Author’s response to reviews

Title: Identifying factors which enhance capacity to engage in clinical education among podiatry practitioners: an action research project

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Identifying factors which enhance capacity to engage in clinical education among podiatry practitioners: an action research project

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Approval for this project was granted by the Cornwall and Plymouth Research Ethics Committee and by the Ethics Committee of the University’s Faculty of Health, Education & Society and is in accordance with the Declaration of Helsinki. The anonymity of participants, those undertaking the survey and those that are members of the action research team, was guaranteed. Information sheets were issued and informed consent was obtained for the participants of the action research team.

The principal author would like to thank the members of the action research team for their valuable input to the project.
Abstract

Background

Health profession students develop practical skills whilst integrating theory with practice in a real world environment as an important component of their training. Research in the area of practice placements has identified challenges and barriers to the delivery of effective placement learning. However, there has been little research in podiatry and the question of which factors impact upon clinical educators’ capacity to engage with the role remains an under-researched area. This paper presents the second phase of an action research project designed to determine the factors that impact upon clinical educators’ capacity to engage with the mentorship role.

Methods

An online survey was developed and clinical educators recruited through National Health Service (NHS) Trusts. The survey included socio-demographic items, and questions relating to the factors identified as possible variables influencing clinical educator capacity; the latter was assessed using the ‘Clinical Educator Capacity to Engage’ scale (CECE). The survey response rate was 42% (n=66).

Results

Multiple linear regression identified four independent variables which explain a significant proportion of the variability of the dependent variable, ‘capacity to engage with clinical education’, with an adjusted $R^2$ of .428, significant at $<.001$. The four variables were: protected mentorship time; clinical educator relationship with university; sign-off responsibility; and volunteer status.
Conclusion

The identification of factors that impact upon clinical educators’ capacity to engage in mentoring of students has relevance for strategic planning and policy-making with the emphasis upon capacity-building at an individual level, so that the key attitudes and characteristics that are linked with good clinical education are preserved.

(Word count 254)

Keywords

Capacity building, professional education, podiatry, psychometrics, questionnaires
Background

Placement and work-based learning is of increasing importance in Higher Education as students build practical skills alongside their academic learning [1]. Placement learning is well established in healthcare settings, where clinical education plays an important role in the development of students’ practical skills. The National Health Service (NHS) requires healthcare professionals that are trained to a high standard, fit for purpose and equipped to provide a quality service. To achieve this, programmes of study which lead to professional registration need to provide appropriate and effective clinical education, facilitated through formal collaborations between Higher Education Institution and the NHS. A key influencing factor in placement success is the role of the clinical educator, facets of which can make a difference between a supportive placement in which learning is maximised, and one in which the student becomes disengaged and potentially fails to achieve learning outcomes.

Within the placement setting, a clinical educator is assigned to facilitate the student’s learning. Although the term ‘clinical educator’ is not clearly defined in the literature, in the context under study, the role is similar to that of ‘nursing mentor’. This role is outlined by the United Kingdom’s (UK) Nursing and Midwifery Council within a framework which supports learning and assessment in practice through eight overarching domains: establishing effective working relationships; facilitation of learning; assessment and accountability; evaluation of learning; creating an environment for learning; context of practice; evidence-based practice; and leadership [2]. The placement learning literature outlines the roles of the clinical educator whilst emphasising the importance of recognising and meeting learners’ needs, goal setting, assessment, and student support [3 to 6].
Placement environment

Research has shown that there are multiple factors extant in the placement environment which potentially impact the student placement experience, including the level of preparation provided to the student by the Higher Education Institute; the requirement for comprehensive orientation to the learning environment upon arrival [7]; student numbers [8]; self-efficacy of the clinical educator in their own practice [7]; effective clinical educator-student partnerships with time allowed for reviewing learning outcomes and provision of feedback [9]; and finally, the complexities of the clinical environment including clinical educator-student relationships [10]. The delivery of effective placements has been an area of research focus [11 to 15] with the clinical educator viewed as influential in the students’ placement experience [16 to 18] and significant in the amelioration of some of the potential challenges within the placement environment.

