CLINICAL PLACEMENT STRATEGY: ANNEXE 2

STAKEHOLDER PERPECTIVES ON CLINICAL PLACEMENT EDUCATION.

1. Introduction

Clinical placements provide a form of practice-based experiential learning and may comprise any arrangement in which a learner is present, for educational purposes, in an environment that provides healthcare, or related services, to patients or the public[1, 2]. For chiropractic students, clinical placements may include chiropractic or non-chiropractic clinical services, as well as placements in either external or in-house settings, with a variety of possible arrangements for supervision. In this review, we use ***practice placements*** where clinical placements for chiropractic students take place offsite, in practices away from the academic institution i.e. in the field/workplace.

This document aims to explore stakeholder perspectives on clinical placement education in chiropractic, focusing on the experiences and insights of key stakeholders following consultation (practice placement educators, potential practice placement educators and chiropractic institutions).

Clinical placements are a critical component of health education, providing students with hands-on experience in real-world settings. However, the feasibility and effectiveness of implementing these placements can be influenced by the perspectives of stakeholders, including students, educators, clinicians, and patients. This document seeks to identify areas of strength and opportunity for improvement in order to enhance the quality and impact of clinical placement education, feeding into an overarching strategy for the profession.

The aims of this project were to:

1. Characterise current clinical placements across UK chiropractic education
2. Explore the perceived benefits, drawbacks, barriers and facilitators for different clinical placement models
3. Among chiropractors, explore the perceived benefits, drawbacks, barriers and facilitators for participating in practice placement models

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2. Outline methodology

The methodology included:

1. Interviews with current providers of chiropractic education in the UK
    - All providers of recognised chiropractic programmes participated
    - Chiropractic and wider health professions clinical placement representatives were included
2. Focus groups (virtual) with current practice placement educators (chiropractic)
    - Chiropractors who currently host and or act as clinical educators for students attending practice placements in the field/workplace
3. A short online survey of potential practice placement hosts or educators (chiropractic)
    - Chiropractors who do not currently have any involvement with chiropractic undergraduate education

A question framework guided each interview and the focus groups. The survey was developed from the question framework.

3. Results

3.1 Perspectives on clinical placement education of current providers of chiropractic education in the UK

The perspectives of all providers of recognised programmes were obtained individually through a series of interviews. Information collected included:

- Details of clinical placement models that are in place
- The perceived benefits and disadvantages associated with any actual or potential clinical placement model
- Perceptions or experiences of the practice placement model
- Barriers that had been encountered, or were perceived, for any model
- Facilitators to implementing any model

Extensive inputs were collected and collated. These are presented as pooled views and experiences across all of the current providers and thus may not represent the individual views, experiences or practices of every provider.

3.2 Where are we in 2024?

Characterisation of current clinical placements across UK chiropractic education

3.2.1 Clinical placements start early and develop progressively

All providers outlined experiential learning through clinical placements that commenced early, in the first year of chiropractic education, and developed progressively over the duration of each programme. In all undergraduate programmes the learning experiences were observational in year one, progressing to autonomous responsibility for providing chiropractic care (under arms-length supervision) by the end of the programme. In some cases there are transition arrangements whereby students take on increased responsibility for patient care from the latter part of year 3, through to the final 4th year of their undergraduate programme.

3.2.2 Students undertake both chiropractic and interprofessional placements

Most providers detailed placements and learning experiences taking place in *both* a chiropractic clinic setting and also in interprofessional settings, with some implementing placements in NHS settings. These might be considered 'non-traditional' placement models for chiropractic students. A range of different arrangements, settings and types of interprofessional placement experience are implemented.

3.2.3 Final year placements are in onsite clinics

All providers have an onsite clinic ('dedicated education unit') that they utilise throughout their programme and where the majority of final year clinical placements take place.

3.2.4 Onsite clinics are used innovatively

The traditional model of clinical experiential learning was that of a final year chiropractic internship in an onsite teaching clinic. Learners provided full chiropractic care and managed their own case load, under the supervision of a clinic supervisor/tutor. Previously, this was directed by requirements for specific inputs, such as the number of patient contacts. The new Education Standards of the GCC moved away from the focus on inputs, to requirements that are based upon the

outputs of clinical experiential learning, permitting greater flexibility in how this may be organised and promoting greater interprofessional learning.

