwives and allied health professionals) two- year foundation programme.

This foundation programme is in two parts: the 12-month preceptorship programme for junior Band 5 staff and a second year leading to promotion to a senior Band 5 post, https://www.ouh.nhs.uk/working-for-us/nursing-midwifery/foundation-programme/default.aspx

After two years the focus is on development of new skills and specialist knowledge.

The **therapeutic radiography network** considered RePAIR Steps 1 and 2 and shared concerns about the challenge of raising the profile of the profession and recruiting students. Under Step 2 they commented particularly on Year 2 students, and discussed whether a focus on this group would be of value. One of the academic members of this network shared their pilot programme for second year students. This is showcased under Evidence of best practice **accessed here**.

5.3.4 Improving communication – Use of social media

Throughout RePAIR there is reference to the need to improve communication about all aspects of the clinical component of the pre-registration courses: communication between HEIs and service and communication with students about their practice placements. A group of learning disabilities nursing students suggested that an App could help with communication. One HEI has responded to this challenge and is developing a 'proof of concept' for an App that could facilitate shared access to information about practice placements. The outline can be **accessed here**.

6 RePAIR Economic Evaluation

6. Economic Evaluation

The approach taken by York Health Economic Consortium (YHEC) to develop the RePAIR economic evaluation and collecting the data is set out in Section 4 page 23.

This section[xii] outlines the combined findings of the economic evaluation across the four case study sites (five organisations) and draws conclusions which should be pertinent at the national level. In addition, the variables applied in this project have been used to develop an economic calculator (known as the RePAIR cost calculator) that can be used by any interested organisations. The calculator allows an organisation to enter data on its own attrition intervention programmes and will output the relevant results. To access the cost calculator, click here.

Each of the five participating organisations deliver a range of pre-registration healthcare programmes for the different professions in scope of RePAIR.

Each case study site has its own unique approach to the four types of intervention programme. An overview of the programmes, interventions and numbers involved in each of the organisations is listed in **table 23**.

Table 23: Programmes provided and numbers by professional group for each intervention

Organisation	Type	Buddying	No.	Transition into practice	No.	Preceptorship	No.	Social Media	No.
1	HEI	MHN	70	MHN	16			LDN	21
		TR	50	LDN	25			TR	195
2	HCP	AN	128	AN	128	AN	458		
3	HEI	AN	177	AN	177			AN	177
		CN	24	CN	24			CN	24
		MHN	28	MHN	28			MHN	28
		Mid	35					Mid	35
	HCP					AN	80		
						CN	25		
						Mid	25		
						TR	5		
4	HCP	AN	103	AN	103	AN	103	AN	103
		CN	8	CN	8	CN	8	CN	8
				Mid	30	Mid	30	Mid	30

Code: AN - Adult nursing; CN - Children's nursing; MHN - Mental health nursing; LDN - Learning disabilities nursing; Mid - Midwifery; TR -Therapeutic radiography

Improving retention intervention models

The intervention models varied by case study site. A brief overview of the key features of the four improving retention intervention programmes as implemented in the participating organisations can be found in **Appendix 6**.

xii The text is based on YHEC's final RePAIR economic evaluation report submitted to HEE

6.1 Programme costs

In health economic evaluations, costs are typically restricted to monetary costs. These usually consist of direct costs such as staff costs or drug costs. Indirect costs such as patients' lost earnings or travel costs are not usually considered, but may be if a more societal perspective is taken.

The costs considered for the RePAIR project were the implementation of the individual intervention programmes. These are direct costs to the organisations and relate mainly to staffing and materials costs. It can be argued that the cost of staff time is not a real cost in the sense that if the time comes from existing staff, there is no additional cost to the organisation. This is referred to as an opportunity cost, where we are costing the time that could be spent carrying out other duties.

For the purpose of developing the economic model all staff costs (staff grade and number of hours the staff spent on the programme), and any non-staff costs were provided by the organisations. A cost was then attributed to these using values from the Personal Social Services Research Unit[72], based on the mean full-time equivalent basic salary for each Agenda for Change Band and include salary on-costs, management and capital overheads. The values used are the costs per working hour, rather than the costs per hour of patient contact.

There is a wide range of costs for each programme, the most important of which is staff costs. **Table 24** shows the proportion of the total costs that are staff costs (set up and running costs) for each site, for each programme.

Table 24: Percentage of staff time for set up and running costs for each intervention programme

Site	Programme	Set up costs - Staff costs as percentage of total (%)	Running costs - Staff costs as percentage of total
1	Buddying	97	88
	Transition into Practice	84	93
	Use of Modern Media	98	98
2	Buddying	99	99
	Transition into Practice		100
	Preceptorship	68	99
3	Preceptorship	100	100
4	Buddying		100
	Transition into Practice		
	Preceptorship	100	100
	Use of Modern Media	100	

The most substantial non-staff costs were the costs of accreditation for the programmes and of externally-contracted training sessions.

6.2 Evidence of impact

To calculate the net cost or benefit of the interventions to improve retention, it is necessary to have an estimate of their impact. This has proved to be particularly challenging for a number of reasons. The participating sites were not able to report data on their attrition levels for this economic evaluation. In two instances, however, sites have had data on the number of staff or students who leave the organisation in ways that might be related to a definition of attrition. For example: for one of the organisations the percentage of preceptee leavers during 2014-15 was 15 per cent. This organisation reviewed its preceptorship programme and the percentage of preceptee leavers dropped by 10 per cent to a consistent 5 per cent annually over the four year period 2015 – 2018.

To augment this limited data set, evidence from literature was sourced. The papers that provided quantified evidence on the impact of specific attrition intervention programmes reported the following:

- A systematic review on the effectiveness of interventions to improve the transition from student to newly qualified nurse showed a 5.8 per cent reduction in turnover[73];
- A study that indicated preceptorship programmes increase retention rates by 30 per cent to 50 per cent[74];
- Specialised orientation programmes improved retention from 84 per cent to 94 per cent[75];
- Sites with transition into practice programmes had turnover of 15.5 per cent compared to 26.8 per cent for the control group. Retention was 86 per cent in high preceptorship hospitals compared to 80 per cent in low preceptorship hospitals[76].

Given the variability of the evidence available, a moderately conservative level of a 10 per cent decrease in attrition was adopted for those intervention programmes for which there is published evidence of impact, i.e. preceptorship and transition into practice. For the other two programmes (buddying and use of modern media), no estimate of impact was made because of lack of evidence and therefore, these have not been included in the cost-benefit analysis.

6.3 Costs of attrition

To compare costs and benefits, and identify a net impact, it is necessary to estimate a cost of attrition for both HEIs and HCPs. In the case of HEIs, the financial loss related to a person abandoning a course is assumed to be the loss of the tuition fees. Over a three-year course, we have assumed the average loss would be 1.5 times the annual fee, based on an assumption that the average leaver would leave halfway through their course.

For HCPs the estimation of the costs of attrition is more complex. As part of the brief literature review, evidence on the costs of attrition was sought. The principal relevant evidence, found, was a 2015 report from the School of Health and Related Research at the University of Sheffield[77]. This report considered the costs of replacing a nurse working in the NHS. It concluded that the total cost of replacement could be two times the annual salary of the nurse who has left. The costs relate to a number of aspects including advertising, recruitment, backfill and lost productivity. For the purposes of this analysis, we have assumed that this would mean two times a Band 5 healthcare practitioner's salary, based on the costs of employment for a Band 5 nurse (not including London weighting).

