NHS
Health Education England

Faculty of Health and Social Care

PRECEPTORSHIP IN NORTH WEST NHS TRUSTS AND THE DEVELOPMENT OF AN EVIDENCE BASED PRECEPTORSHIP TOOLKIT

Final Report

University of Chester

Executive Summary

Background

The overarching aim of Health Education England is 'to ensure the health workforce has the right skills, behaviours and training available, in the right numbers, to support the delivery of excellent healthcare and health improvement'. Delivering high quality, effective, compassionate care: means not only developing the right people with the right skills and the right values, but also establishing robust models or frameworks to facilitate the retention of staff in the workplace. Enhancing the retention of newly qualified staff is of particular importance given that the journey from a new registrant to a competent healthcare professional poses a number of challenges, for both the individual staff member and the organisation.

A scoping review into student and newly qualified staff attrition was commissioned by HEE North West in 2014 (Hamshire, Spearing, & Wibberley, 2014) to explore the current literature in the area. The review found that, in terms of newly qualified staff attrition, there was a strong theme showing that formal support mechanisms, providing a framework to gradually scaffold staff's confidence and competence, improved the retention of newly qualified staff. Structured support/preceptorship programmes were recognised as a valuable method of supporting the transition of new staff (Al-Dossary, Kitsantas, & Maddox, 2014; Fiedler, Read, Lane, Hicks, & Jegier, 2014; Kumaran & Carney, 2014; Whitehead et al., 2013) and also were of benefit to the institution providing them (Fiedler et al., 2014).

Nevertheless, although the evidence demonstrates the positive impact preceptorship programmes have on newly qualified staff attrition, there is little literature available on the measurable impacts of these programmes. Given that no one preceptorship framework was being delivered across the region and programmes were generally understood to be variable in both content and length of time; more information was required to build a clearer picture of the current situation across the North West. In response to this, and building on the scoping review, HEE (NW) commissioned the University of Chester to investigate the current situation across the region.

The project set out to explore the following;

- To review and analyse current preceptorship programmes within NHS trusts in the North West Region and ascertain the impact of these programmes upon retention of newly qualified nurses and midwives;
- To identify and design a preceptorship framework based upon best practice. Working with key stakeholders to develop a core preceptorship programme, to be made available on line via the Health Education England website.

Project method and approach

This project used a mixed methods design, employing qualitative and quantitative approaches to evaluate current preceptorship practice in North West NHS trusts and deliver an evidence based online preceptorship toolkit.

- An online questionnaire sought to gather data on current preceptorship programmes in North West NHS trusts.
- Preceptorship documentation, programmes, and frameworks were analysed using content analysis.
- A small number of interviews were undertaken with new registrants who were currently involved in a preceptorship programme.

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- Conference events were held to share best practice, encourage networking, foster critical debate and further inform the delivery of the project goals. For more details, see:
  - Preceptorship: Learning Together Conference November 2015
  - Improving Pre and Post-Registration Retention Event February 2016

Outcomes / Findings

The findings from the online survey, analysis of preceptorship documents and interviews with preceptees highlighted the following themes:

- No ONE preceptorship framework would meet the needs of all trusts
- Monitoring attrition rates were not uniformly recorded across trusts leading to a lack of clarity with respect to the wider attrition picture across the region.
- Evaluation of preceptorship programmes was generally limited.
- Preceptor training: considerable variation in preparation for role.
- Transition experience from student to practitioner varied and resulted in a different journey for each registrant.

A further key insight arose from the qualitative interviews, when participants were asked “Where do you see yourself in 5 years’ time?” Although some of the interviewees expected to move from their current trust for a variety of reasons including:

- Working closer to home
- Moving trusts to gain different experience – smaller trust/ larger trust
- Specialising

None of the participants expressed a desire to leave their chosen professional discipline and preceptorship had been a significant factor in fostering this outcome.

Co-production

A central tenet of the research innovation and design development was the co-design with preceptorship leads, preceptors, preceptees, educational managers, a newly qualified staff nurse and other key stakeholders. This inclusive approach ensured that user needs were met, cultural change was embedded and sustainability fostered. Membership of the steering group was made up of representatives across the North West region, including:

- Central Manchester Hospitals NHSFT,
- Salford Royal NHSFT,
- Wirral University Teaching Hospitals NHSFT,
- The Christie NHSFT and
- Health Education England.

The three conference events delivered; ‘Preceptorship: The Way Forward’, ‘Improving Pre and Post-Registration Retention’ and ‘Preceptorship: The Next Steps’ provided opportunities for networking and input into the development of the Toolkit.

Implementation

Based on the evidence gathered including, consultation and feedback from across the region, we established a list of the key building blocks needed for a Preceptorship programme (see side bar).

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In order to reach as many practitioners as possible, the University and the steering committee took the decision to develop the Toolkit as an online platform, openly accessible through HEE (North West). The Toolkit, launched in June 2016, was designed in collaboration with the steering group, and hosted on the HEE web space (see link below):

Preceptorship Toolkit

We are currently seeking user evaluation with a view to enhancing the Toolkit based on practitioner feedback. Imperative to the ongoing success of this innovation is the development of a preceptorship network amongst practitioners to further develop the tool and keep it updated in line with best practice advancements. The next stage of the implementation is to establish and formalise a Preceptorship network during November 2016.

Next Steps

The following steps have been identified for future work:

- Establish a preceptorship network – preceptorship champions and technology experts
- Design a work plan for next 12 months
- Implement the recommendations of the toolkit evaluation.
- Explore opportunities for technology and media enhanced inclusion into the Toolkit
- Establish the sustainability of the toolkit

KEY SECTIONS OF PRECEPTORSHIP TOOLKIT

MULTIPROFESSIONAL POLICY

- Trust Policies
- KPIs
- Standards
- Roles and responsibilities
- Guidance on policy content

INDUCTION / ORIENTATION

- Day by day example of what happens during induction
- Protected time and supernumerary
- Examples of meetings / interview format

CASE STUDIES

- Case studies of preceptors, preceptees and other staff

PORTFOLIO

- Portfolio evidence
- Self-assessment tools
- Skills log
- Reflective practice
- Month by month planner

LDA REPORTING TO HEE

- Metrics for reporting

MONITORING AND EVALUATION

- Tools for monitoring and evaluation

DISCUSSION BOARD

- Sharing ideas / problems etc.

RESOURCES

- Resources for Preceptees
- Resources for Preceptors

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Glossary of terms / Abbreviations

HEE	Health Education England
DH	Department of Health
HSCIC	Health and Social Care Information Centre
MAC	Migration Advisory Committee
NHS	National Health Service
NICE	National Institute of Health and Care Excellence
NMC	Nursing and Midwifery Council
ONS	Office for National Statistics
RCN	Royal College of Nursing
NAO	National Audit Office

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1 Background

In the UK there are estimated to be over 600, 000 nurses working within the combined NHS, care and independent health sectors, and within this approximately 361,000 nurses work in the NHS in England. Although this represents an increase in nurse numbers over the last three years, there is still a significant shortfall of skilled nurses within the NHS. The National Institute for Health and Care Excellence (NICE) guidelines recommend a maximum vacancy rate of no more than 5% to enable operational flexibility. Nonetheless, Health Education England estimate the current vacancy rate to be around 9.4%, varying between 7% and 18% across different regions (and approximately 7% in the North West) (Health Education England, 2014).

In a survey conducted by NHS Employers 93% of trusts indicated they were experiencing shortages in registered nurses (NHS Employers, 2015). These shortages have led to an increase in the employment of overseas nurses and agency nurses as short term solutions, but created an unsustainable employment market. In recent years nursing was included on the Shortage Occupation List (SOL) enabling the recruitment of overseas staff to healthcare employers, utilising Certificates of Sponsorship (CoS)[1]. However, the number of CoS in any year is capped across all professions, and therefore overseas nursing staff are restricted within this allowance. This has further exacerbated the shortfall, and the gaps in provision have necessitated the increased use of agency staff, resulting in spiralling costs for the NHS. The Royal College of Nursing (RCN) estimated the spend on agency staff rose from £327m in 2012/13 to £485m 2014/15, and predicted this figure was likely to reach £980m by the end of 2015 (RCN, 2015). To ameliorate this situation in November 2015 the NHS trust Development Authority brought in restrictions on agency staff usage in an effort to reduce wage bills. Paradoxically, although this action may help to reduce the wage bill for agency staff, it may further compound the problem of nurse and midwife shortage in the NHS.

The current shortage in nursing has arisen due to a combination of factors, within both the demand and supply-side for nursing staff.

Factors affecting demand for nurses and midwives:

- The findings of the Francis report, whilst not specifically recommending more nursing staff led to a greater focus on patient care, nursing standards and safe staffing levels. This in turn has led to an increase in demand for nurses in some trusts.

- Changes in the population demographic, with an overall increase in population and specifically in older patients with more complex needs, have necessitated the need for a greater number of highly skilled staff and further exacerbated the demand for nursing staff.

- Moves to integrate health and social care, and provide a full seven days a week service have increased demand for trained staff. In addition, as shortages in social care nurses and independent sector nurses have risen, some NHS nurses are taking opportunities to move into these areas, and effectively the NHS, care and independent sectors are in competition with each other for available nursing staff.

[1] The shortage occupation list is solely intended for employees from the EEA, outside the European Union (EU). Employees from within the EU currently have free movement within the Union and are therefore not included in the cap on certificates of sponsorship.

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Factors impacting on the supply of nurses and midwives:

- Workforce planning has not adequately forecast the needs for nursing staff. This is in part because workforce planning has been an aggregate of forecast figures from local NHS trusts, but has not included the needs of social care or the independent sector in their figures. Therefore, if nurses are trained to work in the NHS, but later choose to move to the care or independent sector trusts may not be able to fill the gaps. More recently changes to the way in which workforce planning is carried out have led to a partial recognition of this problem, and although HEE does not specifically provide nurses for the care or independent sector per se, the impact of nurse migration has been incorporated in the models used.

- Student nursing commissions have failed to keep pace with demand. Demand for nursing education places has remained high. However, funded places have been dictated by levels set through workforce planning and are highly dependent on costs, the number of places available has not always accurately met demand. These planning figures have informed a cap on nursing education places in recent years but has led to a shortfall in nurses being trained. In November 2015 the then chancellor indicated there would be a transformation in the funding system for nurses and midwives, with the abolishment of nursing bursaries, and the introduction of student loans. The imminent removal of funded places for nurses which will come into effect in September 2017, will lead to the removal of this cap, and enable teaching institutes to determine their student numbers. However, as this policy is not yet implemented the actual outcome of these measures on the numbers of student nurses is yet to be seen. Further if it does results in more nurses being trained, these will not be available to the NHS for another three years, and therefore the shortfall remains pertinent in the interim.

- The workforce profile has been a concern over the past two decades, however it has now become a critical factor in the supply of nurses. Older nurses over 50 years have risen from approximately 20 per cent of the workforce in 2005 to nearly 30 per cent of nurses in 2015, and almost 1 in 3 nurses will be eligible to retire over the next 10 years. If these nurses take up retirement, the loss of skills and experience cannot be offset by the number of nurses entering the system.

- In the current climate retention is a critical determinant of the supply-demand equation. In 2012 a study (Heinen et al., 2013) found that 10% of nurses in the UK intended to leave the profession, and more recent data from HSCIC shows the turnover rate increasing over the last five years (see Table 1).

	Leavers	Leaving rate %	Joiners	Joining rate %
2011/12	26,916	7.7	23,688	6.7
2012/13	27,511	7.9	27,240	7.8
2013/14	28,907	8.2	33,924	9.7
2014/15	30,655	8.6	34,617	9.7

Table 1: Qualified nurses and midwives leaving and joining NHS 2012-2014

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Further there are regional variations in the leaving and joining rate across NHS trusts in England, with London and the South East experiencing higher levels of both (see Table 2). However, all levels are above the recommended NICE guidelines, and there are opportunities to address this problem across the nursing workforce.

	Leavers	Leaving rate %	Joiners	Joining rate %
East Midlands	2,226	8.1	2,662	9.7
East of England	3,318	10.2	4,195	12.9
Yorkshire and the Humber	2,912	7.8	2,954	7.9
Wessex	1,502	8.8	1,912	11.2
Thames Valley	1,200	10.4	1,644	14.2
North West London	1,779	11.0	1,917	11.9
South London	2,180	10.5	3,227	15.6
North Central and East London	2,329	10.5	2,984	13.0
Kent, Surrey and Sussex	2,504	9.9	2,626	10.4
North East	1,590	7.1	1,644	7.3
North West	4,427	7.9	4,993	8.9
West Midlands	3,162	8.1	3,436	8.8
South West	2,508	8.8	2,919	10.2

Table 2: Qualified Nursing, Midwifery and Health Visiting staff – Joiners and leavers by region, Nov 2014 – Nov 2015 Health Education region

Data shows that the leaving rates are highest amongst the younger and older age cohorts, with stress and burnout, which are predictors of intention to leave (Coomber & Barriball, 2007), particularly high in these groups. Amongst newly qualified nurses turnover rates are high in the first year, and in some cases increase even further in the second year after qualification before declining (Health Education England, 2014) thereafter. The costs associated with turnover are not easily quantified, but one study estimates they range between 0.75 to 2.0 times the salary of the leaving nurse (McConnell, 1999) and therefore can place a high burden on NHS trusts, and it is clear from the literature that newly qualified staff retention is an international and national concern ((Phillips, Kenny, Esterman, & Smith, 2014).