While all programmes still include the majority of final year clinical experiential learning on-site, it is clear that providers have been innovative in the way that they now utilise their onsite clinics to enable new learning experiences for students.

i) There are examples of the CLiP model in use

In one example, a provider integrates a collaborative learning in practice (CLiP) model into clinical placements in its onsite clinic, using this to support the transition from late year 3 through to year 4 responsibility for patient care. This comprises peer-to-peer learning, where 2 students are paired by the provider ('clipped') at the commencement of their late year 3 clinical placement. Responsibility for providing care to patients is initially shared and learners support each other, receiving feedback from the supervisor. After 10 weeks and providing requisite competencies have been achieved, they are 'unclipped' and thereafter have sole responsibility for care of their own patients. In line with the more adult learning model, they develop their autonomy and progress eventually to take on a mentor role for other learners.

ii) Students may experience public health and wellbeing services

several providers outlined either current arrangements, or plans, to include participation in, or integration with health and wellbeing services as part of the onsite clinical placement experience of their students. These may be considered a role emerging clinical placement.

Examples include:

- An elective placement experience where learners are trained under the NHS Health Check Competency program and then provide free NHS health checks to members of the public that fit the inclusion criteria, within the onsite clinic. This service is contracted by a public health board, shared across local councils.
- Planned opportunities to experience lifestyle coaching approaches for patients who are referred into the Wellness Improvement Service – an NHS service for people with chronic conditions, established by a local health board. The service is provided by Wellness Coaches located within the onsite clinic, giving opportunities for learning, collaboration and cross-referrals.

- Planned opportunities to provide free of charge chiropractic care to patients, connected with primary care network social prescribing services.

iii) Other health professionals and students may deliver specialist services with chiropractic students

There are examples where health professionals and students from other disciplines are brought into the onsite setting, providing interprofessional placement opportunities. This includes elective clinical placements within specialist services such as paediatric, sports and elderly care, whereby chiropractic students work alongside and with other professions to deliver the service.

iv) Group learning is organised and delivered within placements

There are examples of learning within placements in onsite clinics being structured to enable students to participate in and benefit from group learning experiences. These include scheduled case discussion sessions that groups of students participate in.

v) Students attend institutional multidisciplinary team (MDT) clinical meetings and grand rounds

There are also examples of arrangements where chiropractic students participate in regular multidisciplinary team (MDT) meetings and grand rounds sessions established by the provider across its health disciplines programmes. Chiropractic students in their onsite clinical placement attend these face-to-face, and they are also streamed so that other students and staff may attend.

3.2.5 Practice placements are established for some programmes

For clinical placement in chiropractic settings, some providers implement practice placements whereby they place learners into private chiropractic clinic settings that are off-siteThese take place through the first 3 years of the undergraduate programme. In these placements there is 1:1 supervision between a student and a practice educator. This may be considered a CLiP model, albeit that there is not peer-to-peer learning *between* students. Different arrangements for practice placements were outlined.

One approach applies relatively open criteria for the selection of participating practices and educators, who are contracted upon the basis that they agree to uphold required standards for education and practice. The provider facilitates students to arrange a placement with a contracted practice. The key purpose of the placements are to enable the student to observe, experience and compare real world practices. Students are not assessed in practice, but end of year assessment is based upon reflective work.

An alternative arrangement takes a more selective approach to participating practices and educators, the latter are employed by the provider and thus have a greater requirement to undertake training, development and quality assurance procedures. Quality assurance of participating practices utilises the institution-wide procedures for all healthcare professions practice placements. Students have defined learning outcomes for placements that are tightly integrated with the academic curriculum and are assessed within their practice placements. There is progressive involvement of the student in supervised patient care provision as they achieve these competencies.

3.2.6 Placements in non-chiropractic settings/interprofessional placements

Most providers outlined arrangements for clinic placements in non-traditional settings, where care is provided by health or care professionals from other disciplines. There are several types of placement currently implemented, including:

- Hospital placements – pairs of students attend a short block placement (1 week), observing a range of experiences (e.g. orthopaedic surgery, fracture clinics, ward rounds) and engaging with other health professionals (e.g.registrars, surgeons, nurses)
- Interprofessional team-based placements within NHS trusts – commencing in year 1, students are put into wards or teams (e.g. therapeutic care team, rehabilitation ward), observing and also participating within the team role.
- Rotations in other settings (e.g. dentistry, care home, stroke unit), where students in their final year attend in small groups, accompanied by a supervisor.
- Weekly virtual access to local NHS hospital spinal MDT meetings that students are rotaed to experience two or three times
- Multidisciplinary specialist services within onsite clinics – in these examples, other health professionals are brought into the onsite clinic and students undertake elective placements within the service (see also onsite clinics, above)
- Onsite Multidisciplinary team meetings (face-to-face and streamed)

- Telehealth (triage) placement for all year three undergraduates where they are contacting patients, working out their health needs and directing them to the right services

3.2.7 Community practice project

There are instances where students have participated in community-based placement opportunities. These included a 2 week 'pop-up' health initiative where students from different health disciplines, as well as external partners, worked together to provide a drop-in service giving health care advice, support and signposting.