Given the importance of the clinical educator to shape and inspire the next generation of health professionals, it is perhaps surprising that there has been less research on factors which impact upon clinical educators’ engagement with the role. However, some factors have been identified within nursing in respect of developing a good placement culture, such as the potential importance of mentorship, enthusiasm for the nursing profession and collegiality [19]. The degree to which these factors impact upon educators’ engagement, however, is still unclear. Quality placement experiences are perceived to exist where universities provide support including learning objectives, clear supervision and assessment expectations [20,21]; where clinical educators do not view students as a burden [22]; and where protected time for student mentoring is formally timetabled [19].

Over time, the level of clinical educator responsibility has increased with many assuming assessment and sign-off responsibilities for students, thereby confirming or disconfirming
attainment of the required level of competency [16,22]. This has coincided with increased student numbers resulting in a requirement for more clinical educators [23] with clinical educators’ motivation for undertaking the role identified as ranging from managers’ requests, employment conditions, perceived career advancement and direct coercion [24]. In addition to these elements, efficient administration and management of placements have been identified as important factors in facilitating clinical educators in their role [19]. Within nursing recruitment and retention of students has been recognised as important to the maintenance of a stable workforce and the successful training of future healthcare professionals [19], whilst drivers within higher education designed to increase quality and embed good practice [25,26] have led to questions about how the number of student allocated to a clinical placement can be increased, whilst maintaining or improving the quality of those placements.

**Capacity and capacity-building in clinical education**

Recently, research in the UK and Australia has started to focus on how increased numbers of students can be facilitated to undertake practice placement opportunities, driven by changing workforce requirements [27 to 29]. This has necessitated training of more healthcare professionals, particularly nurses, as clinical educators [8,23,30], to meet these operational requirements and to avoid ‘burn out’ of staff that regularly undertake clinical education [29].

The healthcare literature predominantly uses the term capacity to indicate the number of students that can be supported in a particular placement area [8,23,27, 28,30 to 32]. A number of issues pertaining to capacity have been identified, including limitations on the number of placement settings [28], challenges to increasing student numbers, organisational resistance to facilitating placements and lack of experienced staff [27]. Tensions exist
between capacity and the provision of quality placements [33] whilst also providing quality patient care and maintaining professional standards [8]. Decision-making in relation to capacity lies principally at an organisational/strategic level, based upon clinical educator to student ratios, by those responsible for staffing and financial investments [8,19].

Research on capacity has focused on nursing and midwifery and has been limited to staff perceptions of clinical education and specifically the negotiation of student numbers. Identified solutions include regular student allocation, rather than creating peaks and troughs [27]; identifying under-utilised areas as potential placements [30,32]; working inter-professionally to offer new placement opportunities; providing dedicated placement staff to support clinical educators [23], accurate databases for collating placement information and more flexible working patterns to increase students’ learning opportunities [27]. In a previously under-researched area, these studies raise important questions.

As stated, research to date has been based solely on increasing numbers of placement students, without consideration of the wider context within which capacity resides. Maintaining quality placements, learning opportunities and patient care are issues that are mentioned, but how these terms are defined and measured in relation to capacity is often unclear. Further, many are qualitative studies where recruitment has been challenging [23] limiting generalisability. Study details are also not always fully reported [27,30,32], for example, the development and content of interview and focus group schedules [8,23,27].

The current research base in the area of capacity is limited and in order to fully appreciate the demands of increased student numbers alongside creating effective learning environments further research addressing the strategic, organisation and workforce perspectives is required. The CECE scale was developed by the authors [36] to identify the variables that predict clinical educator capacity to engage with the role of mentorship with
podiatry students. Establishing factors that impact upon clinical educator capacity may identify opportunities for placement planning, organisation and support - resulting in more effective practice placement. The CECE scale consists of 74 items within nine sub-scales: anxiety; confidence; culture; job satisfaction; leadership; management; support; positive attitude towards the role of clinical educator; negative attitude towards the role of clinical educator. The scale has been validated with Cronbach’s alpha coefficients ranging from 0.782-0.951 demonstrating overall reliability of the scale.