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The overarching aim of Health Education England is 'to ensure the health workforce has the right skills, behaviours and training available, in the right numbers, to support the delivery of excellent healthcare and health improvement'. Delivering high quality, effective, compassionate care: means not only developing the right people with the right skills and the right values, but also establishing robust models or frameworks to facilitate the retention of staff in the workplace. Enhancing the retention of newly qualified staff is of particular importance given that the journey from a new registrant to a competent healthcare professional poses a number of challenges, for both the individual staff member and the organisation.

A previous study commissioned by HEE explored the current literature relating to preceptorship programmes and the factors that contribute to newly registered staff attrition. The findings of this study are summarised below (Hamshire et al., 2014).

- The transition from student to newly qualified member of staff can be a reality shock and newly qualified staff frequently report stress.
- There is strong evidence that newly qualified staff benefit from supported and structured preceptorship as they become fully competent and such programmes can increase both job satisfaction and retention rates).
- Structured support/preceptorship programmes were recognised as a valuable method of both supporting the transition of new staff and were of benefit to the institution.
    - Consideration needs to be given to role clarity for newly qualified staff including:
        - appropriate workload,
        - initial introduction,
        - collaboration with colleagues,
        - management.
- Tensions can arise when there is a lack of consistency between the expectations of newly qualified staff and the reality of the support that is available in the clinical environment.
- Negative preceptorship experiences and group identification/professional socialisation affect job satisfaction; a good working environment is important for the retention of new graduate nurses.
- High quality structured induction/preceptorship programmes have a positive impact and are necessary to ensure that newly qualified staff can develop as part of a competent workforce.
- The specific content of such programmes varied, however, protected time for learning, a defined person for one-to-one support, accessible learning resources and feedback/de-brief opportunities were all identified as important.
- Offering good role models as skilled preceptors within a supportive culture is essential for gradually building the confidence of newly qualified staff and a successful transition.

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Evidence demonstrates that preceptorship programmes have a positive impact on newly qualified staff attrition; however, there is little evidence regarding how preceptorship is being implemented across the North West region and the preceptorship packages offered to new staff. Given that there is no one preceptorship framework being utilised across the region and programmes were generally understood to be variable in both content and length of time; more information was required to build a clearer picture of the current situation across the North West. In response to this HEE (NW) commissioned the University of Chester to investigate the current situation across the region, and to develop a best practice framework which could be used as a basis for preceptorship by all trusts across the NW region.

2 Aims and Objectives

A mixed methods design was used to address the following project aims:

- To review and analyse current preceptorship programmes within NHS trusts in the North West Region and ascertain the impact of these programmes upon retention of newly qualified nurses and midwives;
- To identify and design a preceptorship framework based upon best practice. Working with key stakeholders to develop a core preceptorship programme to be delivered on line via the Health Education England website.

3 Methodology

The study design was mixed methods, utilising both qualitative and quantitative data (see Figure 1). The philosophical focus of our research was based on appreciative enquiry. The focus of the research aimed to gain further insight into preceptorship and preceptorship frameworks for newly qualified nurses and midwives in North West NHS trusts, and deliver an evidence based online preceptorship toolkit. To explore these phenomena, we adopted an appreciative enquiry approach, which focuses on the positive aspects of an organisation, recognising and valuing the contributions or qualities of 'things' and people in the organisations, and exploring how these can be used to build on in the future. A 4D approach is used to:

1. **'Discover'** what has worked well to date,
2. **'Dream'** of what might be in the future,
3. **'Design'** the future and how to support the vision,
4. **'Deliver'** or implement the vision.

The initial exploratory stage of the project utilised three methods to gather and analyse data; this stage was followed by a conference to disseminate the findings, bringing practitioners together to share their preceptorship methodolgy and expereience of delivering preceptorhsip within their trusts, and building a rich picture of the Preceptorship within North West NHS trusts. Finally, a group of 'expert' practitioners and researchers was established to develop the website offering for the HENW preceptorship guidance moving forward. Each of these stages is discussed in more detail below; describing the theoretical context, identifying the implementation of the method, recruitment and sampling, and inclusion and exclusion criteria. Content analysis is a method of analysing, written verbal or visual communication messages (Cole, 1988). It is a systematic and objective means of describing and quantifying phenomena and is a process whereby replicable and valid instances are drawn from the data with the

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expressed purpose of utilising this knowledge to design and guide new ways of working (Elo & Kyngäs, 2008). An inductive content analysis was employed to explore the content, aims, philosophy, and learning outcomes of the programmes to ascertain best practice when compared against retention levels. To enable this, we developed a proforma based on the key categories from current understanding of the field.

Co-production

A central tenet of the research innovation and design development was the co-design with preceptorship leads, preceptors, preceptees, educational managers, a newly qualified staff nurse and other key stakeholders. This inclusive approach ensured that user needs were met, cultural change was embedded and sustainability fostered. Membership of the steering group was made up of representatives across the North West region, including:

- Central Manchester Hospitals NHSFT,
- Salford Royal NHSFT,
- Wirral University Teaching Hospitals NHSFT,
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The three conference events delivered; ‘Preceptorship: The Way Forward’, ‘Improving Pre and Post-Registration Retention’ and ‘Preceptorship: The Next Steps’ provided opportunities for networking and input into the development of the Toolkit.

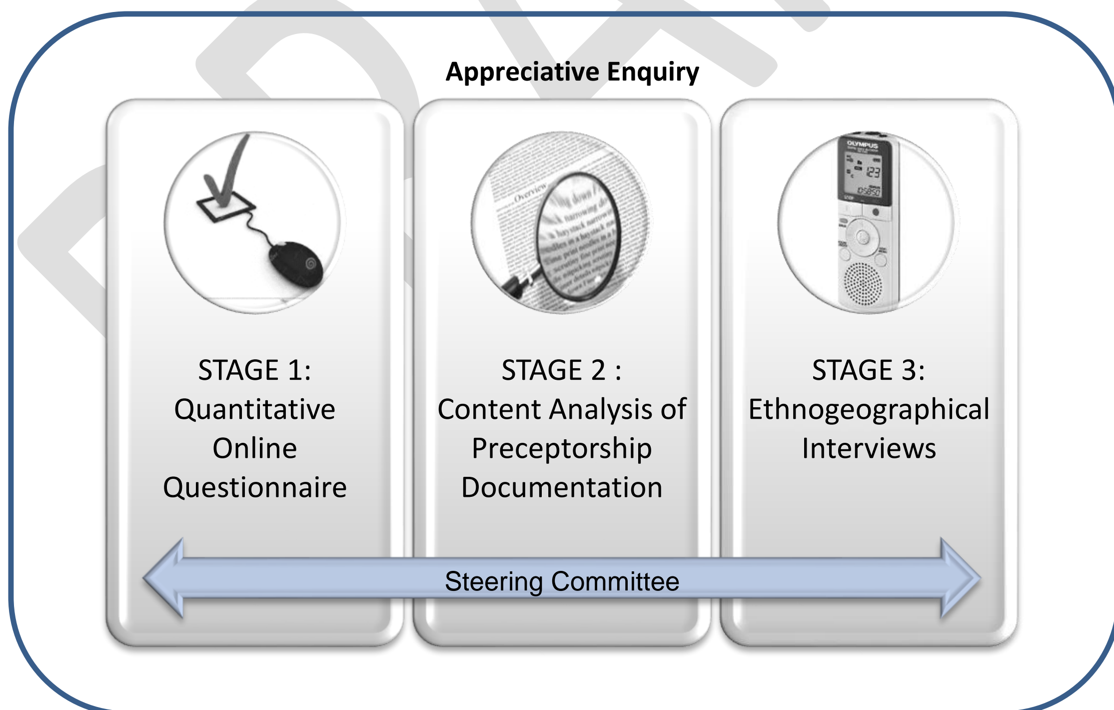

Figure 1: Research framework

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3.1 Stage one: Online questionnaire

An online questionnaire was developed using Bristol Online Survey software, and based around the standards for preceptorship developed by Health Education England (Health Education England, 2015). Areas covered included:

- Provision of a Preceptorship programme and policy documents
- Identification and inclusion of newly qualified nurses and midwives in the programme
- The structure and time available to complete the preceptorship programme
- Monitoring and tracking of the preceptees and costs
- Attrition rates
- Training and development of Preceptors to provide preceptorship.

The questionnaire was devised and piloted within the University, with University staff, and then piloted a second time with external staff at a small number of NHS trusts. Recommended changes were incorporated into the final version of the questionnaire.

3.1.1 Recruitment and sampling

HENW provided a list of all the NHS trusts in the North West region, comprising 43 trusts. After applying the exclusion criteria (see below) the final list comprised 41 trusts. The Director of Nursing (DoN) from each of these trusts was contacted to take part in the questionnaire. trusts were given two weeks to respond to the request, after which time a reminder email was sent to the DoN of trusts where no response had been received. This email also offered the opportunity for the DoN to identify an alternative contact, if they felt there was a more suitable person within the organisation to complete the questionnaire. These alternative contacts were sent an email with access details for the online questionnaire.

3.1.2 Inclusion criteria

All NHS trusts in the North West region under the remit of Health Education North West (HENW) who employed newly qualified nurses or midwives.

3.1.3 Exclusion criteria

NHS trusts who do not employ newly qualified nurses or midwives were excluded from the sample.

3.2 Stage two: Content analysis of questionnaire documents

Content analysis is a method of analysing, written verbal or visual communication messages (Cole, 1988). It is a systematic and objective means of describing and quantifying phenomena and is a process whereby replicable and valid instances are drawn from the data with the expressed purpose of utilising this knowledge to design and guide new ways of working (Elo & Kyngäs, 2008). An inductive content analysis was employed to explore the content, aims, philosophy, and learning outcomes of the programmes to ascertain best practice when

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compared against retention levels. To enable this, we developed a proforma based on the key categories from current understanding of the field.

As part of the questionnaire, trusts were asked to return documentation relating to their preceptorship programme. The Preceptorship policy and framework were requested from each of the 41 eligible trusts, and documents received were analysed using a pro forma based on the national preceptorship standards and KPis ((Health Education England, 2015), see appendix V. The content analysis was undertaken using a cyclical iterative process as depicted in Figure 2.

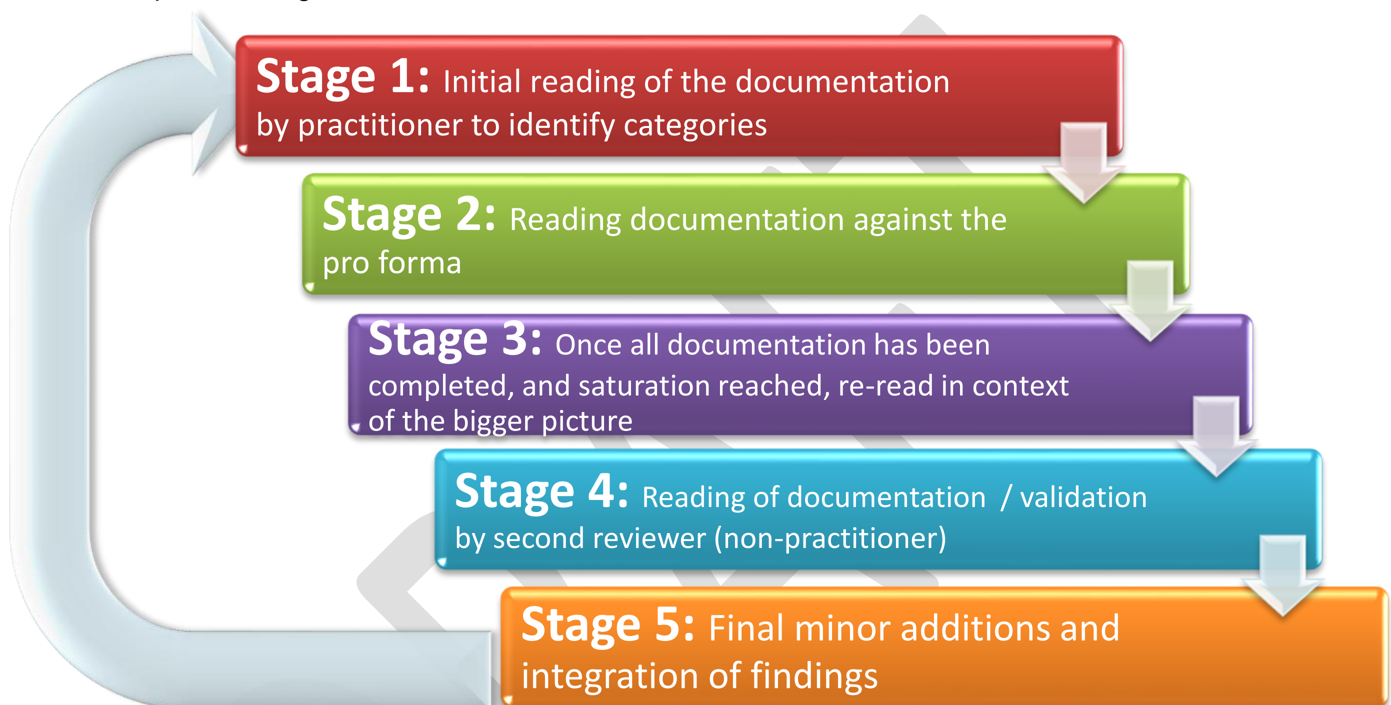

Figure 2: Process followed for content analysis

Researcher 1[2], analysed the documentation with the pro forma, using their experience and knowledge to dwell in the data, and carry out the initial review. This enabled us to compare the documentation against the standards.

