Title: Support for newly qualified practitioners: lessons learnt from an analysis of provision in one region of health care in the UK.

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Abstract

Aim The study mapped the support provided for newly qualified practitioners (NQPs) across Kent, Surrey and Sussex (KSS).

Background NQPs require support and guidance to facilitate their transition from student to their new role as qualified practitioner. Professional bodies advocate that programs be provided but the type and intensity of that support is variable.

Methods Telephone interviews were conducted with 24 people delivering support for NQPs across professions in 13 different Healthcare Trusts. Documents (n=41) related to support programs were analysed. Two case study site visits and a knowledge exchange conference of 45 delegates completed data collection. Data were analysed using the constant comparative method of analysis.

Results Support for NQPs was largely idiosyncratic to profession and Trust. Evidence emerged of a conceptual shift from basic competency acquisition toward a corporate induction program.

Conclusions Interdisciplinary programs can provide generic transitional support, but the NQPs favoured skill acquisition to help them be effective in their new role. Measuring the impact of NQP support on patient outcome and the practitioner is required.

Implications for nursing management A career pathway for those who support NQP and one that includes specific preparation for the role is proposed.

Keywords: Newly qualified practitioners, transition, preceptee, preceptorship supervision.

Introduction

While informal support following an apprenticeship model has been recorded since the 1960s (Becker et al. 1961), programs have more recently been designed to formalise support for the NQP. Policy documents (Department of Health, 2010) provide little prescription on how support should be delivered leading to uncertainty about what and how much support is needed, for whom, and with what outcome (Greenaway 2013). Programs can highlight the tension between the needs and expectations of new practitioners with clinical skill development and the needs of the employer to provide organisational induction (Hughes and Fraser 2011). The situation is complicated further by variation in the use of terms by statutory and regulatory bodies. However, the investment in NQPs is a requirement that demands investment and excellent leadership to be considered effective. Linking NQP investment to improved patient outcome as well as staff satisfaction is a challenge but one that must be met in order to improve quality.

Individuals providing support to NQP are referred to as ‘preceptors’ in nursing and allied health professions (and used in this paper) and by ‘supervisors’ in medicine and dentistry, and both can be used interchangeably with ‘mentor’.

Preceptors are appointed because of their relative seniority and experience. The role requires clinical leadership, communication and role modelling skills (Stewart et al. 2010). Preceptors may not have been specifically prepared for the role (Solowiej et al. 2010; Banks et al. 2011) even though they are seen as core to the success of a preceptorship program (Sroczynski et al. 2012; Whitehead et al. 2013).

NQPs can experience reality shock (Cubit and Ryan 2010) with a lack of knowledge, practical knowhow and confidence to do the job (Hughes and Fraser 2011; Avis at al 2013; Feltham 2014). Limited support in practice on qualification (Brakovich and Bonham 2012; Flinkman

and Salantera 2014) compounds the challenges for a NQP. Preceptorship programs aim to redress this issue through standardised programs that are more successful when given support by senior Trust executives (Jones et al. 2014).

In the UK, linking improvement in NQP support with patient safety outcomes are anecdotal rather than evidence based although Lee et al. (2009) claimed significant reduction in medication errors and staff turnovers, following a preceptorship scheme run in Taiwan. However, isolating patient safety outcomes and attributing them to a single educational intervention remains controversial. Areas where NQP support has been measured have been linked to employee outcomes like retention or reduction in absence (Hickey 2010; Roxburgh et al. 2010). Once again attributing the single cause and effect with confidence requires substantive validity testing that includes timescales by which such data may be considered reliable. To date, UK research on NQP support has centred on the evaluation of preceptorship programs or the lived experience of being an NQP rather than the wider impact of those programs on the organisation. The key issues identified from the literature are captured in Table 1.