The economic benefits of reducing attrition used in the cost-benefit calculations below are, therefore:

- Cost of reducing attrition for one pre-registration student in an HEI: £13,875
- Cost of reducing attrition for one health care practitioner in an HCP: £63,980

There is considerable uncertainty about both these cost assumptions. To mitigate this, a sensitivity test has been carried out, using one year's salary (£31,990) instead of two years' salary to assess the impact of this value on the final results.

6.4 Cost-benefit results

Using the cost and benefit estimates, the net impact has been calculated for the transition into practice and preceptorship programme for each site that provides these programmes. The results are given in **table 25** (transition into practice programmes) and **table 26** (preceptorship programmes).

Table 25: Annual cost-benefit results for transition into practice programmes

Site	No. staff retained	Total benefit of programme (£)	Total cost of programme (£)	Net cost/ benefit (£)	Net cost/ benefit sensitivity test (£)
1	4.1	56,888	20,191	36,696	
2	12.8	818,944	331,450	487,494	78,022
4	14.1	902,118	2,183	899,936	448,877

Table 26: Annual cost-benefit results for preceptorship programmes

Site	No. staff retained	Total benefit of programme (£)	Total cost of programme (£)	Net cost/ benefit (£)	Net cost/ benefit sensitivity test (£)
2	46	2,930,284	602,550	2,327,734	862,592
3	13.5	863,730	10,710	853,020	421,155
4	14.1	902,118	8,123	893,996	442,937

6.5 Economic evaluation results

Among the organisations participating in this economic evaluation, there is widespread use of a variety of programmes designed to reduce attrition and in some cases these programmes have been running for a number of years. At the same time there is considerable overlap between programme types. This implies that there is broad support for the principle of programmes to reduce attrition, but it is difficult to differentiate between the focus of each type of intervention programme.

Some organisations are repeating the same techniques and elements in different programmes for staff or students. Therefore, it is difficult to isolate the effect of one specific intervention programme for a particular professional group. The attrition reduction interventions are broadly seen as an overall programme to reduce attrition rather than having specific targets for each type of approach.

The results of this economic evaluation are generally positive if the assumptions made are valid. That is to say, the estimated benefits of the programmes are greater than the costs of setting up and running them. Adopting a sensitivity analysis, whereby the benefit attributed to the avoidance of attrition for HCPs was halved, did not produce any negative results.

There is a very wide variation in the amount of resource put into these programmes by different sites. One site puts a very large amount of resource into all of its programmes. Other sites put very low resource input into programmes.

The RePAIR cost calculator (**access here**), allows the user to input their own data and to run analyses for their own interventions. The calculator will allow all important cost and benefit inputs to be varied to allow the user to develop different scenarios, such as the threshold of the value of benefits required to ensure that a programme is cost-effective. This should be useful in helping users to make business cases to introduce attrition intervention programmes.

There is a case to be made for inter-organisational learning to compare different interventions and to share the learning from varied experiences. This may help to clarify differences in the interpretation of different interventions and could support a programme of identifying and disseminating good practice across the country. Organisations should be encouraged to collect data on attrition and the effects of intervention programmes more systematically, in order to generate more reliable evidence.

6.6 Limitations of this economic evaluation

The difficulty of isolating the effect of different interventions has meant that a pragmatic approach has been taken to estimating their economic impact. This is compounded by a lack of data on the effect of the interventions and only limited evidence available through literature.

The process of data capture has been challenging for all the participants in this evaluation. Ascribing the number of hours used for each intervention, especially for the set-up phase, which requires retrospective attribution, has most likely resulted in approximations across the board. As a result, these findings should be taken as indicative only and not as precise calculations of the cost-benefit of attrition reducing interventions.

The value of 'benefit per person retained' as used here, is based on assumption. This is the most recent value that has been found in the literature and, in general, this area is not well documented. The sensitivity analysis – reducing this benefit by half – has been undertaken to test the robustness of this value. It produces substantive change, but all results are still positive. The RePAIR cost calculator will allow users to explore how changing the value of key inputs impacts on the results.

A standard value has had to be adopted for the level of benefit from these interventions (i.e. a reduction in attrition of 10 per cent), which has the effect of generating higher levels of net benefit for courses with lower input costs.

It has not been possible to address the question of additionality with the data available. This is the question of whether the benefits of each intervention are additional to the benefits of other interventions. This is pertinent for four of the five organisations providing more than one type of intervention, where participants are benefiting from more than one of them.

7 RePAIR
General discussion, conclusions and recommendations

7. General discussion, conclusions and recommendations

7.1 Introduction

This large scale national project with a unique data set has enabled HCPs and HEIs across England to 'rekindle the discussion' about what we can do to improve retention. It has also enabled stakeholders across England to come together as a RePAIR Community to learn from each other and share examples of best practice.

However, before considering the findings, it is important to reflect on the limitations of the project that are relevant to the conclusions drawn, the key messages from RePAIR and the recommendations made.

Much of the existing evidence about attrition and improving retention in healthcare is primarily, although not exclusively, about nursing. Similarly, a significant amount of the data collected during this national project relates to nursing. Nevertheless, the conclusions and proposed principles of best practice apply equally to the other professions considered in the project: midwifery and therapeutic radiography.

Post the implementation of the Comprehensive Spending Review there is still no nationally agreed HEI standardised approach to collecting continuation and completion data, for students studying programmes in scope of RePAIR, and the opportunity to address this via traditional performance management approaches between HEE and HEIs is no longer feasible. Although, there is some case study data that enables a picture to be built around likely scenarios, without detailed cohort data it has not been possible to provide conclusive evidence of what happens to students who do not complete their programme of study on time, i.e. within the standard time period for a particular course.

Much of the qualitative data was sourced from the student's survey, student focus groups and group discussions. As the participants were largely self-selecting, it is possible that such data may be skewed to present either the best or worst impression.

Although fewer than 5 per cent of the potential survey sample completed the survey, the quantitative data collected was robust and representative of the RePAIR professional groups, such that conclusions could be reached and recommendations made.

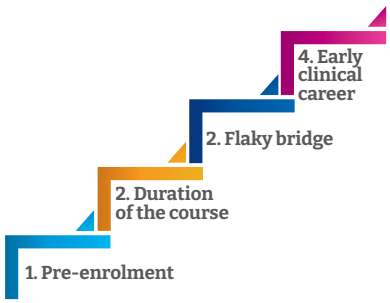
In this section the findings from RePAIR are discussed in line with the project aims, the four Steps of RePAIR and the project commitment framework (**figure 34**). Conclusions are drawn and the recommendations made. Recommendations 1 and 2 apply across all four Steps of RePAIR, the remaining 12 recommendations are presented according to the Steps of RePAIR.

Figure 34: RePAIR project aims, Steps and framework

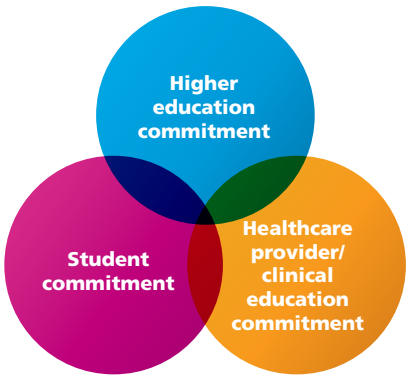
Project aims

- Provide a standard definition for attrition and establish a baseline.
- Establish a detailed understanding of the multi-factorial aspects of attrition and retention in pre-registration education and training.
- Identify best practice and isolate the factors that are in place for retention to be optimised.
- Promote spread of identified best practice across England.
- Agree a sustainable national approach to improving pre-registration retention.