The pro forma was amended and further developed as the database of documents increased. Once the initial reading was complete and saturation reached the second reviewer, Researcher 2[3], read the documents using the final pro forma. As a non- practitioner in the field, this reviewer was able to offer an unbiased second reading of the documentation and give a different perspective on the data. On completion of the second reading any minor alterations and additions were made to the pro-forma, and a last reading of the documentation was made against the final pro forma and the findings from each reviewer integrated.

[2] Researcher 1 was an experienced educationalist / nurse at the University of Chester

[3] Researcher 2 was a non-practitioner in the area, but an experienced researcher

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3.3 Stage three: Ethnogeographical Interviews

Ethnogeography is the study of how people interact and relate to their environment and how this reflexive relationship helps to build their understanding of their own place in society (Boogaart, 2001).

One of the key aspects in promoting staff retention and reducing attrition is a sense of belonging and socialisation (Hamshire et al., 2014). These are complex and nebulous constructs, which can be difficult to examine through standard interviewing. Therefore, we utilised Ethnogeography to explore how these facets impact on preceptee satisfaction, and explored the phenomenon through individual contextual interviews. This encompassed 'walking and talking' with a small number of participants as they guided us through the places, spaces and relationships that were important to them in their workplace.

Researching in situ provides a different perspective and experience compared to researching in a 'neutral' setting. It is argued that the participants are more likely to give a different meaning to their discussion and their choice of discussion due to the 'power of place' or the influence of the cultural environment on the participant how they represent the environment to themselves and to others (Geertz, 1983). The environment or milieu is considered on the following levels: - Macro [wider landscape, architecture, ritual] a Messo [social encounters and networks] and a Micro [daily life, activities, and people].

Ethnogeography applies a theoretical construct that frames the systemic links between individuals, the way they behave in different setting, the influence of the culture and structure of the settings and the wider rituals and architecture.

The analysis of the resulting interviews took a thematic approach in three stages; first reading of the transcripts, second identifying themes and finally categorising themes into a macro, messo and micro framework. The process of thematic analysis safeguards the identity of the individuals and their place of work as much as possible by lifting out the themes and offering them to the reader free of identifiable context.

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3.3.1 Recruitment and sampling

Based on the evidence gathered in Stage 1 and using the geographical footprint of HEE North West, we sought to identify a representative sample of trusts across the North West (see Figure 3) dependant on their geography and the population within each region. We selected six trusts from across the footprint; one in sector 1, and two in each of sector 3&4. Each of the five selected trusts was approached to take part in this stage of the research and to provide staff who had recently completed their preceptorship programme to be interviewed about their experiences. Initially a sample of approximately ten preceptees was sought for this stage of the research. However, despite considerable effort from both practice education facilitators (working as facilitators to identify potential participants) and the research team we were only able to recruit five participants within the time frame.

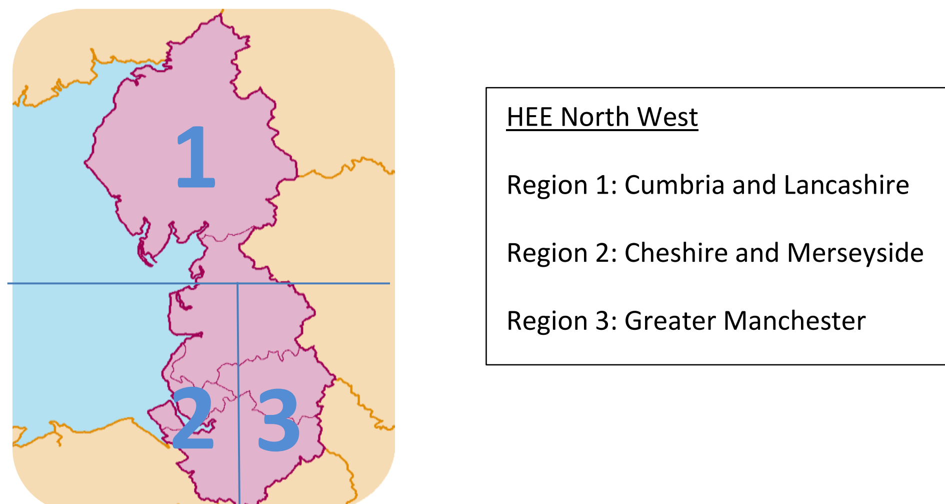

Figure 3: Quadrants of NW NHS trust Geographical Footprint

These five participants including nurses and midwives from different trusts were interviewed, each in their own trust setting. The interviews followed full IRAS and University ethical approval procedures.

3.3.2 Inclusion criteria

Qualified nurses and midwives who have completed a preceptorship programme and are currently working with the one of the 41 eligible trusts in the HENW geographical footprint.

3.3.3 Exclusion criteria

There were no specific exclusion criteria for this phase of the study.

3.4 Ethical consideration

Ethical approval was considered for the relevant aspects of this research. Stages 1 & 2 were gathering and using data which was available in the public domain, and therefore ethics was not considered necessary for these stages. However, ethical approval was sought for the third

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stage of the study carrying out the ethnogeographical interviews. Relevant approvals were sought and obtained from The University of Chester, Faculty of Health and Social Care Ethics Committee, and each of the NHS trusts in which the interviews were conducted. In addition, ethical approval was sought and granted by each of the NHS trusts in which the participants were employed.

Data collected was anonymised using a unique identifier in the analysis.

4 Findings

The purpose of this section is to outline the findings from each of the three stages of data collection:

1. Quantitative online questionnaire,
2. Content analysis of preceptorship documentation,
3. Ethnogeographical interviews.

4.1 Quantitative online questionnaire

An invitation email was sent to the 41 qualifying NHS trusts covered by HENW (two trusts were excluded, as they did not employ newly qualified nurses or midwives). After the initial email, five trusts responded to the questionnaire, and a reminder email was sent. This resulted in one further response. A second reminder was sent directly by HENW to the non-responding trusts. This increased the response rate, and in total 23 trusts completed the questionnaire.

The final response rate for the questionnaire was 56% (23/41).

The data gathered through this survey is presented below under each of the broad section themes from the questionnaire (which was built around the HEE Preceptorship standards):

- Provision of a Preceptorship programme and policy documents
- Identification and inclusion of newly qualified nurses and midwives in the programme
- The structure and time available to complete the preceptorship programme
- Monitoring and tracking of the preceptees and costs
- Attrition rates
- Training and development of Preceptors to provide preceptorship.

4.1.1 Provision of a Preceptorship programme and policy documents

Trusts were asked for details of the preceptorship programme provided within their trust for newly registered nurses and midwives. In addition, they were asked to send their programme documents electronically to a secure password protected email account, set up for this project, to be included in the content analysis.

Current preceptorship programme for newly registered nurses and midwives

Of the 23 responding trusts, 21 reported having a current preceptorship programme for newly registered nurses and midwives. Two trusts stated that they did not have a preceptorship

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programme for newly registered nurses and midwives. However, one of these said they were currently looking into the situation as they had an increase in the number of preceptees joining the trust, and the other said theirs' was not a formal programme (however, they did offer preceptorship), see table 1.

Preceptorship policy

Thirteen of the 23 trusts reported having a preceptorship policy, however of those without a policy, four said their policy was in the process of being drafted, and six stated they had either guidelines, a framework or other policies to address staff training (Table 3).

Trust currently offers a preceptorship programme for newly registered nurses and midwives?	
91.3% (21) Yes	8.7% (2) No
Trust has a preceptorship policy?	
56.5% (13) Yes	43.5% (10) No

Table 3: Trust preceptorship programme and preceptorship policy?

Of the ten trusts who said they did not have a policy, four were currently in the process of drafting a policy, five had either a framework or guidelines and one had other policies which addressed staff induction and training needs, but were considering the introduction of a preceptorship policy in the future.

It is interesting to note that although only thirteen trusts stated that they had a preceptorship policy, eighteen trusts sent through their preceptorship documentation, containing details of a preceptorship policy. Therefore, there seems to be a lack of clarity about what is classed as a policy and what is classed as a framework or guidelines.

Preceptorship Programme Documentation

Twenty of the responding trusts stated that they had preceptorship programme documents, and were asked to send these to an email account linked to the preceptorship project. Eighteen sets of documentation were received, and one further set was inaccessible due to NHS email protection. Three trusts reported that they did not have documentation to send.

These documents were collated and used for the content analysis exercise in stage 2 of the project (see section 4.2).

4.1.2 Identification and inclusion of newly qualified nurses and midwives in the programme

Trusts were asked to provide details of how they identified nurses and midwives to include on their Preceptorship programmes, see Figure 4.

Most of the responding trusts used recruitment information to select preceptees (15 trusts).

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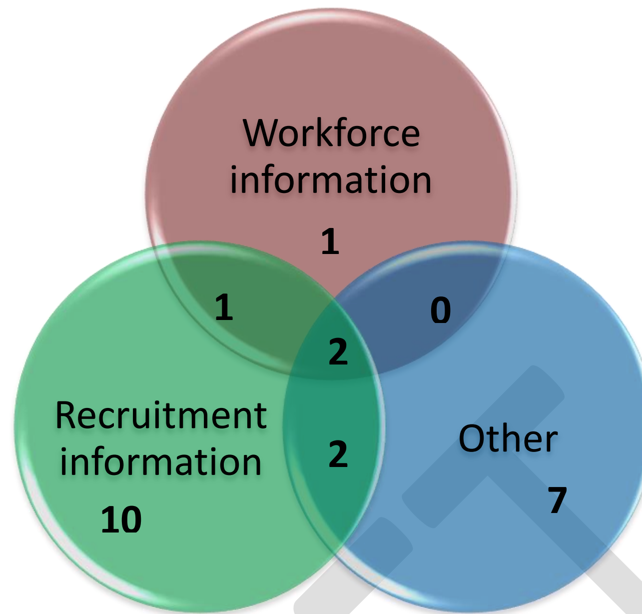

Figure 4: How preceptees are identified by the trust

A number of these trusts also used other information in conjunction with recruitment information to help identify preceptees. Some of the other ways in which preceptees were identified included:

- workforce information
- all new starters, irrespective of whether they were newly qualified

> *'All newly appointed practitioners are offered access to preceptorship, regardless of whether they are newly qualified or not. This is to facilitate access to our in-house educational programmes as well as to ensure support is offered during that transitional phase, in line with NMC recommendations.'* **Trust F**

> *'Our policy doesn't just apply to newly registered nurses. It includes all registered new starters with the trust are provided with preceptorship e.g. a nurse with 10 years' experience within the acute sector starting a new post in community nursing will also receive preceptorship. Recruiting managers/managers identify preceptors for new starters on induction'.* **Trust B**

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- Identification at their induction

"HR currently have no way of knowing who is a preceptee on the job application. This is under review. At present we find out at induction who is a preceptee'. **Trust H**

'Preceptees are identified by the Practice Education Facilitator (PEF) Team at Trust Induction'. **Trust W**

'We have a box on the new starter form that managers indicate the staff member needs preceptorship' **Trust U**

- Through their managers

'From the ward managers' **Trust I**

'Currently identified by managers on recruitment but new Workforce and OD department which has been recently established is working to improve communication and information from ESR to inform on recruitment' **Trust K**

'Identified locally by Ward Manager and area Clinical Skills Trainer and entered onto programme' **Trust L**

'Ward managers and practice facilitators book staff onto preceptorship programme. Although HR will inform T&D when they start for trust induction.' **Trust S**

'By the line manager / recruiting personnel' **Trust T**

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4.1.3 The support, structure and time available to complete the preceptorship programme

This section covered the structure of each trust's preceptorship programme in terms of the support offered, and the amount of time allowed for these activities.

Support for preceptees within the trust

Overall 78% of responding trusts offered preceptees support through an induction, 57% offered study days, and 96% provided preceptees with a named preceptor (Figure 5).