In this context, the authors argue for the need to redefine and broaden the concept of capacity in healthcare clinical education, to include building the capacity of significant individuals, groups and organisations to provide sustainable clinical education within the placement environment [34]. Given the clinical educators’ essential role facilitating placement experiences, generating knowledge in support of that purpose is essential. Therefore, this paper focuses upon identifying the factors that impact upon clinical educators’ capacity to engage with the role of clinical education implementing the CECE scale as the assessment tool.

**Conceptual framework**

Given the strategic and organisational planning of placements, and the collaborative nature of the provision of those placements, delivery by the clinical educator is just one aspect of a more complex system. The authors propose the expansion of the term capacity-building to embrace resource provision, leadership, organizational development, clinical education and student development, and collaborative partnerships [35] which takes account of this broader structure as described in figure one [34]. Baillie et al. [34] proposes that capacity in its simplest terms can be conceived of as a person/group/organisation having the ability to achieve a stated objective, with capacity-building being a set of processes that facilitates
achievement of those objectives. A multi-factorial concept, capacity-building requires a whole system approach to understand and support the complex structures which underpin the increase in students allocated to the placement setting. The clinical educator plays a critical part in facilitating students within the clinical environment and their capacity to undertake the role and manage the learning environment requires support and development. Building capacity in this context involves an on-going process which empowers the organisation, and the groups and individuals within it [34] to achieve the objective of effective, high quality placement learning. It is therefore essential to examine the role of the clinical educator within this whole system approach.

The authors propose a conceptual framework that works towards sustainable outcomes in healthcare clinical training, where capacity-building is based upon partnership, organisation, clinical educator and student development, built upon a foundation of leadership, intelligence and resourcing (see Figure 1).

Aim

The aim of the research was to survey podiatry clinical educators across 15 English Trusts using the CECE scale [36] to explore factors thought to predict the variability of clinical educator capacity to engage in the mentorship role, thus developing capacity-building for healthcare clinical training in podiatry.

Method

This research represents part of a larger collaborative action research project between one Higher Education Institute and an NHS podiatry department. An action research approach allowed for the exploration of the complex issues that surround placement learning and for the instigation of change to address specific work-based matters in context taking a
collaborative approach with stakeholders [37]. The framework supports a systematic
approach to problem-solving [38] where issues/challenges/barriers are ‘analysed/diagnosed’,
which leads to the formulation of an ‘action plan’ which addresses issues and changes
practice (see Figure 2). The action can subsequently be evaluated by the whole action
research team and is a powerful way of informing practice where mixed methodological
approaches to research may be applied [39].

**Action research team**

The stakeholders forming the action research team comprised clinical educators from
podiatry and nursing, who discussed the barriers and challenges to clinical education and
provided a multi-lens perspective of this complex environment. The initial ‘diagnosis phase’
(cycle one) had established that the team held positive attitudes towards the clinical educator
role and regarded it as an integral part of their professional responsibility as a healthcare
professional.

During cycle one, the action research team met to discuss the factors (variables) that
were thought to impact upon this capacity, and subsequently identified from the considerable
combined pedagogical experience of the clinical educators within the team, alongside nursing
and midwifery literature. From these initial discussions, the construct ‘capacity to engage’
was generated and broadly defined. These predictive factors were reworked into hypotheses
that could then be tested against the CECE scale (see Figure 3). The independent variables
that were identified as potentially influential were socio-demographic factors, academic
profile, career profile, and placement organisation.
Ethics

Ethical approval was granted by the Cornwall & Plymouth Research Ethics Committee (09/H0203/95) as well as the Plymouth University Ethics Committee.

Data collection

Recruitment

Heads of Service in 15 podiatry departments were sent a letter inviting staff who act as clinical educators to participate in the research. Postcards were included which advertised the research and offered potential participants the opportunity to win one of two £25 book vouchers on completion of the survey. Participant anonymity was assured, although an email address was requested if individuals wished to be entered into the prize draw; this was administered by an independent third party.

