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

February 2015

Professor Julie Scholes (Nursing)
Dr Nikki Petty (AHP)
Dr Inam Haq (Medical Practitioner)
Dr Tania Mcintosh (Midwifery)
Mirika Flegg (Research Officer & Artist)
Dr Anita Green (MH Nursing)
Dr Jane Morris (Clinical Education)
Lisa Hodgson (Research Officer)
Ruth Chandler (PPI Consultant)
Laura Lea (PPI Consultant)
Glynis Flood (Administration)

!
!
! !

!

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 incre ased commissioning focus on ins /TTTn

!

!

!

Contents

!

Executive Summary

!

The overall project aim is to develop a robust evidence-

!

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 tes. 45 0 0 45 0 0 cTm /TT91 Tf ( ) Tj209 [(to) -60 0t0.24 107.5095 3121 -125 T 45

- ¥ 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);
- ¥

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. Th

practitioners across HE KSS;

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 seit9cm BT 8hust4((0.007420 Tm /e)-9 ([(se) -4 ()9(u) -4 80.0093 Tc 45

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

¥

(!

!

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

*!

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

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

"#!

!

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 programme

- ¥ 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:
  - o

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 employe r:

- 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.

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

cognition and memory, job applications and interview techniques, and

reassurance from preceptors was helpful in developing this. Time constraint s limited opportunity for role modeling. NQPs who enjoyed structured learning may have preferred preceptorship more th n /Cs1 cs 0 07 12 2 (i -6 (n /Cs1 (p) -1 (o3T 50 0 (f) 6 (or0 Tm70

!

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

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 preceptee(l) 1 (y) a.56 cm

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. (p) 3fi658 649.5658 64970.80005 688.4 cm BT 45 0 0 45m BT 40005 66n0 0 0.24 66n0 0 P01p 0 0

!

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 ane rly .v (y) 2yucrnlrct950.56 cnssess[(ca) -1 (r) 7 (eer) 7 (') 5 (s)1 (c) -2 (r) -5 (n)c 2 -2

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, U

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 mi(m) -8eTdvBT 45 s(n) 2 (g) 1 ( ) ( ) (0 45 02 -2 (d8 (i) 6 ((m)44 p) - 4 (k) -1(n)

preceptorship support

#(!

!

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

!

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,

!

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

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 pract

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 moreance r(or3

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 programme s

!

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 of15 362 cm BT 0.010eof7 Tm /TT3 ;7dcm BT 45 0 (a) -2 (t00 0 9

!

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 ÔNQPÕ yellow triangle represent professional and or ganisational support for NQP. PPI is therefore the connection point where each of these areas intersects.

The thick black lines represent the overal l health care management system within the region. There was a sense that structure was both welcomed by participants, but in some ways was also restri ctive and flexibility was needed. The discussions indicated that PPI involvement currently sits within the regional/management le vel- therefore while these feed into the NQP training, it is separate from NQP suppo rt 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 langue 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 NQP s (yellow triangle) are perhaps the closest to PPI within health provision due to their ÔnewnessÕ to the health sy stem and being ÔuntarnishedÕ. Conference participan ts noted the desire to keep NQP s focu ssed on patient care supported by the public health system, organisational structure and professional bodies. As PPI is the area where NQP s, NQP supporters, public health providers and clinical and profes siT 0.0061 31s(n) -4 (d) -5 -5 (n05.

!

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 succe ed.

It was communicated that time restrictions and t he pressures to support all NQP s 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 NQP s who are Ôon parÕ with training receiving less attention and those wh o are doing well often receive the least attentio n (or in some cases provide support to other NQPs). It was noted that recent international recruitment ha s 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 ÔbestÕ 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 Ôsmiling NQPÕ 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

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 same 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

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).

m Im /TTIm /TTThe difficulty 0.24 0 0 1 Mdi80000 0.24 360.4441 716.48 cm BT 0.0128 Tc 45 0 0/6 (ty) -0.4441 ty5 0 0 Tm

preceptorship programme in operation at all (Avis et al 2013). In these data – there was d al

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 Ôweight of red tapeÕ 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

!

%%!

!

References

Adamson BJ, Hunt AE, Harris LM, Hummel J (1998) Occupational therapists' perceptions of their undergraduate preparation for the workplace. British Journal of Occupational Therapy 61(4): 173-179.

Adlam K, Dotchin M, Hayward S, (2009) Nursing first year of practice, past, present and future: documenting the journey in New Zealand. Journal of Nursing Management 17: 570–575.