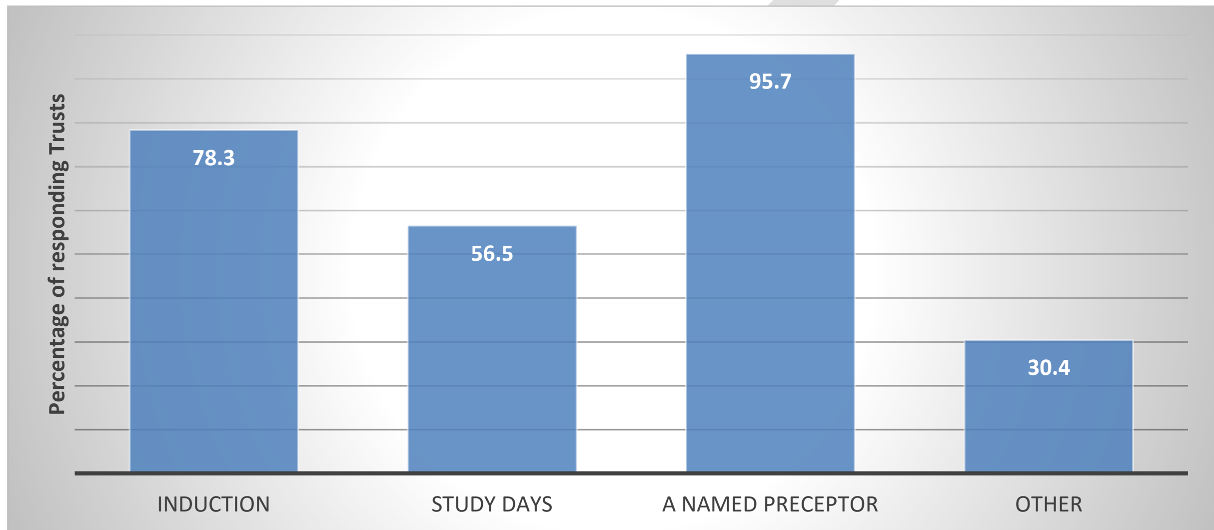

Figure 5: Support offered to preceptees

When explored in more detail, the data indicates that most trusts offered more than one type of support to their preceptees (see Figure 6 below).

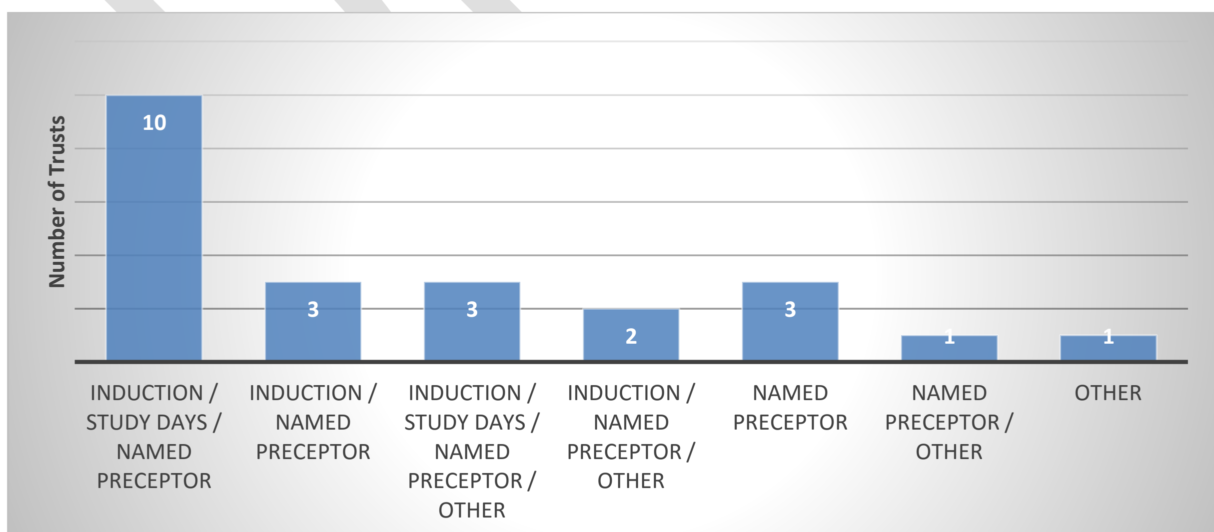

Figure 6: Details of support offered to preceptees

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Eighteen trusts supported preceptees with induction programmes, and all of these offered additional support either through study days and / or access to a named preceptor. A small number of trusts also provided support in other ways, as described in the examples below.

'Preceptorship handbook has tools to identify transferable skills and knowledge and to identify training requirements and development needs. Staff have an annual appraisal with a six monthly review, which also identifies professional development needs. Our policy also provides information about management supervision that all clinical staff access 4 - 8 weekly.' **Trust B**

'4-6 week visit from a PEF' **Trust W**

Three trusts offered access to a named preceptor only, and one further trust offered access to a named preceptor and also *'management and clinical supervision meetings'*. The final trust who did not support preceptees in any of the listed ways, explained:

'the trust have recently recruited ward based practice facilitators to work with new staff and they will identify any needs' **Trust S**

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Participation in the preceptorship programme

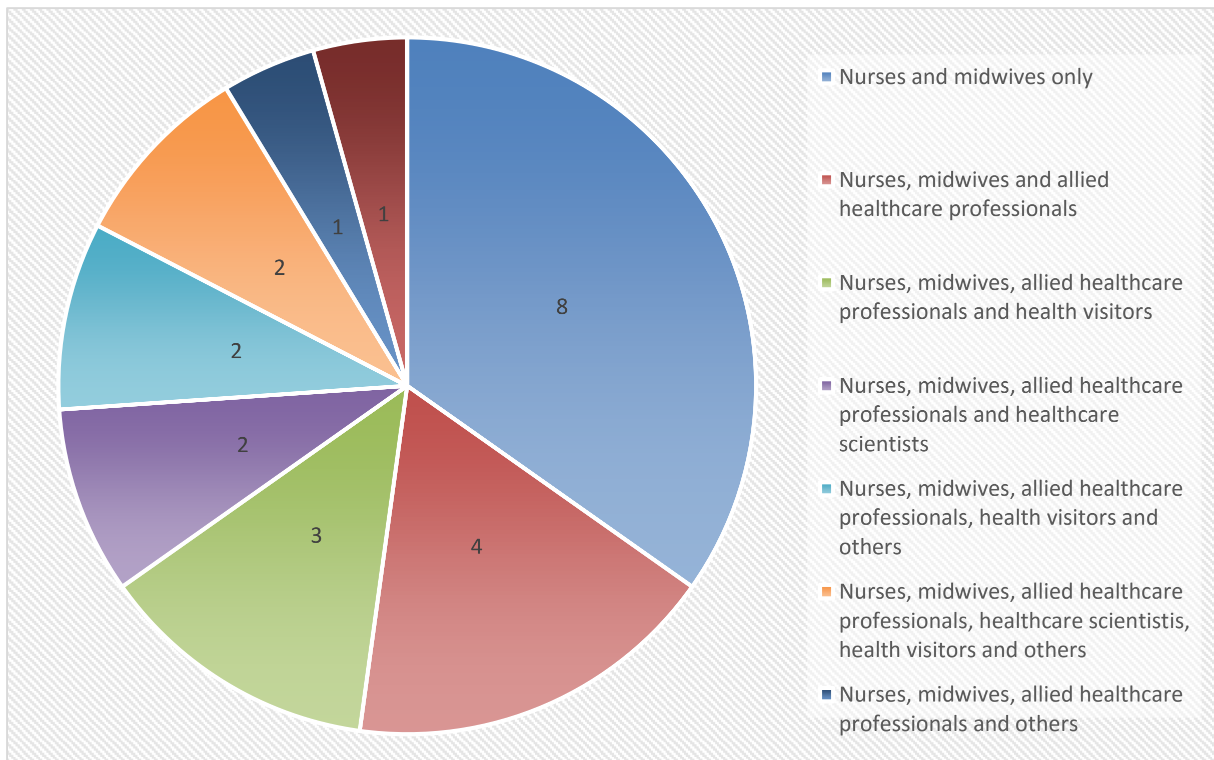

Figure 7: Staff included in preceptorship programme

Fifteen trusts delivered multi-professional preceptorship programmes (see Figure 7). Of these trusts, 14 also offered the Preceptorship training to allied health professionals, five included healthcare scientists, six included health visitors and six included other registered practitioners for example:

'The trust doesn't employ any healthcare scientists. Whilst not registered staff, our public health practitioners, assistant practitioners also receive preceptorship. Dental health nurses also receive preceptorship. **Trust B**

'Assistant Practitioners' **Trust K**

'Any clinical staff new to the trust can attend the preceptorship programme.

Operating department practitioners have attended.' **Trust S**

'We offer the teaching programme to new staff from other countries and non-acute jobs' **Trust U**

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One of the trusts offered support multi-professionally, but not always within the preceptorship programme:

> *'A nurse returning to practice, or coming into the NHS from the private sector may be offered the preceptorship package to support with safe integration into the new post. Newly qualified AHPs are supported into their roles on qualifying, but this is via a different route overseen by the Head Occupational Therapist.* **Trust P**

Eight trusts offered the preceptorship programme exclusively to newly registered nurses and midwives

Protection for Preceptorship activities

Eighteen of the 23 responding trusts provided protected time for at least some preceptorship activities (78%).

Of the eighteen trusts who offered protected time, 12 provided protection for the preceptorship programme, 11 gave protected time for study days, and 14 offered protected time for meeting one-to-one with the preceptor (Figure 8).

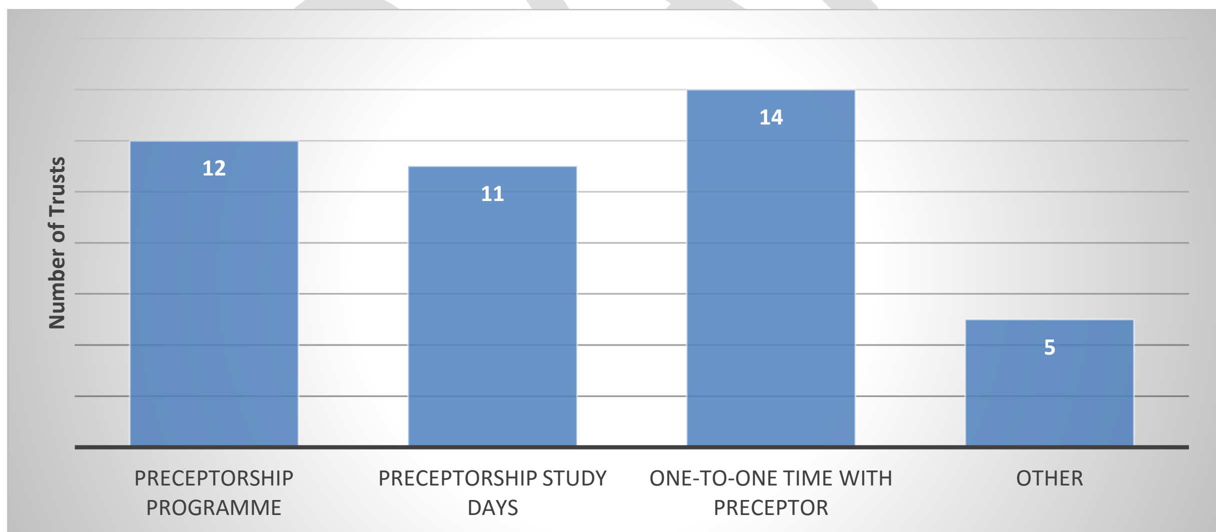

Figure 8: Protected preceptorship activities

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Five trusts included other activities in protected time:

'Meetings with Preceptorship Facilitators' **Trust J**

'New preceptees are supernumerary for two weeks on commencement of preceptorship programme. They are not responsible for clinical areas for the first six weeks in post.' **Trust K**

'New registrants along with new staff to the organisation are required to attend a programme of 'Introduction' study days on radiotherapy, chemotherapy, palliative care, oncological emergencies and clinical skills training' **Trust L**

'Learning experiences offered by Practice Development Sisters/L&D sessions/In House Training and courses' **Trust R**

'In the most part study days are protected. The ward based facilitators are given 2 days supernumerary to support the new staff nurse.' **Trust S**

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In terms of the amount of protected time preceptees were given to complete their preceptorship activities, there was a wide variation (Figure 9):

- Eight trusts offered more than 5 hours / month,
- Ten trusts offered less than 5 hours / month,
- Three trusts protected 1-2 hours / month.

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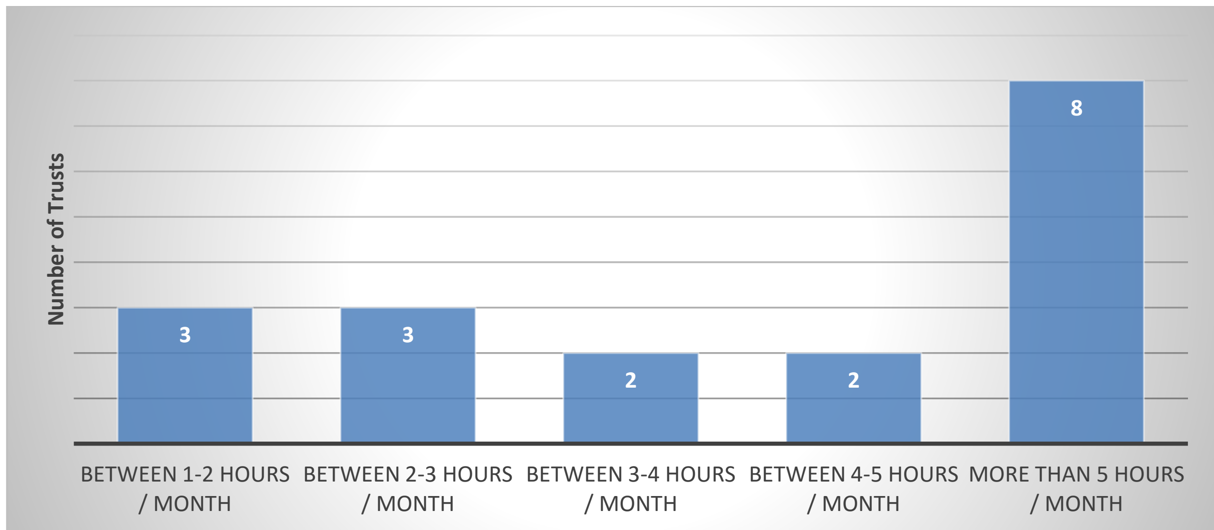

Figure 9: Amount of time preceptees are given for preceptorship activities

In the five trusts who did not offer any protected time for preceptorship activities support was still provided through induction and one-to-one time with a preceptor (although we assume this was not protected), see Figure 10.