3.2.8 Some clinical placement models are not currently used

Placement models that are not in use at all across UK chiropractic education include longitudinal integrated internships, hub-and-spoke and student-led. There is little use of the block placement model (1 example of a short placement block in an NHS setting).

3.3 Where might we go in the future, and how?

What are the benefits, drawbacks, barriers and facilitators for different clinical placement models?

The detailed benefits of various potential models, their limitations, barriers to their implementation and facilitators to implementation that were identified are presented int Table 1. These represent the perceptions, experiences and suggestions across all providers who were interviewed.

3.3.1 Benefits and drawbacks of clinical placement models

It was felt that giving health professions students placement experiences across a range of NHS, private independent and voluntary sector placements gives them a holistic experience of health and social care.

A wide range of benefits and a few drawbacks were perceived across all of the individual models that were discussed. Broadly, these included:

- The ability of the provider to quality assure placements effectively (a key concern)
- The student learning experience
- The outcomes that students gained through placement
- Patients' care and experience in the education environment
- The roles of educators
- Financial and resourcing considerations

3.3.2 Barriers to implementing clinical placement models

A range of barriers were identified (either that had been experienced or were perceived).

A key issue raised across all providers was limitation in their ability to investigate, establish and administrate new placement models due to lack of required staff/time and associated costs. This was identified as a barrier to the ongoing development of clinical placements.

Other key themes included:

- The ability of the provider to fully quality assure clinical placements
- Timetabling and integration of placements with curricula
- Capacity for placements where there are larger numbers of students
- Local variations in external health initiatives (e.g. trusts, public health, community health)
- Local variations in ability to establish initial relationships with potential new placement providers (e.g. NHS trusts)
- Variations in institutional placement resources that the provider was able to tap into
- Financial considerations for the provider

3.3.3 Facilitators of placements

A range of facilitators to establishing and implementing various placement models were identified (either that had been experienced or were perceived). Key themes included:

- New opportunities often come about initially through a personal contact
- Wider institutional placement resources may be available (e.g. for the establishment, quality assurance and administration of placements)
- In NHS settings, liaison with designated practice Education teams facilitates placements
- Availability of funds for placement manager/admin/ institutional systems use and establishing a model
- Availability of quality assurance tools and frameworks e.g. HEE Quality Framework from 2021 (and related multiprofessional QA toolkits), wider institutional placement audits, RCC CMQM, PPQM
- Curriculum design and planning to accommodate placements
- Identification of desired outcomes informing placement model and curriculum
- Range of methods for assessing students' placement learning
- Placements that are 'for academic credit' and mandatory

The detailed perceived benefits, disadvantages, barriers and facilitators to clinical placement models are provided in Table 1. This is broadly organised according to individual placement models, however, as features of these are often combined or delivered in novel ways, there are some departures from this.

Table 1: Perceived benefits, drawbacks, barriers and facilitators for placement models

BENEFITS	DRAWBACKS	BARRIERS TO IMPLEMENTATION	FACILITATORS TO IMPLEMENTATION
1. Onsite clinic (DEU)			
The opportunity to fully quality assure placements is a key benefit (significantly valued) It is easier to audit clinical practice e.g. against quality standards Supervisors/tutors are onsite, so training, development etc can be extensive Supervisors often involved in other aspects of education, so can readily integrate clinical with academic learning Students gain experience of providing patient care/continuity of care for their own case load Students gain experience of a range of different patient types/presentations	The clinic experience is not very 'real world', in a managed environment Patients get used to their intern and may drop out of care when their placement ends Students don't learn how to take payments for patient care There can be a delay between the patient's assessment visit and commencing care There might be a tendency for patients to remain in care for too long	There has to be a transition between the outgoing and incoming internships Curriculum structure can make it difficult to manage handovers, as would require students to stay on beyond the end of the year Space to accommodate onsite clinic requirements can be an issue	Managed transition between incoming/outgoing interns - overlap in placements enables shadowing and for patients to meet their new intern. Patient engagement group feedback shows that they value these arrangements. The patient journey is as seamless as possible Voluntary handover arrangements may be possible where not aligned with curriculum structure. Protocols can be implemented that enable patients with acute symptoms to commence care without delay The use by students of objective outcome measures may help reduce overly long care

