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Rethinking Placement: Increasing Clinical Placement Efficacy for a Sustainable NHS Future

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About the authors

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Foreword

Ed Hughes, Chief Executive, Council of Deans of Health

Clinical placements are the foundation of health and care education. They are where knowledge, skills and professional values come together to shape the workforce our communities need. Yet as this paper makes clear, the placement model that has underpinned education for decades is under significant strain. Capacity is stretched, supervision is challenged, and quality cannot be taken for granted.

The Council of Deans of Health has long championed the need for bold innovation in education and training. The analysis and recommendations in this report resonate strongly with our members across the UK, as they reflect the realities of scaling education while protecting quality and equity. Crucially, this paper places placement reform within the wider policy context: the *10 Year Health Plan for England* and its forthcoming workforce plan. These national strategies set out an ambitious shift: towards care delivered closer to home, the integration of digital technology and a stronger emphasis on prevention. Achieving these ambitions requires a reimagined approach to clinical placements that is sustainable across all health professions, supports local education pathways for a local health service with a workforce reflective of the diversity of the communities it serves and is future-facing, equipping students to work in a wide variety of settings and as part of multi-professional teams.

We cannot simply expand the existing model indefinitely. Changing this will require adaptation from both placement and education providers, including the willingness to take decisions which work in the interests of the system as a whole over addressing issues for particular courses, and which place the student interest at their heart. Placements must be designed to reflect new ways of working, embed simulation and digital learning at scale and develop supervision models that are flexible, safe and resilient. By doing so, we can ensure that student learning both supports and accelerates delivery of the system-wide change envisioned in the *10 Year Health Plan*.

The Council welcomes the leadership of colleagues at the University of East London in bringing forward this important contribution. The report provides practical, evidence-informed solutions and demonstrates how universities, healthcare providers, regulators and policymakers can work together to create placement ecosystems that are inclusive, innovative and robust.

Placements are not a peripheral issue; they are central to the supply, confidence and competence of the future workforce. The vital education opportunities which high-quality placements provide needs to be valued by everyone working in health and care as without this, there is no future workforce. As the NHS and the wider health and care sector enter a decisive period of reform, it is imperative that placement transformation is aligned with national strategy and resourced accordingly. The Council is committed to working with partners to take forward the ideas in this paper, ensuring that every student, across every profession, can access a high-quality placement journey that prepares them to deliver excellent, compassionate and future-ready care.

Preface

Professor Amanda Broderick and Robert Waterson

The NHS stands at a pivotal moment. The demand for a skilled, resilient health and care workforce has never been greater, yet the pressures on the system have never been more acute. Clinical placements – the essential bridge between education and practice – are under strain, with shortages in supervision, limited capacity and uneven quality threatening both student learning and patient safety.

At the University of East London, we have witnessed first-hand the challenges and opportunities of placement reform. As an institution rooted in one of the UK's most diverse communities, we recognise that the future sustainability of the NHS depends not only on the volume of students we train, but on how effectively their education prepares them for the realities of modern healthcare.

This paper argues for a fundamental rethinking of clinical placements. Incremental adjustments will not be enough. We need bold innovative approaches that harness the full potential of simulation, technology and new models of supervision, while deepening partnerships between universities, NHS providers and community organisations.

Our goal is to shift the conversation from 'more placements' to 'better placements': placements that are equitable, flexible, future-facing and designed around both workforce needs and student success. By challenging old assumptions and reimagining what placements can be, we can help build the confident, agile and compassionate workforce the NHS requires to meet the challenges of the next decade and beyond.

Executive summary

The NHS is facing a critical workforce challenge, with more than 106,000 vacancies across secondary care as of December 2024, including 27,452 nursing roles and 8,330 medical vacancies. At the same time, the *NHS Long Term Workforce Plan* sets an ambitious target: by 2031/32, one-in-six students entering higher education will be training for a health or care profession. This workforce plan has now been superseded by *Fit for the Future: 10 Year Health Plan for England*, with an updated workforce plan due to be released by the end of 2025. It highlights the three shifts to changing the NHS:

- Moving care from hospitals to communities
- Making better use of technology in health care
- Focusing on preventing sickness, not just treating it

While this vision is essential for long-term NHS sustainability, it places unprecedented pressure on an already stretched clinical placement infrastructure. Without urgent and transformative action, we risk undermining both student learning and workforce readiness.

Universities have a pivotal role to play in reshaping this landscape. As anchor institutions with strong ties to local communities and health systems, they are uniquely placed to co-design scalable, innovative and high-quality clinical placement models that respond to both the realities of today and the demands of tomorrow.

This report makes the case for change, identifies systemic barriers and outlines practical and policy-level interventions to increase placement efficacy, equity and long-term impact within England.