Steps of RePAIR



RePAIR commitment framework



7.2 Standardisation of indicators of attrition

This project was established in response to the Department of Health's mandate to HEE to reduce avoidable attrition from training by 50 per cent by 2017. This has proved to be extraordinarily difficult because, at a national level, there is no standard definition of attrition, or a standardised approach to measuring pre-registration attrition. Nonetheless, and largely because of the goodwill of the university sector, the first national data set was collected, for the numbers of students on programmes covered by RePAIR, over the two-year period (2013/14 – 2014/15), who completed on time. The result was an average of 33.4 per cent did not complete on time.

Using observed expected attrition to analyse the HESA student records, for the period 2009/10 – 2016/17, the percentage change improvement in years two and three of programme was calculated to be in the region of 50 per cent.

The literature reminds us of the costs, to the system, of non-completion and how essential it is that a single national reliable approach to collecting this data is developed.

Recommendation 1

National Bodies should work together to review the current range of definitions of attrition, and model(s) for measuring this metric, to ensure that the output data is meaningful to all parts of the sector, in particular the HCPs.

7.3 Costs of interventions to improve retention

Despite the resources required to drive improvement in student and newly qualified practitioner retention, RePAIR did not find any evidence of institutions calculating the cost effectiveness of interventions to reduce attrition. HEE therefore decided to commission a model of economic evaluation and the development of the RePAIR cost calculator (**access here**).

Recommendation 2

HEIs and HCPs should work in partnership to acquire a better understanding of the cost effectiveness of interventions that are designed to improve retention.

7.4 Factors affecting retention

The overwhelming preferred concept for the basis of this project was retention: how many students stay in the system and why they choose to stay, rather than the more traditional concept of attrition (why students leave).

The quantitative student survey results were mostly very positive. It is especially encouraging that nearly all students intend to pursue a career in their degree field and feel their degree had been a positive experience, and that nearly nine out of every ten students would recommend their degree to their friends and family. Organisations reviewing approaches to retention should build on these findings.

Step 1: Pre-enrolment

Financial pressures

However, there were some challenging findings from the 2016 survey, which if unaddressed could potentially affect the supply of the newly qualified practitioners in scope of RePAIR. The evidence from RePAIR is that students worry a lot about financial pressures. This may suggest that there needs to be targeted financial support to encourage applications from those considering a career in these fields of healthcare. HEE, HEIs and HCPs should recognise that for some prospective students the alternative routes into the professions including nursing associate and apprenticeship roles may be a more appropriate option and should be encouraged.

Recommendation 3

HEE should seek ways to make hardship funds available to encourage more prospective students, particularly mature students, to embark on a career in nursing, midwifery or therapeutic radiography.

Wrong career choice

The data from RePAIR suggests that students who leave early in the course do so because of a wrong career choice or because they are insufficiently informed about the profession, particularly in adult nursing and therapeutic radiography. Although, there is no evidence to suggest that students recruited during clearing perform less well, the literature suggests that those who apply late have less commitment to the programme and institution.

Post the review of student fees, HCPs need to have developed their relationships with the HEIs so that there is a clear understanding between them that students will not be accepted onto placements unless the HEI is working within the HEE's Values Based Recruitment Framework[34], and that staff from the HCPs are actively involved in recruitment.

Recommendation 4

HEIs should ensure clinical staff are actively involved in recruitment and that prospective students really do understand the career they have chosen to enter and the demands of the course.

Step 2: Duration of the course

Buddy schemes

Surprisingly the project found very little evidence of established buddy schemes, despite the acknowledgement that students turn to other students, and former students, for help and support. Students engaged in formal buddy schemes were very positive about them. Students who did not have the opportunity to participate in a scheme suggested a 'supported buddy scheme' would help them cope with the pressures of the course. Where schemes exist, they normally involve third year students supporting first year students. A buddy scheme that embraces all the Steps of the RePAIR journey, from the time they are offered a place on a course to the early clinical career, would support the students at all stages and help senior students and newly qualified practitioners to develop their mentoring and supervisory skills. It would also help students to think about their personal development and prepare them for revalidation, if it is required.

Recommendation 5

HEIs should review, in partnership with their students, the institution's approach to buddy schemes for healthcare students.

'Year 2' students

Repeatedly students commented on how much harder year two is than year one. The academic demands are much greater in the second year, or the middle part of the course, and Year 2 students are required to submit academic assessments while they are on clinical placement. As a result, 48 percent of this group of students have considered leaving the programme.

The prior clinical experience of Year 2 students is assumed to be standardised, when this is rarely the case.

The evidence from RePAIR is that Year 2 students have less support than either Year 1 or Year 3 students and neither the HEIs nor the HCPs, in the case study sites, had considered introducing programmes aimed at providing additional support, specifically for students in the second year.

Recommendation 6

HEIs and HCPs should work together to develop specific programmes of support for second year students.

Placement allocation and associated costs

A significant number of students reported experiencing enough difficulties to warrant leaving. This suggests that more needs to be done to support students. A noteworthy frustration for students is the disorganisation of courses. Principally, the lack of forward planning about placement allocations. Mature students, particularly those with family commitments or other caring responsibilities, commented on the anxiety of not knowing where they are going to be placed in the following weeks. Both HEIs and HCPs defend the current position and argue that it is not possible to commit placements well in advance. However, given the level of concern about the uncertainty, and that there are institutions that have resolved this issue, it is suggested that more attention should be given to this issue. Students also reported concerns about costs associated with clinical placements: travel, parking and delayed reimbursement.

Recommendation 7

HEIs should work more closely with their HCP partners and map out detailed placement allocations for all the students, throughout the duration of their course. They should also review processes relating to placement costs and ensure students are reimbursed in an efficient and timely way.

National model of support for students in the clinical department

The clinical component of the course is extremely important to students. There were some very positive responses about the clinical learning experience with 85 per cent of the respondents reporting that the clinical placements are of a high quality and offer a good learning environment. The major concern regarding the clinical component of the course is the variation in levels of commitment to student learning. Students are motivated by inspirational teaching and staff who are committed to facilitating learning opportunities. However, they frequently commented on the challenges they face in the current clinical environment. They recognise the clinical pressures and sometimes find the service complex and overwhelming. They worry about staff shortages and low morale. They recognise that for many supervisors/mentors, students' learning is not their main priority and they simply do not have enough time to teach students.

There is evidence from RePAIR that a planned approach to supporting the service to help the students, improves student retention. HEE's quality framework40 provides guidance on the standards of best practice.

It is disappointing to learn from the case study sites that much of the funded support for bespoke clinical practice support posts e.g. practice education facilitators and therapeutic radiography joint appointments between HEIs and HCPs, has or is being discontinued, without a clear understanding of the longer term impact and the ultimate costs of doing so. Some students, particularly adult nursing students, report that they have never been visited by a course tutor while on placement. This may be simply because the student's duty rota did not coincide with a tutor visit. Nonetheless, if this is the perception, then there is a need for a clearer process for communicating to students and supervisors/mentors the different levels of support available to them.