Allen C, Simpson A (2000) Peers and partners: working together to strengthen preceptorship in mental health nursing. Journal of Psychiatric and Mental Health Nursing 7(6): 505-514.

Avis M, Mallik M, Fraser DM (2013) 'Practising under your own pin' – a description of the transition experiences of newly qualified midwives. Journal of Nursing Management 21: 1061-1071.

Bain L (1996) Preceptorship: a review of the literature. Journal of Advanced Nursing 24(1): 104-107.

Baly M (1995) Nursing and Social Change

!

Everett JT (2009) Educational supervision and the impact of workplace-based assessments: a survey of psychiatry trainees and their supervisors. BM3 1 4.C

!

Hardyman R, Hickey G (2001) What do newly-qualified nurses expect from preceptorship? Exploring the perspective of the preceptee. Nurse Education Today 21: 58–64.

Harrison JK, Lawson T, Wortley A (2005) Mentoring the beginning teacher: developing professional autonomy through critical reflection on practice. Reflective Practice 6(3): 419–441.

Heidari F, Andrewes C, Galvin K, Pendlebury R, Graham R (2002) Shared learning and mentoring for newly qualified staff: support and education using an interprofessional approach, Institute of Health and Community Studies, Bournemouth University.

Hickey MT (2010) Baccalaureate nursing graduates' perceptions of their clinical instructional experiences and preparation for practice. Journal of Professional Nursing 26(1): 35–41.

Hinojosa J, Blount MLF (1998) Nationally speaking: professional competence. American Journal of Occupational Therapy 52(9): 699-701.

Hobbs J, Green S (2003) Development of a preceptorship programme. British Journal of Midwifery 11(6): 372-75.

Hobson A, Malderez A (2013) Judgementoring and Other Threats to Realizing the Potential of School-based Mentoring in Teacher Education, International Journal of Mentoring and Coaching in Education, Vol. 2 Iss: 2, pp.89 – 108. (Visit www.emeraldinsight.com/journals.htm?articleid=17091431). - See more at: http://www.sec-ed.co.uk/best-practice/effective-teacher-mentoring#sthash.gUUE0QJt.dpuf

Hodgetts S, Hollis V, Triska O, Dennis S, Madil H, Taylor E (2007) Occupational therapy students' and graduates' satisfaction with professional education and preparedness for practice. Canadian Journal of Occupational Therapy 74(3): 148-160.

Hollis V, Clark CR (1993) Core skills and competencies: part 3, excellence made explicit. British Journal of Occupational Therapy 56(4): 135-139.

Houts PS, Doak CC, Doak LG, Loscalzo MJ. (2006) The role of pictures in improving health communication: a review of research on attention, comprehension, recall, and adherence. Patient Education and Counselling 61: 173-90.

Hughes AJ, Fraser DM (2011) 'SINK or SWIM': the experience of newly qualified midwives in England. Midwifery 27(3): 382-386.

Hyrkäs K, Shoemaker M (2007) Changes in the preceptor role: re-visiting preceptors'

Morley M (2007) Developing a preceptorship programme for newly qualified occupational therapists: action research. British Journal of Occupational Therapy 69(5): 231-233.

Morley M (2009a) An evaluation of a preceptorship programme for newly qualified occupational therapists. British Journal of Occupational Therapy 72(9): 384-392.

Morley M (2009b) Contextual factors that have an impact on the transitional experience of newly qualified occupational therapists. British Journal of Occupational Therapy 72(11): 507-514.

Morley M, Bayliss-Pratt LM, Bagley E (2012) Preceptors' perceptions of the leadership skills of newly qualified healthcare practitioners. Journal of Health and Social Care Improvement 2: 1-14.

Morley M (2013) Preceptorship handbook for occupational therapists, 3rd edition. London: College of Occupational Therapy.

Muir J, Ooms A, Tapping J, Marks-Maran D, Phillips S, Burke L (2013) Preceptors' perception of a preceptorship programme for newly qualified nurses. Nurse Education Today 33: 633-638.

NHS Education for Scotland (2015) Flying Start NHS. Retrieved 27 January 2015 from http://www.flyingstart.scot.nhs.uk.

NHS Scotland (2013) Quality Improvement Hub. Retrieved 20 January 2015 from http://www.qihub.scot.nhs.uk/knowledgePagecentre/quality-improvement-tools/knowledge-cafe.aspx.

Nursing and Midwifery Council [NMC] (2006) Preceptorship guidelines. NMC circular 21/2006, published 4 October 2006. www.nmc-uk.org/aDisplayDocument.aspx?documentID=2088.

