

Mapping the support for newly qualified practitioners across Kent, Surrey and Sussex



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The illustration on the front cover depicts the discussion on **inter-professional education within NQP** support. The various coloured eyelashes represent the management of different professions, the various coloured dots represent the NQPs of each profession and the eye symbol represents health provision within Kent, Surrey and Sussex.

The choice of the eye symbol was selected as conference attendees noted an increased commissioning focus on inter-professional learning within the region. This was causing tension in cases where this approach did not fit with the training needs of NQP- therefore this image aimed to depict that there is an 'eye for the approach, but no clear vision'.

No mention of working together inter-professionally at a programme development level was made. Therefore the eyelashes depicting various professions do not touch one another. This appears to have resulted in separate professions including inter-professional education within individual Trusts (for example a simulation session arranged for F1s which includes nurses from that specific Trust or joint training sessions on communication skills). This is represented by connecting the individual coloured 'NQP' dots and the chaotic image this creates when viewed strategically.

The overall sense is that those responsible for the training of NQP within each Trust and profession are attempting to 'connect the inter-professional education dots'; the overall picture of how this can benefit NQPs is still unclear. There was a desired sense for 'vision before provision'.

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Executive Summary

The overall project aim is to develop a robust evidence-base of the type of support provided for newly qualified clinical practitioners across Kent, Surrey and Sussex (KSS). The findings are compared with the support recommended in the preceptorship framework for newly registered nurses, midwives and allied health professionals (Department of Health 2010), the Shape of Training for medical professionals (Greenaway 2013) and other key literature.

The report is based on a systematic review of 47 published papers relating to nursing, midwifery, health visiting and the allied health professionals and 7 papers relating to Foundation Doctors; telephone interviews (n=24) with people delivering support for newly qualified practitioners (NQP) across HE KSS and across professions and representing 13 different Trusts; documentary (n=41) analysis provided by 20 of the participants. Finally, data derived from two case study site visits and from a knowledge exchange conference of 45 delegates held in December 2014 has been used to explore the issues raised in the telephone interviews in more depth and consider the conclusion and implications of the findings.

The literature identifies the following key issues relating to the support of newly qualified practitioners:

- Transition from student qualified status remains challenging for practitioners, regardless of profession;
- NQPs valued support and guidance to help develop their practice knowledge, build confidence, adapt to their professional role identity, understand the practical know-how of the job and acquire additional and advancing skills;
- National policy around preceptorship programmes has been enabling rather than prescriptive (no KPIs etc);
- Preceptorship programmes vary in length the most common being 6-9 months post qualification;
- Supervision for Foundation Doctors is a 24 month structured programme that might include additional induction in the final year of medical school training;
- Preceptorship/Foundation programmes need support from whole organization, including managers;
- Programmes in the support of NQP need to have a clear structure;
- Preceptors and educational supervisors need training and on-going support to fulfill the role;
- Evidence around value of inter-professional programmes of preceptorship is very limited;
- Facilitation of peer support between preceptees was not evident in the literature.

What this research adds

- There is a wide difference in NQP support across disciplines, across and within Trusts in HE KSS;
- What has to be completed by whom and the timescales for that activity does vary across the professions;
- The amount of time given to NQPs to participate in a support programme varied considerably with up to 18 study days offered in one Trust and none in others where the programme was considered fully integrated into the working week;
- In the main, the support provided was delivered to uni-professional groups from same profession supervisors/preceptors. There was little appetite for multi professional programmes other than expressed by those in senior managerial positions;
- Those supervising the Foundation year 1 (F1) NQPs do have compensation for their time. Other professions invest money in specialist tutors;
- Generic transitional skills are seen as 'softer' and are less valued than demonstrable competence acquisition, although this emphasis does differ when speaking to advocates of reflective and resilience programmes;
- Examples of additional pedagogic scaffolding in support of the NQP was provided across professions e.g. skills training either through simulation work or in clinical practice, mandatory training and reflective support;
- Largely, preceptorship for nurses and allied health professions was modelled on a six to 12 month programme;
- Some locations provided a much more explicit programme for allied health professionals, notably when this led to a separate academic award (Postgraduate Diploma in Pharmacy Practice) or was linked to a rotational programme;
- Medicine has the most uniform programme that is explicit in purpose and outcomes. Those supervising the F1 NQPs do have compensation for their time. Other professions invest money in specialist tutors;
- There is a conceptual shift from considering support for NQPs in the first six months as a period of preceptorship or supervision, to a more explicit probationary period that provides some support to achieve stated goals;
- Two agendas in NQP support were identified: the ecology model focused on the NQP learning needs and the individual's professional growth, and the corporate induction model which focused on the organisational needs and shaping the NQP as a Trust employee embedded within the organisation values of the NHS;
- The model of support provided was shaped by the rationale for support, the corporate values of the Trust, the service delivered by the Trust, and how the positional authority of the senior manager with responsibility for NQP support was situated in the Trust;
- Isolated NQP workers (community, smaller Trusts or disparate localities where there was minimal opportunity for peer support) were cause for concern and additional support for NQPs in such localities was required;
- Access to support that is timely (often immediate) and a shared experience from a credible role model were seen as important features of NQP support;

- Conference delegates wanted clear direction of how they should implement support across the Trust and a minimum standard that had to be provided that enabled great consistency within and across disciplines;
- Conference delegates expressed a need for specialist training for preceptors;
- Conference delegates also suggested a career pathway for those supporting NQPs could be facilitated by a commitment to longer term planning investment;
- A national minimum standard of achievement by NQPs at a given point (outside probation and performance review) and what was to be achieved by the NQP during that period was advocated by some participants and confirmed as highly desirable at the knowledge exchange conference;
- Further, it was indicated that an external independent review to quality assure and rate the support of NQPs in individual Trusts was suggested by some delegates as long as this did not become too onerous on providers;
- PPI involvement in NQP support was underdeveloped;
- Outcome measures to determine the impact of any mode of NQP support was largely absent;
- Difference in current provision was accounted for by a requirement for flexibility to meet local setting and practice needs alongside the individual NQP transitional needs.

Recommendations

Access to different models of good practice, research reports and dissertations be held in an **online repository. The repository could also house:**

- Documentation shared (with a careful evaluation of what works well and what needs improvement);
- To build a library of dissertations and other research reports relating to the support of NQPs;
- A library of film, video and digital recordings of patient engagement with NQPs and feedback (Creative Commons Attribution Licence);
- Building interactive materials to deepen thinking and reflection on the transitions for NQPs;
- Generate a web page that can host open letters, the exchange of ideas and a monitored chat room that also house online questions and responses. This would require careful management and funding to support the activity.

Staff providing support to NQPs, need support themselves especially when trying to implement whole system change (e.g. multi disciplinary approaches to the support of NQPs in their Trust). In recognition of the difficulty to get time release away from the Trust, it is recommended that these meetings largely take place online with opportunity to meet face to face three times a year, thus creating **a community of practice or network of practitioners** supporting NQPs holding similar posts across HEKSS. Funding to support such a network would be required. The network could also provide opportunity to share best practice and then take that back to local settings to be shaped to meet the Trusts' needs and those of the NQPs.

Greater consistency be considered in the provision of support for NQPs that enables the best of both the ecology model and corporate induction model to be realised. Any model developed needs to first address the fundamental rationale for support and this type of values clarification could start in the community of scholars.

Any model provided would need to be simple, accessible and meaningful.

Specialist training for preceptors/supervisors be reinvigorated.

The potential for a specialist career pathway for those dedicated to the support of NQPs. This requires posts to have long-term investment and sustainable funding models to provide greater consistency and acquisition of expertise.

Develop evidence of how PPI is integrated into support for NQPs and to evaluate if this has any impact on the NQPs experience;

Systematic and planned funding for patient and public involvement in the support for NQPs that is ring fenced and culturally embedded into the Trusts as a model of good practice.

2. Introduction

This study was commissioned by Health Education Kent, Surrey and Sussex (HE KSS) in February 2014. The brief was to map support provided for newly qualified practitioners across Kent, Surrey and Sussex across professions and where newly qualified practitioners take up post.

The research has been designed to engage participation across the region and from different professions. The design aimed to capture any change as it happened during the life of the project, and offer recommendations that have been verified by the participants, thus providing a rich, robust and relevant account of the support for newly qualified practitioners in the KSS region. To facilitate this, the research team included interdisciplinary researchers with backgrounds in medicine, nursing, midwifery and physiotherapy. Of note, we included patient and public involvement consultants to help steer the project and ensure the PPI agenda was addressed.

The report has been written in collaboration with our partners and has been subject to peer, patient and public review¹.

The aims of the study were to:

- 1) Scope the range of activity undertaken to support newly qualified

¹ Representatives from the lived experience forum (LEAF, our PPI consultants) contributed to the steering group and research team meetings; for example, they were involved in the pre-ethics review and interviewing the research assistant. The case studies were undertaken by Scholes, Petty, and Flegg and the telephone interviews were conducted by Scholes, Petty, Flegg, Green, McIntosh and Haq). Documentary analysis and the literature review was completed by Petty, McIntosh, Flegg, Scholes. Administrative support was provided by Flood. Data were analysed by the core research team and subject to the scrutiny of the Steering Group. The Steering group was convened on three occasions (beginning, middle and end of the project) and included representatives from HE KSS. The University of Brighton held responsibility for the governance of the project and the Steering group timely delivery of the final report and intellectual support to the research team.

- practitioners across HE KSS;
- 2) Identify the outcomes of NQP support programmes and how these differ by mode of delivery, discipline and/or service;
 - 3) Collate the data from the different programmes to determine what works for whom and under what circumstances;
 - 4) Build a framework from the views of key stakeholders including the views of patients and the public;
 - 5) Ensure the framework facilitates newly qualified staff to determine their own personal, professional and career developmental needs;
 - 6) Share the framework across KSS to enhance the careers of newly qualified staff and help contribute to improving staff retention and recruitment.

As data emerged it became apparent that the last three aims had to be reconstructed as data did not support the preliminary outcomes. The report is divided into four sections. First the methods and data sources are described. A literature review follows, to set out what is already known about support for newly qualified practitioners. The findings demonstrate what was found in the mapping of provision across HE KSS and what this research adds. The final section compares these findings and sets out conclusions and recommendations.

2. Methods

2.1 Scoping

A telephone survey of 24 participants was undertaken between late June and September 2014. Participants contributed from Trusts in Kent (n=7); Surrey (n=8) and Sussex (n=9) and represented 13 different Trusts delivering primary secondary or tertiary care, in acute adult, mental health and community services. Participants represented the following professions: AHPs, medicine, nursing, midwifery, physicians' assistants and pharmacists. Despite efforts to include the social care, third sector and social enterprise, the team were unable to recruit a representative from these sectors to speak to the support they provided for NQPs.

On average it took 7 telephone calls to locate the person within a Trust who could speak to the research team about the support provided for their newly qualified professionals. The agenda for the telephone interview included the following topics:

- The individual's role in support of NQP and how that articulated with the role of others in the Trust who provided a similar level of support;
- The extent of public and patient involvement in their programme;
- The type of support provided and the structure of that programme;
- If assessment was involved, how that was undertaken, recorded and how those results were managed;
- The challenges and concerns associated with the Trust's bespoke delivery;
- A request for further documentation

The full survey is available (Appendix One)

In total, 41 documents were returned to the research team (Table 1). Of the 24 interviews, 20 interviewees sent documents representing information from (10 out of the 13 Trusts interviewed); 3 out of 4 that did not send documents were from Sussex. An additional Trust sent further recommendations as they were unable to participate in the study.

A total of 41 documents were received and reviewed.

Table 1: Document by type returned to the research team

	Policy	Workbook	Portfolio	Competency	Other	Total
Documents	5	9	4	14	9	41

Policy: The majority of Policy documents provided an overview of the programme, key dates and formal roles and responsibilities and referenced further staff development policies of interest (in many instances the links to these forms were included in the document). Only two Trusts had policy documents instead of workbooks; however the majority maintained both documents.

Workbook: The majority of Trusts provided workbooks. The content of workbooks did vary, however many comprehensively included organisational diagrams, personal contact details of relevant staff and some also included a month-by-month planner (including advance details of all training dates). Some workbooks, appeared to be more like a 'sign-off book' than a learning document and were mostly comprised of a collection of competency and appraisal forms in addition to a brief overview of their NQP role. Many of these workbooks embedded details of organisational policy documents for further reference and included competency and performance review forms.

Portfolio: The reviewed portfolios were similar to a collection of competency based sign-off sheets in conjunction with career planning and development reviews. An additional two Trusts required the completion of an E-Portfolio. One Trust additionally required the completion of a 30 credit University course in addition to portfolio completion, performance reviews and additional competency documents.

Competency: These were specific to the professions. The majority of Trusts included time-lines for competency based reviews at 1 month/3 months and 6 months where NQPs would have scheduled time to discuss their progression with their preceptor.

Other: Of the 'other' documents received, 3 of these were promotion documents such as NQP Training Flyers and Programme Presentation Slides. Only one Trust provided a promotional document aimed at preceptors. This Trust had further provided tips for teams who are supporting NQPs - suggesting that teams meet to mutually agree how to provide NQP support.

Documents cited as framing the models deployed in the Trusts included:

- Preceptorship Framework (Department of Health 2010);
- Confidence in Caring (Department of Health 2008a);
- The NHS Knowledge and Skills Framework (Department of Health 2004a);
- Agenda for Change Terms and Conditions Handbook (Department of Health 2005);
- Preceptorship for Nurses, Midwives and Specialist Community Public Health Nurses (Nursing and Midwifery Council 2006);
- Bain L (1996) Preceptorship: a review of the literature. *Journal of Advanced Nursing* 24 (1) 104 -7.

Also noted:

- The Post Registration Education and Practice Proposals put forward by the NMC (United Kingdom Central Council for Nursing, Midwifery and Health Visiting) in 1990;
- Royal College of Speech and Language Therapists Communicating (2013);
- Quality 3: Professional Standards for Speech and Language Therapists (Royal College of Speech and Language Therapists 2006).