Introduction: The case for change

In July 2025, Wes Streeting MP, the Secretary of State for Health and Social Care, candidly stated that 'the NHS is broken', reflecting a deeply felt truth across the system: services under pressure, staff overstretched and declining confidence in clinical career pathways.[1]

For students entering the health and care professions, the contrast between the sense of purpose ignited during the COVID-19 pandemic and the realities of clinical training today is stark. Burnout, limited placement opportunities and disjointed education-to-employment pipelines create additional challenges for healthcare students and risks deterring new entrants at a time when the country needs them most.

To reverse this trajectory, we need more than just an increase in placement opportunities – we need better and more innovative models too. This requires a fundamental rethink of how clinical placements are planned, delivered and supported.

Universities must work in deep partnership with health and social care providers to create flexible, future-facing placement ecosystems that support growing and increasingly diverse student populations, reflect the shift from hospital to community-based care, integrate digital transformation and prioritise preventative and person-centred approaches.

By addressing clinical placement efficacy through these lenses, we can help deliver not just a workforce, but a sustainable, agile and confident NHS for the future.

The current landscape of placement provision

Evaluating dimensions of placement efficacy

Delivering high-quality clinical placements requires more than availability; it demands a rigorous, systemic approach grounded in regulatory standards, quality assurance and student-centred design.

At the heart of this is the imperative to protect patient safety, enhance learning and ensure fairness and consistency across the system.

Patient safety and risk management

Patient safety is non-negotiable. Regulatory bodies – including the Care Quality Commission (CQC), General Medical Council (GMC), Nursing and Midwifery Council (NMC), Health and Care Professions Council (HCPC) and General Pharmaceutical Council (GPhC) – require that placements uphold the highest standards of care. Students must work within their level of competence and under appropriate supervision. Institutions must also have robust systems for raising and responding to concerns, including whistleblowing mechanisms that are accessible and non-punitive.

Supervision ratios and professional oversight

Each regulator sets distinct expectations around student supervision. Nursing students, for example, require designated practice assessors and supervisors, while medical and allied health students follow similarly structured mentorship frameworks. As new models like simulation and virtual placements emerge, these must also comply with supervisory standards to safeguard learning integrity.

Curriculum alignment and learning outcomes

Placements must be educationally purposeful and explicitly mapped to national curriculum frameworks and professional competency requirements. Regulators assess not just experience but measurable achievement. Whether in-person, observational or digital, every placement must contribute to meeting defined learning outcomes and ensure graduate readiness.

Practice hours and accreditation compliance

Minimum practice hour requirements, as mandated by regulators, are essential for ensuring that students gain sufficient real-world experience. These thresholds underpin programme accreditation

and must be strictly monitored and enforced. Flexibility in delivery models must not compromise total hours or the quality of learning opportunities.

Placement site quality assurance

Every placement environment must be audited regularly to maintain quality standards. This includes site visits, student evaluations, staff training and review of available learning opportunities. CQC ratings and reports should form a critical part of placement decision-making. If a site poses risks to student or patient safety, institutions must act swiftly, regardless of standard quality assurance cycles.

Equity, access and inclusion

Equity must be central to placement design and allocation. All students, regardless of background or geography, should have access to high-quality placements. This includes addressing barriers for those in rural or underserved areas, providing the necessary financial support for students to travel and ensuring placements accommodate diverse learning needs. Transparent allocation and appeals processes are key to ensuring fairness and trust.

Simulation and technology-enhanced learning

Simulation is a rapidly growing part of modern clinical education. While regulators generally permit its use, they often impose limits and conditions. Simulated experiences must be educationally valid, realistically designed and delivered by appropriately trained staff. As placements increasingly involve technology – such as telehealth, AI or remote diagnostics – these must enhance, not replace, experiential learning. Guidance on balancing digital with hands-on training is urgently needed.

Data, reporting and continuous improvement

Effective placement systems are data driven. Institutions must collect and report on key metrics, including hours completed, student outcomes, satisfaction scores and concerns raised. These data not only ensure regulatory compliance but support strategic planning and

policy development – vital as the NHS seeks to expand and diversify its workforce.

Placement hour requirements by profession

Clinical placements in the health and care sectors are governed by a wide array of professional, statutory and regulatory bodies (PSRBs), each with distinct requirements and approaches. Some PSRBs prescribe a set number of placement hours and clearly defined competencies, while others mandate only that students demonstrate proficiency against a set of core capabilities, without specifying time-based thresholds. For example, in medicine, regulators define the number and type of clinical conditions students must encounter during placements, whereas in other disciplines the emphasis may be on demonstrating outcomes rather than exposure to a set caseload. This variation creates a fragmented and complex ecosystem in which academic institutions and clinical providers must operate.