It is easy to provide incoming students with a transition into their placement. Patients know that they are part of the education process. They enjoy meeting students. Prices are very low for patients Cost effective for the provider in terms of facilities			
2. Peer-to-peer CLiP (in DEU, or practice placement offsite)			
Student journey through placement can aid learning (phased progression from CliP, to autonomous care, to mentorship enables students push their skills and then share their knowledge) Many AHP professions have taken up the adult learning coaching approach Students may feel they can take more control Enables a higher level of patient case contacts early on – this takes the pressure off students later		Educators may feel that it will be hard to mentor 2 students (a 'buddy pair' or student diad) When under pressure, the mentor may revert to 'supervision' as this is what they know best Clipped students may not get on A strong with a weak student pairing doesn't always work Students may not like working with a student in a different year	Paired by the provider, in conjunction with students, before commencing placement Any issues in pairings can be reviewed and resolved as they arise 'near-peer' pairings are used Coaching/mentoring training for people that support learners

On first entering clinic, assurance of somebody else in the room that they can collaborate with builds confidence faster Patients are less likely to drop out of care with students who are weaker early on when there are 2 students to interact with For patients, presence of 2 students provides better care (safety, quality, communication) early on in placements			
3. Practice placement (chiropractic setting) e.g. 1:1 student:supervisor			
Good opportunity for students to see what a more real practice setting is like, and the sort of issues they may encounter They are given exposure to working in practice (but needs to be good practice) Provides the bigger picture - how to work in teams, in private practice and in different environments	Less experience gained of directly providing patient care/contiuity of care Ensuring a standardised student experience is a concern Patients are generally happy to help with student learning on	Quality assurance of student experience (learning and clinical) is seen as a significant barrier. There needs to be standardisation of experience for all students Capacity to place students is a significant barrier for providers with large cohorts Issues around different approaches from different chiropractors. There would be a need to find clinics that	An initial scoping review identified clinics that were not high volume, open plan etc Utilise wider institutional onboarding approach for new placements For quality assurance, include an educational audit. This is usually mapped to the health education England Quality Framework (2021)

Develops a sense of professional identity which helps the student transition into healthcare Students transition from being a student to being a clinician within their first semester of university. They 'grow up' and become a lot more professional faster Students discuss what they've seen. They start to become passionate about what they're doing and can see what they're going to be doing in a few years time Students are applying the skills that they've learned in real practice Practice placements are preparatory for patient care responsibility Students see different styles of practicing, different ways of talking to patients. This helps them think about what kind of practitioner they want to be	placements, do sometimes get 'placement fatigue' where there is always a student present When students go into other private clinics it may be harder to gain the patient's direct feedback	are low volume, evidence based chiropractors, making sure students aren't exposed to standards that are less than what would be expected by the GCC The cost that would be involved to pay the practice educators/clinics is an issue (as this would be for 1:1 supervision ratio) Administrative burden and associated cost to the provider The ability to audit and train participating educators/clinics and that requires time/personnel Would need a placement officer. There would be additional costs to utilise wider faculty administrative systems for health professions placements Practice educators would need to become employees of the university and engage in all the different requirements of being an employee	Wider institutional practice support site provides resources for placement providers around supporting practice education For ongoing QA, collect student evaluations that are also mapped to the same quality framework as the audit, so that you can see that quality is still being maintained. If problems are flagged, support and reevaluate Student evaluations may be encouraged on the basis of candour, duty to report concerns and professionalism Placement platform software may collect and collate audits/evaluations into quality reporting mechanisms There may be a regional shared educational audit developed together to cross professions. There may be local variations, but they are usually all mapped to the same HEE QA framework.

Chiropractors enjoy passing down their knowledge		If chiropractor is managing students learning, it has to be formalized. There would be training issues and associated costs Not having AHP status excludes placement providers/educators from the institution-level training Issues around what the students do on practice placements. Before they can manage patients, they need to have all the skills and competencies Insurance issues if students are to be involved in patient care provision off-site Student-incurred expenses, including accommodation, food and travel. Train costs and reliability have been an issue. Not having AHP status excludes students from eligibility for institutional placement hardship fund Difficulties for students to get to practice placement location e.g.	students complete mandatory e-learning for health training before they're allowed on placement Student takes their placement assessment document with the learning outcomes for each module specification on. Early LOs may include e.g. being punctual, professional, interpersonal skills and presentation. Horizontally integrated with modules about professionalism, consent, confidentiality, the GCC, the Code etc A student hardship fund for placements would help with the expense A ‘Placement Champion’ in each year group who speaks to the year below enhanced engagement Students have to retake placements if they fail to engage sufficiently Chiropractors are looking for associates, may see this as a recruitment opportunity