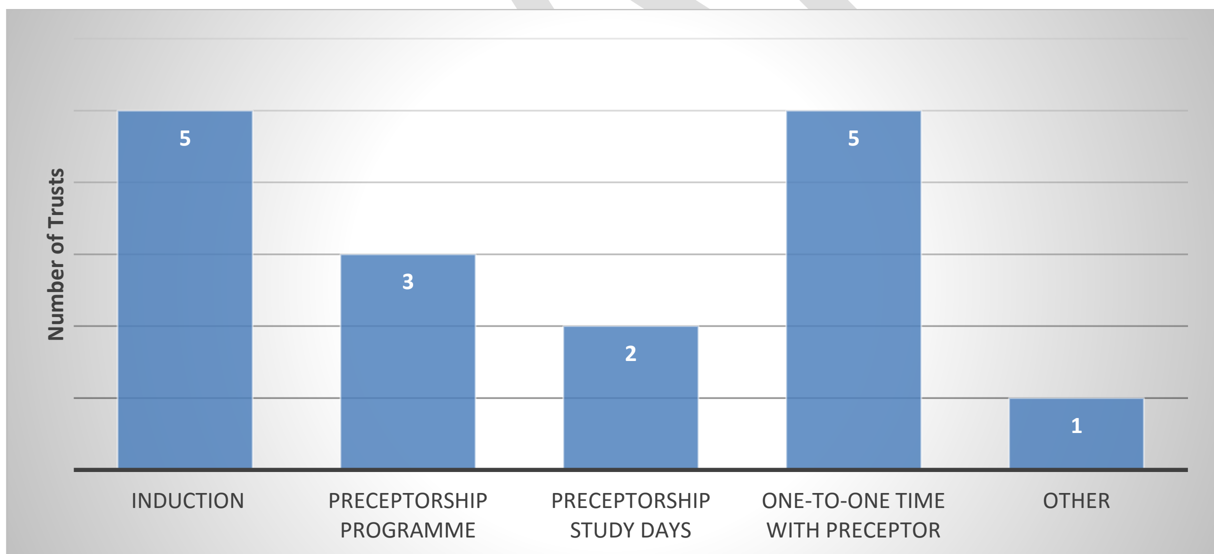

Figure 10: Preceptorship activities in trusts where preceptorship time not protected

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The trust offering other preceptorship activities stated:

> *'Additional training and development identified by preceptor. Simulation sessions with junior doctors to look at human factors and clinical skills'*
>
> **Trust O**

4.1.4 Monitoring and tracking of the preceptees

Monitoring of the preceptees progress through their preceptorship period, and the process used to evaluate each trust's preceptorship programme were explored in this section.

Monitoring preceptees progress

The systems in place to monitor and track newly registered nurses and midwives from their appointment through to completion of their preceptorship period were varied including:

- Monitoring by database
- Monitoring by managers
- Completion of questionnaires

Evaluation of the preceptorship programme

Trusts were asked if they evaluated their preceptorship programme. Just under half (48%) reported that they did evaluate their programme, and just over half (52%) did not evaluate. Those who did evaluate used a number of methods for doing this, including:

- Questionnaires following each study day / event
- Preceptorship feedback survey at the end of the preceptorship period
- On-line survey questionnaires
- Yearly feedback

Those who did not evaluate gave a range of reasons for not doing so, including:

- Lack of robust process in place
- The annual audit allows us to share areas of good practice and areas for improvement across all professions and services
- Local implementation, so no overall monitoring within the trust
- The trust evaluates each element, but does not evaluate as a whole. The policy is audited and monitored.
- In the process of addressing this issue and / or currently developing a more robust process

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4.1.5 Costs of providing preceptorship programme

When trusts were asked about the cost per head of providing the preceptorship programme for newly registered nurses and midwives (preceptees) only six trusts were able to provide any indication of this, see Figure 11.

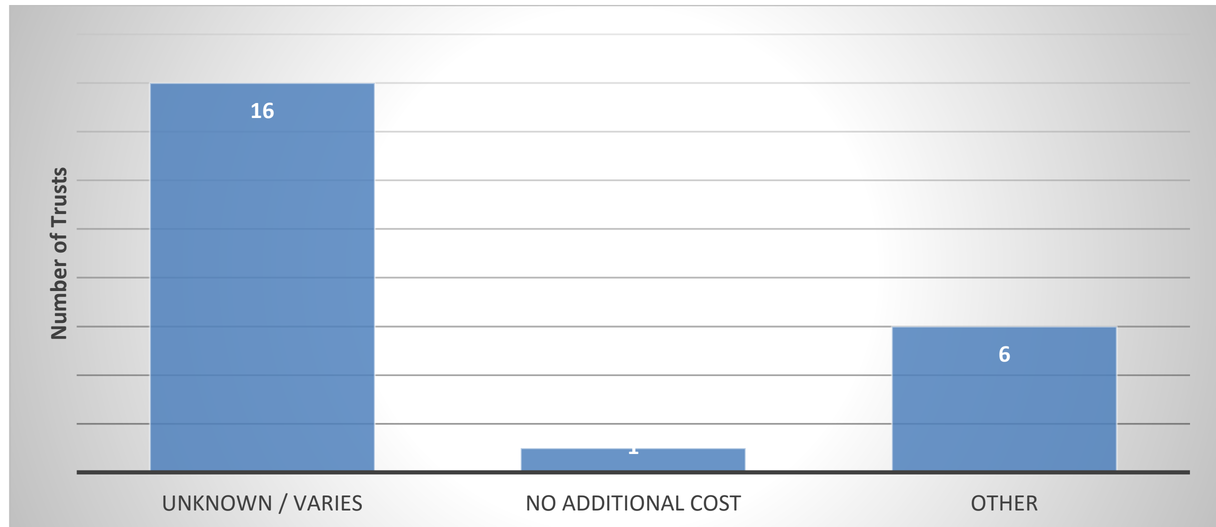

Figure 11: Cost per head of providing preceptorship programme

Sixteen trusts did not know the cost of providing their preceptorship programme, or said it varied. The trusts who provided information for this question gave a variety of responses, and the costs involved were not always clear, ranging from one trust who said there was no additional cost, to another trust who estimated the cost to be £3000 per head to cover back filling etc. Only one trust identified the cost as being £550 per head (which was the value of HEE NW funding for each preceptee).

4.1.6 Recruitment and Attrition rates

trusts were asked to provide details of their recruitment and attrition rates for nurses and midwives during the years 2102 – 2015.

Recruitment rates for newly qualified nurses and midwives

Trusts were asked for details of their recruitment of newly qualified nurses and midwives in the years 2012-2013, 2013-2014, and 2014-2015. They were also asked how many newly qualified nurses and midwives commenced and completed the preceptorship programmes in each of these years. Seventeen trusts provided at least partial data for either newly qualified nurses, newly qualified midwives or both.

The responses provided a mixed picture and illustrated the wide variation in recruitment and preceptorship rates across the HENW region. For details of newly qualified nurses recruited, commencing the preceptorship programme and completing the preceptorship programme see Figure 12, Figure 13 and Figure 14; and for newly qualified midwives see Figure 15Figure 16Figure 17.

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Recruitment of Newly qualified nurses

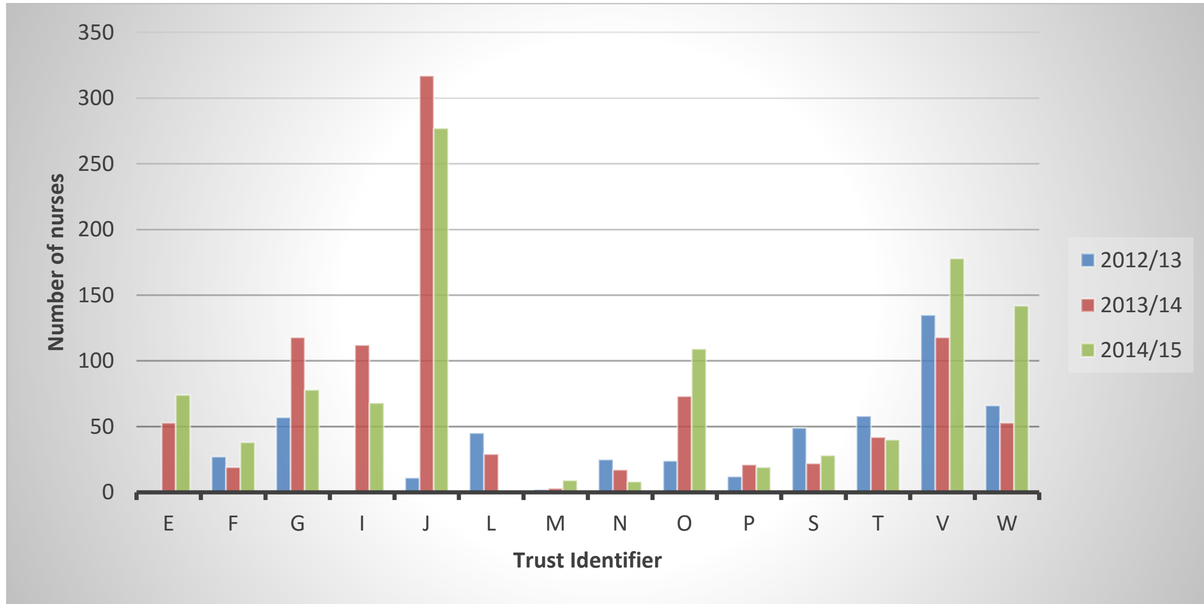

Figure 12: Number of newly qualified nurses recruited by trust

Figure 13: Number of newly qualified nurses who commenced the preceptorship programme by trust

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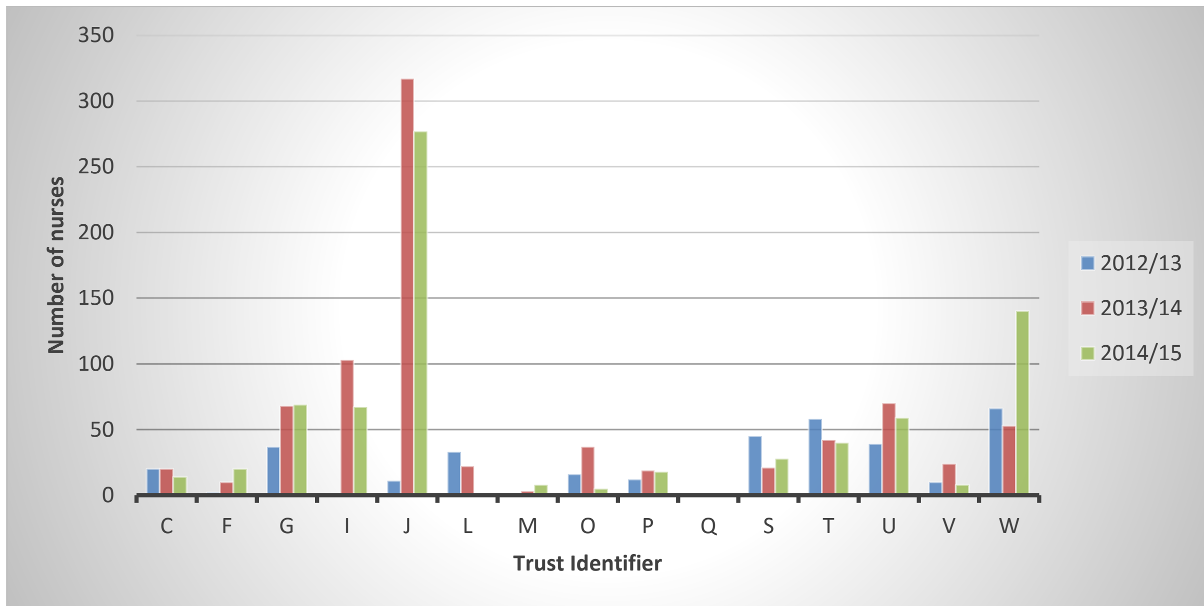

Figure 14: Number of newly qualified nurses who completed the preceptorship programme by trust