Compounding this are pressures within the system itself: workforce shortages, high service demand, evolving supervision models and constraints on physical placement capacity. For staff responsible for coordinating placements across a wide range of professional programmes, this landscape can be challenging to navigate, often requiring bespoke solutions to meet divergent regulatory and pedagogical standards.

To support clarity and strategic planning, Table 1 summarises the key regulatory bodies, required placement hours, supervisory expectations and competency frameworks. A more detailed reference list of PSRB competencies is provided at the end of this paper, highlighting the intricate landscape that universities and clinical partners must navigate to deliver safe, high-quality and future-ready clinical education at scale.

Table 1 Key regulatory bodies

Student group	Regulator	Number of required hours	Supervisory requirements	Competency requirements
AHP (allied health professionals)*	Health and Care Professions Council (HCPC)	No set number	Practice educator	Standards of education and training
Nursing Associate	Nursing and Midwifery Council (NMC)	1,150	Practice supervisor and assessor	Standards of proficiency for registered nursing associates
Nursing and Midwifery	Nursing and Midwifery Council (NMC)	2,300 (up to 600 simulated for nursing)	Practice supervisor and assessor	Standards of proficiency for registered nurses / midwives
Physician Associates (to be renamed Physician Assistants) (PA)	General Medical Council (GMC)	Competency based (up to July 2025, 1,600)	Named educational supervisor	Standards for PA
Sports Therapy	Society of Sports Therapists (SST) / British Association of Sport Rehabilitators (BASRaT)	200 (SST) / 400 (BASRaT)	Supervisor	Standards of proficiency
Medicine	General Medical Council (GMC)	Competency based	Named educational supervisor	Promoting excellence: Standards for medical education and training
Pharmacy	General Pharmaceutical Council (GPhC)	Variable between institutions	Mentors	Standards for the education and training of pharmacists

*The 14 allied health professions are: Art therapists; Dietitians; Drama therapists; Music therapists; Occupational therapists; Operating department practitioners; Orthoptists; Osteopaths; Paramedics; Physiotherapists; Podiatrists; Prosthetists and orthotists; Radiographers; Speech and language therapists.

Core challenges to placement efficacy

Despite the urgency of scaling up student numbers, current placement models face some key limitations.

- **Staff shortages:** With over 106,000 NHS vacancies, finding supervisors across the medical and allied health fields is increasingly difficult.
- **Inflexible models:** Traditional 1:1 and on-site learning structures are no longer universally feasible.
- **Supervision model development:** While there has been a growth in the development of supervisory models, this has not kept up with the speed of change required to meet the demand of students.
- **Placement saturation:** Many physical sites (hospitals, GP practices, community health centres, pharmacies) are already operating at full capacity with little scope for new provision while other locations are underutilised.
- **Quality concerns:** Pressures on stretched clinical resources can reduce the time available to be spent on providing a high-quality student learning experience.
- **Patient safety concerns:** All students should be placed in learning environments that are clinically safe, to minimise risks to both students and their learning. However, if a learning environment is deemed no longer clinically safe, student placements must be withdrawn – creating further constraints on the expansion of clinical learning opportunities.
- **Placement tariff:** There is a significant difference between placement tariff for medical students and physicians' assistants and all other non-medical student tariff.[2] The imbalance in tariff funding, with significantly more placement funding attributed to support medical students, makes it unattractive for some placement providers to offer placements for other health students.
- **Technological delays:** There are still some organisations where IT services lag current practice, and therefore students are not able to

use the advanced skillset they gain at university or at a neighbouring placement opportunity across the board.

- **Limited integration of simulation:** Simulated learning remains underutilised, despite regulatory allowances. Professional bodies and regulators have supported the incorporation of simulated practice learning to varying degrees, and its adoption by education providers is sometimes constrained by cost pressures.
- **Regulatory body compliance:** PSRBs (including GMC, NMC and HCPC) can sometimes act as bottlenecks for achieving large scale placement transformation. This is due to a variety of issues including strict regulations on placement hours / competencies, who can supervise and where in the curriculum placement opportunities can be used.
  - **The GMC:**
    - has rigorous standards for student placements detailed in *Outcomes for graduates* and *Promoting excellence: standards for medical education and training*.[3]
    - expects the same quality metrics present in university teaching to be present on placements, with details of how placement educators are trained and supported and how they communicate concerns about a student.
    - there is no requirement for a minimum number of student hours in GMC accredited programmes, but they expect the university to evidence how all the learning outcomes have been met while on placement.
  - **The NMC:**
    - has rigorous standards for placement hours, where all Nurses and Midwives are expected to achieve 2,300 placement hours and Nursing Associates 1,150 placement hours.
  - **The HCPC:**
    - does not stipulate minimum practice hours but higher education institutions looking to be accredited need to ensure

robust rationales. They must provide the HCPC with robust evidence of how their approach to placement hours ensures that competencies are met – and what the rationale is for the number of placement hours the higher education institution has chosen.