Table 1 Key issues in preceptorship

1. Transition from student to qualified status remains challenging for practitioners.
2. National policy around preceptorship and foundation programs has been enabling rather than prescriptive.
3. Preceptorship programs vary in length.
4. Programs in support of NQPs require support from the whole organisation.
5. NQP programs need to have a clear structure with individualised learning needs.
6. Educational preceptors need training and on-going support.
7. Evidence of the value of inter-professional programs is very limited.
8. Facilitation of peer support between preceptees was not evident.
9. Evidence of PPI within preceptorship and foundation programs was largely absent in the literature.

The aim of this research was to harness the support provided for NQPs, from a range of disciplines and healthcare Trusts within Health Education Kent, Surrey and Sussex (HE KSS) and compare these findings to recommendations set out in key policy documents.

Methods

The study was designed with four sequential activities: an on-going literature review, a mapping exercise, conducted by telephone survey and documentary analysis; case study visits, and a knowledge exchange conference.

- 24 Interviews completed (Kent (n=7); Surrey (n=8) Sussex (n=9) Acute, Community, Mental Health, Commissioners

Data collection and analysis

The initial mapping exercise involved 24 semi-structured telephone interviews who delivered support for newly qualified practitioners across three counties (7 Kent; 8 Surrey; 9 Sussex) in England that constituted a Health region. Medical (n=5), nursing (n=9), midwifery (n=3) and allied health professional leads (n=6) from 13 different Trusts participated. Program documents (n=41) were provided by 20 participants. The telephone survey and documentary analysis identified sites where programs differed. Using a pragmatic case study approach, two site visits were undertaken to facilitate a deeper discussion with key stakeholders about NQP programs. The findings were used to inform topic areas for discussion in a knowledge exchange conference with 45 stakeholders which included regional Health Education leads, project leads for innovative schemes, representatives from the third sector; newly qualified staff and PPI representatives. The data generated from all phases were subject to the constant comparative method of analysis, with coding and categorisation of the main concepts. The knowledge exchange conference served to verify the findings and to further advance the analytical understanding of these data through discussion with the delegates.

Figure 1

Ethical consideration

Ethical approval for the study was granted by the University Ethics Committee. NHS approval was not required as the data were collected in educational facilities. The research team complied with governance arrangements set out by the University and each host institution.

Results

Research participants from the interviews and delegates from the conference highlighted that while programs to support newly qualified practitioners (NQPs) were in place, there was wide variation between professions within and between healthcare organisations. Support was largely delivered to single professional groups, with preceptors/supervisors from the same profession. In some instances, the overall management of NQP support spread across both nursing and allied health professions, but delivery remained largely at a uni-professional level. There were a small number of inter-professional programs that provided shared-learning opportunities rather than a common framework founded on wider inter-disciplinary principles.

Diversity in provision was evident in content, program length and assessment. Generally, preceptorship for nurses and allied health professions ran between 6 and 12 months. There was variation in NQP programs and study leave provided to enable the NQP to attend various training / educational events. For example, one trust allowed NQPs 18 study days, while another integrated support during normal working activities and allocated no study days. There was also difference in the support and leadership of the NQP programs with investment by some Trusts in external specialist tutors and others providing a program that led NQP towards a Postgraduate Diploma (Pharmacy Practice). Some programs mixed face to face with online learning. In one Trust, for example, nurses were given time to attend mandatory training (ALERT courses, health and safety training) but in their own time were expected to access support online via the Edward Jenner, Flying Start program. Some programs included regular

lunchtime seminars, action learning sets for reflection, and a drop-in service for pastoral support. Medicine had the most uniform program explicit in purpose and outcomes and providing supervisors/preceptors compensation for their time for F1 NQPs. The medical F1 NQPs were given 30 study days of which 17 were prescribed, but the NQP was given study leave budgets with which to purchase additional learning packages / training / education for the remaining 13 days. The national program was overseen by the Foundation Faculty (The postgraduate Deanery of Medical and Dental Education) with the learning objectives set by the GMC (www.gmcuk.org) and quality managed by HE KSS. The program was run daily by specifically appointed managers with education providers pulled from other disciplines to deliver the content. Some of the seminars were open to other professions to join. Senior medical practitioners who had received specialised training assumed the role of a clinical supervisor.