Recommendation 8

HEE should work with HCPs and HEIs to ensure that its' national strategy, to support students in clinical practice and their supervisors/mentors, is implemented.

Student's role in the clinical department

A substantial number of students expressed concerns around expectations of training. In some services they are seen as 'extra pairs of hands', so potentially missing out on valuable clinical training. Equally challenging is the way that supernumerary is interpreted. For some centres supernumerary means students are not allowed to take any responsibility, even in the period leading up to qualifying. Students who commented on this urged the HCPs to give final year students more opportunity to take responsibility towards the end of their course, and enable them to gain the confidence in their knowledge and skills before they cross the 'flaky bridge'. There is evidence in the literature that points to risks of 'fragile confidence' amongst newly qualified practitioners, who have been given very little chance to demonstrate, to themselves, their confidence in their decision making and competence to manage routine care.

Recommendation 9

HCPs and HEIs should work together to resolve the dissonance that exists concerning some students' understanding of their role in the service and the interpretation of students' supernumerary status, particularly for third year students.

Standardised approach to clinical assessment documentation

A challenge for the clinical assessors is the multiple models of practice assessment documentation they must complete. For some mentors they may have up to six different designs of practice assessment documents. The mentors emphasised how difficult this situation is and some of the students noted that the mentors ask them for help in completing their documentation.

This unsatisfactory situation is further complicated by an expectation that at any stage of a course all students on that course at a particular time will have had the same, if not very similar, clinical experience up to that point. However, this is not always the case. For example, some pre-registration programme leaders enable their students to gain clinical experience within the first three months of a course and to gain a range of different experiences early in the programme of study, whereas others prefer to defer allocating students to placement until later in the programme. Some students have tried to address this problem themselves to help the supervisors/mentors and provide details of their clinical experience at each stage of the course. From a clinical perspective referring to the students as first year, second year, third year students may not truly indicate their previous clinical experience.

Recommendation 10

HEIs should work together to agree a national standardised approach to assessing and recording students' clinical competence, including a simple process of recording students' prior clinical experience.

Step 3: Flaky bridge

Levels of student confidence

Very little is understood about students' confidence levels at different stages of the course. The project found no evidence of the sector trying to understand this and the factors that affect their fluctuating levels of confidence.

Recommendation 11

HEIs should develop a clearer understanding of factors that affect student confidence levels, particularly at the point of progressing from student to newly qualified practitioner.

Step 4: Early clinical career

Preceptorship model as an aid to recruitment and retention

One of the key trust recruitment aids is the preceptorship model. Students who are not tied to a particular location will judge a trust by its' model of preceptorship: the level of support they will get; whether there is an optional rotation, and any rewards (accreditation) during the preceptorship period.

Students about to qualify are also interested to understand if the preceptorship programme requires them to demonstrate, for a second time, previously acquired and signed off competencies. Only one of the HCPs in the RePAIR Community reported that they had designed their preceptorship programme in partnership with their local education provider. The suggestion from the RePAIR preceptorship network is that 12 months should be the minimum length of time for a preceptorship programme.

RePAIR evidences a direct correlation between the support offered during preceptorship (the smooth transition across the flaky bridge) and newly qualified practitioner attrition. The participants in the project repeatedly asked for dedicated time when the preceptor and preceptee can discuss the preceptees development. Furthermore, RePAIR found little evidence of robust training programmes for the preceptors.

RePAIR

The indication in the literature is that some newly qualified practitioners, particularly those from the younger generations, prefer a range of different clinical experiences before they settle into one clinical field. A preceptorship model with an optional rotation offers them this opportunity.

Recommendation 12

HCPs should review their preceptorship programmes, ideally in partnership with HEIs, to improve recruitment and retention of their newly qualified staff and ensure the preceptors are appropriately trained.

Recruitment of newly qualified practitioners

As recruitment of newly qualified practitioners becomes more competitive trusts are starting to advertise their posts to students who are either at the end of year two or the beginning of year three. The evidence from RePAIR does not favour one approach over another. However, what the evidence shows is that students hope to be offered a post where they have been trained, and do not understand why trusts, that pass students as competent to practise, will not offer them a post as a newly qualified practitioner.

The emerging evidence suggests organisations that have established a co-ordinated approach to local recruitment, whereby students looking to work in a particular location know when the trusts will be recruiting and what the process will be, are finding that this is proving to be popular with the students and that recruitment is more successful. Organisations that are struggling to recruit, in some areas, might like to consider integrated/cross organisational rotations which may attract the younger generation of newly qualified practitioners.

Recommendation 13

Neighbouring HCPs should work together, and with their local education providers, to agree a shared model of recruiting newly qualified practitioners.

Impact of culture of care and early career choices

Students have pointed out that if they experience a poor culture in a particular clinical setting they will not consider applying for a post in that trust. Worryingly, there is some evidence within the RePAIR Community that a poor culture of clinical care negatively impacts on how well the students perform in that setting, and some students reported being bullied in the clinical placement. This project did not find any evidence of trusts tracking students who train in their organisation to determine who then goes on to work for them.

Recommendation 14

HCPs should gather data about the culture of care in the clinical environments, in which the students are training, to understand the impact of that culture on students' early career decisions.

Summary

RePAIR has reaffirmed the well-established fact that attrition and retention are affected by many different factors (**figure 35**). Stakeholders (students, higher education institutions and healthcare providers) must all do better to increase their commitment to each other, in order to improve retention and own the individual contribution they can make to reduce attrition.

Figure 35: Summary of factors to improve retention – according to RePAIR

8 RePAIR

Application of RePAIR to the new models of pre-registration education and training

8. Application of RePAIR to the new models of pre-registration education and training

Since the start of RePAIR there have been two significant national initiatives concerning pre-registration health and social care education and training. The first relates to HEE's introduction of the Nursing Associate role, with the option to progress to pre-registration nursing, originally conceptualised in the study 'Raising the Bar - Shape of Caring'[3]. The second is the development of pre-registration apprenticeship programmes in health and social care.

The extent to which the findings from RePAIR can be read directly across to these additional new models of education and training was not in scope of RePAIR. However, throughout RePAIR consideration has been given to the wider application of the findings and recommendations of this large project.

Recommendation 15

HEE should seek to understand the relevance of the findings from RePAIR to the new models of pre-registration education and training that are being implemented in health and social care.