Rethinking the placement model

To future-proof clinical education, we must adopt a mindset of a fundamental rethink: challenging legacy assumptions and designing placement systems around quality, scalability and innovation.

The key questions to guide reform are:

- How can placement capacity increase amid staff shortages?
- How can placement quality be assured at scale?
- How do we balance patient safety with learner development?
- How can simulation and technology fill real-world gaps?

Transformative placement models

Table 2 Placement groupings and their modalities

Placement grouping	Types of placement
Participatory	Traditional direct patient care; ward-based, community-based, primary care
Observational	Shadowing models for medical students, physician assistants and for observing patient journeys, observing new roles (i.e. site nurse practitioners or paramedics in primary care)
Simulation	Hands-on lab-based simulation; virtual reality; scenario-based e-learning
Mentorship (experiential)	Leadership placements, quality improvement projects, research placements
Technology-led	Telemedicine, remote clinics, AI-assisted diagnostics, digital health innovation

Each model offers a unique value proposition and requires different supervisory and infrastructural inputs. Blended placement design, integrating multiple types, is the most sustainable route forward.

Table 3 Comparing placement types

Placement type	Strengths	Weaknesses	Opportunities	Threats	Risks	Risk mitigations
Participatory	High authenticity; real-world skills; confidence-building	Capacity-limited; supervision-heavy; inconsistent quality	Extend to underused settings; student-led clinics	Staffing shortages; service pressure; patient safety concerns; cancellations	Inconsistent learning; safety risks	Supervision standards; pre-site audits; agile response audits; planning tools
Observational	Low resource demand; good for early learners; good for specialist exposure; broad exposure	Passive learning; limited assessment; unstructured	Embed reflection; embed detailed hub and spoke opportunities within placement journeys; pair with active learning	Perceived as low value; low regulatory priority	Disengagement; poor learning retention.	Structured guides; learning logs; blended support
Simulation	Safe and scalable; enhances decision-making; recognised hours	Costly setup; requires trained staff; less realism	Expand virtual; align with needs; add AI	Funding cuts; over-reliance; limited acceptance	Mismatch with outcomes; technical failures	Align with standards; blend with clinical; invest in staff
Mentorship (experiential)	Develops leadership, research, critical thinking	May seem less relevant; limited mentors; unclear outcomes	Partner with trusts; integrate quality improvement projects	Competes with service time; low mentor buy-in	Misalignment with curriculum; poor engagement	Define projects; measure impact; develop strong links to learning outcomes, so both staff and students see importance; mentor incentives
Technology-led	Future-oriented; scalable; supports remote learning	Tech-dependent; less patient contact; evolving regulations	Link with NHS digital; prepare for new roles	Digital exclusion; rapid tech change	Privacy issues; platform instability	Digital training; secure platforms; structured reflection

Understanding placement modalities

Observational

Observational placements provide students with valuable opportunities to shadow professionals across a range of healthcare settings. They serve as effective early exposure experiences for newer students, while also offering final-year students the chance to observe senior staff and deepen their understanding of advanced practice.

These placements, typically short in duration, allow students to explore the day-to-day realities of specialist roles, enhancing their awareness of how such expertise integrates with their own developing professional identity.

Crucially, observational placements also support interprofessional learning by helping students understand how different roles intersect within multidisciplinary teams, strengthening their preparedness for collaborative healthcare practice after qualification.

Table 4 Examples of observational placements

Opportunity	Student Group	Level
Shadowing a GP	PA or medical student	4/5 or 7
Observing surgical procedures	Any	All
Following a patient journey	Any	All
Observing an advanced clinical practitioner	Nurse, midwife, pharmacist, AHP	5/6
Sitting in on MDT patient case conferences	Any	5/6/7

Simulation

Simulated placements offer a valuable opportunity for universities and clinical providers to collaboratively design hybrid, multi-modal placement pathways. These placements are already embedded in many university curricula, but their full potential remains underutilised. Simulated placements encompass a range of modalities, including low

and high-fidelity mannequins, actors, and virtual platforms. They can take place in dedicated simulation facilities or be accessed remotely via digital tools, allowing for flexible learning experiences, including from a student's home.

Designed to reflect realistic clinical environments, simulated placements enable learners to develop and refine key competencies such as patient assessments, communication skills, and clinical decision-making in safe, controlled settings. These experiences can be tailored to the student's level of study and provide a crucial bridge between theoretical learning and real-world practice.