Materials

The survey was hosted online and Heads of Service were asked to engage their staff in the research by forwarding the postcard to them. The survey was live for a six-week period and at two weekly intervals reminder emails were issued.

The Sample

The population for the research comprised all podiatrists with clinical educator responsibilities, regularly or on an ad hoc basis, for the BSc (Hons) Podiatry programme at one UK University.

Data analysis

All analysis was undertaken using software (PASW®) version 18 (previously known as SPSS). Descriptive statistics were used to examine demographic data. The relationship
between the CECE scale and socio-demographic factors, academic profile, career profile, and placement organisation was examined. Inferential statistics were used, specifically the Mann-Whitney U and Kruskal-Wallis tests leading to multiple linear regression. A stepwise approach was utilised to systematically review each variable where the hypothesis was found to be significant. The variables were considered together which led to the identification of one variable that was best able to predict the outcome based on levels of significance. The chosen variable was then retained within the model and a second predictor variable was subsequently identified. This process was repeated until all the variables had been either included or excluded from the regression model. This enabled the generation of a model to ascertain the extent to which the variables identified from the initial analysis were predictive of the variability of the dependent variable, ‘clinical educator capacity to engage in the mentorship role’.

Results

Response rate

The response rate was 42% (n=66) from an estimated 158 clinical educators, which was considered acceptable for an online survey [40]. Of the 66 respondents to the survey 23% (n=15) were male and 77% (n=50) were female (one unknown). This ratio of approximately 1:3 (male: female) reflects the professional trend (Health and Care Professions Council 2012; personal email). Of the 66 respondents, 18.2% (n=12) were between 20-29, 24.2% (n=16) between 30-39, 31.8% (n=21) between 40-49 and 25.8% (n=17) between 50-59 years of age.

Hypotheses testing

Non-parametric statistical tests were conducted to test hypotheses relating to factors associated with podiatrists’ capacity to engage in clinical education. A number of significant
results were obtained and are detailed in Table 1 (A significance level of 0.05 was set throughout; non-significant results are reported in Table 2). Increased capacity to engage in clinical education was found to be associated with clinical educators volunteering for the role; full-time employment of the clinical educator; time being allocated to the clinical educator for preparation in advance of the student joining the placement; protected time for clinical education within the working day but outside clinical hours; mentors having a number of students, rather than a single student, to mentor; responsibility to sign off students’ learning outcomes; and proximity of the placement to the university.

A prior relationship with the University and the distance from the University both approached significance and to explore whether either had any potential explanatory value in predicting clinical educator capacity to engage with the role within the regression model the significance level was raised to \( p \leq 0.1 \). Ten Mann-Whitney U tests were performed for each category resulting in ten paired independent samples. The significance level was relaxed and set at \( p \leq 0.1 \) and the results were significant for four of the paired independent samples; 0-49 miles and 50-99 miles \( p<0.046 \); 0-49 miles and 100-149 miles \( p<0.046 \); 0-49 miles and 150-199 miles \( p<0.096 \); 0-49 miles and 200-249 miles \( p<0.063 \). Although, the results for distance from the university were not all significant at \( p>0.05 \) they were at \( p \leq 0.1 \) and these four variables were included within the regression analysis in order to determine whether they had any explanatory value for predicting capacity to engage with clinical education within the regression model.

**Multiple linear regression**

In total eleven variables were considered within the initial regression, subsequently producing a model comprised of four variables. The results are presented in Table 3. The regression model summary produced was as follows: \( R^2 0.428 \); F-test 11.664; and \( p < 0.001 \).
Assumptions of linearity and homoscedasticity were met overall [41]. The four independent variables identified (protected mentorship time, clinical educator relationship with university, sign-off responsibilities and volunteer status of clinical educator) represent 43% of the predictive variability of the dependent variable - capacity to engage in clinical education.