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10 RePAIR Appendices

10. Appendices

Appendix 1: Student survey statements and response rate

Appendix 2: Different approaches to measuring attrition

Appendix 3: Methodology for measuring observed expected attrition

Appendix 4: Reference table - Higher Education Statistics Agency attrition trends

Appendix 5: Reasons why students considered leaving

Appendix 6: Economic evaluation intervention programme models

Appendix 1: Student survey statements and response rate

Application process

Statement	% strongly agree/Agree
The application process was straight forward.	91
Securing a place at the university of my choice was very important.	97
The reputation of the university in terms of teaching and/or research is the most important criteria when choosing a course.	88
The reputation of the university in terms of social life is the most important criteria when choosing a course.	33
I struggled to make a choice about which course to study as there were so many to choose from.	14
Visiting a clinical placement prior to starting the course is very important.	62
Where I would get my clinical training was a deciding factor when choosing to apply for this course.	66
The university was a deciding factor when choosing to apply for this course.	64
It is important that this professional course is delivered equally by the university and the clinical placement providers.	97
The students I met at the open day were very positive about the course.	93
The information that the university provided prior to starting the course was excellent.	84
I would not have applied for this course if I had been required to pay the course fees.	63
My future employment prospects upon graduation was an important criterion when selecting a course.	96
An important criterion for selecting a course was the overall value for money I felt the course would provide, in terms of both academic and social life.	59

Introduction to academic and placement learning

Statement	% strongly agree/Agree
At the beginning the university provided sufficient information about the course.	89
I was buddied with a more senior student at the beginning of the course.	32
The student buddy was key to helping me settle into the course.	18
The length of the clinical induction (first clinical placement) was sufficient.	89
I was sufficiently supported during the clinical induction (first clinical placement).	83
My mentor (placement educator) was hardly ever on the same shift as me.	27
I was able to feedback my concerns to the university.	89
The university effectively actioned my feedback.	78

University-based learning

Statement	% strongly agree/Agree
The academic workload was a bit of a shock at first.	68
The academic staff are really helpful, if you are struggling they will listen and try to help.	88
The quality of the teaching is very high.	86
My personal tutor has been fantastic, really supportive.	81
The programme feels a bit disorganised at times.	69
The course documentation is very informative.	85
The online resources are really good.	92
The PowerPoint presentations were informative.	88
I like small group sessions.	86
Sometimes I struggle to complete course work on time.	36
The feedback on my assessments has not been helpful.	32
On the whole it has been a positive experience.	93

Placement-based learning

Statement	% strongly agree/Agree
It is very important that I am allocated to a placement of my choice.	66
I attended the first clinical placement too early on in the course.	12
I have enjoyed every single placement.	62
The clinical placements are of a high quality and are a good learning environment.	86
Placement allocation is a problem, there seems to be no consideration of where you live.	47
Travelling to and from placement was hard work because it meant long days	62
As long as I covered the hours in practice my mentor (practice educator) gave me permission to start and finish a shift to help with the travelling.	45
I think the staff in the placement are using the students as an extra pair of hands.	67
The amount of thought, care and consideration that has gone into looking after students was impressive.	67
You feel you are not really respected on placement.	34
My visiting lecturer (a member of the university staff who visited me in clinical placement) was really helpful.	64
My visiting lecturer gave me good advice	66
I feel very supported while I am in clinical placement.	77
I am confused about the use of the terms mentor and sign off mentor.	28
I am struggling to complete my practice assessment document.	25
The staff on the ward or in the department are very committed to their career choice.	80

Personal circumstances

Statement	% strongly agree/Agree
I was quite unprepared for the amount of work I had to do.	40
I have a lot of support from my family.	85
I spend a lot of time caring for a family member (e.g. child or parent).	37
Money is tight so paying for placement travel is a struggle.	86
I have the constant worry that I am getting more and more into debt.	74
The friendships I have made have helped me to continue on the course.	87
I carry on because I just keep thinking about the end goal and where it is going to get me.	97
I made the correct decision to enrol on this course	96
I feel like a student while I am on the university campus	82
I feel like a trainee/apprentice while I am on the university campus	42
I feel like a student while I am in the placement-based learning setting.	81
I feel like a trainee/apprentice while I am in the placement-based learning setting.	65
I am well supported in developing my career.	89

Personal reflections

Statement	% strongly agree/Agree
The programme of study has met or meets the expectations I had at the start of the course.	86
The curriculum has been appropriate to my learning needs.	86
I was very clear before I enrolled on the course what type of clinical service I wanted to work in e.g. acute, community, elderly care, oncology.	56
I still want to work in the same clinical service as I did before I enrolled on the course.	51
I would recommend my course to friends and family, if any of them expressed an interest in pursuing a career in this area.	87

Furure career

Statement	% strongly agree/Agree
It is too early to say whether I plan to apply for a post once I am qualified.	28
I am confident that I will be fully prepared for employment at the point of qualifying.	77
There are plenty of employment opportunities in my chosen profession.	93
I intend to pursue a career in my degree area within the next three years.	97

Appendix 2: Different approaches to measuring attrition

Education Commissioning for Quality (ECQ)

HEE's use of ECQ definition has been used to good effect at programme, HEI and local office level, but variation in interpretation regarding interrupts and extenders, starters and definition of transfers means that this data cannot be aggregated at a national level. The data also remains live and therefore changes until a cohort is 'complete' means that attrition is only ever correct at a point in time.

Uni stats

This method uses the student identifier number and tracks whether a student continued the following year. Individuals are only seen as 'continuing' if they are registered on the same course and same HEI a year later. If completing a course that year they will be classified into the 'qualifying pot'.

Performance indicators

This is an extension of method above. It tracks from first year into following year across courses and HEIs. E.g. if a student starts on one course but transfers to another course or another university. This method uses name/ date of birth etc. to track students. It is a complicated methodology to pick up across institutions.

It has a supplementary table: indicating those students who appear not to be continuing, and whether they then return to their study a year after. Published the following year to pick up students a year on. (1st December census point).

Projected method

This uses the mapping method of tracking students between HEIs and presents a forecast or projected pattern of student movement, based on historic patterns from that particular HEI. E.g. an 80% completion rate would be carried forward. Using the same projection method, it is possible to model how many go from inactive to studying the following year, until they all reach an end point. A student having 'left' a course is defined by them as being inactive on a course for 2 consecutive years.

It makes some very broad assumptions based on patterns from individual HEIs, regardless of subject. Benchmarks are produced alongside this to indicate how an HEI is performing in line with the sector and is based on other assumptions.

Appendix 3: Methodology for calculating observed expected attrition

HEE, using HESA student records, has developed observed expected attrition as a high level measure for measuring attrition during training. This measure assumes that students will generally graduate after completing three years of a programme. It also assumes that for a cohort starting in a given academic year, expected attrition after three years of a programme should therefore be equal to:

*100 * ((100-Y1 attrition%)/100) * ((100-Y2 attrition%)/100) * (100-Y3 attrition%)/100)*

Where:

- Y1 attrition% is % of students leaving in Year 1 of the programme;
- Y2 attrition% is % of students leaving in Year 2 of the programme;
- Y3 attrition% is % of students leaving in Year 3 of the programme.

We have counted a student as having dropped out in HESA student record data, where 'reason for ending instance' on an individual student record is either of the following:

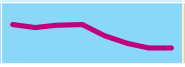
- academic failure/left in bad standing/not permitted to progress;
- health reasons;
- death;
- financial reasons;
- Other personal reasons;
- Written off after lapse of time;
- Exclusion;
- Gone into Employment;
- Other.

It is likely actual attrition – the actual attrition for those starting in the first year of a programme for a given year – will differ, and may in fact be higher. This reflects the fact that even for programmes of three years duration, a number of students will often need longer to complete, meaning up to five to six years of data is required for accurate assessment.

We therefore use observed expected attrition to provide an approximate assessment of attrition in the absence of a sufficient number of cohorts, based on observed patterns by year of programme.