Table 5 Examples of simulated placements

Opportunity	In-person or tech	Level of study
Skills-based simulation	Both	All
Scenario based (e.g. cardiac arrest)	Virtual	4
Scenario based (e.g. cardiac arrest)	In-person	5/6
Virtual placement – getting to know a clinical environment	In-person and Tech	4
Virtual placement – Managing a clinical environment	In-person	6
Managing complex scenarios	Both	6
Virtual placements – utilising software	Virtual	5/6

Case study: simulation at Anglia Ruskin University

In 2021, Anglia Ruskin University, in partnership with the Samaritans, introduced a first-of-its-kind online placement for pre-registration students in mental health nursing and social work. This two-week placement was designed to build competence in active listening and communication with vulnerable individuals.

Facilitated by experienced Samaritan trainers, the programme provided a safe and structured environment for students to engage with simulated mental health crisis scenarios. Learning outcomes included enhanced understanding of self-determination, suicide awareness,

mental and physical health, addictions and loneliness. Students also developed skills in empathy, honesty, confidentiality, safeguarding and non-judgemental practice.

In 2023, the placement was refined into a one-week format, tailored to specific disciplines. Paramedic students, for example, were trained to recognise indicators of suicidal ideation across the lifespan, create safety plans and manage high-risk conversations. Children's nursing students focused on communication strategies with young people and appropriate interventions to reduce self-harm risk. The shorter model increased accessibility, enabling a wider cohort – including adult nursing students – to participate.

Since its inception, the placement has engaged 690 pre-registration students across nursing (adult, children's and mental health), paramedic science and social work. Student feedback consistently evidences increased confidence in communication, particularly in techniques such as silence, concise language, summarising and reflective listening. Importantly, students report feeling more prepared to approach individuals demonstrating signs of mental distress or emotional vulnerability.

The placement has been positively received by health and social care providers, who acknowledge its contribution to workforce readiness and the development of essential transferable skills for supporting vulnerable populations.

Case study: simulation at Northumbria University

Northumbria University has developed a nationally recognised simulation-based placement model known as SkillsFest, integrating virtual reality, immersive technologies and structured clinical rehearsal into its undergraduate nursing curriculum.

Led by Claire Ford, SkillsFest was designed as a four-week simulated placement alternative for over 500 second-year nursing students. Delivered in collaboration with NHS partners and aligned to NMC proficiencies, the programme combined virtual reality scenarios using Oxford Medical Simulation (OMS) with practical sessions covering 31

patient cases across the lifespan.

In total, nearly 13,000 simulation sessions were completed, each involving structured pre-briefing and debriefing, formative reflection and direct input from academic and practice assessors. All student learning was mapped to practice assessment documentation and signed off accordingly. The scale, structure and educational value of SkillsFest led OMS to name Northumbria as a national exemplar, with the programme now embedded in the undergraduate curriculum and being extended into postgraduate provision.[4] The initiative demonstrates how immersive technology can meaningfully expand placement capacity and support high-volume and high-quality skills development.

Mentorship (experiential)

Mentorship placements are experiential in nature and differ from observational placements in that students take an active role, leading or contributing to real-world projects rather than just shadowing clinicians. These placements became more prevalent during the COVID-19 pandemic and have proven to be effective in meeting academic learning outcomes and professional proficiency standards, when thoughtfully designed and embedded within curricula.

Mentorship placements can include leadership roles, quality improvement initiatives and research-based projects. They provide students with hands-on experience in non-clinical but critically important aspects of healthcare delivery, helping to broaden their understanding of the whole system. This type of placement also introduces students to alternative career pathways and expands their vision of what is possible post-qualification.

Table 6 Examples of mentorship (experiential) placements

Opportunity	Time	Level of study
Leadership	2 weeks	6
Quality improvement	2 weeks	5/6
Research	2 weeks	6

Technology-led

Technology-led placements represent the most radical and fast-evolving modality in clinical education. As innovation outpaces traditional clinical practice, students are increasingly being trained to engage with technology in ways that differ significantly from how long-standing clinicians were educated. This creates a valuable opportunity to align with the industry 5.0 agenda: shifting the focus from simply using technology to developing adaptability, critical thinking and tech-integrated clinical decision-making.

Technology-led placements allow learners to apply clinical judgement in non-traditional formats, moving beyond peer-to-peer interactions in physical settings. For example, AI might assist a physiotherapist and their student in designing a care plan, but it is still the clinician's responsibility to ensure that care meets clinical standards and patient needs. AI will be a powerful tool for – rather than replacement for – clinicians. Embedding such technologies into placements empowers students to gain hands-on experience with the digital tools shaping the future of healthcare.

By integrating advanced digital competencies into pre-registration education, these placements help future-proof the workforce and support the NHS ambition to be a digitally-literate and innovation-ready system.

Table 7 Examples of technology-led placements

Opportunity	Supervision	Level of study
Telemedicine	1:many	6
AI enabled	1:1	4/5/6
Remote clinics / virtual wards	1:many / long-arm / peer-assisted	5/6
Digital health creation	1:1	6

Supervision models: Rethinking the role of the educator

Flexible supervision models can support capacity growth while maintaining quality.