		dependent upon reliable public transport Low interest from the profession In small clinics the very individual relationship that e.g. a sole practitioner has with their patient is seen as a barrier Cost of care to patients. May have to be subsidised Cost to participating clinics in patient numbers, fee income and resources etc. There has to be a financial benefit. The burden for clinics to initially set up as placement providers is significant (QA requirements, training etc)	Institutional systems may provide placement educator training, while chiropractic faculty focus on the chiropractic-specific aspects For QA of educational support and practice, keep revisiting, checking and reinforcing the requirements M-level module open to anybody around supporting practice Education Patients pay full fee and placement providers/educators receive a stipend per day for having an observing/participating student OR Providers volunteer to host placements and must sign an agreement. There is no payment for hosting. As they are voluntary, there is no mandatory training requirement etc for providers. Students and providers feedback on the placement Availability of funds for placement manager/admin/ institutional systems use and establishing a model would help

			RCC CMQM and PPQM are useful indicators that a clinic understands proper governance, at the level needed to ensure that students are getting a safe and consistent experience Integration of academic learning with placement for that year is important OR Provider holds a list of placement providers. Students give preferences and are allocated. student then liaises directly with the provider to arrange hours/days etc. Placement may be undertaken any time during the relevant year Talking to partners and establishing placement availability before beginning to write a new course
4. Interprofessional placements (including NHS settings, specialist services, social care and other private healthcare settings)			
Students see what working in the NHS looks like. This provides the bigger picture and how to work in teams and in different environments	For attendance in blocks, these work well for nursing, but may be too intensive an environment for chiropractors	Difficult to expand to other interprofessional opportunities as they're all busy	All interprofessional placement opportunities were initiated through personal contacts in the first instance Chiropractic faculty liaise with the NHS trusts and their staff to arrange

Feedback from the students is really positive It builds their confidence They see other health professionals Students get a greater insight into the ‘real world' Attending nursing homes would be beneficial, for students to talk to older people Opens students minds to thinking differently and how they interrelate with fellow professionals They learn about referral network or there any referral routes Experiences builds their competences in different ways, and if they can see it differently, then more likely to do something differently Some students and staff really like the MDT working and see the benefits		Cant overwhelm placement hosts with a continuous stream of students In NHS settings placement capacity is a problem for all disciplines. We compete with other professions (e.g. medicine, nursing etc) Chiropractic placement requests can be at the end of the queue There has been some opposition from physiotherapists in the hospital setting NHS placement providers find it harder to know where to put chiropractic students Scheduling is quite hard because around timetabling there are only certain days that students can go A minority of students lack engagement with placements Transportation to get students to placements can be unreliable	placements – usually this has been via nurse educators for the placement provider Need to be creative and say students can do simple tasks, like taking tea and coffee orders, so that they're walking around, have got a role and have to talk to patients The trusts appreciate that to increase the workforce, they need to take students students attend NHS placements 1 day at a time - timetabling would make it too difficult to accommodate a block OR students attend NHS settings for a short 1-week block The institution has staff who are in charge of placements and who are responsible for developing relationships with trusts. They request and arrange placement opportunities To have university support, we need to demonstrate a real impact in terms of promoting an interprofessional learning

Remote spinal MDT meetings gain very good student feedback because they get to hear about what would happen to patients who are not appropriate for chiropractic care (e.g. CES, AxSpA) and what happens to them afterwards Triage (telehealth) teaches students to work with other services, recognize other people's strengths' and to focus on the patient's health needs as the main concern. They learn the skills of putting the patient at the centre of what they do with their decision making		Organisation and management of interprofessional placements is a big job It can be hard to ensure an equitable experience for students Some chiropractic staff don't see why chiropractors should be working with other people. It can be challenging to manage that so that patients always achieve the best outcome Trying to open up new opportunities with individual hospitals is time-consuming and can be demoralising. Theres a balance between the time and effort and the added value that may be achieved. There needs to be the time and the space to be innovative and think about these things	day for the students, with genuine integration Liaison with designated practice Education teams within NHS settings. Their capacity is mapped already and may be possible to fit into quieter times during the academic year Have initial conversations with stakeholders, placement providers about where the gaps might be For different sorts of experiences at different points in the curriculum, you need to be able to match the curriculum to the availability Specific placements can be made relating to specific learning opportunities/outcomes It is easier to build a programme around placements than fit placements to an existing programme Placement education organisations have a placement tariff that is used to fund the roles to manage Placement education. Chiropractic is not on the

			tariff list, but providers can offer tariff equivalent NHS Trusts have been positive about taking Chiropractic learners. Everyone's keen on the benefits of interprofessional working key facilitators would be good leadership, forward planning and a person with the time to develop and implement placements. Having someone who's role included that would make things a lot easier The university has lot of health and social care disciplines. Tapping into those resources could be helpful A regulatory requirement for supporting the development and arrangement of interprofessional placements with adequate staff/resources would give leverage with the institution to provide this Regular online meeting to discuss updates, innovations or anything placement related helps facilitate those relationships