Appendix 4: Reference table for observed attrition

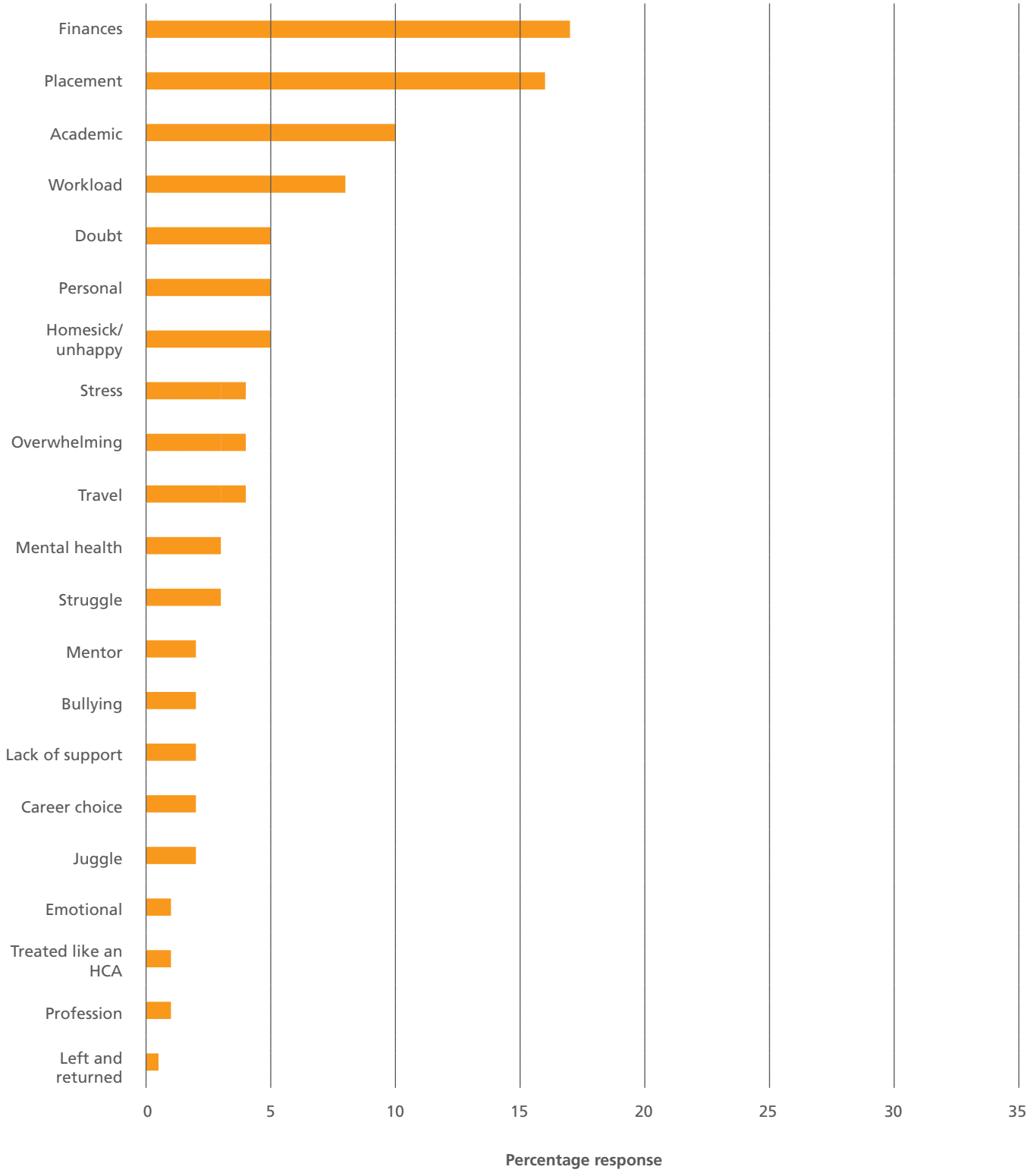
Table 27: Reference table - percentage attrition, by year of programme and course, 2009-10 to 2016-17

		& attrition, by year and course										
Year of Prog.	Subject	2009 -10	2010 -11	2011 -12	2012 -13	2013 -14	2014 -15	2015 -16	2016 -17	Trend	Average attrition	% change in expected attrition 2009-10 to 2014-15
1	Midwifery	7.0%	6.3%	6.6%	7.0%	6.3%	6.0%	4.8%	5.5%		6.2%	-21%
1	Nursing - adult	9.2%	8.0%	8.4%	8.1%	6.2%	5.4%	6.1%	6.3%		7.2%	-31%
1	Nursing - children	7.7%	8.3%	8.2%	8.4%	7.7%	6.0%	5.8%	6.9%		7.4%	-10%
1	Nursing - learning disability	7.4%	8.0%	10.8%	9.5%	9.5%	9.2%	9.6%	7.5%		8.9%	1%
1	Nursing - mental health	10.5%	8.0%	7.9%	7.6%	8.2%	8.0%	5.8%	6.6%		7.8%	-37%
1	Radiography - therapeutic	28.8%	18.3%	11.5%	12.8%	10.8%	9.6%	9.7%	10.8%		14.0%	-63%
1	**TOTAL**	**9.2%**	**8.0%**	**8.2%**	**8.1%**	**6.7%**	**5.9%**	**6.0%**	**6.4%**		**7.3%**	**-30%**
2	Midwifery	6.0%	5.6%	6.9%	6.0%	4.7%	4.8%	4.6%	4.1%		5.3%	-31%
2	Nursing - adult	6.5%	6.8%	6.8%	6.1%	4.5%	3.7%	3.3%	3.5%		5.1%	-46%
2	Nursing - children	6.6%	6.3%	5.7%	5.0%	4.5%	2.4%	3.1%	2.7%		4.5%	-58%
2	Nursing - learning disability	10.5%	8.2%	8.4%	7.4%	4.5%	4.0%	8.9%	8.1%		7.5%	-23%
2	Nursing - mental health	6.2%	6.6%	5.8%	5.3%	4.8%	3.1%	4.1%	3.7%		5.0%	-41%
2	Radiography - therapeutic	14.3%	6.9%	9.8%	8.4%	5.6%	6.0%	5.4%	6.4%		7.8%	-55%
2	**TOTAL**	**6.6%**	**6.6%**	**6.7%**	**5.9%**	**4.6%**	**3.7%**	**3.7%**	**3.7%**		**5.2%**	**-44%**
3	Midwifery	2.6%	2.8%	3.2%	3.4%	2.2%	1.8%	1.4%	1.3%		2.3%	-51%
3	Nursing - adult	2.5%	2.5%	2.6%	2.5%	2.0%	1.6%	1.3%	1.2%		2.0%	-53%
3	Nursing - children	2.9%	2.1%	1.0%	2.2%	1.5%	0.7%	1.2%	1.2%		1.6%	-60%
3	Nursing - learning disability	4.0%	2.1%	2.3%	1.7%	2.2%	1.9%	1.9%	1.2%		2.2%	-71%
3	Nursing - mental health	3.2%	3.0%	3.4%	3.4%	1.8%	1.6%	1.0%	1.2%		2.3%	-61%
3	Radiography - therapeutic	0.8%	0.8%	2.2%	2.8%	3.2%	2.3%	1.0%	0.7%		1.7%	-3%
3	**TOTAL**	**2.7%**	**2.5%**	**2.6%**	**2.7%**	**2.0%**	**1.5%**	**1.3%**	**1.2%**		**2.1%**	**-55%**