- **1:1 supervision:** Traditional, high-touch model; best for critical or high-risk settings.
- **1:many supervision:** Common in simulation and group-based care settings.
- **Long-arm supervision:** Remote guidance using digital tools.
- **Peer-assisted learning:** Senior students support junior learners under staff oversight.

Universities must co-design these models with NHS partners, ensuring regulatory compliance while easing pressure on clinical teams.

Case studies in innovation

Participatory

Case study: nursing in social care

University of East London (UEL) students have been successfully placed in social care settings that do not follow the traditional 1:1 nursing care model. While these environments may not initially appear innovative in terms of direct participatory care delivery, they have required novel supervisory models to meet the NMC Standards for Student Supervision and Assessment (SSSA), which traditionally posed barriers to placements in non-traditional settings due to heightened oversight requirements.

To overcome this, UEL has worked collaboratively with providers to implement a blended supervision approach that includes: long-arm supervision; structured weekly clinical supervision sessions; ongoing

responsive communication between the institution and placement providers; and training and support for clinical educators outside of traditional healthcare settings.

This approach has enabled UEL to:

- Increase student placements in alternative settings by 20%.
- Ensure SSSA standards are consistently met across these environments.
- Maintain student satisfaction levels above 95%.
- Sustain student progression and objective sign-off rates above 95%.
- Expand clinical education into new, community-based care settings.

By redefining how supervision can be delivered in social care, UEL is broadening placement capacity while ensuring quality, compliance and positive student outcomes.

Case study: prison nursing at Pentonville Prison (University of Sunderland in London)

The University of Sunderland in London has evolved a participatory placement model by placing students at HMP Pentonville, offering valuable exposure to an alternative care setting. This innovative placement focused on the intersection of mental and physical health within the prison population. Despite the non-traditional setting, the placement was designed to align fully with the NMC's Student Supervision and Assessment (SSSA), using a traditional 1:1 supervision model to ensure appropriate oversight and support.

This example illustrates that alternative care settings – including custodial environments – can provide high-quality participatory placements, provided that supervision standards are robustly met. These placements broaden students' understanding of diverse care environments and challenge them to apply their learning in complex, underserved contexts. The University of Sunderland in London shared the following student testimonial:

During my placement at Pentonville Prison, I learnt a great deal about the mental health needs of the prisoners and how this relates to their physical health. The main health concerns for prisoners are drug and alcohol addiction and attempting suicide and self-harm. It is therefore imperative to provide medications for withdrawal symptoms while closely monitoring them by carrying out detoxification observations, and furthermore risk assessments, and escalate concerns where necessary.

There are also other clinics, whereby I had opportunity to practise giving vaccinations; and a triage clinic where I was able to assess the patients and provide wound care. There is also a Wellman clinic where we take on-the-spot tests for STIs. I had the chance to also work in the pharmacy medication hatch, where I gained knowledge of dispensing medications and the system they use for the dispensing of methadone, while connected to a software program called 'methasoft'.

The unscheduled care shifts include a paramedic and a nurse – the radio would call us when there is a code red or blue, we would run to the scene, either the prisoner's cell or a public area, and respond to the prisoners' emergencies, equipped with the para bag, which is like a hospital crash trolley.

In general, the prisoners are friendly and talkative; they may ask you to come through the gate to get to a class, as staff all have keys. However, a polite 'no' to them is all you need to say. Overall, I think this is a good placement to attend even if you have no intention of working in a prison, as it provides deeper knowledge of what I consider to be quite vulnerable individuals.

Observational

Case study: medical students at the University of Buckingham

Most medical student placements are observational in nature, as students do not hold a formal role in the workplace while learning. This can make it difficult to sustain engagement over extended periods, sometimes impacting attendance. In addition, students often face limited opportunities to develop competencies in sensitive areas such

as breaking bad news, where participation may be restricted due to concerns about gaining 'legitimate peripheral participation' and their ability to fully integrate into the community of practice.

While simulation and role play can supplement ward-based teaching, these approaches are resource-intensive and challenging to scale for large cohorts. To address these issues, the University of Buckingham has developed a more structured approach to observational placements.

Traditionally, medical students are attached to senior clinicians in secondary care, observing clinics or ward rounds with some patient interaction. However, senior clinicians are often balancing heavy service delivery demands, with education taking a secondary role. Clinical teaching fellows are present in some settings, but typically interact with students only once a week.

The University of Buckingham's model shifts greater responsibility for teaching onto clinical teaching fellows, supported by reduced, but more focused, access to senior clinicians. Teaching fellows deliver seminars, clinical skills training, bedside teaching and debriefs after patient contact, ensuring students receive structured learning alongside clinical exposure. This model provides more consistent engagement for students while alleviating pressure on senior clinicians.