Recruitment of Newly qualified midwives

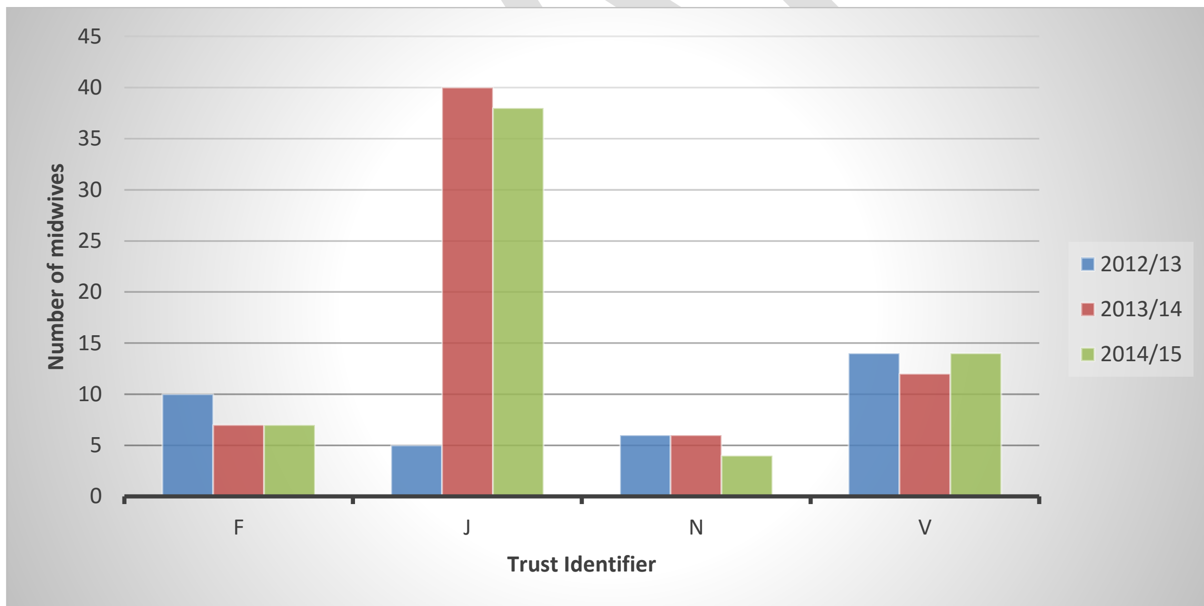

Figure 15: Number of newly qualified midwives recruited by trust

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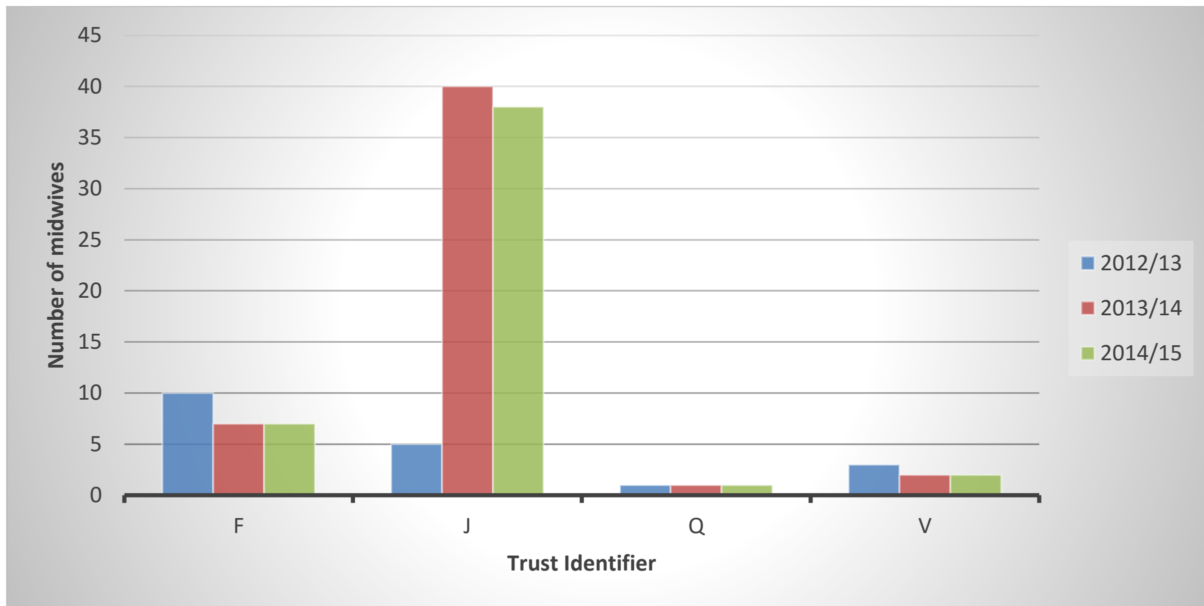

Figure 16: Number of newly qualified midwives who commenced the preceptorship programme by trust

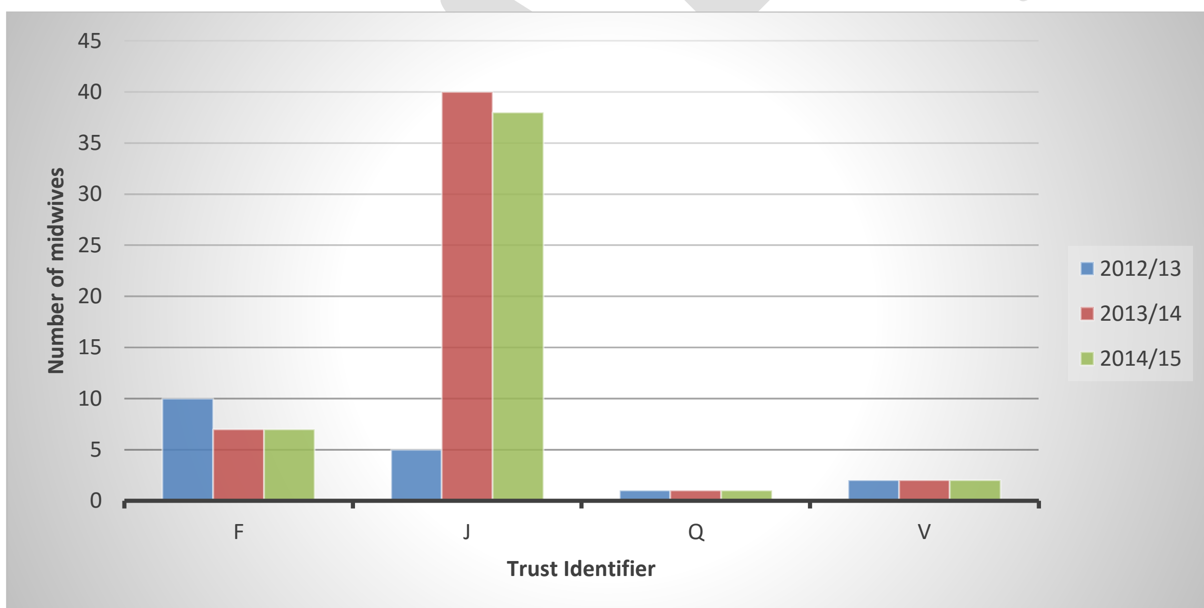

Figure 17: Number of newly qualified midwives who completed the preceptorship programme by trust

4.1.7 Attrition rates for nurses and midwives

Trusts were asked to provide data for their attrition rates in the years 2012-2013, 2013-2014 and 2014-2015. Eleven trusts provided at least partial data for either nurses, midwives or both. Figure 18 shows the rates provided for nurses, and Figure 19 the rates provided for midwives.

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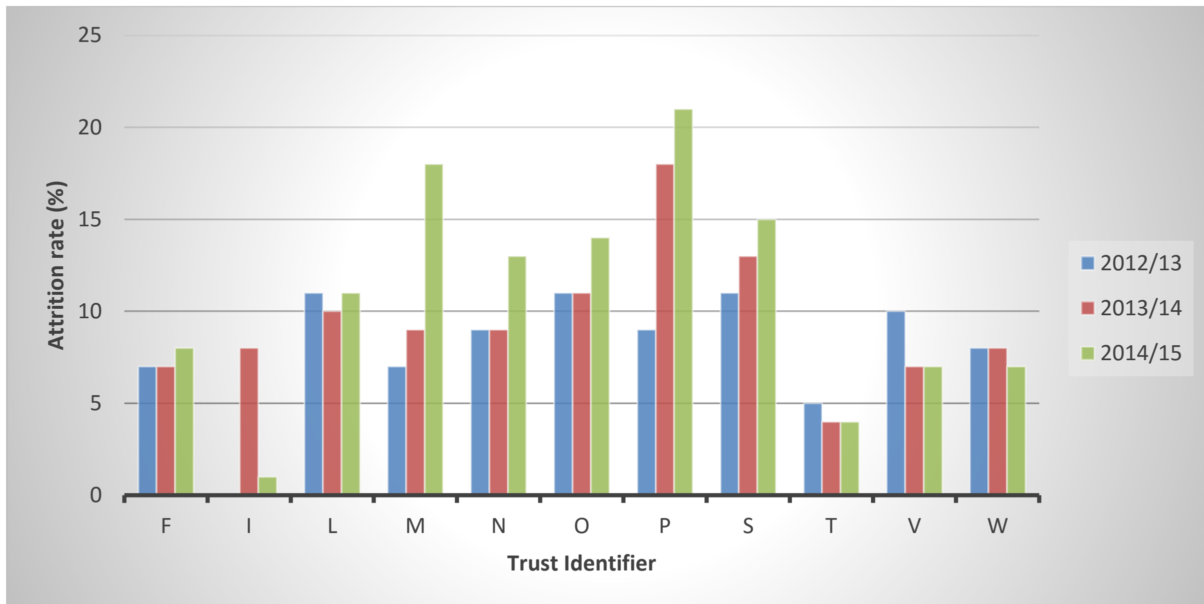

Figure 18: Attrition rates for nurses

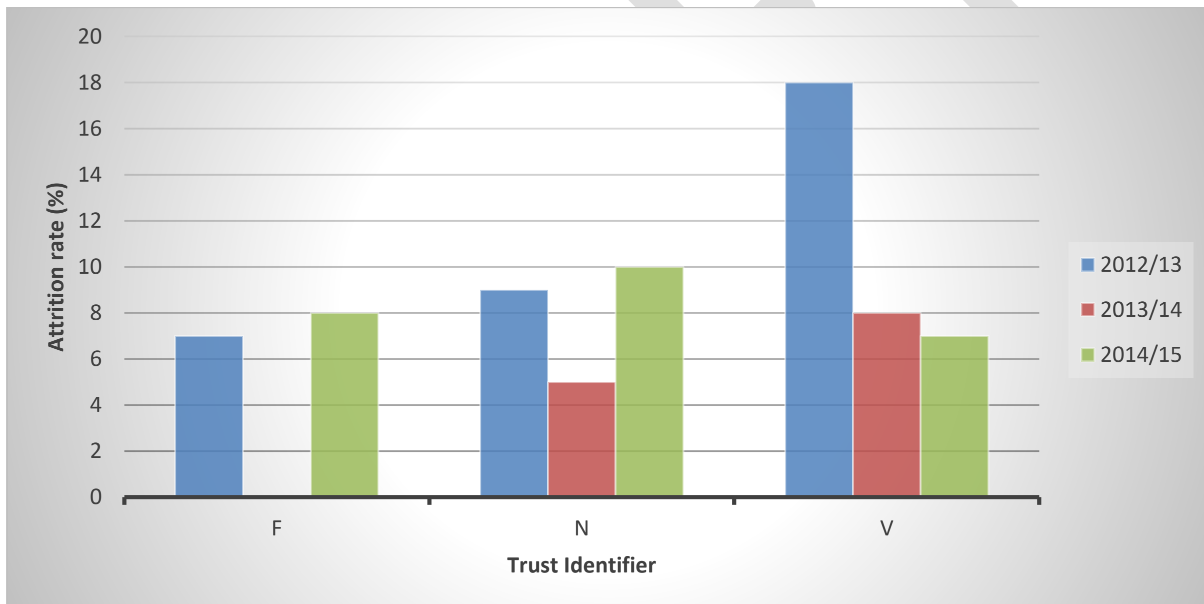

Figure 19: Attrition rates for midwives

Trusts were also asked if they kept separate attrition rates for newly qualified nurses and midwives (those who have joined the trust in the last 24 months). Only three trusts reported that they recorded this data and only two provided any data see Figure 20.

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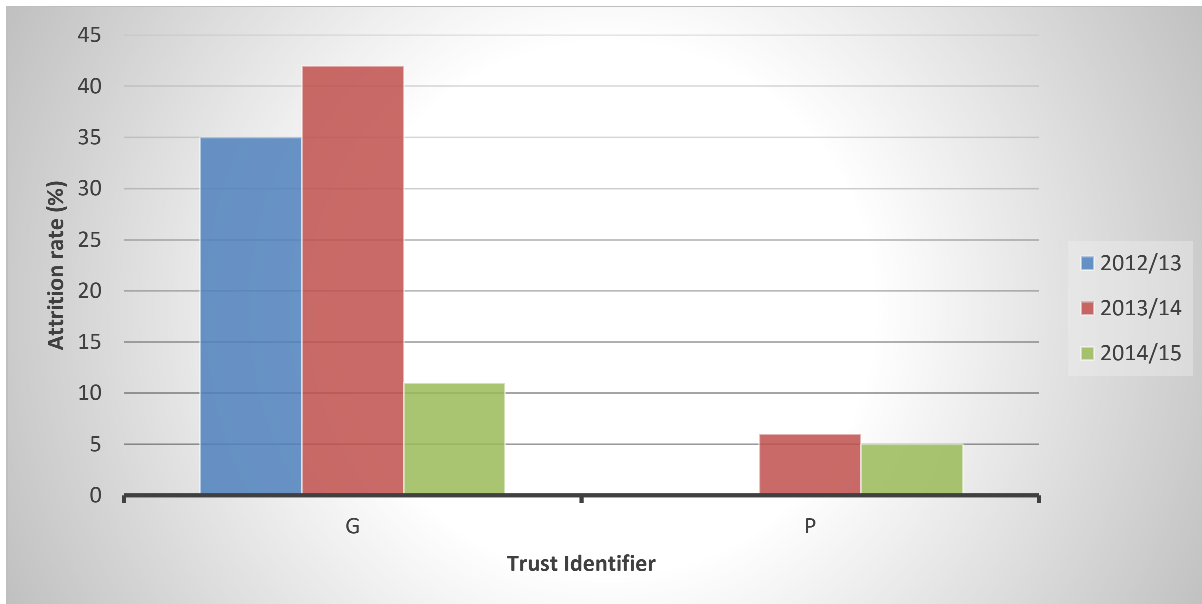

Figure 20: Attrition rates for newly qualified nurses and midwives

4.1.8 Training and development of Preceptors to provide preceptorship.

The questionnaire also covered the identification, selection and training of Preceptors within each trust. trusts were asked if they had a named organisational lead for preceptorship, and 21 of the 23 trusts stated that they did. Contact details of these preceptorship leads were recorded for future reference.