Discussion

This research aimed to identify the factors that impact upon clinical educators’ capacity to engage in the role in the context of podiatry. Findings revealed factors which increase the capacity of clinical educators in this role to include: being provided with protected time to engage in preparation and support of students; having a current or previous relationship with the university which goes beyond the clinical educator role; having assessment and sign-off responsibilities for students; and volunteering for the role.

These findings are supportive of Jokelainen et al. [19] who found protected time to be valued by clinical educators. The mentorship role is a major responsibility for the clinical educator both in terms of the student’s placement experience and their progression within the clinical environment. Ideally time should be embedded within the timetable for the clinical educator and student, outside the podiatrist’s clinical responsibilities, to engage with mentoring. This may include reflecting on the day’s or week’s events to contextualise experiences and reinforce theory, providing pastoral support and setting new goals and learning opportunities in partnership with the student.

This study has shown that where the clinical educator has a previous or existing relationship with the university, capacity for mentorship is increased. This result supports
previous work where loyalty links have been established with a place of previous study or where endeavours which result in the attainment of an award are currently being undertaken [42]. This type of allegiance can be conceptualised as brand loyalty, with the University representing the brand. The students’ relationship with ‘using the brand’ appears to create a sense of loyalty which extend to actions beyond graduation [43].

Where clinical educators undertake the responsibility for signing-off learning outcomes there was found to be an increase in capacity for the role [22]. Assessment of competency is integral to the role and often necessitates liaison with other clinical educators regarding their assessment of student capabilities conferring considerable extra responsibility to the clinical educator who will decide on students’ ability to progress. The placement process may be more challenging for some students than for others, and ultimately be more rewarding for the clinical educator when a successful achievement of summative assessment is reached. Where clinical educators are not given this responsibility it may have a negative effect, with the clinical educator having spent time developing a student, but without recognition of this substantial investment.

Volunteering for the clinical educator role increased capacity scores. It would seem natural that individuals that choose to undertake a role are more likely to be well disposed to the role, as it is perhaps viewed as vocational rather than compulsory [24]. A requirement for an increase in placements allocations may result in staff having to take on these roles. This may be counter-productive as unwilling staff are unlikely to mentor students effectively, and may even impact on student attrition.

The insignificant results concerning the clinical educator’s education and experience are surprising, especially given evidence in other professions of the importance of qualifications on student learning (e.g. Nasr et al. [44]). This finding may reflect the
homogeneity of variance associated with the sample which may not be reflective of samples in previous research. It is possible that less experienced staff are better able to understand the perspective of students than their more experienced colleagues, thus they off-set a lack of experience with an increased enthusiasm for the role.

The CECE scale provides a useful tool to examine the engagement of clinical educators in students’ learning. Further research using the scale with podiatrists both in the UK and internationally would provide important comparative data. The scale could also be adapted for use with other health professionals engaging in clinical education; this would be beneficial given the multi-professional context within which both practitioners and students frequently work. Building the body of work involving the CECE would yield larger samples thereby enabling more sophisticated statistical analyses with greater power. Given that the CECE scale is self-report, it would be important for future research to also measure aspects of the clinical environment independently (e.g. the ratio of educators to students; clinical caseload; student feedback).

Further research to explore other factors that impact upon capacity to engage in the role of clinical educator is required which surveys all podiatrists who undertake clinical education. Other possible factors which affect capacity could be included, such as the total number of students mentored each year by an individual clinical educator, perhaps from other health professions or universities and possibly on an ad hoc basis, thus reducing clinical educator capacity for the role. Factor and Rasch analysis with a larger number of respondents may then be possible, statistical power of the study. With further development, the CECE scale could be adapted and utilised with other healthcare professionals, increasing the sample size and inclusive of an international perspective. There is also scope to include other dimensions in the CECE scale, such as clinical educators’ perception of the responsibilities and ambit of the role. This work has the potential to provide guidance to the organisation and
resourcing of healthcare students’ placements more generally across the health education arena.