2.2 Literature review

The literature was used to compare the models of delivery from across KSS with programmes in support of NQP available nationally and internationally. The literature review took into account evidence to support the impact of the programme on practitioners, the hospitals and community settings in which they worked and the clients/patients they served. To ensure capture of the most up to date models of practice, web based representations, academic and grey literature were reviewed to identify: (i) potential stakeholders or collaborators, (ii) sites for innovative practice, and (iii) emerging evidence of different approaches to supporting newly qualified practitioners.

Table 2: Search strategy for the literature review

The following databases were used: Cumulative Index to Nursing and Allied Health Literature (CINAHL) British Nursing Index Public/Publisher MEDLINE (Pub Med) Allied and Complementary Medicine (AMED) Wiley Online Library Science Direct Google Scholar
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Department for Health
NHS Evidence

The following search terms were used:

Newly qualified practitioners, nurses, AHPs, AND preceptorship physiotherapy, occupational therapist, podiatry, midwives, support AND newly qualified health professionals, practitioners, support; mentorship AND newly qualified health professionals, practitioners; mentoring; supporting new qualified practitioners, preceptorship AND NHS.

The medical search was conducted on Pubmed AMED (Allied and Complementary Medicine), Wiley Online Library, Science Direct, Google Scholar, Department for Health NHS Evidence using the search terms: educational supervision, doctors, transitions, medical education.

Literature Search Limits:

- Searched for articles over 14 years, between 2000-2014 (AHPs, Nursing and Midwifery);
- Only searched for articles relating to newly qualified practitioners;
- Excluded preceptorship related articles referencing undergraduate/training, support, trainee, medical student.

Results of the literature search

Following the search strategy (Table 2), 47 publications were found between 2000 and 2014 (Table 3). 26 were concerned with nursing, 9 with midwifery and 12 with AHPs (some publications were involved in more than one profession). The medical papers (7) were searched from 2007 (the introduction of Foundation Programmes).

Table 3 Summary of the literature search

	Development of NQP programme	Evaluation research	Opinion piece/review article	TOTAL
AHP literature	1	7	4	12
Nursing	1	21	4	26
Midwifery	1	7	1	9
Medicine	1	6	0	7

AHPs

Of the 12 papers identified, 8 were by Morley from 2006 to 2012 (1 describing development of a programme, 4 evaluation papers and 3 opinion pieces) who developed and evaluated a preceptorship programme for OTs in London. One

paper in 2008 was an opinion piece by a radiographer advocating a formal structured programme for NQP in radiography. One evaluation study was funded by Yorkshire and Humber Strategic Health Authority (Flynn and Jones 2009) and two evaluation studies were funded by NHS Scotland (Solowiej, Upton, Upton 2010, Banks et al 2011).

Midwives

There were 9 papers identified, of which 7 used exploratory and evaluatory methodologies to consider implementation of preceptorship programmes for midwives, and the perceptions of new registrants around the support offered. Earlier papers considered the value of preceptorship in relation to individual professional development rather than with a service need focus (Hobbs and Green 2003, Boon et al 2005, van der Putten 2008). An opinion piece by Davies and Mason (2009) called for a one year period of targeted support for new registrants. Hughes and Fraser (2011) conducted focus groups with newly qualified midwives, together with preceptors and practice development midwives. Avis et al (2013) conducted a wide ranging study looking prospectively at the expectations of senior students (about to qualify) for their first year in practice, and retrospectively at how things developed for them once they were in practice. Most recently two papers explored the expectations of senior students around preceptorship (Feltham 2014) and the retrospective experiences of newly qualified midwives (Foster and Ashwin 2014).

Nurses

Twenty six relevant papers were identified. Of these, 21 used research or evaluation to explore issues related to the support of newly qualified practitioners across a range of sub-specialties including mental health nursing and rural practice. Nursing has attracted more international attention (10 of the 26 total papers were international (Australia n=2; Canada n=1; Finland n=2; Taiwan n=1; USA n=4). Of the 16 UK focused papers, 11 reported primary research studies or evaluations, 4 were practice based or opinion pieces, and 1 was a literature review (Whitehead et al 2013). The focus of this review will be on the UK experience, although international perspectives are referred to in order to give context.

Foundation Doctors

Seven relevant papers were identified. Of these six were either research or evaluation studies examining the experience of newly qualified doctors, their self assessment of capabilities to undertake professional tasks compared with that of their education supervisors, how to effectively supervise junior doctors, and one policy document of modernizing medical careers and one that evaluated the Foundation Programme. Of note, four used qualitative and interpretive approaches to illuminate the Foundation year 1 (F1) experiences while two explicitly set out to measure anxiety and/or capability.

2.3 The Case Studies

Two site visits were undertaken to facilitate a deeper discussion about the programme with key stakeholders (**Pragmatic Case Study approach**). This generated

a rich portrayal of programmes to support NQPs within those Trusts, but the telephone interviews had illuminated great diversity in provision. Therefore the two sites were selected as they provided insight into areas where multi-professional interdisciplinary approaches to the support of NQPs were being planned and where models of good practice were identified. Data included interviews with newly qualified staff who were currently on the support programme.

2.4 Knowledge Exchange Conference (KEC)

The conference (45 delegates) was held in December 2014 at the University of Brighton conference centre. The conference was advertised with the explicit purpose to exchange ideas, learn from others and create opportunity to develop indicators that captured the impact of support programmes for newly qualified practitioners. The advert was widely disseminated through the networks of HE KSS and the University of Brighton in an attempt to have representation of the widest constituency. An invited keynote speaker, Lynn Dunne gave an address on the role of patient and public involvement in the support of newly qualified practitioners.

Invitees included key stakeholders (including regional HEE leads who had an oversight of innovative examples of support for NQP across the professions and health care sector); project leads for innovative projects; representatives from the Council of Heads and Deans, representatives from the third sector; newly qualified staff and patients.

The purpose of the knowledge exchange conference and in particular the group work at the conference was to gain a:

- mutual understanding of the range of support provided for newly qualified practitioners (through a conversation with a very explicit purpose) to:
 - deepen understanding of the different perspectives held by people with regard to the support of NQP help;
 - deepen understanding of one's personal views and thought processes (through comparison and from hearing the views of others);
- and to flush out issues which need to be aired to help build a consensus around the support for NQP.

Further, the purpose was to:

- knowledge share;
- build networks;
- gain new perspectives and new ideas (for the research team but also each delegate).

The ideas generated in the working groups were then taken back to the plenary and combined to propose a way forward (this enabled the research team and delegates the opportunity to reflect on what they had learnt through the discussion and think about what they could take back to their individual Trusts).

Of note, the knowledge exchange conference did not have any intention to

generate new knowledge (for the conference members) but deepen the understanding of all those who participated in the knowledge they already held by comparing their own provision with that of others.

Visual techniques have long been used within the medical profession as a means to ensure communication is achieved with patients (Houts et al, 2006). Specifically within health research, evaluating a patient's response to visual data has, for example, been used to better understand public access of health information (Jewitt 1997 and 1998). Patient generated artwork can further be analysed by researchers and has been employed in studies aiming to better understand how children with limited verbal communication skills experience poor health (Pascuet et al 2010). McNiff (1998) suggests visual methods as a complement to traditional health and social science based research methods stating, '*just as science assists art-based research through its emphasis on systematic inquiry, art enhances the process of discovery in science by its responsiveness to the unexpected*' (p 39).

The Knowledge Exchange Conference used visual methods in a new way, to provide increased opportunities for the research team to communicate and validate their findings with participants. The approach to each piece of work was informed by thematic analysis (Braun and Clarke 2006) with additional influence taken from grounded theory (Glaser 1992, Charmaz 2006, Strauss and Corbin 1998). Thematic analysis involves reviewing the entire data set (Punch 2005) with note taking and visual techniques often included to provide an opportunity for unexpected data to be highlighted (Braun and Clarke 2006, Van Leeuwen and Jewitt 2011). Artwork was created to visually represent the entirety of group discussions and ideas were captured onto a single page while the discussion occurred. Drawing from grounded theories ideology, that data should be collected until saturation occurs (Glaser 1992, Strauss and Corbin 1998), 'saturation' in this case was evident when no further visual representation needed to be added to the picture to represent a new idea.

In addition to analyzing data via this visual approach, a PPI participant was involved in creating artwork based on her impressions of the discussion. This provided additional data as it communicated the ideas from a patient perspective. These pictures were displayed for attendees of the conference and influenced the overall analysis, with a few included in this report.

2.5 Generation of the HEKSS framework in support of Newly Qualified Practitioners

The original intention was to develop a framework based on the data and comparison with the issues mapped against the outcome measures cited in the Department of Health Preceptorship Framework (Department of Health, 2010) that took account of the content for NQP programmes identified in Flying Start NHS (NHS Education for Scotland 2015) and The Shape of Training (Greenaway 2013). It was hoped from these data, the knowledge, behaviours and attributes that enabled a NQP to self evaluate their developmental needs and where they might find the learning resources to meet those needs would be identified.

However, it soon became apparent that there was considerable resistance to external frameworks in favour of locally produced materials. Furthermore, the

comprehensiveness and duration of Flying Start was considered burdensome. Therefore, this component of the original proposal was changed significantly to respond to the data analysis to propose a network of support and a generative educational forum where practitioners could meet to discuss ideas and work together. That learning could then be taken back into their own Trust and adapted to local need and culture.

2.6 Data analysis

The data were managed using thematic analysis, laddering with coding and categorisation of the main concepts. The data were then subject to comparison to illuminate similarity and difference and display these issues in tables (for an example see appendix two)

2.7 Ethical Review

An **ethics application** was submitted to the University Research Ethics and Governance Committee and was approved (June 2014). An addendum to include permission to data collect from the knowledge exchange conference was submitted in November 2014 and approved by nominate Chair's action. Approval for access was confirmed prior to the case study visits.

3 The literature Review

3.1 Introduction

The terms used by different statutory, regulatory and advisory bodies to describe the support provided for newly qualified practitioners (Table 4) has changed over the past two decades. However, the term to describe the role of the person who supports a newly qualified practitioner (NQP) is often a **preceptor** or a **supervisor**. Ergo, the programme of support delivered to newly qualified nurses, midwives, health visitors and allied health professionals (AHPs) is **preceptorship** and for junior doctors, pharmacists and dental practitioners is **supervision**. Of note, historically a senior colleague within the same profession as the NQP has provided this support. There is an emergent shift to see the support of the NQP to take on a shared and multi-professional dynamic.

The support provided to NQPs is conceptually different to the clinical supervision of pre-registration students. This literature review maps those differences. However, the scope of this review examines the support offered to post registration health care professionals in their first two years of taking up a qualified post.

3.2 History of policy relating to the support of newly qualified practitioners

Support for the newly qualified practitioner alongside pre-qualification supervision, has existed in the training and experience of health professionals. Throughout history this has transformed from an idiosyncratic apprenticeship model (Becker Hughes, Geer and Strauss 1961, Baly 1995), 'learning from Nellie', being supervised by someone with more experience than the other even if that person was not yet themselves qualified (Melia 1984), through to a formalised period of supported practice that has been recognized as having a particular value to both employee and employer. To this end, policy documents have increasingly highlighted expectations and outcomes related to NQP programmes of support. **Policy documents have tended to be enabling rather than prescriptive.** This has had the advantage of allowing local Trusts, regions and professions to develop programmes in a way that worked for them. However, it has led to continued uncertainty about what support for the NQP actually is, for whom it is designed to work, and how an effective programme may be achieved. For example, within nursing and midwifery, preceptorship was first recommended by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1993) for the first four months after qualification although no specific guidance on what should happen during that period, other than supernumerary supervised practice, was offered.

Table 4: Definition of terms associated with support for newly qualified practitioners

Preceptorship	A period of preceptorship to guide and support all newly qualified practitioners to make the transition from student to develop their practice further	Nursing and Midwifery Council 2006
Support for newly qualified	A foundation period (for practitioners at the start of their career which will help them begin the journey from novice to expert)	Department of Health 2008b
The transition for student to qualified professional	Within nursing, midwifery and health visiting in the UK, it refers to an individualised period of support under guidance of an experienced clinical practitioner which attempts to ease transition into professional practice or socialisation into a new role	Bain 1996
Support for newly qualified practitioners	A model of enhancement, which acknowledges new graduates/registrants as safe, competent but novice practitioners who will continue to develop their competence as part of their career development/continuing professional development, not as individuals who need to address a deficit in terms of education and training	Council of Deans of Health 2009
Structured transition	A period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning.	Department of Health 2010
Preceptor ²	Registered practitioner who has been given a formal responsibility to support a newly qualified practitioner through preceptorship.	Department of Health 2010
Newly registered practitioner (NRP) or newly qualified practitioner (NQP)	Someone who is entering employment for the first time following professional registration.	Department of Health 2010

3.3 Preceptorship in Nursing, Midwifery and AHPs

Agenda for Change [AfC] (Department of Health 2004b) described the process of preceptorship that enabled Band 5 practitioners to achieve acceleration progression through the first two pay points, provided they met relevant standards of practice. AfC recognized that midwives were quickly required to exercise a

² A practitioner supporting a NQP is sometimes referred to as a **mentor** in the literature

significant level of autonomy in their practice post-qualification, a factor reflected in their initial employment at Band 5 and expectation of a move within around 12 months post-qualification to Band 6. Local preceptorship programmes for midwives were often designed to facilitate skill development (cannulation, giving of intravenous therapies, perineal suturing etc) to allow progression through the pay bands.

The value of preceptorship was highlighted in 'A High Quality Workforce: NHS Next Stage Review (Department of Health 2008b) and preceptorship was included in the Handbook to the NHS Constitution (Department of Health 2013). Preceptorship supported the policy drive to place 'quality at the heart of everything we do' in health care (Darzi 2008 p46) to enhance patient and service user experience (Department of Health 2010). For example, when patients see that individuals have the *skills* to do the job and the *will* to provide the level of care the patients want (stated in Confidence in caring: a framework for best practice). In 2008, the Department of Health provided funding to support preceptorship and strategic health authorities were required to report quarterly to the Department on the progress in investing these funds (Department of Health 2010). The stated aim of preceptorship was to enhance the competence and confidence of NQP as autonomous professionals (Department of Health 2010). Whichever definition is used (Table 4), they all assume the NQP is safe and competent (Department of Health 2010).