The role of teaching fellow is also an attractive option for post–Foundation Year 2 doctors considering career progression. It also represents a cost-effective use of placement tariff funding, enabling large numbers of students to be taught within the clinical setting without compromising quality.

Simulation

Case study: virtual simulation in nursing at the University of East London

During the COVID-19 pandemic, UEL successfully implemented a blended placement model in line with the NMC's Student Supervision and Assessment (SSSA), incorporating simulation placement hours to support first-year Nursing students. As part of this approach, each

student completes 150 hours of virtual simulation as a preparatory pre-placement experience. These hours are delivered through a variety of interactive virtual simulation tools and structured to replicate real-world scenarios. Activities focus on foundational communication and care skills and are supported by university staff acting as designated practice supervisors and assessors, with clear separation from academic assessors to maintain the integrity of the SSSA standards.

This immersive model integrates theory and practice through supervised sessions, debriefs and clinical teaching, helping students build essential skills in a safe and supportive environment.

The outcomes from the programme have been compelling:

- 95% student satisfaction with the placement experience;
- 40% increase in students reporting improved confidence in clinical reasoning;
- year-on-year growth in academic progression from Level 4 to Level 5, attributed in part to increased clinical confidence; and
- 100% pass rate among students undertaking the virtual simulation placement.

This model demonstrates that blended, simulation-based placements can be both impactful and scalable, supporting high-quality clinical education while responding to placement pressures and workforce training demands.

Mentorship (experiential)

Case study: leadership placements in AHP at the University of East London

UEL's BSc Physiotherapy team introduced a leadership placement some years ago to expand placement capacity and help students address the leadership pillar of the Allied Health Professional (AHP) framework, which is often the most challenging of the four pillars to evidence. This five-week placement is embedded at Placement Block B of Level 5. Supervised by a university academic, students undertake a leadership-

focused project aligned with defined aims and learning outcomes.

Each year, a new project is selected based on departmental priorities:

- In 2023/24, students contributed to the development of an AHP education conference at UEL. Their project explored how to enhance the clinical experience for neurodivergent students, and their findings were presented at the conference.
- In 2024/25, students explored the role of simulation in physiotherapy education, gathering insights on learner perceptions and expectations to help develop approaches to embed simulation into the curriculum.

The placement allows students to meet the leadership-focused learning outcomes of Placement Block B. These outcomes may also be addressed through traditional NHS placements for those not undertaking the UEL-based leadership placement. In addition to module outcomes, the supervising academic sets specific project aims. Students complete relevant sections of the Common Placement Assessment Form (CPAF), used nationally in physiotherapy education.

Students participating in the leadership placement have achieved higher grades and developed transferable skills that enhance employability, such as project leadership, collaboration and communication. Feedback has been consistently positive, with students reporting high levels of satisfaction and a strong sense of professional development.

Beyond the immediate learning outcomes, the academic supervisor supports students in disseminating their work at the national level, further reinforcing the impact and value of the leadership placement model.

Technology-led

Case study: telehealth clinics for AHP

In partnership with a London NHS Trust, UEL launched a telehealth clinic for physiotherapy students – supervised remotely, students managed non-critical musculoskeletal (MSK) patients via video consultations.

The UEL Physiotherapy team supervised virtual MSK assessment placements, whereby students engaged virtually with patients to assess their needs and provide guidance and advice on safe mobilisation.

These placements were supervised by academic colleagues and enabled students to gain placement hours and to develop competence during the main period of COVID-19 lockdown which prevented face-to-face contact. Although this innovation was born out of necessity, the lessons learnt during this period were very valuable.

The full-scale virtual placements have not been adopted in physiotherapy to date (as the professional body standards of proficiency are largely based on physical contact), but the team have embedded virtual assessment for MSK conditions into academic modules to support career-readiness and to prepare students for evolving practices within contemporary healthcare.

Case study: virtual simulation at King's College London

King's College London has implemented a bespoke virtual placement programme guided by Aby Mitchell and digital learning specialist Behnam Jafari Salim. Launched in July 2024, it has already delivered over 10,000 hours of simulated learning across first- and second-year cohorts. The programme replicates a GP surgery on King's Road using a mix of AI-driven virtual patients, live one-to-one interactions and 360° immersive scenarios. This narrative-led model supports clinical decision-making, digital documentation, telehealth skills and integration of primary and secondary care. Daily debriefs with practice assessors ensure reflective learning and personalised feedback. Students report enhanced confidence in managing referrals, communication, and documentation. The success of this initiative contributed to Aby and Behnam being shortlisted for 'Nurse Educator of the Year' by the British Journal of Nursing.[5]

Recommendations for action

For universities:

- Expand simulation infrastructure and train academic staff in digital pedagogy.
- Embed flexible placement design into curriculum validation.
- Co-create placement strategy boards with NHS trusts to support student-centred placement models.