The theoretical framework shaping the pedagogic content of a program was distinct. This was a matter of emphasis rather than exclusivity, but the core agenda shaped the content and its delivery and the approaches are summarized in Table 2. 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 program (e.g. learning and teaching department, quality and patient safety, HR directorate, line manager, HE KSS Trust Academic Board/Faculty Foundation). Other than medicine, preceptors were given little or no specialist training for their role. Further, there was no career path for those who supported NQPs and their preceptors. Indeed, frequent role change and redefining expectations for those who held these posts led to insecurity and fragmentation. Delegates at the conference considered this to be problematic and that there was value in the development of a specialist expertise in NQP support.

Table 2

The theoretical framework shaping the pedagogic content of a program

- **Clinical safety** where learning opportunities were generated to meet competency acquisition. Simulation and topic lectures framed the pedagogic agenda. Often practice educators were in place to work with NQPs to ensure they learnt the right skills to function independently.
- **Resilience** A program to enable the NQP to draw upon a range of practical and psychological strategies to manage transitional role strain facilitated by experts in psychology and/or resilience.
- **Corporate Integration** offering a menu of options exposing the NQP to a range of experiences to induct the NQP into the Trusts' business. For example, executive board meetings and learning about how the organisation works (e.g. human relations policy and mandatory training).
- **Leadership** delivered online through the Edward Jenner Program provided by the NHS Leadership Academy.
- **Portfolio based self-directed learning** supervised by a preceptor or clinical manager.

Documentary analysis identified a conceptual shift from considering support for NQPs as a period of learning and transition to a more explicit probationary period that provided support to achieve pre-determined organisational goals, NHS requirements for induction and outcomes to be met linked to an employment contract. Of note, where the person charged with responsibility for the NQP program held a senior position in the Trust, the program was more likely to be inducting the NQP into the corporate values of the NHS rather than addressing individual NQP learning needs.

Programs for NQPs were largely developed in-house and guided by policy documents to demonstrate how they met national standards. However, the conceptual thrust, championed by the local authors of the programs resulted in a wide variation in NQP support across disciplines and Trusts. Difference was also noted in the requirements of the programs and the timescales for activities. This variation in provision is consistent with findings reported in the literature (Price 2013). Measuring the outcomes of these models and their impact on NQP's evaluation of their experience can attribute the learning support provided by the Trust with NQP satisfaction. However, trying then to determine a causal link of these different approaches to improved patient outcome and staff capability and competence would require detailed audit made possible in very specific aspects of practice, but may prove unwieldy, time consuming and expensive across the service. Self-assessment of competence may serve as a proxy measure to determine impact on patient outcome but would require normative adjustment that may render the assessment invalid.

Two agendas in NQP support were identified: the ecology model which focused on the NQP's learning needs and the individual's professional growth, and the corporate induction model that focused on the organisations needs and shaping the NQP as an employee to reflect the values and culture of the organisation. In the latter model there was more likely to be release to attend mandatory training sessions with the NQP meeting their professional development needs in their own time. The risk here is that where there was professional control over the NQP program the agenda set was around professional learning and transitional need. Where the organisation was leading NQP support the agenda became more directed toward generic employability principles including managerial oversight of progression and capability including performance management.

The interaction between preceptor/supervisor and the NQP was variable as was the seniority of the person appointed to that role. Direct supervision/ observation of performance was more likely to occur where a named practice educator/clinical facilitator/supervisor was in post.