Employers were able to provide evidence of effective preceptorship arrangements to regulatory bodies such as Care Quality Commission (supporting workers to deliver safe and appropriate standard of care and treatment); to Agenda for Change terms and conditions; and improvement in relevant scores of staff and patient surveys (Department of Health 2010).

A Preceptorship Framework for Nursing (Nursing and Midwifery Council 2008) was published in 2008 and the following year was developed further and extended to other professions in the Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professions (Department of Health 2010) and is summarised in Table 5 below.

Table 5: Summary of the Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals (Department of Health 2010)

<p><i>Benefits of preceptorship:</i></p> <ul style="list-style-type: none">• Enhanced quality of patient care;• Enhanced recruitment and retention;• Reduced sickness and absence;• Enhanced service user experience;• Enhanced staff satisfaction;• Opportunity to identify staff that require additional support or change of role;• Reduced risk of complaints;• Opportunity to talent spot to meet the leadership agenda;
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- Progression through the pay-band gateways for organisations that implement Agenda for Change (AfC);
- Registered practitioners who understand the regulatory impact of the care they deliver and develop an outcome/evidenced-based approach.

Standards of preceptorship:

- Systems are in place to identify all staff requiring preceptorship;
- Systems are in place to monitor and track newly registered practitioners from their appointment through to completion of the preceptorship period;
- Preceptors are identified from the workforce within clinical areas and demonstrate the attributes of an effective preceptor;
- Organisations have sufficient numbers of preceptors in place to support the number of newly registered practitioners employed;
- Organisations demonstrate that preceptors are appropriately prepared and supported to undertake the role and that the effectiveness of the preceptor is monitored through appraisal;
- Organisations ensure that their preceptorship arrangements meet and satisfy professional regulatory body and the Knowledge and Skills Framework requirements;
- Organisations ensure that newly registered practitioners understand the concept of preceptorship and engage fully;
- An evaluative framework is in place that demonstrates benefits and value for money;
- Organisations publish their preceptorship framework facilitating transparency of goals and expectations;
- Organisations ensure that evidence produced during preceptorship is available for audit and submission for potential verification by the NMC/HCPC;
- Preceptorship operates within a governance framework.

Design of preceptorship:

- Programmes are personalized to meet the needs of individual practitioners
- Learning achieved through a variety of methods:
 - in the organisation
 - in partnership with higher education institutions (HEIs)
 - through work-based learning
 - through web-based learning (e.g. flying start)
- attitudinal and behavioural based learning e.g. role modelling;
- 6 - 12 months;
- Stakeholders suggest mix of 4-6 days of classroom or distance/elearning and 18 hours supervision/guided reflection in practice (may vary with profession).

Outcome of preceptorship:

Anticipated that *'the registered practitioner will have become an effective,*

confident and fully autonomous registered individual, who is able to deliver high quality care for patients, clients and service users' (Department of Health 2010 p21).

Outcome measures could include:

- All newly registered practitioners employed, access preceptorship;
- Robust preceptorship is in place;
- Retention rates for newly registered practitioners;
- Time taken to progress newly qualified practitioners through knowledge and skills framework (KSF) gateways (where relevant) or other indicators of completion;
- Sickness/absence levels of newly registered practitioners;
- Number of clinical incidents reported by newly registered practitioners undertaking preceptorship;
- Number of actual or near miss incidents reported involving newly registered practitioners during preceptorship as a percentage of their professional group.

Preceptorship pledge of the employer:

- Commits to delivering responsibilities for preceptorship including to:
- identify a Board Member who has accountability for the delivery of the preceptorship programme and assessing its impact;
- ensure that all newly registered practitioners have equitable access to preceptorship and, as appropriate, access to an identified, suitably prepared preceptor;
- ensure that preceptorship is adequately resourced;
- ensure that a system is in place for appraising the preceptees' performance through the Knowledge and Skills Framework process or other structure to support appraisal;
- evaluate the process and outcomes of preceptorship.

The Nursing and Midwifery Council [NMC] recommended that all new registrants have access to an identified period of preceptorship for four months after initial qualification (Nursing and Midwifery Council 2006). In the same year, occupational therapy introduced guidance for managers and NQP in preceptorship. Following the publication of the framework document (Department of Health 2010) and building on the expectations of Agenda for Change (Department of Health 2004b) local Trusts began to develop targeted preceptorship programmes for nurses and midwives. Organisation and implementation has remained at the local level, however, and the lack of a clear steer from the Nursing and Midwifery Council (NMC) has led to suggestions that organisations do not therefore prioritise the provision of preceptorship programmes (Davies and Mason 2009).

A summary of preceptorship programmes provided across the UK is set out in Appendix Three.

3.4 Research and Evaluation of Programmes in support of the newly qualified practitioner

3.4.1 Foundation Doctors

Four papers were found that examined the experience of Foundation Doctors. Each one focused on the experiences of the junior doctors within one Deanery, Region or Trust linked to a medical school. The papers all highlighted how the first year of medical training was the most stressful in a doctor's career. One examined the impact of NQP status on the wellbeing of Foundation Year One (F1) doctors (Goodyear 2014). A second at the transitional challenges facing the junior doctor (Brown, Chapman and Graham 2007) in their first post graduate year. A third compared the transitional challenges of medical students, F1 trainees and compared that the experiences of FY2 (Foundation year 2) trainees, notably in how trainees estimated their competence to undertake specific clinical and general activities related to their work (Wijner-Meijer et al 2012). The final paper evaluated the experiences of specialist psychiatry trainees and the impact that workplace based assessments had on the trainees (Everett 2009). Therefore the papers tended to be addressing the junior doctors experiences rather than a specific programme aimed at facilitating their transition.

Of note, the papers conceptualise the challenges facing NQP medical professionals as transitional and the key person to facilitate them as educational supervisors. A fifth paper was written as a guideline for best practice for educational supervision and was based on an extensive literature review and a survey questionnaire (Kilminster et al 2007).

Two seminal papers were also examined that evaluated first The Foundation Programme (Collins 2009) and the final recommendations of the independent inquiry into modernising medical careers (Tooke 2008). For a fuller precise of the papers see Appendix three.

3.4.2 AHPs

Yorkshire and Humber Strategic Health Authority 6 month preceptorship scheme for community AHPs was evaluated to see if it enabled band 5s who had been out of work for some time, to work in a community setting (Flynn and Jones 2009). The scheme provided opportunity for a peer support network, development of their knowledge that was applied to their clinical work, and development of their portfolios in line with the Knowledge Skills Framework (KSF). They felt they initially wanted to work in secondary care settings and once they had developed their skills and knowledge in a more professional secure environment, then they could move into community care settings. The mentors were initially not clear on the expectations and their role. They felt that **formal training in preceptorship was needed for both preceptors and NQPs**. The scheme involved an initial introductory session for both preceptors and NQPs. Together they devised a 4 hour monthly training session covering the following topics: chronic pain, mental health, respiratory care,

cognition and memory, job applications and interview techniques, and interview questions. Data was collected via focus group interviews with NQPs and with preceptors and analysed using thematic content analysis. The impact of the scheme on NQPs included:

- increased confidence in working autonomously as they learnt new skills, and limits of their knowledge and skills;
- enhanced future employment potential having gained experience with preceptorship and the community.

Mentors felt a rotational system for band 5s in secondary and community care would help employment and retention of band 5s working in the community. Preceptors considered a training programme would be helpful as they were unsure of their role initially. Preceptors noted that initially band 5s needed a lot of support and guidance but this reduced over time. Preceptors believed the scheme was too short and 12 months would be better.

Evaluation of a preceptorship programme for NQ Occupational Therapists (Morley 2009a, b). Four NQPs working for less than 13 weeks along with their preceptor were each interviewed at 6 months and 12 months; all were female. The preceptorship programme aimed to support NQP transition, to develop clinical skills and professional behaviours and to promote reflective practice. In the first 6 months, the NQP undertook four tasks on a core skill area with standards adapted from the College of Occupational Therapy (COT) professional standards and included observation of practice (Morley 2013). The NQP wrote four reflective accounts, shared this with the preceptor, and then mapped them to the Knowledge and Skills Framework (KSF) outline. The preceptor provided advice, formative feedback and support. The manager determined whether the NQP was on target to achieve the KSF outline; if they were, the NQP received a pay lift. The content of the second 6 months was individualized to each NQP and their learning needs. At the end of 12 months the NQP underwent a development review and if the KSF outline was achieved, they received another pay uplift.

The initial introductory workshop was well received by NQPs and motivated them to be involved. The programme caused preceptors to feel more comfortable observing NQPs and explore their understanding. While **some NQPs ring fenced time for the programme in work time, others did it in their own time**. Preceptors and NQPs both agreed that **senior managers support was important**. Agreeing expectations together was important for preceptors and NQPs and helped develop an effective working relationship. While some NQPs wanted weekly structured sessions, others wanted informal supervision; where this mismatch occurred in a pair, this led to a poor working relationship. The opportunity to co-work with a senior sometimes did not occur. Preceptors welcomed the opportunity to observe NQPs in practice, they were sometimes anxious to do this; the process however, gave them permission. NQPs appreciated receiving normative and formative feedback, which bolstered their confidence and built self awareness; it also enabled preceptors to demand being observed and thus gain support from their preceptor where this was not forthcoming.

At the end of 12 months, all NQPs felt **improved competence and confidence**;

reassurance from preceptors was helpful in developing this. **Time constraints** limited opportunity for role modeling. NQPs who enjoyed structured learning may have preferred preceptorship more than those who preferred more informal learning opportunities. NQPs who had planned, and had, regular supervision were more positive about the impact. The impact of the session was greater when expectation of the purpose and structure of the supervision and their respective roles was discussed at the start. NQPs who identified their learning needs had better experiences than those who tried to appear competent. **Feedback from the preceptors was extremely valuable to the NQPs.**

The **AHPs Support and Development Scheme** was a pilot project developed by NHS Education for Scotland. NQPs were given preceptor (referred to as mentor) support, an online learning facility (Flying Start NHS) and financial incentives over 24 months. An independent evaluation of the two year scheme was undertaken (Solowiej et al 2010). Questionnaires were completed from 154 NQPs in Scotland from physiotherapy (36%), occupational therapy (29%), speech and language therapy (15%), radiotherapy (12%), dietetics (5%) and podiatry (3%). Most accessed the units in year one rather than year two. The most useful units were communication, reflective practice and research for practice. However the online learning material developed their understanding of communication and team working but did not help to actually develop their skills in these areas. In year one, communication and reflective practice were the most useful for supporting their work; a number of participants however did not answer this question. In year 2, research for practice and reflective practice were the most useful. The mentorship (preceptorship) was thought supportive by 44% in year 1 and 46% in year 2. From all NQPs, 85% would recommend NHS flying start to other NQP, with 61% considering the scheme supportive or very supportive overall. They thought the scheme:

- reflected on their practice and identified their CPD needs;
- reflected on their experience with patients;
- helped them apply the evidence to practice;
- prepared them for future experiences.

Participants mostly (75%) used colleagues in the same profession for support, which the vast majority thought very effective source of support. They did not tend to access the online community.

Around half of NQPs thought the preceptors, senior staff and management did not know sufficient about the scheme. Some NQPs were not allocated a preceptor (n = 32) while others had new preceptors when they rotated through specialties. The majority of NQP recommended that preceptors are given sufficient **guidance/training in their role as preceptor** and that senior staff and management be made aware of the scheme. The tasks required in the units would benefit from being relevant to the specific AHP.

3.4.3 Midwives

Evaluation of the **Bristol Trust preceptorship programme**, which sent out a questionnaire to 11 preceptors and preceptees. The very small sample size was

clearly problematic, but findings suggested that **protecting time for preceptor and preceptee to meet was very problematic** in a busy clinical area (Hobbs and Green 2003). Additionally, **preceptors were not confident in their role** as supporter, particularly faced with newly qualified midwives who, by virtue of their educational programme, were much more confident handling concepts such as reflection.

The **Oxford programme** used a practice model for support, rotating new registrants through clinical areas in an attempt both to socialize them into their role and to build confidence. The findings of an evaluative study (Boon et al 2005) interviewing 14 participant preceptors (n=4) and preceptees (n=10) suggested that midwives valued the support of a preceptorship period, but that crucially their place of work impacted on their philosophy as midwives. Those who rotated to community during their preceptorship period continued to view maternity care as normality focused, whereas those who were solely hospital based articulated an increasingly medically based philosophy of practice.

Foster and Ashwin (2014) evaluated a **preceptorship programme for midwives** which was designed to last for between 18 months and two years. They conducted semi-structured interviews with one sixth of new registrants over a three year period, and found that despite the existence of a programme, respondents felt unsupported. **Named preceptors were not readily available**, the burden of expectation around Trust induction and associated paperwork was considerable and individuals felt that their careers had not progressed as they expected given the length of the programme. The importance of a named preceptor was also highlighted by van der Putten (2008) in her exploration of the lived experience of being a newly qualified midwife.

It is worth noting that the evaluations of the above programmes (Hobbs and Green 2003, Boon et al 2005, Foster and Ashwin 2014) were carried out by the individuals who had implemented the programmes; this is likely to have had an impact on the findings and discussions.

3.4.4 Nurses

Leigh et al (2005) evaluated a **preceptor programme in Salford using the European Foundation for Quality Management (EFQM) tool**. The evaluation focused primarily on the use of the tool, but did demonstrate growing confidence on the part of preceptees who had taken part in the supportive programme. Preceptees still wanted more training in discrete **clinical skills and medical equipment, rather than in broad soft skills of team working and communication**. Similarly, when questioned prior to the commencement of the programme, preceptees wanted concrete learning around policies, procedure and mandatory training.