For clinical partners:

- Pilot new supervision models with higher education institutions.
- Identify alternative placement opportunities and work with higher education institutions to look at scalability and how they meet the outcomes required.
- Identify low-risk and high-learning-value clinical tasks for student delegation.
- Invest in digital platforms for virtual supervision.

For policymakers:

- Provide capital funding for simulation centres.
- Provide funding for practice education teams, noting the difference between clinical placement tariffs between medical students and all other health care students.
- Support innovation in placement accreditation.
- Mandate placement reporting and benchmarking nationally.

For all:

All stakeholders across education, healthcare and policy should work

together to develop and expand collaborative models that transcend institutional boundaries. This includes creating opportunities and dedicated spaces for cross-institutional and system-level collaboration to address placement inefficiencies collectively. By fostering a culture of shared innovation and co-design, stakeholders can drive system-wide transformation in placement redesign, ensuring solutions that are scalable, sustainable and responsive to the evolving needs of both students and the healthcare workforce.

A call to partnership and innovation

Incremental change will not address the challenges to creating high-quality placement opportunities across the health and care sector; bold and transformative action is needed. Now is the moment to fundamentally rethink and redesign clinical placements collaboratively, equipping the next generation of clinicians to meet evolving healthcare demands and restoring confidence in health careers. A strategic, regionally coordinated approach to placement design, supervision, organisation and evaluation can unlock significant growth in student capacity across the health ecosystem.

This is especially critical as the Secretary of State for Health and Social Care advances the shift towards community-based care, where current supervision requirements limit the number of students able to train in neighbourhood health settings. Without innovative training models embedded in community care and new ways of working, the current cycle will persist.

Universities, clinical providers and the wider health and care sector, including the NHS, must embrace quality improvement methodologies to create agile and effective solutions to the placement challenge. Only by working together with shared purpose and innovation can we secure a sustainable and resilient health and care sector for the future. It is time to think differently – and act decisively – to build the collaborative system that the NHS and its future workforce urgently need.

Endnotes

1 **https://www.gov.uk/government/speeches/statement-from-the-secretary-of-state-for-health-and-social-care**

2 Placement tariffs are a funding model to pay for clinical placements and undergraduate medical placements in secondary care, introduced by the Department of Health and Social Care in 2013. It is a nationally controlled fund that ensures equity in funding, although there is a large disparity between medical students and non-medical students placement tariff. Clinical (non-medical students, including Nursing, Midwifery and AHP): £5,866 plus market forces factor per full-time equivalent. Medical undergraduates: £35,981 plus market forces factor.

3 General Medical Council, Outcomes for graduates 2018, June 2018 **https://www.gmc-uk.org/-/media/documents/dc11326-outcomes-for-graduates-2018_pdf-75040796.pdf** and General Medical Council, Promoting excellence: standards for medical education and training, July 2015 **https://www.gmc-uk.org/-/media/documents/promoting-excellence-standards-for-medical-education-and-training-2109_pdf-61939165.pdf**

4 **https://www.digitalhealth.net/2024/02/northumbria-university-simulation-tech-receives-best-practice-praise/**

5 **https://www.kcl.ac.uk/virtual-placements-kings**

Links to relevant regulatory body policies

BASRaT	https://www.basrat.org/policies
GMC	https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/standards-for-pa-and-aa-curricula https://www.gmc-uk.org/education/standards-guidance-and-curricula
HCPC	https://www.hcpc-uk.org/standards/
GPhC	https://www.pharmacyregulation.org/pharmacists/standards-and-guidance-pharmacy-professionals
NMC	https://www.nmc.org.uk/standards/standards-for-nursing-associates/standards-of-proficiency-for-nursing-associates/ https://www.nmc.org.uk/standards/standards-for-nurses/standards-of-proficiency-for-registered-nurses/ https://www.nmc.org.uk/standards/standards-for-midwives/standards-of-proficiency-for-midwives/
SST	https://thesst.org/standards-of-proficiency/

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This paper argues for a fundamental rethinking of clinical placements, suggesting that incremental adjustments are not enough. Instead, it outlines bold and innovative new approaches that harness the full potential of simulation, technology and new models of supervision, while also deepening partnerships between higher education institutions, NHS providers and community organisations.

The paper proposes a shift in thinking from 'more placements' to 'better placements', to ensure that placements are equitable, flexible, future-facing and designed around workforce needs and student success. This, it argues, will secure the future workforce the NHS requires to meet the challenges of the next decade and beyond.

HEPI was established in 2002 to influence the higher education debate with evidence. We are UK-wide, independent and non-partisan.

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