Limitations

While this research has contributed new knowledge in the area of podiatry training, the study suffers a number of limitations. First, the sample comprised podiatrists from a single region of the UK, which limits the generalisability of the findings. Although the sample was drawn across both rural and urban placement contexts within a range of organisational environments of varying sizes, it is possible that regional variation may impact clinical education practice. Second, while the response rate to the survey was satisfactory, it is possible that non-respondents may have differed from respondents in relation to characteristics that were relevant to capacity to engage. The research findings, therefore, need to be interpreted with some caution. As with much survey research of this nature, the study assessed the perceptions of clinicians as to the barriers and facilitators to their engagement with the clinical educator role. Such perceptions are important as they describe the lived experience of clinicians and will affect their practice. Nevertheless, perceptions are not necessarily accurate reflections of the external environment.

Conclusions

Establishing the factors that are significant in influencing capacity to undertake the role of clinical educator is crucial in the further support and development of placements in Higher Education. Capacity-building requires a sustainable approach with participation at an organisational, group and individual level, impacting upon management of placements at both a local and national level. This study has specifically focused on the individual, and on relationships between the university and practice setting. Commitment to investment of
resources and opportunities is required, not only to increase individual capacity, but also to support quality and effectiveness of training opportunities. Enhancing clinical educator capacity for the role will promote the development of effective placements leading to the potential for increasing allocations and impacting positively upon attrition rates. At a practical level, this research informs podiatry placement recruitment to the role of clinical educator, which will promote engagement with the task. These findings are of relevance in relation to strategic planning, policy-making in the NHS and for the Higher Education Institutes organising placements at a local level.

**Competing interests**

There are no competing interests in relation to this research.

**Abbreviations**

CECE: Clinical Educator Capacity to Engage; NHS: National Health Service; UK: United Kingdom

**Authors’ contributions**

The principal author undertook this research as part of a larger action research project in pursuit of a PhD and therefore took the primary role in all aspects of the research. The director of studies, Professor Lea and second supervisor, Dr Callaghan were engaged in the design, development and analysis of the scale and contributed fully to the writing of the paper. Dr Shaw provided guidance and advice relating to the statistical analysis and Professor Cotton provided guidance around action research and reviewed the paper.
References


Table 1  Hypotheses not rejected as non-significant

<table>
<thead>
<tr>
<th>Hypotheses</th>
<th>Statistical test</th>
<th>N</th>
<th>Results</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>H₁</strong> Participants who volunteer to be clinical educators will demonstrate greater capacity to engage with the role.</td>
<td>Mann-Whitney U</td>
<td>66</td>
<td>U = 306.0</td>
<td>Significant at p = 0.003, two-tailed</td>
</tr>
<tr>
<td><strong>H₁</strong> A relationship with the university, outside the clinical educator role (e.g. previous student, external examiner), will be associated with greater capacity to engage in the role.</td>
<td>Mann-Whitney U</td>
<td>65</td>
<td>U = 253.5</td>
<td>Not significant at p ≤ 0.05, two-tailed (p = 0.099)*</td>
</tr>
<tr>
<td><strong>H₁</strong> Clinical educators engage more with the role when employed on a full-time basis. p = .010, two-tailed</td>
<td>Mann-Whitney U</td>
<td>60</td>
<td>U = 260.5</td>
<td>Significant at p = 0.010, two-tailed</td>
</tr>
<tr>
<td><strong>H₁</strong> Preparation time prior to the student attending placement would increase capacity to engage.</td>
<td>Mann-Whitney U</td>
<td>59</td>
<td>U = 132.5</td>
<td>Significant at p = 0.002, two-tailed</td>
</tr>
<tr>
<td><strong>H₁</strong> Where protected time outside clinical hours was timetabled into the placement, the hypothesis stated that capacity to engage would be higher.</td>
<td>Mann-Whitney U</td>
<td>59</td>
<td>U = 115.0</td>
<td>Significant at p = 0.002, two-tailed</td>
</tr>
<tr>
<td><strong>H₁</strong> Clinical educators with only a single student to mentor per placement would show greater capacity for engagement.</td>
<td>Mann-Whitney U</td>
<td>66</td>
<td>U = 361.5</td>
<td>Significant at p = 0.037, two-tailed</td>
</tr>
<tr>
<td><strong>H₁</strong> Responsibility for signing-off students’ learning outcomes would impact positively on clinical educators’ capacity to engage.</td>
<td>Mann-Whitney U</td>
<td>65</td>
<td>U = 248.0</td>
<td>Significant at p = 0.006, two-tailed</td>
</tr>
<tr>
<td><strong>H₁</strong> Where clinical educators’ employment was closer to the university capacity scores would be higher. There were 5 categories for distance; 0-49 miles; 50-99 miles; 100-149 miles; 150-199 miles; and 200-249 miles.</td>
<td>Kruskal-Wallis</td>
<td></td>
<td>H(4)=8.78</td>
<td>Not significant at p ≤ 0.05 (0.67)*</td>
</tr>
</tbody>
</table>