The **preceptorship programme offered in London** has been evaluated from the perspective of preceptee (Marks-Maran et al 2013) and preceptor (Muir et al 2013). Preceptee engagement was high and the programme was valued with **clinical skills development and broader professional development** perceived as taking place (Marks-Maran 2013). Respondents felt that the programme helped to support them through the inevitable stress of being an NQP. Practical difficulties revolved around

the difficulty in **finding time** for preceptor and preceptee to meet. Issues with finding the time to give the support were echoed in preceptors' responses (Muir et al 2013). Equally, however, the programme was judged to have a positive impact on preceptor and preceptee, as well as on the wider organisation.

The **Nurse Foundation programme (NFP) in Cardiff** aimed to provide a common framework to support nurses in their first year post-qualification (Jones et al 2014). The programme developed after it was found that **ad hoc support systems varied significantly between wards and departments**, with some offering a comprehensive programme and others nothing at all. The NFP standardized support and training across the Health Board, with the intention of providing orientation, induction, training and support. This was achieved through the release of staff for 13 study days in the first year of employment, covering mandatory requirements as well as essential skills. These appear to be entirely practice based rather than communication, team working etc. NQPs were also allocated a preceptor to provide one to one support. Managers were very positive about the standardized training offered, whereas individual nurses valued the support of a preceptor.

3.4.5 Multi-professional

The **shared preceptorship scheme between doctors and nurses in Wessex** generally evaluated positively, with **shared mentoring** seen as more valuable than shared workshops (Heidari et al 2002). The project was felt to impact positively on communication and support across professions. There were, however, practical and philosophical hurdles. **Finding times and spaces for workshops appropriate to both professional groups proved difficult**. More broadly neither **facilitators nor preceptees had much experience of shared learning**, which made effective learning more problematic. **Cultural differences between occupational groups were a further significant barrier**. Recommendations included strengthening preparation of preceptors and tutors to help overcome these barriers

The **Flying Start NHS web based programme** for nurses, midwives and AHPs was evaluated by Banks et al (2011). The study initially conducted a scoping exercise using telephone interviews across 21 Flying Start leads. Focus groups and individual interviews were then carried out with NQP (n=95) and preceptors (n=22). This was followed by an online survey with 547 NQP (334 nurses, 20 midwives and 193 AHPs). The vast majority (79%) of NQP had completed less than five of the 10 units. Almost a third of participants did not think the programme had helped them understand their future career options. The majority of participants (75%) had been allocated a preceptor and by 3 months, 90% had a preceptor. If NQPs were being rotated, half would keep the same preceptor, a quarter would have a change and the remainder did not know. Almost all (89%) met with their preceptor on request; frequency varied between occasionally (n=85), months (n=30) and weekly (n=12). Time with the preceptor varied between one and six hours per month. Just over half (56%) had protected time to participate, however almost half of these were usually not able to take protected time due to work pressures, availability of preceptor or incompatible shift patterns. The satisfaction in support by NQPs varied from very poor to very good; there was greater satisfaction for those in the community than in the acute settings. Time taken for the programme was an issue for both the preceptor

and NQP. The authors concluded that **preceptors needed to be provided with training and time to support NQP**. Expectations of NQPs need to be made explicit for them to complete the programme in 12 months and that sufficient support is needed to enable this. This support needs to include the allocation of a preceptor who is compatible with the NQP in terms of location and shift patterns, protected time and access to the internet in a non clinical area.

3.5 Perspectives on transition to qualified status

3.5.1 NQP

The sense of shock felt by a range of health professions when first taking up the role as a newly qualified practitioner is well attested in the literature. In nursing, this stress and bewilderment of the NQP was referred to as 'reality shock' in the USA (Kramer 1974) and reality stress in the UK (Gerrish 2000), considered to be due to lack of necessary skills and knowledge and limited support on qualification (Hughes and Fraser 2011). For occupational therapists it was described as 'transitional anxiety' (Shanahan 2002). Studies continue to bear witness to this culture shock (van der Putten 2008). It is acknowledged that entry level professional education cannot cover all skills and knowledge required for practice (Hinojosa and Blount 1998, Tryssenaar and Perkins 2001, Hodgetts et al 2007). For midwives this can be exacerbated by the high level of practice autonomy expected by their professional body (Nursing and Midwifery Council) at the point of qualification, and the sense that 'competence' does not necessarily equal 'confidence' (Maben and Macleod Clark 1996, Scholes et al 2004, Kelly and Ahern 2008, Doherty et al 2009, Hughes and Fraser 2011, Avis et al 2013, General Medical Council 2013, Tapping et al 2013, Feltham 2014).

NQPs reported that at qualification they were well prepared in terms of seeking information, problem solving and clinical skills (Tryssenaar and Perkins 2001) but they were ill-equipped for practice; 63% of occupational therapists felt their undergraduate education was insufficient to meet their needs (Craik and Austin 2000) and were uncertain how to apply theory to practice (Parker 1991, Adamson et al 1998, Tryssenaar and Perkins 2001, Hodgetts et al 2007). Speech and language therapists (Bebington 1995, McCartney et al 1993), podiatrists (Mandy and Tinley 2004), have also been reported to undergo similar stresses. This was exemplified by occupational therapists who reported a range of concerns including limited practical experience and misunderstanding their role (Parker 1991); interpersonal skill demands (Leonard and Corr 1998, Hollis and Clark 1993, Rugg 1999); receiving less professional supervision than expected (Rugg 1996, Barnitt and Salmond 2000); and having to work independently and take initiative with little time for reflection (Rugg 1996, Barnitt and Salmond 2000). Clark and Holmes (2007) argued that both ward managers and NQPs lacked confidence in the abilities of NQPs at registration and suggested that preceptorship could address these concerns.

Prior to qualification, senior midwifery students (prior to qualification) expressed their expectation that preceptorship would aid them in building confidence, developing clinical and managerial skills, and workplace socialization (Feltham 2014). Other studies suggested that NQPs believe that preceptorship enhanced their

communication skills, their clinical skills and impacted positively on their role, personal and professional development (Marks-Maran et al 2013, Muir et al 2013). Furthermore there is evidence that effective preceptorship programmes can ease the stress of role transition (Gerrish 2000, Hardyman and Hickey 2001, Ross and Clifford 2002) and improve confidence and competence (Whitehead et al 2013)

NQPs need support (according to preceptors) to develop their leadership skills, in particular learning to delegate and support staff to take on more responsibility and being confident to challenge current ideas and practice (Morley et al 2012).

For foundation doctors the first year of practice is exceptionally challenging. Medical school equipped them with the scientific knowledge to practice, but the Foundation Year was identified as one that was fraught with emotional, intellectual, practical and social challenges (Brown, Chapman and Graham 2007). The physicality of undertaking a junior doctors responsibilities, learning how to do all that was required of them, whilst adapting to shifts, multiple requests to assess new patients, coping with administration, adapting to the clinical pace, fitting in with new teams and forming a new professional identity were cited as anxiety provoking and exhausting. Distance from normal networks of support (family and friends) in particular added to the emotional and social burden (Goodyear 2014). For this reason, educational supervisors were urged to adopt the roles of a teacher, assessor, mentor, role model, counsellor, career's adviser and clinical expert (Kilminster et al 2007). The quality of the supervision was considered to be the single most important factor in NQP satisfaction and the ease of their transition into their new professional role. For this reason, educational supervision was seen to be a role that required specialist training (Ibid). However one later paper (Ibrahim et al 2013) opined greater support could be achieved through peer rather than senior support.

3.5.2 Preceptors

In terms of induction of preceptors, there is wide variation in the literature. There may be a one-day induction or none at all (Banks et al 2011). Even where induction is provided, however, practice pressures can make attendance problematic (Hobbs and Green 2003). Whitehead et al (2013) argued that **supporting preceptors is vital** in the success of any programme.

Skills required of preceptors (McCusker 2013) include:

- Ability to act as a professional role model (Rose 2007, Stewart et al 2010);
- Effective communication, interpersonal, reflective, critical thinking and decision-making skills (Harbottle 2006, Rose 2007, Smedley and Penny 2009);
- Ability to recognize cultural and individual diversity needs (Smedley and Penny 2009, Stewart et al 2010);
- Effective leadership skills, assertiveness and flexibility in relation to change (Rose 2007, Smedley and Penny 2009);
- Effective clinical, teaching and facilitation skills and delivering evidence based practice (Harbottle 2006, Rose 2007, Smedley and Penny 2009);
- Competent, confident and motivated in their own role and in the role as a preceptor (Leigh et al. 2005, Smedley and Penny 2009).

It is generally agreed that **preceptors need some support and guidance** to prepare them for the role (McCusker 2013). Preceptors believed they could have a positive impact on NQPs and that the role enhanced their own professional development and that of the organisation (Muir et al 2013). Little or no induction can lead to ineffective support of NQPs, since preceptors are unclear of their role (Solowiej, Upton and Upton 2010). Dearmun (2000) extended this to the role of lecturer-practitioner, another suggested formal support for NQPs.

3.5.3 Employer perspective

AHPs have largely worked in secondary care with well-established support mechanisms for NQP. Community services were traditionally carried out by more senior band 6 or 7 therapists. With the shift in healthcare services to community (primary) care, Band 5 therapists are likely to be working in the community and this creates challenges for supporting practitioners who are often working in isolation.

Managers rated NQPs to have acceptable or high levels of competence (Barnitt and Salmond 2000, Shanahan 2002).

Preceptorship is proposed as a strategy for the **recruitment and retention of NQ staff** (Hardyman and Hickey 2001, Halfer et al 2008, Giallonardo et al 2010; Hickey 2010, Roxburgh et al 2010) because the provision of peer support encouraging critical reflection has been found to help develop the competence and confidence of NQ practitioners (Maben and Macleod Clark 1996, Harrison et al 2005, Gregory 2007, Kilminster et al, 2007). Preceptorship may also be useful in a multi/inter-professional context to facilitate the skills and attitudes necessary for **collaborative practice and teamwork** (Bayliss-Pratt et al 2012). Preceptorship for NQPs who are undertaking lone working in the community may be particularly beneficial.

Preceptorship has also been seen as a way of inducting new registrants in terms of both clinical skills and philosophy prevalent in an organisation (Boon et al 2005). Hughes and Fraser (2011) highlighted the tensions between the needs and expectations of new registrants and of their employing Trust, suggesting that organisational induction took precedence over support for individual development.

3.5.4 International perspectives

International literature around preceptorship programmes and support for NQPs tends to focus on issues in adult nursing. Similar themes occur to those found in the UK literature, particularly around support through the shock of role transition (Scells and Gill 2007, Cubit and Ryan 2011). This support was considered to feed more broadly into the acquisition of confidence and competence and to a reduction in attrition of NQPs (Salonen et al 2007, Brakovich and Bonham 2012, Flinkman and Salanterä 2014). Lee et al (2009) evaluated a preceptorship programme developed in Taiwan which they claimed led to immediate and significant reduction in medication errors and staff turnovers, although cause and effect was not demonstrated.

The need to **support preceptors** and to provide them with a period of formal role preparation is seen as essential (Hyrkäs and Shoemaker 2007, Lee et al 2009, Sroczynski et al 2012) although Fawcett (2002) argued that preceptors are born and not made in terms of their communication skills and role modelling attributes. The programme developed by Lee et al (2009) included nine hours of formal training for preceptors. Similarly Rush (2013) and Rush et al (2013) argued for formal training programmes for preceptors, together with a focus on practical skill acquisition by preceptees and a period of support lasting at least 6-9 months post-qualification.

3.6 Summary of the literature: what works for whom and under what circumstances

Student nurses and midwives have supernumerary status whilst they are undertaking pre-registration programmes of education. They are therefore able to prioritise their learning needs over those of the clinical area, although workload does impact on the student experience. Once qualified, however, they are part of the workforce and expected to prioritise the needs of the clinical area over their own learning. There is a body of evidence describing the '**reality shock**' felt by newly qualified nurses and midwives on their transition from student to registered practitioner (Kramer 1974, Gerrish 2000, Hughes and Fraser 2011). This may impact on their confidence and their competence in practice.

The journey undertaken by clinicians to learn their role, was described by Benner (1974) as a process of embedding knowledge and understanding. As practitioners learn, it was suggested, they move along a continuum from novice towards expert. The reality shock of the move from supernumerary student to registered practitioner status can impede the process of learning and the development of confidence and competence. In extreme cases, this can lead to the newly qualified member of staff leaving the service, which represents not only a loss to the individual but also to the health service.

Programmes of preceptorship have been developed in some, primarily acute, clinical areas in order to support newly qualified staff in developing confidence and competence. The broad intention of preceptorship is support to new practitioners in their development from senior student to fully-fledged practitioner. Programmes or models of preceptorship might include named support, a period of supernumerary status, a formal induction programme or pathway. Literature suggests that there are a **wide variety of schemes and programmes**, varying in length, complexity, form of delivery and type of engagement expected of those involved. The emphasis remains on **identification of need at a local level**, and with the implementation of local solutions.

There seems to be broad agreement that **preceptorship programmes are a good thing, regardless of profession involved**. They are seen as supporting NQPs through the reality shock of transition from student to registrant. Furthermore, they assist in concrete skill acquisition and in confidence building. Evidence around their usefulness in individual career development is not so apparent.

There is little UK consensus about the wider value of preceptorship programmes in relation to structural issues such as recruitment, retention and patient safety. This means that there is **little consensus apparent around the ideal form or content of**

preceptorship support. However, there is a national framework for Foundation Doctors that does have some local variability but is largely uniform in its approach (Collins 2009). However, despite a framework that is uniformly applied, there is ongoing variability in time spent in supervision, the interactions between supervisors and their supervisee's, the extent to which pastoral care is included in the support and how feedback is given (Everett 2009). These differences relate largely to the individual educational supervisor characteristics but are also influenced by out of hours cover and also how the trainee was to be debriefed after an emergency (Kilminster et al 2007, Goodyear 2014).

Arguably, the most successful schemes are those that are instituted through a top down approach, are very standardised and carry a requirement of support by managers (Jones et al 2014). Programmes such as this, however, may place undue emphasis on the acquisition of concrete local skills such as the use of ward paperwork or particular medical equipment. However evidence from NQPs themselves suggests that they place a high value on these types of skills. This suggests the tension between the needs and expectations of the service and that of the NQP may not be as great as might be imagined.