			Efforts are made to place students locally, considering postcode and whether the student drives Ensure that the educators are always involved in multidisciplinary working and learning work with the staff team to ensure there is consensus and make sure the staff team are open to different ideas Elective specialist placements contribute to overall mandatory placement requirement
5. Role-emerging, health and wellbeing placements			
Delivering NHS checks harnesses the students' skills on promoting and being able to talk about public health. They very much transfer the skills they learn and deliver Participating in a social prescribing initiative expands students view of what services patients require, how they may access those and how those systems work, to broaden understanding of health and social care		Need to establish a system for interprofessional experiences and cross-referrals through connections with social prescribing and/or health coaching initiatives Would need to be compulsory and then you've got to have someone manage that	Contracted by local public health board to provide NHS checks Identify and connect with link worker at GP surgeries whose objective is to is to go out and find links of other services As the social prescribing service is usually for NHS funded care, referral for chiropractic would need to be provided through clinic pro-bono scheme

Embeds chiropractic more closely within the solution of dealing with GP surgeries and where chiropractic fits in terms of primary care Students experience working with people with chronic conditions e.g. diabetes, obesity, alcohol issues or chronic pain Students experience working with people from more challenging socioeconomic backgrounds who they may not otherwise encounter			Need to explain and demonstrate how chiropractic may fit with social prescribing/health coaching services and what sort of patient may benefit
6. Community practice project			
Great experience for students to work in a novel environment Working in an MDT manner Opportunity to work with members of the Community that wouldn't usually enter a setting where cost is often a barrier for to accessing chiropractic' Students worked with a very diverse population, including		May be difficult to replicate on a yearly basis Barriers are logistical around timetabling to get students from different disciplines off on the same day. You have to plan two years in advance. For disciplines where students have a block placement, this cant just be interrupted	There may be other local community health initiatives (e.g. HSE Sussex community appointment day)

homeless members of the Community, or those that are recovering drug or alcohol users On a community health appointment day, students could follow a patient on their care journey		Students from different disciplines will have different learning outcomes for the placement. This is complex to manage Time constraints of individuals to organise initiatives, due to very high workload already	
7. Group learning in onsite clinics			
Formalised group learning at the end of every clinic session enables students to present and discuss cases together Encourages the students to come forward with their own ideas Receives very positive feedback from students		Learning space to accommodate the larger groups For clinic supervisors/floor tutors, leading group session at end of a hard shift is tiring	Ensure that students and tutors have a break before commencing a group session
8. Referral of patients into onsite clinic from GP cluster (for chiropractic pain care)			
Students would see patients from different socioeconomic groups and with more chronic pain conditions This would address long waiting times for e.g. physiotherapy, and		Need to provide the ethical approval in house for either audit, service evaluation or research to monitor the service. The requirement is very unclear	Referral would be directly from the GP to the on-site clinic.The treatment would be funded by the provider (no cost to the patient)

may improve rates of patients ending up in pain clinics Would also raise the profile of chiropractic – if the patient did well, they would report that back to the GP		Unable to gain funding for patient care costs Pre-and post-treatment PROMs would need to be used, and reports written back to the GP. This all needs systems and personnel to implement and monitor	
9. Hub and spoke			
Using a hub and spoke model enables students to spoke out from a main placement site into the plethora of different professional groups that could potentially meet a patient along their journey Gives a greater background understanding into how things sit together		Local variations – ease of arranging depends on the placement structure in the locality	Talking to partners and establishing placement availability before beginning to write a new course
10. Simulated and non-patient facing placement experiences			
Aim to recreate placement experiences on campus Emerging evidence that these may be just as effective as real placements	Students respond best to real people students don't like this to feel too similar to class-room learning		Could arrange placement dates with online simulations and involve students from different disciplines, talking through scenarios and how each how each student would approach that scenario