* significance level was raised to p ≤ 0.1.
Table 2  Hypotheses rejected as non-significant

<table>
<thead>
<tr>
<th>Hypotheses</th>
<th>Statistical test</th>
<th>N</th>
<th>Results</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>H₁</strong> The length of time a clinical educator has been qualified as a podiatrist will result in higher capacity to engage scores</td>
<td>Spearman’s rho</td>
<td>65</td>
<td>$r_s = 0.119$</td>
<td>Not significant at $p \leq 0.05$ (two-tailed)</td>
</tr>
<tr>
<td><strong>H₁</strong> The length of time a clinical educator has worked for a particular NHS Trust will result in higher capacity to engage scores</td>
<td>Spearman’s rho</td>
<td>66</td>
<td>$r_s = 0.173$</td>
<td>Not significant at $p \leq 0.05$ (two-tailed)</td>
</tr>
<tr>
<td><strong>H₁</strong> The length of time a clinical educator has worked in a particular role will result in higher capacity to engage scores</td>
<td>Spearman’s rho</td>
<td>65</td>
<td>$r_s = 0.073$</td>
<td>Not significant at $p \leq 0.05$ (two-tailed)</td>
</tr>
<tr>
<td><strong>H₁</strong> The length of time a clinical educator has undertaken the mentoring role will result in higher capacity to engage scores</td>
<td>Spearman’s rho</td>
<td>64</td>
<td>$r_s = 0.051$</td>
<td>Not significant at $p \leq 0.05$ (two-tailed)</td>
</tr>
<tr>
<td><strong>H₁</strong> Higher levels of banding will result in higher capacity to engage scores</td>
<td>Kruskal-Wallis test</td>
<td>66</td>
<td>$H(3) = 1.55$</td>
<td>Not significant at $p \leq 0.05$</td>
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<tr>
<td><strong>H₁</strong> The level of academic qualification will affect capacity to engage scores</td>
<td>Kruskal-Wallis test</td>
<td>65</td>
<td>$H(4) = 4.97$</td>
<td>Not significant at $p \leq 0.05$</td>
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<tr>
<td><strong>H₁</strong> Attainment of clinical educator training will impact on capacity to engage scores</td>
<td>Kruskal-Wallis test</td>
<td>66</td>
<td>$H(4) = 1.34$</td>
<td>Not significant at $p \leq 0.05$</td>
</tr>
<tr>
<td><strong>H₁</strong></td>
<td>Mann-Whitney U</td>
<td>66</td>
<td>$U = 485.50$</td>
<td>Not significant at $p \leq 0.05$</td>
</tr>
</tbody>
</table>
Table 3 Results of multiple regression

<table>
<thead>
<tr>
<th>Step 1</th>
<th>B</th>
<th>SE.B</th>
<th>β</th>
</tr>
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Note: adjusted $R^2 = .17$ for Step 1 *p ≤ 0.001, adjusted $R^2 = 0.28$ for step 2, adjusted $R^2 = 0.37$ for step 3, adjusted $R^2 = 0.43$ for step 4. ** p < 0.001