The emphasis appears to be on the **value of formal programmes of support**, which include **preceptor training**, that have **skill acquisition** at their core, and are designed to last for 6-9 months post-qualification for Nurses, midwives and AHPS but extends to 24 months for Foundation Doctors. There is little mention of informal or peer support for NQPs.

3.6.1 Summary points

1. Transition from student qualified status remains challenging for practitioners, regardless of profession;
2. National policy around preceptorship and foundation programmes has been enabling rather than prescriptive (no key performance indicators (KPIs) etc);
3. Preceptorship programmes vary in length, the most common being 6-9 months post qualification for nurses and AHPS, but 24 months for Foundation Doctors and some online courses for AHPs and nurses;
4. Programmes in support of NQPs require support from the whole organization, including managers;
5. NQP programmes need to have a clear structure in to which individualised learning needs can be set;
6. Educational supervisors and preceptors need training and on-going support to fulfill the role;
7. Evidence around value of inter-professional programmes of preceptorship is very limited;
8. Facilitation of peer support between preceptees was not evident in the literature;
9. Evidence of PPI within preceptorship and foundation programmes was largely absent in the literature.

4 Findings: mapping support for newly qualified practitioners across HE KSS

4.1 What works for whom and under what circumstances in HE KSS?

Research participants and delegates from the conference were clear that systems to support newly qualified practitioners (NQPs) were in place. However, there was inconsistency in the experience provided within and between different Trusts across the KSS locality and across professions. Support was largely delivered to individual uni-professional groups, although in some instances, the management of the support covered both nursing and allied health professions. Medical NQPs were supported by a system managed by the General Medical Council (GMC) and through the Foundation Faculty (the postgraduate Deanery of Medical and Dental Education). Inter-professional learning opportunities were evident in a small number of cases, but this largely referred to shared learning opportunities rather than a framework founded on wider inter-disciplinary principles.

Mechanisms of support varied considerably across Trusts and this was, in part, shaped by the nature of the Trust's business (e.g. acute care or a mental health service) as much as the location of the NQP in a primary, secondary or tertiary care setting. NQPs might find themselves among a critical mass of similarly experienced practitioners, starting at the same time and sharing their learning with opportunity to reflect together. However, there were examples of NQPs starting asynchronously and located in dispersed communities that led to a sense of isolation. This seemed to be apparent when an NQP was a lone starter in the workplace even if they came together to meet other NQPs in collective meetings for induction, programmed teaching and/or seminars.

There was also a wide variation in what was being delivered across Trusts and disciplines. The conceptual and sometimes the theoretical framework shaping the pedagogic programme or the transitional support was distinct. For example, support framed around the concept of:

1. **Resilience** tended to be through action learning sets, reflection and exploration of the transitional experiences of the NQP. Group work was facilitated by experts in psychology and/or resilience.
2. **Clinical safety** where learning opportunities were generated to meet competency acquisition. Simulation and topic lectures were the pedagogic agenda. Often practice educators were in place to work with NQPs to ensure they learnt the right skills to function independently.
3. **The corporate agenda** supporting the NQP induction into the Trusts' business. Here, learning opportunities were aimed at exposing the NQP to executive board meetings, patient experiences and learning about how the organisation works (e.g. human relations policy and mandatory training). The student was tasked with organising their programme from a menu of options.
4. **Leadership** delivered online through the Edward Jenner Programme provided by the NHS Leadership Academy. Much of the context has been taken from the

Flying Start programme but organized to establish principles of good leadership from qualification.

5. **Promoting life long learning** through self directed learning, to enable the NQP to establish their own learning programme, shaped by a portfolio and supported by a preceptor or clinical manager.

In reality, the philosophical orientation of the programme made priorities evident and illuminated difference in the content and medium by which NQP support was delivered. The philosophical emphasis framed who provided that support (a practice educator, the service manager, a preceptor or a clinical leader), and which department managed the programme (e.g. learning and teaching department, quality and patient safety, HR directorate, a line manager, HE KSS Trust Academic Board/Faculty Foundation).

Protected time for the NQP to engage with the support varied considerably within and across Trusts. Some NQPs were not given any protected time because the programme was considered to be integral to their working lives. In one Trust, NQPs were given up to 15 study days and could attend monthly seminars. Whereas others were given time to attend mandatory training only (ALERT courses, health and safety training) and the rest of the support was provided online (Edward Jenner, Flying Start Foundation Faculty) with an NQP expected to complete the online course in their own time. Regular lunchtime seminars or a prescribed number of action learning sets for reflection were offered. One Trust provided all of these options plus a drop-in service for pastoral support. Most NQPs had opportunity to work directly with a practice educator at some stage in their programme or were given a named preceptor (by their clinical manager) or supervisor to discuss their learning needs and review their progress. Often this took place out of hours and relied heavily on the good will of the preceptor and NQP to engage in the process³.

The number of study days allocated to NQPs and how they were allocated is illustrated in Table 6 using six examples from the data to demonstrate the diversity across Trusts. Of note, where the study days were structured and linked to a pedagogic programme this tended to correspond with Trusts who employed large numbers of NQPs starting at a similar time.

³ Support provided by preceptors appointed by a clinical manager or undertaken by the clinical manager themselves, struggled to allocate dedicated time within working hours to support an NQP and this was often provided through good will and referred to as the **giff economy**. In some cases, supervision for NQPs took place in a social space, around meal breaks.

Table 6: Diversity in provision

	Range of support
A	12-15 study days plus monthly meetings (on-line self directed learning, simulation, face to face taught sessions), action learning sets/weekly lunchtime meetings with supervisor (template for all professions)
B	8 study days in one year
C	2 hours in-service training each fortnight
D	5 study days plus mandatory one to one coaching with a clinical facilitator (nursing) 3 skills days. 2 mandatory training days, 4 meetings with clinical facilitator at quarterly intervals over the first year (midwifery)(medicine)
E	Clinical supervision bi-monthly
F	Mandatory training. Outreach seminars action learning sets and working with Practice Educator in clinical practice
G	No study days. NQP programme integrated into the working day

At the conference, this disparity was an important issue for delegates who called for a generic framework that would provide a greater equity and parity in provision, or at least a minimum threshold standard that had to be met. However, counter to this suggestion ran a deep scepticism about external frameworks (other than the one generated by the Foundation Faculty for Medicine and Dental NQPs). For example, the Flying Start programme was considered to be comprehensive and good, but too complex and unwieldy to manage within the current provision of support (notably the time to undertake the programme). Latterly, this online programme has been replaced by the Edward Jenner programme available online. The need for flexibility to meet the needs of the individual and discipline group within a particular work setting was also of concern in relation to over-prescriptive external frameworks. It was acknowledged that engagement with the programme required the NQP to demonstrate their own commitment to their continuing professional development but floundered on the reality of time restrictions and other clinical priorities, notably at times of peak clinical demand.

Finally, there was a very clear view of what was required dependent on who was spoken to and their position within an organization (Table 7). For those who participated in the telephone survey, seven identified their role as a senior manager responsible for the support of NQP within their Trusts. Two Trusts were reluctant to provide access to people responsible for the delivery of the NQP support programme below the senior management level, declaring pressure of work prohibited their participation. However, they were prepared to discuss provision from their perspective. Where access was permitted, finding the people who were delivering the programme was difficult with personnel (email addresses) and changing job titles making it difficult to locate the right person to speak to (each phone call required an average of 7 calls to find the right person and then set up the appointment). It questioned the ease of practitioners seeking support within their own organisation and whether they could find the appropriate person. However, the Trust documentation for NQP support submitted to the research team did identify contact details, so once the NQP was in possession of that information they would be able to source the appropriate support. Emails alerted those responsible for the NQPs

about start dates and locations, but at conference, some delegates expressed some reservation over the risk of missing new starters especially when the start date was atypical.

Table 7: Job categorization⁴ of participants in the Knowledge Exchange Conference

	Education	Clinical Manager	Service Manager	NQP/PPI	Other/non specified
Telephone interview	14	3	7		
KEC delegates ⁵	16	4	6	5	14
Case Sites	2		2	3	2

Significantly, the priority given to the approach to supporting NQPs was shaped by the job specification of the person speaking about it and the degree to which they had direct engagement with NQPs. NQPs, practice educators and people from training departments were more likely to stress the importance of up-skilling activities, building confidence, addressing learning needs, resilience work and or, enabling professional autonomy. This frame of reference, which actively invests in the growth and development of the individual practitioner, has been termed the **ecology model**. Those speaking from an organisational perspective were more likely to talk about NQP support as a strategy to promote recruitment and retention and generally contribute to the Trusts quality agenda. For example, support as a means to assure patient safety, improve the patient experience, induction to the corporate agenda, quality assurance, appraisal and the assessment of progression within a probationary period. This frame of reference has been termed the **corporate induction model**. At some point in the NQP programme, usually around six months, the emphasis on either an ecology or explicit corporate induction model converged in the form of a summative performance review. This was when the probationary period for the NQP expired and they were assessed against the KSF (Knowledge and Skills Framework) or other competence/performance criteria generated by the Trust; in some settings, satisfactory performance would lead to a pay increase in others, this uplift in salary had stopped as a cost saving exercise.

The corporate induction or ecology model was in reality not quite as stark and dichotomous, but indicated the emphasis on one approach over the other. In some Trusts both opportunities were made available to the NQP. However, those

⁴ Education: practice educator, practice development facilitator, training and development, clinical educator.
 Clinical Manager: Practitioner with responsibility for a clinical service.
 Service Manager: Senior member of staff responsible for leading a service or directorate.
 NQP or PPI newly qualified practitioner or engaged in patient/public involvement.
 Other non specified job titles: academics, support workers providing pastoral care for NQPs. 3 delegates identified themselves as holding a role in a third sector or social enterprise organisation.

⁵ Of note, no one attending the conference labeled himself or herself a preceptor. The clinical educators made up the majority of people attending the conference with a third of the delegates representing those responsible for managing NQP support in their Trust.

advocating the ecology model tended to focus on the immediacy of need – that someone was there to respond to a situation for example, a critical incident review, facilitated reflection on a practice situation, or pick up on skill training in real time and in response to an immediate situation in practice. They spoke of the priority to provide clinical education as the model of support backed up by preceptors there to deliver day-to-day support/supervision. Examples cited by participants as requiring immediate attention included: debriefing a midwife after a difficult birth, setting up an IV line in the community, ordering an X-ray after 5pm on a Friday. The purpose being to provide a pedagogic scaffold for the NQP to enable them to move toward independent decision-making, build confidence and or, integration within the team. The reflective component in support of the transitional experience to be managed in discrete, confidential and supportive peer groups facilitated by an expert.

In contrast, those fostering the corporate induction model emphasised how the programme of support for NQPs was fed back to the Executive Board. Examples cited by participants included: a member of the Executive Board joining the NQP last action learning set (ALS) session (calling into question the purpose of the ALS and how this format would have been affected by the participation of this person); using an interlocutor to feedback the evaluation of the NQP experience to the Executive Board; a summation of the NQP's progress and performance, a summary of the evaluation completed by the NQPs about their experience and opinion about the Trust submitted as a formal report reviewed by the senior management team. The emphasis here was on the NQP's integration into the Trust and building a corporate identity.

4.2 How was engagement facilitated?

Time was seen as critical to enabling full participation in the programme of support. In-house study days (seminar series, specific teaching programme), time in the simulation suite for specific programmes such as ALERT, Basic Life Support and Advanced Life Support, Health and Safety training and other mandatory sessions dictated by HR, seemed to be provided. Reflective sessions (action learning sets or other formalized discussion meetings) required release from practice so they had to be planned well in advance. It was assumed the NQP could attend, clinical workload permitting. Programmes delivered online (Edward Jenner, Flying Start) were undertaken by the NQP in their own time with no study time to offset this commitment. To compensate for this, engagement in these programmes was deemed voluntary with no reward offered other than the satisfaction of completing the programme.

Inconsistency of provision for NQP support and the lack of a minimum standard to determine what NQPs had to achieve by a certain point beyond their probation period and, for some, meeting KSF (Knowledge and Skills Framework) requirements (seen by some participants as a completely distinct procedure) within and across Trusts, was mentioned in 8 telephone interviews and a topic picked up by delegates at the conference.

Time for the preceptor was not protected in any of the professions bar medicine (where the supervisor had a 0.5 PA per doctor supervised as part of their workload

plan). Only three participants identified that they had time to attend mentorship updates run by the Trust (n.b. mentorship not preceptorship), and the remaining 18 participants identified that preceptorship was embedded within the professional role of the practitioner and additional attention to precepting that did not fit into the working day came through the **gift economy**. Only 9 telephone interviewees identified the lack of dedicated time for preceptorship as a detrimental issue and a further six participants identified lack of preceptorship training as a concern (this is in contrast to the literature on these issues). However, roles that were to enable support of the NQP (e.g. Clinical educators, practice placement facilitators, practice development facilitators, clinical skills advisors, clinical tutors) were posts dedicated to that provision. However, 5 telephone participants identified these posts as too few in number to cover the scope and range of placements, notably in community settings. At the conference, delegates identified that fixed term contracts led to short term planning and job insecurity for these post holders. It was suggested this sort of role could make for a meaningful career pathway but required a more secured long-term investment.

4.3 Consistent Inconsistency

A difference in the assumptions of what NQP support set out to achieve led to significant variation in what was being provided. Within the ecology model, two variations appeared according to the primary focus of the support.

Where the **competency agenda** was paramount, the NQP programme was seen as an opportunity to provide a skills amnesty whereby NQPs could declare what additional skills they required to function as a qualified practitioner. If the NQP was joining a specialist environment, for example critical care, operating department, midwifery unit, health visiting practice, or community practice, the NQP programme provided an opportunity to develop a range of competencies necessary for that specialist practice. The programme was more specific to include, for example, taught components and simulation experience and learning was assessed using competency frameworks (14 such documents were submitted from 13 Trusts). This pedagogic scaffold was different to providing remediation to redress shortfalls in pre-registration training. However, on the case study site visits and talking with NQPs (Foundation Year 1's), they identified certain skills and know how could only be learnt on the job⁶.