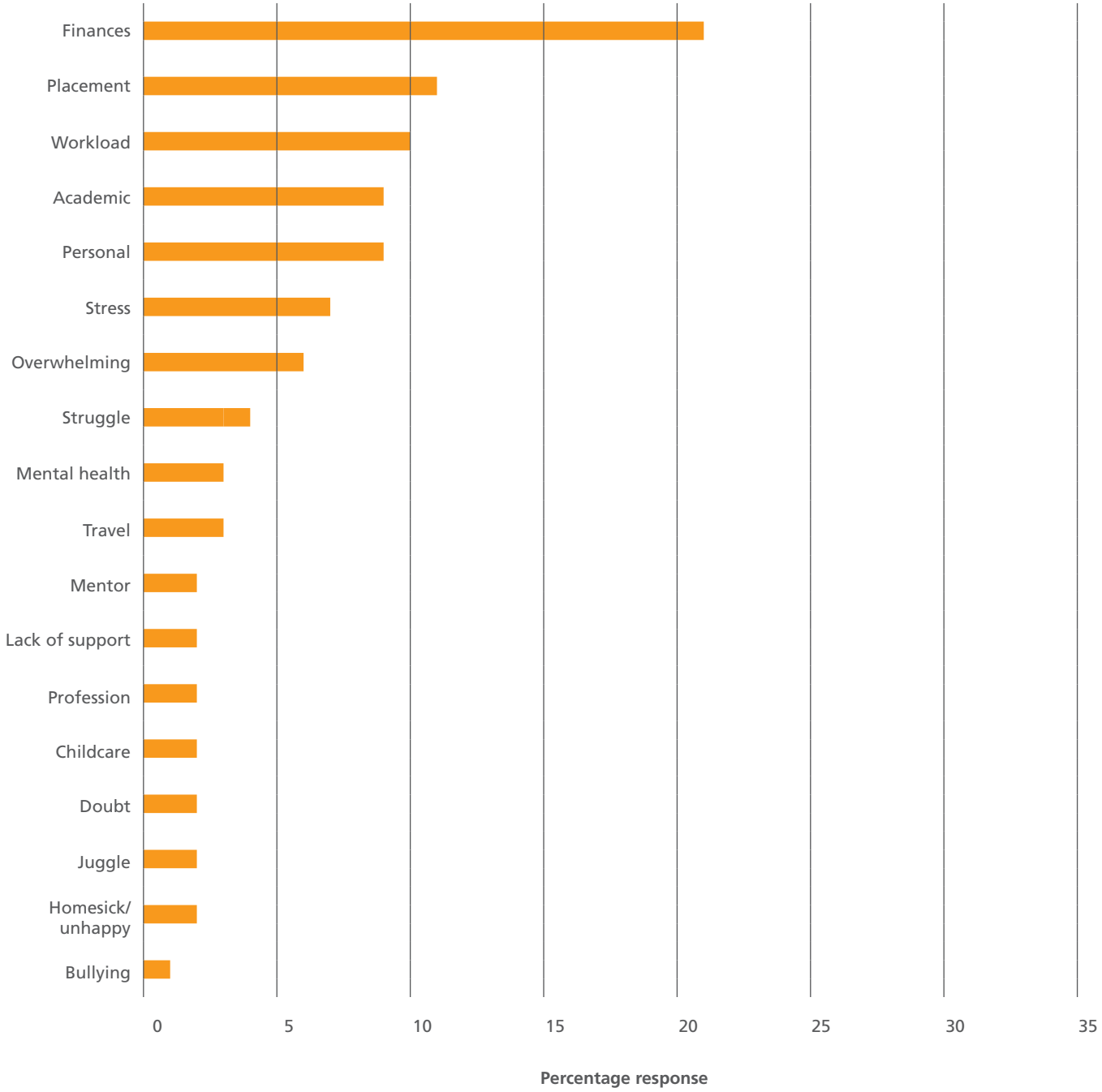
Source: HEE analysis of HESA student records, 2009-10 to 2016-17

Appendix 5:

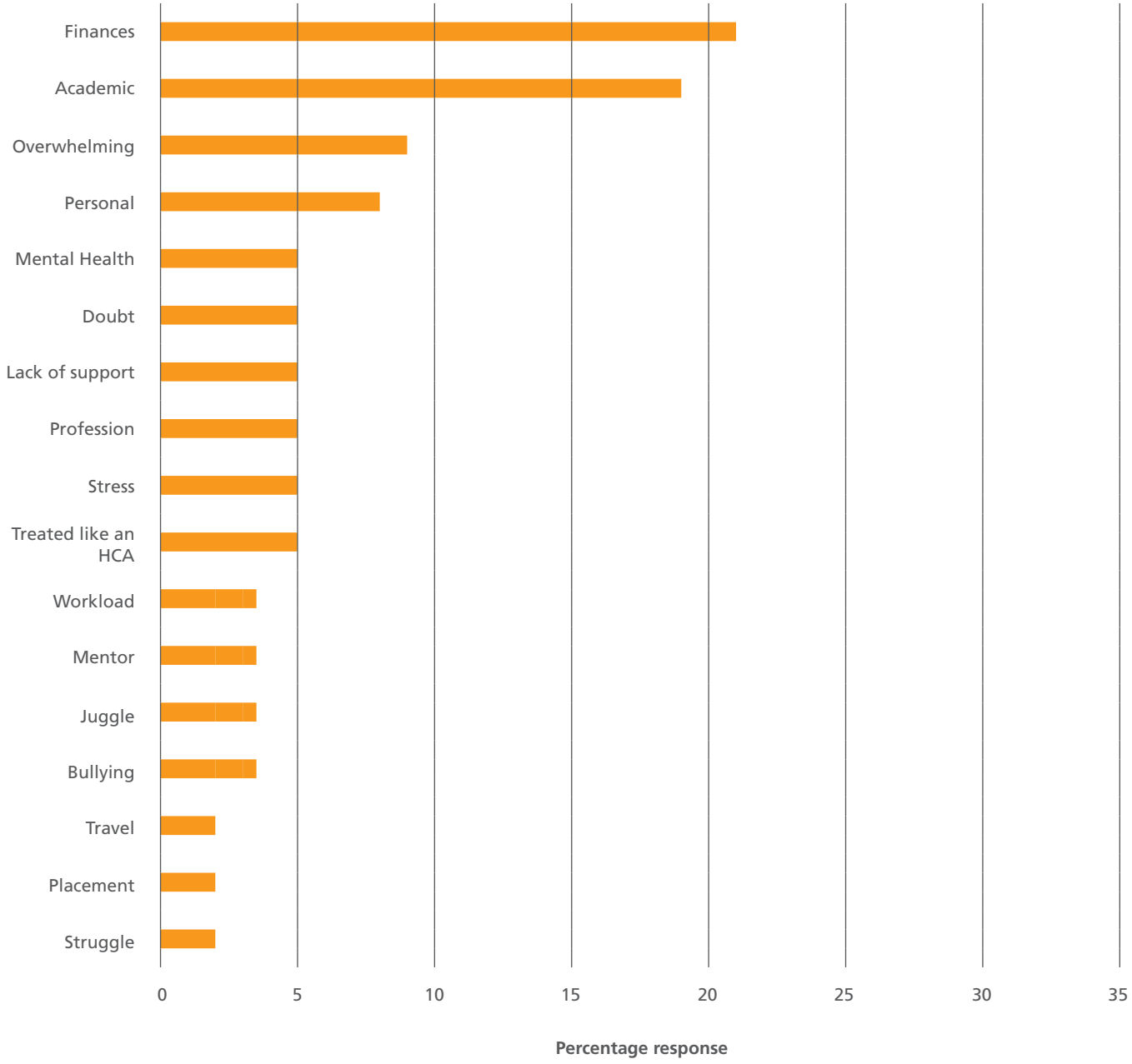
Reasons why students considered leaving in year 1