Nursing and Midwifery Council [NMC] (2008) Standards to support learning and assessment in practice, 2nd ed. NMC, London.

Omansky GL (2010) Staff nurses' experiences as preceptors and mentors: an integrative review. Journal of Nursing Management 18: 697–703.

Parker C E (1991) The needs of newly qualified occupational therapists. British Journal of Occupational Therapy 54(5): 164-168.

Pascuet E, Valliancourt R, Collins MA, Moore A, Scoular D, Gaboury I, Ullyot N, Stewart C, (2010) Visual thematic analysis of children's illustrations to improve receptiveness to pictorial asthma action pla

Ross H, Clifford K (2002) Research as a catalyst for change: the transition from student to Registered Nurse. Journal of Clinical Nursing 11: 545-553.

Roxburgh M, Lauder W, Topping K, Holland K, Johnson M, Watson R, (2010) Early findings from an evaluation of a post-registration staff development programme: The Flying Start NHS initiative in Scotland, UK. Nurse Education in Practice 10: 76–81.

Royal College of Speech and Language Therapists (2013), Five Good Communication Standards, RCSLT, London.

Royal College of Speech and Language Therapists (2006) Communicating Quality 3. RCSLT's Guidance on Best Practice in Service Organisation and Provision. Royal College of Speech and Language Therapists, London.

Rugg S (1996) The transition of junior occupational therapists to clinical practice: report of a preliminary study. British Journal of Occupational Therapy 59(4): 165-168.

Rugg S (1999) Junior occupational therapists' continuity of employment: what influences success? Occupational Therapy International 6(4): 277-297.

Rush H (2013) Improving performance in complex product systems production via inter-project knowledge capture and transfer (IPKCT). Available from: http://centrim.mis.brighton.ac.uk/research/projects/ipkct.

Rush KL, Adamack M, Gordon J, Lilly M, Janke R (2013) Best practices of formal new graduate nurse transition programs: An integrative review. International Journal of Nursing Studies 50: 345-356.

Salonen AH, Kaunonen M, Meretoja R, Tarrka M-T (2007) Competence profiles of recently registered nurses working in intensive and emergency settings. Journal of Nursing Management 15: 792-800.

Scells M, Gill R (2007) An evaluation of a strategy to improve the support of orthopaedic nurs

Tapping J, Muir J, Marks-Maran D (2013) How first experiences influence newly qualified nurses. British Journal of Nursing 22(2): 102-109.

Tooke J (2008) Aspiring to excellence: findings and final recommendations of the independent inquiry into modernizing medical careers London: Aldridge Press.

Tryssenaar J, Perkins J (2001) From student to therapist: exploring the first year of practice. American Journal of Occupational Therapy 62(3): 107-112.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) (1990) Report of the Post Registration Education and Practice Project October 1990.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC

Appendix One: The Telephone Survey

a) No

- Do you think they should be?

b) Yes

How are they assessed?

Self assessed Online

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

	Who	Scope	Offer	Managed by
1	PDN - Educator	Nurses ÐRegister with registered mentors (a preceptor = an experienced registered mentor to act as a buddy)	1/12 Ð8 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 PhysioÕs Ð		

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

#

#

	Protected time for preceptors	Preceptee protected time	PPI	WhatÕs missing	Specific comments
8	No	Approved by PPIÐ For AHPs this is clear , not so for nurse0 0 45 0			

#

An example of data extraction sheet topics 10 Ð14)

20	Portfolio of evidence. Reflective essay for uni module for 30 level 6 credits.	None.	Portfiolio	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 Ð but GP has to rele ase 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.

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

$%#

#

suppo rt during t heir first year post -qualification. Data was collected through

Everett (2009)
All junior doctors and their educational supervisors in one UK psychiatric training scheme

In this study, the term Ôjunior doctorÕ 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 work place -based assessment (WPBA) and how this impacted upon education superv ision. In the first wave, 11 supervisors and 11 junior doctors returned the questionn aires (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 asses sment 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. EverettÕs data identified a discrepancy over the time spent in educational supervision. Supervisors being more likely to over estimat e 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 e xplicitly 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 t o 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. Workin g 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 F 1 Ðfactors affecting wellbeing

Nine F1 doctor s 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 prepar es 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

The second significant finding of this study was that trainees scored themselves higher than their supervisors in terms of their capa bility to undertake a task. Wij ner-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 VygotskyÕs theory (1978), the authors describe the

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.