Where the **transition from student to employee agenda** prevailed, facilitating an autonomous qualified practitioner and/or providing emotional support, the programme took on a more reflective and facilitative agenda. The experience was considered a personal process and one that had to be self-directed, reflected upon and written about in a portfolio or an account of a career transition toward goals set out in a bespoke organisational tool.

So what was done, by whom, and when, was different. The greatest consistency came from the performance review at six months after the probationary period. Six

⁶ This know how was captured in a book authored by NQPs and passed onto the next group of starters. It included instructions on, for example, how to organise requests and arrange investigations out of hours and other practical tips that experience by fellow NQPs had revealed to be important.

participants identified the Knowledge and Skills Framework (KSF) as the framework against which performance was assessed. Whereas 12 participants identified an organisational tool used at six and 12 months to assess NQP performance. Of note, performance review at the end of probation was performed by managers and was considered something quite distinct to the scope of support for NQP. In other more formalised programmes, normally framed around competency acquisition, the two processes were seen as inextricably linked: with the performance review as a summative point from which to determine career progression

Pharmacists, Physiotherapy and Foundation Doctors described a professional competency tool or University tool (where credit leading to an additional qualification) to assess performance was used. These programmes tended to be at 24 months (with additional months as required) and included rotational placements. Data was collated in a portfolio, a workbook or as part of an online programme. On one case study visit, Foundation Doctors identified that they had to complete different workbooks and portfolios for the Trust, The Foundation Faculty and the GMC, each requiring different login identification and these

programmes were not necessarily accessible through the Trust firewall. Duplication of material was not cited as an issue. However, the allocation of F1 (Foundation Year 1) placements through the GMC assessment system was considered burdensome, the scoring insensitive to capture nuanced performance, and was not valued.

Within the ecological model, and more surprisingly, with the corporate induction model, there was very little evidence of inter-disciplinary working. In some Trusts, Nurses and AHPs might have a single manager responsible for an integrated team providing NQP support, but the lead individuals responsible for delivering the programme focussed upon a single professional group. Although the system might be managed to meet the needs of different newly qualified professionals, there was little appetite for a generic multi-disciplinary tool. The concern was that the items in that tool would become so generic or abstract they would become meaningless at the point of delivery. Secondly, that newly qualified professionals were so concerned to learn their job, they did not have much interest or time to concern themselves in a broader agenda. It was notable that participants were particularly averse to inter-disciplinary and/or shared frameworks, especially when their pre-registration experience of shared learning was considered unsatisfactory (to quote the NQP participants: 'wishy-washy', 'pointless', 'pathetic', 'waste of time').

4.4 Training for preceptors

A concern expressed by delegates at the conference (nurses, midwives and allied health professions) was that money was largely invested in mentorship training (programme of study to enable a qualified practitioner to supervise a pre-registration student). Delegates considered training for preceptors and supervisors was a necessary and worthwhile investment⁷. This implies delegates considered there to be

⁷ In medicine, specialist training is provided to support the NQP. This was funded by HE KSS but recently discontinued.

a specialist skill in supporting an NQP that generic skills of student supervision (mentorship) did not provide. Furthermore, as indicated earlier, delegates also recognised a niche for a career pathway specifically focussing on the support of NQPs.

4.5 Patient and public involvement in the NQP programmes

The data from interviews and the conference strongly suggested that the role of patient and public involvement (PPI) in NQP support was under developed and had the potential to expand. PPI in the development of the pre-registration curriculum is well documented in the literature. PPI involvement in NQP support programmes was less well defined. Participants identified that even though PPI was included in the pre-registration curriculum, it was not explicitly embedded into the NQP programme other than by association through patient and public involvement in the governance of the Trust. Furthermore, in the documents submitted to the research team, there was no evidence that PPI was an integral part of the programme.

Ideas generated by conference delegates to promote greater involvement of PPI included:

- The 15 steps challenge (NHS Institute for Innovation and Improvement);
- The 'mystery shopper';
- Collating high impact stories from patient feedback;
- Using positive stories from users and expert patients;
- Nurses who become patients relaying their experiences;
- Opening lines of communication using internet, web pages, emails, social media to enable instant discussion forum;
- Buying in expert patients to relate stories;
- Enabling NQPs to buddy with volunteer expert patients;
- 360 degree evaluation as part of performance review;
- Portfolios to also contain patient testimony;
- Filming scenarios with feedback from patients that are widely available on a repository for others to view;
- Time to consider implications of the PPI so it is planned, sustainable and effective;
- Acknowledging the negative side of PPI as well as the positive: careful consideration of PPI representation and suitability for purpose;
- Ring fenced funding dedicated to sustainable, authentic and effective PPI engagement.

Conference delegates identified that to achieve this, a whole system culture shift was required to ensure such an approach was significant and worthwhile. At the same time, delegates stressed that NQPs needed to see the benefit and experience the positive outcomes of learning from patients, and through sharing experiences about their patient journeys.

This illustration was created during discussions on PPI. The black lines represent the public health provision at a regional/management level. The yellow triangle represents NQP, the red square represents PPI. The green and pink triangles on either side of the 'NQP' yellow triangle represent professional and organisational support for NQP. PPI is therefore the connection point where each of these areas intersects.

The thick black lines represent the overall health care management system within the region. There was a sense that structure was both welcomed by participants, but in some ways was also restrictive and flexibility was needed. The discussions indicated that PPI involvement currently sits within the regional/management level- therefore while these feed into the NQP training, it is separate from NQP support development and provision. The red dots on the outside of the black lines depict discussions around creative PPI involvement at a systems level and to note that more could be done to include diverse PPI voices within the overall health care system.



The language used by conference participants in regards to NQP was similar to the language used in relation to patients- to provide them with holistic and compassionate care and support to assist them with transitions. There was a sense that NQPs (yellow triangle) are perhaps the closest to PPI within health provision due to their 'newness' to the health system and being 'untarnished'. Conference participants noted the desire to keep NQPs focussed on patient care supported by the public health system, organisational structure and professional bodies. As PPI is the area where NQPs, NQP supporters, public health providers and clinical and professional bodies all intersect, may indicate a starting point for inter-professional collaborations.

4.6 Building evaluation into the programmes

There was a clear indication that more evaluation was required to determine what works well and for whom. For example, the longer term impact of online provision compared with study days. The value of the Edward Jenner Leadership programme (NHS Leadership Academy) and whether this focus on leadership from starting in a new job was useful to employers and employees was unknown. Correlating the impact of the various approaches on outcome measures for NQP performance would require rigorous research.

Delegates at the conference were clear that when seeking further investment for NQP support, evidence had to be provided about the impact of any particular model. This is complex and challenging and requires considerable thought to generate a credible and workable model that can isolate the variables and impact of the NQP support, from other confounding factors. Notwithstanding that caution, outcome measures may include:

- Staff retention;
- Sickness and absence;

- Uptake of non-mandatory learning opportunities;
- Plaudits and complaints;
- Incident Forms;
- Exit interviews;
- Staff appraisal;
- Audit of culture and environment to determine what enables individuals to flourish and score the locality against those criteria;
- Incentives to participate – banding;
- Performance review;
- Intention to practice;
- Expectation at the outset in comparison with self reflection on performance one year later.

4.7 Summary

1. There is a wide difference in NQP support across disciplines, across and within Trusts in HE KSS;
2. What has to be completed by whom and the timescales for that activity does range across the professions;
3. The amount of time given to NQPs to participate in a support programme varied considerably with up to 18 study days offered in one Trust and none in others where the programme was considered fully integrated into the working week;
4. In the main, the support provided was delivered to uni-professional groups from same profession supervisors/preceptors. There was little appetite for multi-professional programmes other than expressed by those in senior managerial positions;
5. Generic transitional skills are seen as 'softer' and are less valued than demonstrable competence acquisition although this emphasis does differ when speaking to advocates of reflective and resilience programmes.
6. Examples of additional pedagogic scaffolding in support of the NQP was provided across professions e.g. skills training either through simulation work or in clinical practice, mandatory training and reflective support;
7. Largely, preceptorship for nurses and allied health professions was modelled on a 6 to 12 month programme;
8. Some locations provide a much more explicit programme for allied health professionals notably when this led to a separate academic award (Postgraduate Diploma in Pharmacy Practice) or was linked to a rotation programme;
9. Medicine has the most uniform programme that is explicit in purpose and outcomes. Those supervising the F1 NQPs do have compensation for their time. Other professions invest money in specialist tutors;
10. There is conceptual shift from considering support for NQPs in the first six months as a period of preceptorship or supervision to a more explicit probationary period that provides some support to achieve stated goals;

11. Two agendas in NQP support were identified: the ecology model and corporate induction model;
12. The model of support provided was shaped by the rationale for support, the corporate values of the Trust, the service delivered by the Trust, and how the positional authority of the senior manager with responsibility for NQP support was situated in the Trust;
13. Isolated NQP workers (community, smaller Trusts or disparate localities where there was minimal opportunity for peer support) were a cause for concern and additional support for NQPs in such localities was required;
14. Access to support that is timely (often immediate), a shared experience from a credible role model was seen as important features of NQP support;
15. Conference delegates wanted clear direction of how they should implement support across the Trust and a minimum standard that had to be provided that enabled great consistency within and across disciplines;
16. Conference delegates expressed a need for specialist training for preceptors;
17. Conference delegates also suggested a career pathway for those supporting NQPs that could be facilitated by a commitment to long term planning investment;
18. A minimum standard of achievement by NQPs at a given point (outside probation and performance review) and what was to be achieved by the NQP.
19. An external reference to confirm the support was high quality and independently rated;
20. PPI involvement in NQP support is under-developed;
21. Outcome measures to determine the impact of any mode of NQP support are largely absent;
22. Difference in current provision was accounted for by a requirement for flexibility to meet local setting and practice needs alongside the individual NQP transitional needs.

This piece was created during one of the break-out sessions at the conference:

Making it happen-What works for whom and under what circumstances

The faces represent NQPs who are achieving various levels of success within the programme. The clock indicates limited time frames and the black hash marks and red dots in the background indicate pressure from the public and the public health system on NQP supporters to both ensure Patient and Public Safety while supporting all NQPs to succeed.



It was communicated that time restrictions and the pressures to support all NQPs to be successful often results in a deficit model where NQPs who are failing to thrive receive the most attention (as depicted by the 1st sign), those NQPs who are 'on par' with training receiving less attention and those who are doing well often receive the least attention (or in some cases provide support to other NQPs). It was noted that recent international recruitment has resulted in the need for holistic support of NQPs who may be dealing with homesickness or working in a second language (depicted by the shaded circles around the NQPs). Likewise, it was noted that retaining the 'best' NQPs is harder because they are not getting the focused attention to match their ambition/skill. This is shown in the picture by the thriving 'smiling NQP' positioned in the very bottom left hand corner of the page.

Balancing the support of NQP and ensuring safety of patients was noted as requiring time and skill. The overall sense was that NQP supporters would be enabled to provide holistic support with more time or staffing support and more recognition from the public and public system of the importance of this work. The yellow shading behind the 1st symbol is used to show that time and recognition of the importance of this work is therefore the first step. Increased opportunities for NQPs to support one-another may also be appropriate.

5 Discussion

The findings from this study are now compared to those reported in the literature.

5.1 Variability in content and delivery

Programmes were largely developed in-house and made reference to policy documents to demonstrate how they met national standards. This resulted in a wide difference in NQP support across disciplines, across and within Trusts. Difference was also noted in the requirements of the programmes and the timescales for activities. This seemed to range within Trusts most notably across professions, but variation was seen for some profession NQPs who worked in different clinical environments (e.g. critical care environments or general ward). Largely, preceptorship for nurses and allied health professions was modelled on a six to 12 month programme, but this could extend to 24 months for the Flying Start or Edward Jenner Programmes undertaken online. These programmes were not mandatory so study days were not necessarily provided by the Trust to allow NQPs to complete them. This variation in provision is consistent with findings reported in the literature (Wood 2007, Price 2013). Some locations provided a much more explicit programme for allied health professionals notably when this led to a separate academic award (Postgraduate Diploma in Pharmacy Practice) or it was linked to a rotation programme that had explicit purpose and outcomes.

The Faculty Foundation programme runs over 24 months and this model has been adopted by the Physician's Assistants and Pharmacists.

5.2 Interaction between preceptor/supervisor and the NQP

Direct supervision, observation of performance and feedback was described by participants of this study as more likely to occur where a named practice educator/clinical facilitator/supervisor were specifically programmed to review performance. The preceptor might well have a less formal role in providing support and in providing reflective debriefs on or shortly after clinical events. This was notable where the preceptor was also a line manager and where the boundaries between preceptorship or supervised practice during the NQP's probation had an overlay of performance management. This could lead to a phenomenon called **judgementoring** (Hobson and Malderez 2013). Although judgementoring was a concept developed from researching the experience of new teachers in their first teaching post and their mentors, it holds resonances with the comments made by some delegates at conference who identified a similar model exercised in their own Trust. A manager might be well placed to broker professional opportunities, enable the NQP to fully participate in the professional community, act as a professional role model but it might be more delicate to provide emotional support. In situations such as this, the NQP would be less likely to share personal issues surrounding transitional career adjustments and would require external and discrete support to facilitate that aspect of their experience. In some Trusts in HE KSS this was provided through a reflective forum (e.g. action learning sets, communities of practice focusing on resilience) or by pastoral support offered by independent persons to the clinical

directorate. This finding did differ from that reported in the literature where much is made of the relationship between the preceptor/supervisor and the NQP (Adlam et al 2009, Marks-Maran et al 2013, Mason and Davies 2013) and the confidence they have in the feedback they get from the supervisor/preceptor (Hobbs and Green 2003). Creating a third party does address the concern of the intensity between a preceptor and preceptee but only one study identified some instance of bullying and harassment (Mason and Davies 2013).