Preceptors had a less formal role in providing reflective debriefing after clinical events. Data could be collected that captured time spent in 'line of sight' supervision as opposed to facilitated reflective review and link this to self-assessment of an NQP to determine their competence to practice. However, caution would be required here as our data illustrated that when a preceptor was also the NQP's line manager the NQP's probation had an overlay of performance management. Therefore, the collation of data to evaluate the impact of an NQP program would need to be distinct from data that monitored individual performance with measurement of patient outcome exacerbating rather than ameliorating the NQP's anxiety. This could lead to a phenomenon called *judgementoring* (Hobson and Malderez 2013) especially where employment was linked to achievements. Although the concept of *judgementoring* evolved from new teachers experience in their first teaching post, delegates at the knowledge exchange conference recognised the phenomenon. Managers as preceptors were well placed to broker professional opportunities, enable the NQP to fully participate in the professional community and act as a professional role model. However, the dual role of preceptors and manager made it more delicate to provide amnesty to declare learning needs and call for remediation to right any shortfall in competence – especially when this involved the direct observation of the NQP's performance. Where patient safety was at risk, a third party may be required to assess the NQP's competence and provide the necessary learning to right any deficit.

A reflective forum (e.g. action learning sets, or communities of practice focusing on resilience) or pastoral support offered by independent persons to the clinical directorate was made available in some Trusts to counter judgementoring. This finding did differ from that reported in the literature where much is made of the relationship between the preceptor/supervisor and the NQP (Marks-Maran et al. 2013; Mason and Davies 2013) Creating an independent peer support forum does address the concern of a potentially intense or toxic relationship between a preceptor and preceptee although only one study identified some instances of bullying and

harassment (Mason and Davies 2013). Measures of anxiety and well-being, absence and retention may be useful measures to gauge the impact of such interventions on the NQP.

Engagement in study days, seminars, action learning sets or other reflective sessions were impeded by clinical priorities taking precedence but this issue was increasingly encroaching on protected time for the preceptor and NQP. This phenomenon is a persistent issue (Carlson et al. 2010; Phillips et al. 2013) that may be countered by planned support from a manager (McCarthy and Murphy 2010; Omansky 2010; Foster and Ashwin 2014). Flexible strategies and mixed mode of delivery to support NQPs can be supplemented by status investment in the role of preceptor/supervisor (McCarthy and Murphy 2010) and adequate preparation for preceptors/supervisors (McCusker 2013). Normative and formative feedback, regular supervision and regular access to the preceptor (Morley et al. 2012; Foster and Ashwin 2014) are considered essential to the NQPs positive experience and can be easily measured or collated through self-report. The link between good preceptorship/supervision that enables the NQP to be a good preceptors/supervisor in the future (Marks-Maran et al. 2013) could be measured through longitudinal studies comparing the data on the individual's NQPs satisfaction scores with the data provided by NQPs they precept in the future.

Despite initiatives to drive NQP toward an interdisciplinary program, there was little appetite for multi-professional programs. NQPs and clinicians supporting clinical competencies stressed the importance of understanding one's own role before being able to share learning with others in the multi-disciplinary team. Further, the generic transitional skills were seen as 'softer' and of less value than demonstrable competence acquisition. Hobson and Malderez (2013) identified for teachers, the best 'mentoring' (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.

Meaningful measurement of the outcome of an NQP program is essential to argue for sustained funding and improvement. High quality NQP support does act as a marker to any external agency reviewing Trust performance, however, what is measured, when and by whom is a challenge. The risk is to attribute outcome where no direct causal link can be determined. Conversely, what may be measured are data that are readily accessible to measurement but are rendered unreliable and invalid. These data did point to the need for a career pathway dedicated to the support of NQPs. The advantage of such careers would be to consolidate expertise in the support of NQPs but also provide insight into what should be measured over time to capture the real impact of high quality NQP support.

The data from this study indicated that the role of patient and public involvement (PPI) in NQP support was under developed. Ideas generated by conference delegates to promote greater involvement of PPI included:

- Sharing high impact stories from patient feedback through social media;
- Buddying NQPs with volunteer expert patients;
- Involving patients as an integral part of 360-degree evaluation in performance review.

Conference delegates identified that to achieve sustainable, authentic and effective PPI engagement, a whole system culture shift was required to ensure such an approach was worthwhile; and of course funding would be needed for this.