Preceptor training

When asked about training for the Preceptors, ten trusts said they offered training to their Preceptors and 13 trusts did not.

All the training offered to preceptors was delivered in house by the trusts, although one trust also supplemented this with additional bespoke local training if required. Seven of the trusts who offered training had no additional budget for this, and of the three trusts who said they did have a budget; one misread the question and gave the budget for preceptees not preceptors. The remaining two used monies from cash allocation and CPD funding.

trusts were asked about the amount of training time each preceptor received, and this varied. The majority of trusts who answered this question provided less than one day's Preceptor training (five trusts), two trusts offered a day and three trusts more than a day's training for Preceptors.

Those trusts who did not offer training to their Preceptors gave a range of reasons for not doing so, including:

- There is guidance within the preceptorship framework but we don't offer face to face training for the role currently.

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- A review has just taken place and the following is being implemented: Badges to identify preceptees, training for preceptors, exit interviews/questionnaires, attrition monitoring.
- There is not a separate training package although all our mentors undergo mentorship preparation and mentorship courses at a variety of levels.
- We offer training to our mentors, which is felt covers preceptorship training
- There is not a separate training package although all our mentors undergo mentorship preparation and mentorship courses at a variety of levels
- Some preceptors have had training but not all. It is a trust objective for 2015-16

4.1.9 Sharing of ESR data from HENW, and any other comments regarding preceptorship programme

All trusts were asked if they were willing to allow HENW to share their ESR data with the University of Chester for the purposes of this project. Eighteen trusts were willing to share their data and five trusts were not willing for HENW to share their data. The reasons for this were not requested.

4.2 Content analysis of trust Preceptorship documentation

Eighteen trusts returned documents relating to their Preceptorship Programmes. These documents were used to build a picture of current trust preceptorship programmes, using the pro forma in appendix V.

Recommendations from General Overview of Documentation

Although there was a wide variation in the documents received from trusts, there were a number of general recommendations gathered from the information.

- We would recommend a house style for Preceptorship documents within a trust. This helps to add consistency and to the documentation, and presents a professional front to the programme.
- We also recommend the programme documentation should be succinct and in an ‘easy to read’ format.
- Each trust will have its own style and content depending on trust priorities and focus, however there are key areas which should be included in any preceptorship programme across trusts (discussed in section 5.1).
- Ensure Protected time is given for Preceptorship, and that this is given a high priority or made mandatory.

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Recommendations for Document Content

- 9-12-month preceptorship period, with the option to review if not all competencies achieved within this time frame. Clear pathway as to the outcomes if competencies are not achieved at this point.
- Multi-professional Preceptorship programmes are recommended to facilitate inter disciplinary consistency and understanding
- Include clearly articulated aims and outcomes / objectives in the framework
- Align framework with strategic aims of the trust and reflect the core values and key goals of the organisation.
- More robust evaluation of the programme and ongoing detailed audit, would allow trusts to understand what they are doing well, and any areas for improvement

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4.2.1 Best Practice for Preceptorship Programme

From the data gathered through the online questionnaire and the content analysis, and working together with the steering group in co-production, the key elements recommended for inclusion in a preceptorship programme were identified. A mind map was developed to visualise, and order the areas to be included in a best practice preceptorship programme (see Figure 21), and this was used as basis for developing the final Toolkit.

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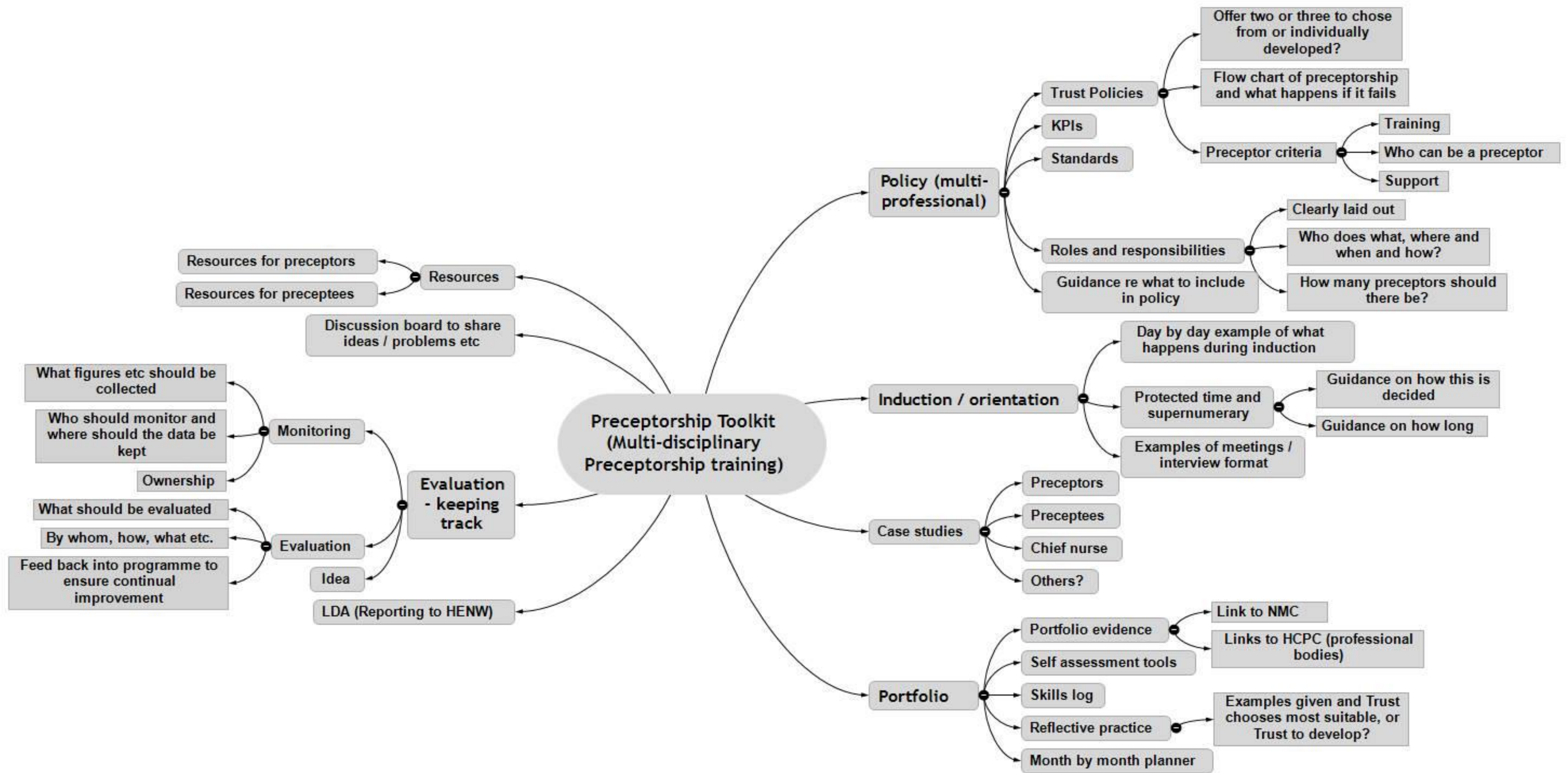

Figure 21: Mind map of best practice Preceptorship Framework

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4.3 Ethnogeographical Interviews

The themes from the interview data are presented under the macro, messo and micro levels. However, it is important to reiterate the small sample size, and the subsequent difficulty in generalising the findings from the interview data.

4.3.1 Macro level

Key themes from the macro level included:

- Value of trust reputation, e.g. as a caring organisation or as a pressured environment
- Trust geography and demography, e.g. travel, cultural diversity, and inner city experience compared to sub-urban and rural experiences
- Trust culture, systems and structures, eg open and honest
- Lengths of preceptorship ranged from 12 - 24 months
- Perceptions of power over staffing numbers, shortages and retention were viewed differently by the preceptees

‘ …the Trust wanted me, I was given options for where I wanted to work. This Trust provided Trust, Hospital, ward induction and the organisation has a culture of caring, where everyone is helpful and you can ask anything.’

At this macro level trust reputation, culture systems and structures played a significant part in not only the preceptees choices of where to work, but also how long to stay and where to move next (if at all). Inner city services were narrated as fast and complex organisations, busy and almost too busy to support the preceptorship needs of newly qualified staff. More sub-urban experiences were mixed, with some exemplary culture which was caring and supportive, but also with other organisations that were less forward thinking in some service areas.

4.3.2 Messo level

Key themes at the messo level:

- Preparedness – participants identified the need to revisit pre-registration curricular to enhance final year preparation for practice. Suggestions included gaining competence beyond the basic clinical skills, for example venepuncture and catheterisation.
- Final or transitional placement prior to registration is of vital importance to promote confidence and self-esteem.
- Positive team working with positive, friendly and inclusive teams
- Tailoring a programme to meet the needs of the registrant
- Clear structured preceptorship process or framework
- Preceptors need the appropriate skills set to be a ‘good preceptor’
- Preceptors need to be given time and support to be preceptors
- Preceptorship is everyone’s business – a trust wide responsibility
- Utilising a portfolio as a tool to structure preceptorship
- Integrating reflection to promote learning
- A period of supernumerary status is advantageous for all new registrants, ranging typically from two weeks to two months

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4.3.3 Micro level

Key themes emerging from the micro level overlapped considerably with those from the messo level. However, additional key insights included:

- When participants were asked "Where do you see yourself in 5 years' time?" Although some of the interviewees expected to move from their current trust for a variety of reasons including:
  - Working closer to home
  - Moving trusts to gain different experience – smaller trust/ larger trust
  - Specialising
- None of the participants expressed a desire to leave their chosen professional discipline and preceptorship had been a significant factor in fostering this outcome.
- Preceptorship had fostered career development and subsequent ambitions for progression.
- The respondents understood their roles and responsibilities as autonomous practitioners.

4.3.4 General suggestions from preceptees included:

a. Have time with other preceptees
b. Have allotted time for preceptorship
c. Preceptors should be good and knowledgeable teachers too
d. Preceptors should have clinical experience
e. On-line to access the courses I need
f. Learn lots from others, have this learning recognised
g. Use the wellness recovery action planning tool to develop student / staff nurse resilience
h. Need more service user carer input into feedback for portfolios

5 Discussion and Conclusions

The findings from the online survey, analysis of preceptorship documents and interviews with preceptees highlighted the following themes.

5.1 No ONE preceptorship framework would meet the needs of all trusts

Based on the findings of the questionnaire, content analysis and ethnogeographical interviews, a best practice Toolkit was devised in co-production with the steering group and practitioners. The outline of the Toolkit is shown below (see Figure 22). It was decided that in order to enable as many people as possible to access the Toolkit, it would be set up as an online Toolkit, hosted on the Health Education England online platform. This would allow free access at any time or place that was convenient to the user, and facilitate the central repository of all Preceptorship related documents.

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KEY SECTIONS OF PRECEPTORSHIP TOOLKIT

MULTIPROFESSIONAL POLICY
- Trust Policies
- KPIs
- Standards
- Roles and responsibilities
- Guidance on policy content

INDUCTION / ORIENTATION
- Day by day example of what happens during induction
- Protected time and supernumerary
- Examples of meetings / interview format

CASE STUDIES
- Case studies of preceptors, preceptees and other staff

PORTFOLIO
- Portfolio evidence
- Self-assessment tools
- Skills log
- Reflective practice
- Month by month planner

LDA REPORTING TO HEE
- Metrics for reporting

MONITORING AND EVALUATION
- Tools for monitoring and evaluation

DISCUSSION BOARD
- Sharing ideas / problems etc.

RESOURCES
- Resources for Preceptees
- Resources for Preceptors

Figure 22: Outline of the completed online Preceptorship Toolkit

5.2 Monitoring attrition rates

Attrition rates were not uniformly monitored and recorded across trusts, leading to a lack of clarity with respect to the wider attrition picture across the region. This is consistent with the consensus in the literature highlighting a lack of robust or systematic monitoring

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of attrition nationally across the NHS. This also meshes with the literature regarding the inadequacy of current workforce planning in addressing the sector as a whole, and the omission of social care nurses and independent sector nurses in the planning figures, resulting from a lack of strategic oversight. We recognise this as an area for further development in the Toolkit, and acknowledge the difficulties in collecting data in this area, however it is imperative that the problem is addressed holistically in order to meet the demand for nurses across the sector.