The difficulty in finding time for NQPs to meet with their preceptor/supervisor was challenging in this study and that finding is consistent in almost all studies; scheduled meetings were sometimes cancelled due to service needs and cover for staff sickness (Hobbs and Green 2003, Banks et al 2011, Grant et al 2003, Mason and Davies 2013). Participants in this study did clearly speak of the problems associated with the lack of time for NQPs to meet their supervisors/preceptors, as well as the freedom to fully engage in the study days or seminars, action learning sets or other reflective sessions due to clinical priorities.

In the literature effectiveness of a programme was dependent upon:

- support from a manager (Bates et al 2010, McCarthy and Murphy 2010, Omansky 2010, Foster and Ashwin 2014);
- protected time for the preceptor/supervisor and NQP (Hobbs and Green 2003, Carlson et al 2010, Phillips et al 2013);
- recognition and status of the role of preceptor/supervisor (McCarthy and Murphy 2010) and adequate preparation for preceptors/supervisors (Hobbs and Green 2003, McCusker 2013);
- normative and formative feedback, regular supervision and regular access to the preceptor (Miller and Blackman 2003, Morley et al 2012, Foster and Ashwin 2014).

In this study it was clear that support from the manager was evident – but the manager in question was the lead person providing support for NQP. The research team did not gain access to service managers to hear their views on the provision, as the purpose of the review was to map provision across HE KSS not the process by which that was delivered or received.

An outcome of experiencing good preceptorship is that NQPs would consider becoming a preceptor and would recommend preceptorship to others, suggesting that excellence has an impact and is sustainable in the long term (Marks-Maran et al 2013).

5.3. Assessment

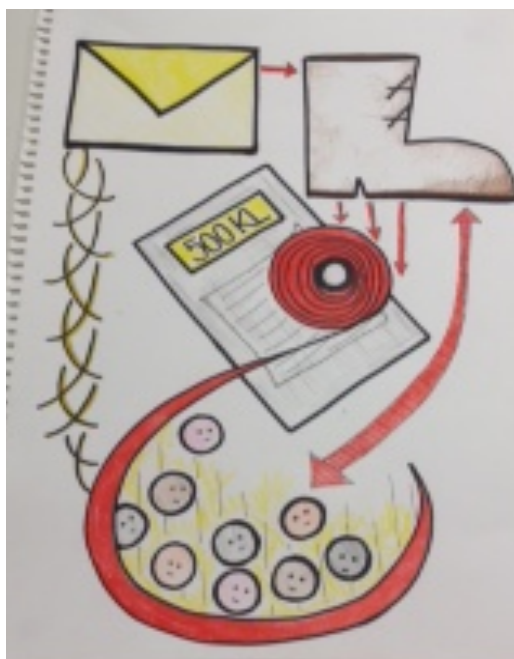
Variation exists in assessment; there may be self and/or peer assessment of preceptees' knowledge and skill, with or without reference to the Knowledge and Skills Framework (KSF), or no formal assessment at all. This variation was recently highlighted in a review of preceptors and preceptees from across the UK, which found instances of a **structured preceptorship programme, limited preceptorship with ad hoc meetings** initiated by the preceptee, and, in other instances, **no**

preceptorship programme in operation at all (Avis et al 2013). In these data – there was documentary evidence of competency assessment by others, and self-assessment of progression through the use of portfolios to capture reflective transitional encounters. Line managers undertook performance review against KSF (Knowledge and Skills Framework) criteria, but this was seen as a separate activity to NQP provision and assessment. However, in some Trusts NQP support was seen as the enabler to help the NQP achieve organizational outcomes set out in a bespoke corporate tool. There did seem to be a conceptual creep toward seeing NQPs recruited to a period of probation rather than preceptorship/supervision. This might well hold significant challenges for those providing support of the NQP and a dynamic shift in what is provided.

5.4 Multi-professional working

The support for NQPs is delivered uni-professionally. There is little appetite for multi-professional programmes. NQPs and clinicians supporting clinical competencies stress the importance of understanding one's own role before being able to share learning with others in the multi-disciplinary team. Essentially, the generic transitional skills are seen as 'softer' and are less valued than demonstrable competence acquisition. These sessions were more likely to be provided by cross professional experts. Hobson and Malderez (2013) identified for teachers, the best 'mentoring' (a term used to describe the supervision and support of a newly qualified teacher in their first teaching post), was where the supervisor was of a similar age, taught the same subject and had no role in performance management.

What needs to happen to make the support for NQP sustainable



This illustration was created during discussions on sustainable NQP support. The boot represents the system which is limited by the 'weight of red tape' and often sees all NQPs lumped in together despite requiring individually tailored support systems. It was felt that the system perhaps does not fully understand the needs of NQP, and that creating opportunities for NQPs to understand and communicate their experience may alter this opinion.

The increased communication between NQPs and system providers is represented in the yellow envelope. This symbol was chosen due to an example given where NQPs write a letter to themselves when they first join the team and then it is left sealed and mailed back to them at sign-off (that they may understand how they have grown).

It was suggested that further research and consultation directly with NQP is needed.

Access to a resource-sharing platform was suggested.

Recommendations

Access to different models of good practice, research reports and dissertations to be held in an **online repository. The repository could also house:**

- Documentation shared (with a careful evaluation of what works well and what needs improvement);
- To build a library of dissertations and other research reports relating to the support of NQPs;
- A library of film, video and digital recordings of patient engagement with NQPs and feedback (Creative Commons Attribution Licence);
- Building interactive materials to deepen thinking and reflection on the transitions for NQPs;
- Generate a web page that can host open letters, the exchange of ideas and a monitored chat room that also houses online questions and responses. This would require careful management and funding to support the activity.

Staff providing support to NQPs need support themselves especially when trying to implement whole system change (e.g. multi-disciplinary approaches to the support of NQPs in their Trust). In recognition of the difficulty to get time release away from the Trust, it is recommended that these meetings largely take place online with opportunity to meet face to face three times a year, thus creating a **community of practice or network of practitioners** supporting NQPs holding similar posts across HE KSS. Funding to support such a network would be required. The network could also provide opportunity to share best practice and then take that back to local settings to be shaped to meet the Trusts' needs and those of the NQP.

Greater consistency be considered in the provision of support for NQPs that enables the best of both the ecology model and corporate induction model to be realised. Any model developed needs to first address the fundamental rationale for support and this type of values clarification could start in the community of scholars.

Any model provided would need to be simple, accessible and meaningful.

Specialist training for preceptors/supervisors be reinvigorated.

The potential for a specialist career pathway for those dedicated to the support of NQPs. This requires posts to have long-term investment and sustainable funding models to provide greater consistency and acquisition of expertise.

Develop evidence of how PPI is integrated into support for NQPs and to evaluate if this has any impact on the NQPs experience.

Systematic and planned funding for patient and public involvement in the support for NQPs that is ring fenced and culturally embedded into the Trusts as a model of good practice.

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Appendix One: The Telephone Survey

Survey of Support for Newly Qualified Practitioners (NQP) across KSS

Your role

1. What is your role?
 - a. What is your title?
 - b. What do you have responsibility for?
 - c. What professions are you responsible for in terms of supporting NQP?
2. In terms of NQP what do you offer?
3. How is support for NQP organised within the organisation? Is it centralised? If so how is this administered?
4. Is there any patient and public involvement (PPI) in your programme of support for NQP?
5. Is there protected time to carry out the role of preceptor/X?

Who's who

6. Is anyone allocated to look after NQP and if so, what are they called ('X')?
7. How are preceptors/X supported to do this role?

Induction day	Online/elearning	inservice	Study days	Other
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8. How are they allocated to look after a NQP?

Support for newly qualified staff

9. Is the programme structured in any way?

Taught	Online/e-learning	Self-directed	Performance review	Other
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- a) If Yes
 - o Is it documented? If so, can we have a copy of the documentation?
 - o Do we need to seek permission for the documentation from anyone in your organization?
- b) If No (not structured and/or unable to have documentation):
 - o How does the programme operate?
 - o How long is the programme (for any one individual practitioner), e.g. 3, 6, 9months? Does this correspond to being considered a NQP?

Assessment of newly qualified practitioners

10. Are NQP assessed in any way?

- a) No
- o Do you think they should be?
- b) Yes

How are they assessed?

Self assessed	Online	Preceptor/X	Other
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Who receives the feedback on the NQP assessment?

Senior staff	PPI	Preceptor/X	Practice educator	Other
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Is there are threshold point at which people move to a performance review?

Do you have documented assessment tools?

If yes

- o could we have a copy?
- o Is there anyone we need to write to for the release of this information?

11. What do you do best to support newly qualified practitioners? What are you proudest of?
Who benefits from this?

12. What part of your support for NQP needs to be further developed?
Are there any barriers to this?

13. Is there anyone else in your organization we should talk to in terms of responsibility of supporting newly qualified practitioners?

14. Would you be willing for us to contact you again to clarify any issues from the documentation you will be sending us?

15. Would you be willing to be a case study site if we were to ask you?

Yes

No

Remind them of your request for documentation, if agreed earlier.

Appendix Two: An example of a data extraction sheet (topics 1-4)

	Who	Scope	Offer	Managed by
1	PDN - Educator	Nurses – Register with registered mentors (a preceptor = an experienced registered mentor to act as a buddy)	1/12 – 8 study days Clinical Skills training Induction/orientation (e learning) Optional 20 credit module (level 6) poor uptake no funding to support this as mentorship gets the money Annual preceptorship conference	Quality Pt Safety Division Organised within the programme
2	Physio Clin Manager	Integrated teams mainly nurses, rapid response physio dieticians, neuro rehab (AHPs) Community Physio's – 19 NQPTs	4 month rotation Mentor – 2-3 yrs or as long as they remain on Band 5 Annual review of rotation info Mentors set annual objectives and these are reviewed Band 5s get 2 hrs in service training a fortnight Updates clinical educators	Clinical Division (as clinical manager) and Professional Lead linked across to Learning and Development Dpt Aggregate of overall feedback and report area of development for the Trust
3	C Prof Dev Facilitator	Standard and Mandatory training Overview std in training – and commissioning Uni modules Clinical education for physios Care certificate pilot Nurses and AHPs	Clinical Ed for Physios Small number 1-2 induction a month Package of all that is required for the first 6 months Nurses have preceptorship program – manager/preceptor appointed to manage the pack - Largely reflection on critical incidents	HR Directorate LandD dept.
4	Chief Nurse	Nursing (30-40 across services at any one time) Governance patient safety and patient experience	Promoting LLL Development plans with line manager Individually tailored. One day sessions Alert Course, In-house clinical days – monthly outreach seminars by Outreach team a 'sample' over 6 months. Rostered to attend them. Self directed follow up of a patient	Working within surgical directorate – Governance pt experience, patient safety across all services – manage senior nursing team
5	Practice Placement	Nurses Quality and quantity of practice placements – plus preceptorship Inter-professional programme – but someone else has lead role for AHPs	Preceptorship package/workbook Clinical Sessions bi-monthly ALS preceptees E learning - Edward Jenner Prog (vol) KSF plus 'portfolio' of evidence	Learning and Training Dept. Medicine completely separate.

An example of a data extraction sheet (topics 5-9)

	Protected time for preceptors	Preceptee protected time	PPI	What's missing	Specific comments
8	No	Approved by PPI – For AHPs this is clear, not so for nurses	Community Forum – inform policy	ALS and evaluation of Edward Jenner and impact.	1:1 support practice development team Preceptorship Qual mandatory and annual updates required – embedded in Prac Ed teacher role
9	Should meet once a week	Should meet once a week	Not for NQPs but for std HVs	Formal time set aside to deliver the expectations – embedded and expected to be found within the working week – however model of HV and supervision model does make this more likely? Clinical Supervision update – annually (e.g. safeguarding issues) and mentors update largely about support of students Standardisation in supervision groups – lacks commonality of approach More support for mentors and preceptors Time – work pressure Increase in HV numbers	Mentor/preceptor terms used interchangeably No more than 3 NQP per team – and this is balanced with number of students and HV students.
10	0.5 PA for each doctor they supervise	10/7 shadow prog from back Weds includes mandatory induction – paid basic rate by Foundation Programme	Encyclopedia of know how: peer –to peer	Not consistent across the patch – smaller hospitals (notably MH – fewer students) Dispersed placements – lack of peer support – critical mass (Faculty Ed Directors) More numbers – building critical mass and peer on peer support F1 F2 continuity of support They take in the students who are asked to redo – marker of success than missing F1/F2 buddying – coming in from next year.	Additional buddying from F2s for F1s in addition to other support they receive here Pre-sessional – shadow F1 prev yr – social and defined learning. Includes alert, BLS, IT High challenge high support – most popular placement

An example of data extraction sheet topics 10 – 14)

20	Portfolio of evidence. Reflective essay for uni module for 30 level 6 credits.	None.	Portfolio	12 months	Self directed learning. New programme. Legal and ethical issues, health promotion, immunization, asthma, diabetes, contraception. New uni module Intro to District Nursing to start: 6 study days on core competencies – but GP has to release staff.
21	E portfolio review with educational and clinical supervisors reports. Progress regularly reviewed by Faculty group.	Must pass each foundation year.	e-portfolio	24 mths.	Weekly protected teaching programme (80% attendance required); mandatory training e.g. equality and diversity; South Thames Foundation website. Study leave to attend conferences etc.
22	Portfolio	Annual review - supervisor reports competency assessment UKAPA appraisal documents	Portfolio of experience	?	Weekly teaching. Proud personal development – push to be research audit active – publish and present
23	Objective setting with supervisors 1-2-1 supervision initially Peer review 3mthly Pt feedback	Six monthly review Used internally by managers in department Formal review for failure to thrive at 12mths	Objectives and competence – workbook/portfolio Includes patient feedback	12 months	1-2-1 weekly/bi-weekly and monthly as they progress. In service training teaching bespoke to meet training needs. Staff forum and monthly meetings with Band 7 organised and delivered by physio dept.
24	Objectives – portfolio Self assessed and SDL	None But there are performance reviews! Clinical skills assessment and direct observation! Also portfolio of evidence	Portfolio and pro formas	6 -12 months people can complete at 6 months	Regular contact with senior staff – work alongside colleagues constructive feedback – open communication and SDL encouraged to meet skills gap

Appendix Three: Mapping preceptorship across the UK (outline of courses provided)

1. AHP Preceptorship Programmes

Yorkshire and Humber Strategic Health Authority funded an evaluation of a 6 month preceptorship scheme for community AHPs (physiotherapists, occupational therapists and speech and language therapists) to determine whether Band 5 AHPs could work in the community if they were given appropriate support (Flynn and Jones 2009). The programme was designed following consultation with newly qualified practitioners, mentors, educational coordinators and university facilitators. A four hour monthly teaching session covered 6 sessions: chronic pain, mental health, respiratory care, cognition and memory, job applications and interview techniques and interview questions. The programme was subsequently evaluated (Flynn and Jones 2009).