Staff providing support to NQPs needed support especially when trying to implement whole system change (e.g. multi-disciplinary approaches to the support of NQPs). A network of NQP leads supported by online seminars/webinars has been established following this research study to facilitate interdisciplinary sharing and peer support. In addition, we have built a repository of research papers, recorded seminars and workshops that can be accessed by

members of the network. This has helped facilitate learning when members of the network are unable to attend virtual meetings in real time. A discussion forum enables the exchange of ideas, and raising questions and open debate across Trusts in the region. It is hoped by uniting NQP leads in such a network, greater consistency in the provision of support for NQPs that enables the best of both the ecology model and corporate induction model can be realised. Further, the potential of an online network that extends nationally and includes international colleagues could serve to further strengthen innovation and support for the newly qualified practitioner.

Limitations

The initial individual telephone interviews were from a sample of 24 participants from across 13 Trusts in one healthcare region. During the study, named personnel in the Trusts charged with the responsibility to lead NQP provision often changed without refreshing the details of who took over this responsibility. This made accessing the participants a lengthy process that led to over representation from more established environments where systematic provision of NQP support was in place.

Conclusion

Two agendas in NQP support were identified: the ecology model which focused on the NQP's learning needs and the individual's professional growth, and corporate induction model which focused on the organisations needs and shaping the NQP as an employee to reflect the values and culture of the NHS organisation. Although currently underdeveloped, enhancing PPI engagement in NQP support programs may mediate the dichotomous framing of NQP support between individual learning needs and corporate induction.

There is considerable variation in what is provided to whom and for how long in the provision of NQP support in this one health care region. However, where high quality consistent support was known to be delivered, that hospital was able to select their further workforce from a wider pool of applicants. Achieving excellence required there to be consistent leadership and vision. Too many of those appointed to facilitate NQPs were appointed on temporary contracts or were subject to role realignment or deployment. All organisations want to be lean and agile, to respond to the dynamics of change and too often NQP support is seen as a resource to reallocate funds in times of difficult financial decision. However, one consistent aspect of practice is the vulnerability experienced by those who are newly qualified. In this paper we have argued that NQP support requires leadership, vision and investment. Investment in NQP programs can serve to spot and manage talent for the future. The programs can nurture compassion, expressly address communication, encourage critical thinking and engagement with colleagues through interdisciplinary workshops that also actively encourage participation from the patients and public. The challenge is enabling these outcomes to be attributed directly to these interventions.

Implications for Nursing Management

The importance of the right support at the beginning of a NQPs professional life is recognised as a strategic measure to enhance recruitment and retention but also critical to enable the NQP to realise their potential and deliver the highest quality care. Quality NQP programs are made sustainable by creating second generation quality preceptors/supervisors for subsequent intakes of NQPs. Quality could be enhanced by formalising a career pathway for those who support NQPs that leads to senior managerial responsibility and governance for this responsibility within Trusts. Consistent provision delivered by a stable, expert team enables the growth of expertise in those who facilitate NQPs in a changing landscape of requirements and challenges. NQP support can consume time and funding that might otherwise be invested in clinical priorities. For continued funding the outcomes of NQP

interventions and their impact must be measured to ascertain the causal link between quality NQP support and improved patient outcomes.

Table 1 Key issues in preceptorship

10. Transition from student to qualified status remains challenging for practitioners.
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12. Preceptorship programs vary in length.
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16. Evidence of the value of inter-professional programs is very limited.
17. Facilitation of peer support between preceptees was not evident.
18. Evidence of PPI within preceptorship and foundation programs was largely absent in the literature.

Table 2 The theoretical framework shaping the pedagogic content of a program

- **Clinical safety** where learning opportunities were generated to meet competency acquisition. Simulation and topic lectures framed the pedagogic agenda. Often practice educators were in place to work with NQPs to ensure they learnt the right skills to function independently.
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