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Can be beneficial to use simulation for rare events that might happen that you're very unlikely to see in placement Increase placement capacity and avoids burdening trusts Could be good in terms of interprofessional learning and education This supports digital empowerment that is key now at universities Provides a backup if for some reason a trust didn't have enough placement capacity (e.g. Covid)			Could bring in an actor patient and construct a scenario around that Simulation technology is built into earlier years clinical and communication skills learning and can be combined with clinical placement e.g. as part of the induction for Pediatrics, students practice listening to heart sounds on the simulation model then listen to those sounds with a patient Could include leadership placements (e.g. developing a project), or quality and safety placements Could include research placements

3.4 Perspectives on clinical placement education of current practice placement educators.

To gain the views of current practice placement educators two online focus groups were facilitated and semi-structured discussion yielded the responses below. Following the focus groups, review of the answers provided was conducted and thematically analysed to provide some broad themes that are presented below.

Themes extracted from Focus Group Data – practice placement providers

3.4.1 What motivated you to become a placement provider / educator?

Difficult to gain associates.	**Give something back to profession.**	**Good for personal development.**	**Provides opportunity to be involved in education.**
1 of 2 main themes emerged. This primary theme is in contrast to next main theme, very much driven by personal gain.	1 of 2 main themes emerged. Some clinicians felt it was the 'right thing to do' and wanted to 'give back'.	Those involved did see it as a way to 'force' their personal development as they would need to 'up their game' in front of students.	Few participants did highlight the opportunity to be involved in education was a draw as previously this had only been possible in higher education institutions.

3.4.2 Did you have any initial concerns when you first considered becoming a placement provider/educator?

Time commitment.	**Unknown extra insurance requirement.**	**How patients will feel.**	**Unknown requirements of the model. Inc. Logistics.**	**Associated costs to being involved.**
Could they commit to the placement scheme and students learning needs and maintain their clinical		This was highlighted as an important unknown.	What the process would look like including operational demands like hours required, lunch procedures or downtime requirements,	A concern was raised regarding lost income from time absorbed by placement. This was linked to time commitment but was focused on

provision standards.			feedback mechanisms etc.	potential lost income.

3.4.4 What challenges have you encountered throughout the process?

i) *Challenges / barriers in becoming a provider / educator.*

No issues.	**Minor paperwork and visit for audit.**	**University placement IT software issues.**	**Covid-19.**
No barriers for some institutions with no detailed audit process. Some reported the 'onboarding process' to be a conversation.	Some institutions do complete a clinic audit process, but participants reported this as not overly challenging a process.		Restrictions and operational demands during covid were difficult to overcome in some clinics and not challenging in others.

ii) *Ongoing challenges.*

Unacceptable or poor student conduct or behaviour.	**'Placement fatigue' for Pts.**	**Certain demographics preferring not to have students.**
Poor student attire, lateness, issues with student conduct and or not engaging well.	Some patients that visit chiropractors on certain days often meet with students frequently.	Challenge in areas of high concentration of certain demographics. This seems to be dependent on the students and certain religious groups. This was discussed in the context of clinics being clear that having a student in the room during consultation is entirely optional to patients.

3.4.5 What factors helped you to overcome any of these challenges?

Placement educator training.	**Regular clinic staff meetings.**	**Detailed and clear student induction.**
Some institutions offer formal placement educator training days throughout the year. This also includes online resources for educators and a	This was reported as an internal process to ensure clarity amongst all clinic personnel.	Helps to set clear boundaries and rules for students.

specific 'onboarding process'.		

3.4.6 From your perspective what do you see as strengths and weaknesses of a practice placement model?

i) For the educator

Strengths	Supports DC's personal development.	Meet potential new associates.	Good to see student development.	Welcome change of pace from general practice.
Weaknesses	Initial apprehension.	Time lost = slight income decrease if not recompensed as some HEI's offer.	Unfair if all locations are not providing similar standards of placements.	

ii) For the student (perceived by educators)

Strengths	Opportunity to practice 'being a professional'.	See the 'real world'.	Exposed to diversity of practice.	Supports their motivation for study.
Weaknesses	Can be long days and tiring, hard to maintain focus.	Could be seeing non-evidence-based practice.	Travel for students.	

iii) For patients (perceived by educators)

Strengths	View clinic and chiropractors in a positive way as they are involved in education.	Enjoy having students see their case.		
Weaknesses	Placement fatigue.	May hold back accurate and full information due to presence of student.		

3.4.7 What do you perceive the main barriers to be if this model was to be adopted more widely?

Standardisation due to diverse profession.	Not enough DC's willing to engage.
Including poor educators, as at times there have been examples of poor PRT supervisors.	In part maybe due to the unknown (a video or media may help to disseminate knowledge). Chiropractors may also not want to be under the microscope. Another potential view was aired including 'why do something you don't need to'.