A preceptorship programme for NQOTs was developed by Morley (2007) as part of her Doctorate in Occupational Therapy at the University of Brighton. The programme was developed using action research. Five recently qualified occupational therapists, four supervisors and five occupational therapy managers took part in interviews and focus group to explore the perceived development needs of newly qualified practitioners and what supported and hindered these needs being met. This was the first preceptorship programme for occupational therapists to be developed and implemented in the UK and was adopted by the professional body in 2008. The programme was subsequently evaluated (Morley 2009a, b).

The Scottish Government and NHS Education for Scotland (NES) developed the **AHP Support and Development Scheme for NQPs** for physiotherapy, occupational therapy, speech and language therapy, podiatry, radiotherapy and dietetics. This was triggered by a realisation of the transition process for newly qualified practitioners who may leave their roles due to unmet expectations (that may be unrealistic) and low job satisfaction (Solowiej et al 2010). This scheme to facilitate transition from student to practitioner incorporated a mix of learning methods designed to encourage self-directed lifelong learning:

- Flying Start (web based learning based on the NHS Knowledge and Skills Framework that enabled a portfolio to be used for career development and progression (NHS Education for Scotland, 2015) developmental modules. Practitioners reflected on their practice, which facilitated their own continuing professional development and in addition demonstrated their continuing competence to a variety of stakeholders;
- Online discussion forums;
- Access to mentors;
- Financial support.

The scheme ran over two years. The first year involved completion of Flying Start modules and developing a portfolio of evidence to demonstrate their learning outcomes. The second year involved focusing on how they could improve patient

care and to build upon their self development from year 1. They were required to submit a reflective summary of a project that had resulted in improved patient care. At the end of years one and two, an assessor reviewed the practitioners work and if deemed satisfactory, the practitioner continued to work for NHS Scotland, and would be offered development funding. This scheme was evaluated (Solowiej et al 2010).

2 Midwives' Preceptorship Programmes

North Bristol Health Trust and University of Western England worked in partnership to develop a preceptorship programme designed to develop both socialisation and clinical development in the preceptee (Hobbs and Green 2003). The period of preceptorship was set at 12 months, and included a reflection based learning package. The expectation was that preceptors and preceptees would meet at least quarterly to discuss the package.

Preceptorship programme for midwives developed in Oxfordshire (Boon et al 2005) rotated newly qualified midwives between labour suite and ward for a 6-month period. Some midwives were additionally offered a fortnightly rotation to community.

A **Preceptorship programme for midwives at a local Trust** was evaluated by Foster and Ashwin (2014). The programme was designed to give newly qualified midwives 75 hours of supernumerary practice in each rotation, to work with a named preceptorship, and to complete a skills-based learning package.

3 Nurses Preceptorship Programmes

Leigh et al (2005) evaluated a preceptorship programme for **adult nurses in an acute Trust in Salford**. The programme gave NQPs 3 weeks of supernumerary orientation followed by a 6 month supported preceptorship period, following the model of the European Foundation for Quality Management [EFQM] which supports the notion of development around competence, confidence and retention. The evaluation included NQPs completing a questionnaire prior to, and after, their experience of preceptorship. Twenty seven nurses completed the final questionnaire (response rate 78%) and 27 ward managers also completed an overall questionnaire.

A **preceptorship programme in an acute Trust in London** explored the perspective of preceptors (Muir et al 2013) and preceptees (Marks-Maran 2013). Data was collected from 40 preceptors (44% response rate) and 44 preceptees (49% response rate) in the form of questionnaires and semi-structured interviews. Preceptees also kept written and oral reflective journals. The intention of the preceptorship programme under evaluation was to ease the transition of newly qualified nurses from student to staff nurse, to support career development and to reduce attrition.

A project in **Cardiff was designed to evaluate the experience of the Nurse Foundation Programme** (NFP) for both those taking part and ward managers (Jones et al 2014). The NFP was introduced in 2008 to give newly qualified nurses structured

support during their first year post-qualification. Data was collected through anonymous evaluation forms (n=212) and through semi-structured interviews (NFP attendees n=15; ward managers n=5).

Other recent research projects have explored the experience of being an NQP, and expectations around role transition and support rather than evaluating particular projects (Allen and Simpson 2000, Gerrish 2000, Hardyman and Hickey 2001, Ross and Clifford 2002, Clark and Holmes 2007). Dearmun (2000) explored the value of the role of Lecturer-Practitioner in supporting the transition from student to NQP.

4 Junior Doctors

North West Deanery, UK

Brown, Chapman and Graham (2007)

Data were gathered in 2001 from 237 pre-registration house officers (PRHO), 166 educational supervisors in one deanery that included 12 local Trusts. This case study, a case bounded by locality, was designed in six phases with each phase informing the next round of data collection. Qualitative (focus groups, semi structured interviews) and quantitative data (questionnaires) were amassed. The findings identified that PRHOs found shadowing, whilst adapting to professional working life, raised a number of issues for the newly qualified doctor. The paper identifies the tension inherent to transitioning from a student into a professional role. The challenges were identified as struggling to adapt and fit in, whilst being highly conscious of, and defensive about, judgements being made of the PRHO as they struggled to acclimatise themselves to all the demands of the junior doctor's role. Contrary to this sensitivity, the PRHO did want feedback and assurance that they were fitting in, doing a good job, and were a valued member of the team, to address the insecurity inherent in starting out in a new job, especially one that held so many responsibilities.

This paper was written prior to the inception of the Foundation programme, but the authors argued that many of the findings were important for the success of the support for NQPs (medical). The authors identified that the induction of junior doctors held folklore that framed the expectations of the NQP. This included an expectation to be treated like a dog's body, that it was traumatic and that the period had to be survived as part of a professional rite of passage. PRHOs opined that valuable learning opportunities were missed because their first responsibility was for clerking new patients, new skills (inserting a chest drain) and new experiences (e.g. opportunities to visit theatres) were lost to the basic requirements to complete fundamental task on the wards. Participation on ward rounds, support from educational supervisors and a formal learning plan were cited as practice that would enhance the experience of the NQP. This was most critical in the early weeks of starting out.

Everett (2009)

All junior doctors and their educational supervisors in one UK psychiatric training scheme

In this study, the term 'junior doctor' refers to Foundation Year 2, General Practice trainees and trainees in pursuit of a career in psychiatry. Data were gathered in two waves to capture the experience of educational supervisors as well as those of the junior doctors. The focus here was on the introduction of workplace-based assessment (WPBA) and how this impacted upon education supervision. In the first wave, 11 supervisors and 11 junior doctors returned the questionnaires (70% response rate), while the second wave had questionnaires returned by 10 trainees and 10 supervisors (67%).

Of note, the findings revealed the impact that assessment had on the supervisory relationship. This included the time taken out of educational supervision to assess rather than attend to broader learning needs of the trainee. Further, it was found that the assessment determined the theoretical and practical programme over trainee identified learning needs. The tension between trying to provide support whilst also acting as an assessor raised questions about objective assessment and the failure to fail.

At the time of data collection, the recommended time an education supervisor spent with their trainee was one hour a week. Everett's data identified a discrepancy over the time spent in educational supervision. Supervisors being more likely to over estimate time spent with their trainee (between 15-30 minutes discrepancy). Activities included setting ground rules, pastoral care, feedback on performance and writing reports. Junior doctors wanted feedback in writing or formal verbal feedback that was framed explicitly for that purpose.

The most important factor cited by the trainees was the quality of supervision they encountered. As this was such a subjective experience, discussing expectations and setting an agenda for how those goals might be met helped to both facilitate shared responsibility between the education supervisor and also served to create clarity for the trainee.

Supervisors did feel that they needed further guidance on what their role entailed and how they might provide good support. Working in simulation, using observed role play (Tavistock circles), and clear peer feedback was considered one way in which the skills of educational supervision might be enhanced.

Goodyear (2014)

West Midlands F1 – factors affecting wellbeing

Nine F1 doctors were interviewed along with two Foundation Directors. Data were analysed using grounded theory techniques. The paper identifies the anxiety associated with the transition into a professional medical identity. Goodyear identifies how medical school prepares doctors for the science of medicine whilst the first Foundation year is about learning to do the job. This marks a significant shift for the NQP as they cope with work pattern shifts, the burden of their responsibility to

patients and their families, colleagues and the organization whilst learning the 'know how' of getting things done (administration, knowing who to ask, where to find things and doing a good job). It is a steep learning curve beset with emotional and intellectual challenges and one that has been identified as the most stressful year of a doctor's career. There is a need for immediate debriefing after a critical incident, support from family and friends (access to whom may be affected by shift patters), serious adjustment to the physical demands of the work and adjustments to their social life to accommodate all the demands of a junior doctor's role. Despite interventions to address the needs of F1 doctors introduced over last ten years, for example, the introduction of Foundation Faculties (Collins 2009) the impact of modernising medical careers (Tooke 2008), the students interviewed in this study still expressed high levels of anxiety associated with their transition.

Goodyear recommended that preparation needed to start in medical school, the support be provided by all members of the healthcare team, especially senior nursing and medical colleagues, there needs to be organisational support in place to formalise the support and that strategies be put in place to enable the NQP to plan social support from family and friends. She mentions the requirement for facilitation to specifically enable identity reconstruction and resilience i.e. to foster a capability to thrive in challenge and engage support to learn from tough or difficult experiences.

Wijner-Meijer et al 2012)

Readiness of trainees to be entrusted with professional tasks

Leeds Medical School and associated Trusts

A study comparing the readiness to undertake professional tasks reported by final year medical students (n=41), F1 trainees (n=44) and F2 trainees (n=25). These data were collected by a questionnaire of 16 'entrustable professional activities' (EPAs) and were matched with scores of the trainee's competencies provided by their supervisors. The questions were divided into two core categories: clinical and general activities and the respondents were requested to score competence to perform the task on a five point Likert scale. The aim of the study was to examine competence development in the transition from medical school and through the Foundation years.

Two transition points were identified:

- 1) The responsibility transition from medical student to F1, junior doctor status (can prescribe drugs);
- 2) Licensure transition (F1- F2) full registration as a physician from General Medical Council (GMC) working under clinical supervision.

The authors found that the most significant transition was the responsibility transition from medical student to F1 and accounted for this by suggesting the F1- F2 transition was made within a community of doctors.

The second significant finding of this study was that trainees scored themselves higher than their supervisors in terms of their capability to undertake a task. Wijner-Meijer et al (2012), concluded that supervisors were aware of more complexity and therefore complications arising from activities, be they clinical or general and were, therefore, more cautious in the ranking.

Situating the findings to Vygotsky's theory (1978), the authors describe the performance of a task just outside current competence as 'constructive friction' necessary for the development and advancement of the trainee. In this way the trainees learn to embrace challenge but to also recognise the boundaries of their competence and balancing when to take cautious risk and when to seek supervisory advice to ensure patient safety. The authors highlight the importance of negotiating sufficient balance between enabling development of the trainee and facilitating their advancement, independence and confidence with patient safety and the necessity to perform competently even if that is not perfectly.

Kilminster, Cotrell, Grant and Jolly (2007) Effective Educational and clinical supervision

A guide on educational and clinical supervision based on a literature review and a questionnaire survey. The evidence indicated that supervision was highly variable in terms of time, quality and frequency and that 'out of hours' supervision was particularly a concern as was debriefing after an emergency. The literature reported a problem with the failure to fail trainees in difficulty, and also the lack of performance management for supervisors who perform sub-optimally.

Effective supervision is provided in context. Supervisors are appointed because of their clinical competence and knowledge but should also be specifically trained to undertake the role of a supervisor. Supervision in this guideline recommends direct observation of performance and working together with the supervisee, it includes constructive feedback on performance that can take place in practice as well as formal meetings that are scheduled. Supervisees are encouraged to take responsibility for directing the content of supervision first by determining their own learning needs and also setting the agenda for supervisory meetings. The role of the supervisors is extensive and includes assessment of performance, pastoral responsibility, facilitating reflection, taking responsibility for learning about clinical management, teaching and research, administration and fostering the interpersonal skills. Supervisors are therefore encouraged to develop teaching, counseling, appraisal and careers advice. Thus blending the responsibilities of a role model, a career's coach with that of a mentor and a formal assessor. They are charged with the responsibility to be encouraging, inspiring, astute, empathic and insightful. A significantly demanding role that requires specific training.

4 Multi-professional programmes

A scheme of **sharing learning and mentoring for newly qualified nurses and doctors took place in Wessex** and was evaluated in 2002 (Heidari et al 2002). The scheme developed shared mentoring, workshops and informal support for newly qualified

nurses and doctors. Data was collected through observation, interview and questionnaires. 141 questionnaires were completed (representing all NQPs, project leads and tutors) and 34 interviews were carried out.

The **Flying Start NHS web based programme** for nurses, midwives and AHPs was evaluated in a 2 year multi method study design (Banks et al 2011). The study surveyed 334 nurses, 20 midwives and 193 AHPs (speech and language therapy, occupational therapy, physiotherapy, dietetics, podiatry, radiography (diagnostics and therapeutic), orthoptics, arts therapy and prosthetics and orthotics). The programme consisted of 10 learning units to be completed over one year. NQPs chose to undertake the learning process for each unit or take a final activity at the end. They were linked with a preceptor (referred to as a mentor) and each pair decided how they would work together. NQPs were asked to access protected learning time in their work schedule wherever possible.