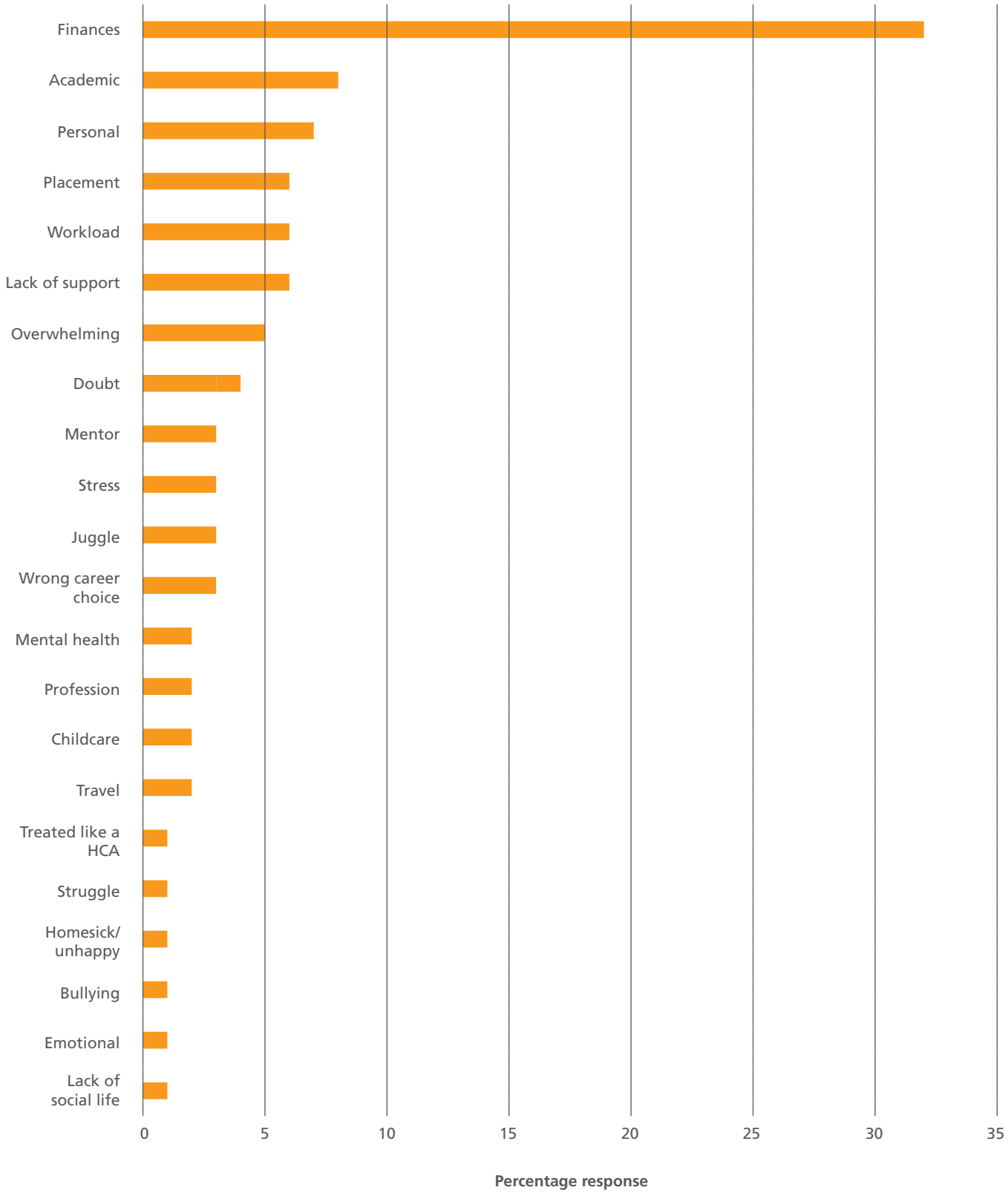
Reasons why students considered leaving in year 2



Reasons why students considered leaving in year 3



Reasons why students considered leaving - no year specified



Appendix 6: Economic evaluation intervention programme models

Buddying

Buddying programmes are based on support between experienced and less experienced colleagues and are centred on supporting the development of learning and confidence for less experienced colleagues.

These programmes may make use of informal support, such as mixing between experienced students/staff and new starters during break times, buddy lunches, drop-in sessions and social get-togethers such as a Christmas party. Where possible, staff are buddied with someone on the same placement or ward.

In the participating sites buddying programmes also include more formal learning and support. For example, one programme requires six meetings during a year to offer buddying using a clinical supervision model. Meetings may include taught sessions and seminars and may address specific skills such as literature searching or IT use.

Transition into practice

Transition into practice programmes focus on the move from final year student to newly qualified practitioner. This may consist of low key activities, but also more specifically 'transition into professional roles' sessions and workshops for students. Such interventions may be run jointly by HEI and HCP partners, bridging as they do the shift from one to the other.

These programmes may have a 'staff induction' type element to them, introducing newly employed staff to the organisation they will be working for. This may be aimed at supporting new staff to build their confidence as practitioners, which can be particularly important when they are on an unfamiliar ward or in a speciality that is new to them.

At the same time, these programmes may aim to prevent new staff from going beyond their skills and confidence. For example, existing staff may be keen to have support from new staff as soon as possible in high risk skills (such as IV provision). Instead the organisation will work to help new staff build their skills and confidence more steadily.

Transition into practice programmes may involve a range of staff in the employing institution. They may also include (in the case of one organisation working with student mental health nurses) experts by experience, who are HCP service users, to help prepare the nurses for employment.

Preceptorship

Preceptorship programmes are the most extensive, and the most formal, of the retention improving interventions included in this project. These programmes are generally mandatory for all new-starters amongst nurses, although it is recognised that not all staff will be able to attend every session.

A common format is to have a number of standard study days for staff, focussing on core skills – typically those of a Band 5 nurse. These are often paired with additional study modules for specific skills and aimed at the professional groups requiring those skills.

The preceptorship programmes among the sites participating in this evaluation were either 12 months or 18 months long. Their primary focus is to support staff in their transition to being independent, accountable practitioners. In addition to core skills and specific role-related skills, these programmes may include the development of leadership and managerial skills, which will help staff to support others in practice.

Use of modern media

Use of modern media intervention programmes make use of a range of social media to instigate and maintain contact with current and future staff. Websites and Facebook pages dedicated to a service are common, as are Twitter accounts. These may be popular ways of maintaining communication among a relatively discrete staff group, such as all the midwives in a specific hospital.

These media may also be used to attract students, enabling interested individuals to learn about roles, ask questions and familiarise themselves with the HEI. In addition, they may be used to counter negative comments among HCP staff. Senior staff may dedicate time to social media, for example ensuring there are regular updates to Twitter feeds. However, this does not tend to be particularly time consuming.

In addition to the use of these, widely-known media, some organisations are planning to move beyond this type of usage and to build 'communities' of practitioners, using online platforms. These will typically include new joiners, alumni and current staff with the aim of creating on-going interaction.