3.4.8 Do you have any suggestions for reducing or addressing barriers?

CPD credit for engagement.	Clear 'cookbook' instructions for educators.	Formal feedback for educators.	Mentorship from more experienced educators.
	Training / Learning and Development opportunities to support new AND existing providers.	This was discussed in the context of feeding back into learning and development opportunities for new providers.	

3.5 Perspectives on clinical placement education of potential practice placement educators

To gain the views of potential practice placement educators a short survey was distributed to people that responded to a call for information. It was made clear the respondents should not have any involvement in undergraduate chiropractic education and they under no circumstances had to provide their views if they did not want to. The following opinions are all presented anonymously.

On receipt of all surveys a thematic analysis was conducted on each question to provide broad themes that are presented below.

Themes extracted from survey data – potential practice placement providers

3.5.1 Have you ever considered becoming a chiropractic placement provider?

i)If yes, what motivated you to consider it?

Some reported having been involved in unofficial shadowing / school work experience previously.

iii) If no, are there any specific reasons you haven't considered it.

Significant distance from an institution.	**Wouldn't consider it if students were 'hands on'.**
Distance from an education institution was a frequently reported reason. When prompted, they had **not** considered attempting to engage remotely / online.	Some respondents reported being hesitant if students were to physically engage with their patients and the potential impact of this if they were to engage in this way.

3.5.2 Given the concept of an undergraduate chiropractic practice placement model, what personal concerns would you have with regards becoming a placement provider / educator?

Time lost for patient appointments.	**What learning outcomes are there for students?**	**Clinic requirements.**	**Students questioning practice styles.**	**GDPR, Patient data security.**
Potential providers were unaware of the time commitments and impact on their clinic.	Chiropractors were unaware of where and how the model fits into their education requirements.	Who can sign off students, insurance requirements and audit requirements were discussed as concerns. However, respondents just seemed unaware of this detail.		Respondents were not sure if it was acceptable for students to be seeing or hearing consultations and what standard of confidentiality they were held to. This demonstrated an understandable lack of knowledge regarding

				undergraduate Fitness to Practice processes.

3.5.3 Would you perceive there being any operational barriers to becoming a placement provider / educator?

Time lost for patient appts.	Patients not liking students being in Rx.	Distance from institution.	Time required to give to student's good experience.

3.5.4 What factors could potentially help you overcome some of these concerns/challenges/barriers?

Benefit for being involved.	Clear strategy and policy.	More guidance on process.	Not too many placement students.	Training.
Some sort of 'kite mark' for education locations showing a standard.	Key theme identified was training. A clear learning and development process.	This reiterates the L&D need.	Knowing involvement could be linked to capacity.	This reiterates the L&D need.

3.5.5 From your perspective what do you see as the strengths and weaknesses of a placement model?

Strengths	Real life practice for students.	Great for students.	Valuable clinical lessons for students.	Networks in the profession.
Weaknesses	Students seeing inappropriate practice activity when impressionable as undergraduates.	Clinic specialisms could bias case mix seen or experienced.	Variable learning opportunity.	Time consuming and detrimental to chiropractic clinic.

3.5.6 Do you have any other suggestions for reducing or addressing barriers to the placement model?

Online seminars to explain process.	Students well prepared for placement.	Funding towards travel for students.	Clear guidance and training.
This reiterates the L&D need.	Knowing how to act.	This was for clinics some distance from institutions. The consideration of online or distance learning opportunities were not fully understood.	This reiterates the L&D need.

4. Towards a strategy for clinical placements in chiropractic education

The information collected enabled characterisation of the current nature of clinical placements for students across UK chiropractic education providing the baseline for a strategy for the future development of clinical placements.

Perceptions of the perceived benefits, drawbacks, barriers and facilitators for different clinical placement models were explored among programme providers, practice placement educators and chiropractors who are not currently engaged in education.

Many similarities were identified with reports in the peer-reviewed literature (see ‘Clinical placement strategy: review of the literature’). These included perceived benefits and disadvantages of various models, as well as barriers and facilitators. In the case of disadvantages and barriers, some literature, as well as the experiences of some stakeholders who participated, indicate that perceived disadvantages and barriers may not always be born out, or that there may be ways to mitigate these.

These collated perspectives and experiences of providers and of actual, or potential, practice placement educators/hosts comprise a discussion document to inform the development of a profession-wide strategy for clinical placements in chiropractic education. This will include the identification of strategic goals, objectives and possible facilitatory measures to address barriers.