5.3 Evaluation of preceptorship programmes

The absence of a strategic framework in Preceptorship has led to a lack of clear planning in local preceptorship programmes. We noted a dearth of reported evaluation for preceptorship programmes, although there were some excellent examples in a small number of trusts. Understanding local preceptorship programmes is vital to ensure that the evidence can be utilised to identify strengths and weaknesses, and build on these where possible. This enables the trust to continuously develop their preceptorship programmes and enhance the provision of support for newly qualified nurses and midwives.

5.4 Preceptor Training

The literature has identified preceptor training as an area of weakness in many organisations, and there has been considerable discussion regarding the preparation and training for the role of preceptor (Muir et al., 2013; Panzavecchia & Pearce, 2014). Since the preceptor plays a pivotal role in the transition of newly qualified members of staff from novice to expert a well- functioning preceptee-preceptor relationship should support professional growth (Kaihlanen, Lakanmaa, & Salminen, 2013). Further, since a preceptor can help to facilitate socialisation in the workplace, their capability in the role can have a major impact on preceptees sense of belonging (Phillips et al., 2014).

However, the body of evidence regarding preceptor training in practice is weak, and this was reflected in our research. There was scant evidence of formal preceptor training in the surveyed Trusts, and often mentorship training was considered sufficient to produce preceptors. However, the roles are not identical, despite considerable overlap, and we would suggest this is an area which could be strengthened in many of the trusts.

The Department of Health identified thirteen attributes of an effective preceptor (Department of Health, 2010) and these form a good framework on which to build, however it is important to note that not all nurses will be well suited to the role of preceptor, and that being a good mentor does not inherently make you a good preceptor. In addition, the role of a preceptor should be recognised as having a separate identity from the mentor role, and consequentially be given the recognition, time and preparation required to produce high quality preceptors.

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6 Recommendations and Next Steps

The Toolkit was established on the HENW platform, and went online in July 2016. In order to ensure the Toolkit meets the needs of the practitioners for whom it is designed to provide support and guidance, it was essential to evaluate the content and structure of the Toolkit. This is currently in progress through an online evaluation questionnaire which has been sent to all NHS trusts in NW England. The results of this evaluation will inform the next stages of development.

In addition, we have recommended the formation of a preceptorship network, comprising interested parties, who will take over the ownership and maintenance of the Toolkit in the future. They will also be tasked with enhancing the toolkit to include any feedback from the evaluation, and bring the Toolkit to life by making it more interactive. This is designed to facilitate ownership of the toolkit within the community of practice, and ensure it accurately reflects the needs of its users.

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Appendix I: Systems to monitor and track newly registered nurses and midwives from their appointment through to completion of the preceptorship period

Trust	System
A	Through their line manager
B	Completion of the preceptorship programme is monitored by line managers and a preceptorship final review form (appendix 8) is completed and held on staff personal record. We do not centrally record completion of the programme currently. Preceptorship is subject to annual audit.
C	Add on Study days following the initial 7 day programme
D	Questionnaire completed by PEF on behalf of DON. The PEF team hold a spreadsheet which is updated monthly. There is a completion of Preceptorship link within the intranet which informs the training database and PEF team. The policy requires a 1/4ly audit
E	At the moment preceptorship is managed at a local level with ward managers/team leads taking responsibility for monitoring completion of a preceptorship programme. Different teams and specialities have different methods in terms of offering study days and preceptorship paperwork. It has been recognised as a risk and the education, training and professional development team have created a new post with lead responsibility for preceptorship so that the governance and assurance arrangements will be looked at from a whole trust perspective. A business case is in development that will look at a clinical educator role that will work in practice with new preceptees.
F	Currently attendance at the core study days is tracked and monitored. Because of issues that have arisen with being able to centrally monitor completion of the preceptorship programme itself rather than simply attendance at study days, our new Induction programme has been designed to inform a more complete picture around the completion of the preceptorship programme.
G	Currently staff are asked to get their manager to inform Clinical Skills on completion of their pack on a recent survey majority had completed their preceptorship but not informed us.
H	The central nursing team (CNT) are now recording who is a preceptee and ensuring this is completed. The CNT are also required to see and sign off completed preceptorship files
I	Preceptorship Lead monitors preceptees attendance, as they attend follow on sessions for six months till the end of the programme; ward visits, liaising with ward managers
J	A Database is in place to track attendance of study days Preceptorship facilitators monitor support given within clinical areas

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K	Documented meetings with preceptor and competency / achievement documents
L	Until 2015 Ward/Unit Managers tracked preceptees preceptorship programme as documents kept locally, final sign off sent to Clinical skills Manager to acknowledge completion. Audit of data should this not robust. From April 2015 preceptorship documentation has been amended to include that all new registrants starting preceptorship need to contact Clinical Skills Team Manager to inform start date of preceptorship process.
M	Lead practitioner in Learning & Organisational Development oversees the preceptees centrally.
N	Each Nursing role has to comply with a series of KPI's which are monitored by Preceptorship Lead.
O	Nominated practice educator who maintains contact throughout preceptorship period
P	Each Preceptee is allocated a Preceptor. The Preceptor Package is a live document that records induction, skills and competencies (e.g. medicines management), any training attended and reflections during the preceptorship period.
Q	Delivered by the preceptor and becomes part of the PDP process.
R	Incremental pay progression tracked by ESR Line managers
S	We use the practice facilitator role to monitor progress and on study days we set aside some time for feedback on transition.
T	Processes are being developed at the current time
U	We rely on ward/Team managers to identify the new staff member needs preceptorship; we have made it mandatory for all newly qualified band 5 staff.
V	The Practice Development team monitor attendance to preceptorship training days and completion of the preceptorship portfolio. The area managers record completion of preceptorship on ESR.
W	PEF team monitor at the 4-6 weekly meetings

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Appendix II: Preceptees by Year

2012-2013

Trust	Number of newly qualified nurses recruited	Number of newly qualified midwives recruited	Number of newly qualified nurses who commenced the preceptorship programme	Number of newly qualified midwives who commenced the preceptorship programme	Number of newly qualified nurses who completed the preceptorship programme	Number of newly qualified midwives who completed the preceptorship programme
A			20		20	
B						
C	27	10	27	10	2	10
D	57	0	57	0	37	0
E						
F	11	5	11	5	11	5
G	45	0	39	0	33	0
H	2	0	2	0	1	0
I	25	6				
J	24		24		16	
K	12	0	12	0	12	0
L			1	1	1	1
M	49	0	46	0	45	0
N	58	0	58	0	58	0
O	0	0	120	0	39	0
P	135	14	24	3	10	2
Q	66	0	66	0	66	0

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2013-2014

Trust	Number of newly qualified nurses recruited	Number of newly qualified midwives recruited	Number of newly qualified nurses who commenced the preceptorship programme	Number of newly qualified midwives who commenced the preceptorship programme	Number of newly qualified nurses who completed the preceptorship programme	Number of newly qualified midwives who completed the preceptorship programme
A	-	-	20	-	20	-
B	53	0	-	-	-	-
C	19	7	19	7	10	7
D	118	0	118	0	68	0
E	112	0	112	0	103	0
F	317	40	317	40	317	40
G	29	0	28	0	22	0
H	3	-	3	-	3	-
I	17	6	-	-	-	-
J	73	-	73	-	37	-
K	21	0	21	0	19	0
L	-	-	1	1	1	1
M	22	0	21	0	21	0
N	42	0	42	0	42	0
O	0	0	42	0	70	0
P	118	12	28	2	24	2
Q	53	0	53	0	53	0

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2014-2015

Trust	Number of newly qualified nurses recruited	Number of newly qualified midwives recruited	Number of newly qualified nurses who commenced the preceptorship programme	Number of newly qualified midwives who commenced the preceptorship programme	Number of newly qualified nurses who completed the preceptorship programme	Number of newly qualified midwives who completed the preceptorship programme
A	-	-	14	-	14	-
B	74	0	-	-	-	-
C	38	7	38	7	20	7
D	78	0	78	0	69	0
E	68	0	68	0	67	-
F	277	38	277	38	277	38
G	-	0	-	0	-	0
H	9	-	9	-	8	-
I	8	4	-	-	-	-
J	109	-	109	-	5	-
K	19	0	19	0	19	0
L	-	-	1	1	1	1
M	28	0	28	0	28	0
N	40	0	40	0	40	0
O	0	0	43	0	59	0
P	178	14	12	2	8	2
Q	142	0	142	0	140	0

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Appendix III: Preceptees by trust

Trust	Number of newly qualified nurses recruited	Number of newly qualified midwives recruited	Number of newly qualified nurses who commenced the preceptorship programme	Number of newly qualified midwives who commenced the preceptorship programme	Number of newly qualified nurses who completed the preceptorship programme	Number of newly qualified midwives who completed the preceptorship programme
A						
2012-2013			20		20	
2013-2014			20		20	
2014-2015			14		14	
B						
2012-2013						
2013-2014	53	0				
2014-2015	74	0				
C						
2012-2013	27	10	27	10	2	10
2013-2014	19	7	19	7	10	7
2014-2015	38	7	38	7	20	7
D						
2012-2013	57	0	57	0	37	0
2013-2014	118	0	118	0	68	0
2014-2015	78	0	78	0	69	0
E						
2012-2013						
2013-2014	112	0	112	0	103	
2014-2015	68	0	68	0	67	
F						
2012-2013	11	5	11	5	11	5
2013-2014	317	40	317	40	317	40
2014-2015	277	38	277	38	277	38
G						
2012-2013	45	0	39	0	33	0
2013-2014	29	0	28	0	22	0
2014-2015		0		0		0
H						
2012-2013	2		2		1	
2013-2014	3		3		3	
2014-2015	9		9		8	

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Trust	Number of newly qualified nurses recruited	Number of newly qualified midwives recruited	Number of newly qualified nurses who commenced the preceptorship programme	Number of newly qualified midwives who commenced the preceptorship programme	Number of newly qualified nurses who completed the preceptorship programme	Number of newly qualified midwives who completed the preceptorship programme
I						
2012-2013	25	6				
2013-2014	17	6				
2014-2015	8	4				
J						
2012-2013	24		24		16	
2013-2014	73		73		37	
2014-2015	109		109		5	
K						
2012-2013	12	0	12	0	12	0
2013-2014	21	0	21	0	19	0
2014-2015	19	0	19	0	18	0
L						
2012-2013			1	1	1	1
2013-2014			1	1	1	1
2014-2015			1	1	1	1
M						
2012-2013	49	0	46	0	45	0
2013-2014	22	0	21	0	21	0
2014-2015	28	0	28	0	28	0
N						
2012-2013	58	0	58	0	58	0
2013-2014	42	0	42	0	42	0
2014-2015	40	0	40	0	40	0
O						
2012-2013	0	0	120		39	0
2013-2014	0	0	42	0	70	0
2014-2015	0	0	43	0	59	0
P						
2012-2013	135	14	24	3	10	2
2013-2014	118	12	28	2	24	2
2014-2015	178	14	12	2	8	2
Q						
2012-2013	66	0	66	0	66	0
2013-2014	53	0	53	0	53	0
2014-2015	142	0	142	0	140	0

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Appendix IV: Additional information provided by trust

Trust	Comments
B	Our preceptorship procedure and supporting documents are currently under review as we respond to Department of Health recommendations that preceptorship for newly qualified health visitors is extended to 2 years and Shape of Caring review recommends 12 months for newly qualified nurses. The preceptorship training presentation will be reviewed in light of these changes.
C	We are running in September again to include all AHP/Departments not just for nurses. Each professional group will be allocated a bespoke day to support clinical duties.
D	A full review has just been carried out. Questionnaire completed on behalf of DON by PEF Team Leader. I am unable to add figures in as our Preceptorship previously was for all new starters not solely newly qualified
E	A new post education, governance and assurance lead was appointed in December 2014 with preceptorship being a key priority for development. The trust recognises that we are not able to effectively monitor newly qualified professionals on the programme. A business case has been developed for a trust wide preceptorship programme that will create new posts of clinical educators that will work in practice alongside new starters. They will monitor, support and evaluate their progress delivering bespoke training as required. A policy will also be developed to support the programme. A pilot of a 6 week induction programme commences this month in the Harbour (new inpatient facility) for all new nurses.
F	Much of the data included in this questionnaire has been difficult to locate within the trust, and has served to highlight the gaps that we already suspected existed and had plans in place to address.
G	I would like to have the resource of a Preceptorship lead for the trust this is a part of my huge portfolio and I do not have the dedicated time to lead effectively. I would also like to set up a preceptorship training programme to prepare preceptors with the appropriate resources.
H	The trust has developed a preceptorship standard pack for GMW. This has been in place now for 12 months and preceptorship is more standardised than it was. The CNT lead on this and have an overview, however, we still have work to do with HR on reporting. I am unable to complete those sections of your questionnaire how numbers of preceptees etc. as HR does not hold this information. As lead I continue to work on this with HR.
I	To engage Healthcare scientist in preceptorship. To review preceptorship programme. To expand Preceptors' training
J	The CMFT programme is constantly evaluated and therefore evolving also the information provided was for nursing and midwifery but the programme is multi-

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	professional. Some of the information within this questionnaire was difficult to quantify due to the information available Q6b , Q10, Q11, Q12,Q13,Q16 Please see separate e-mail
K	A new lead for preceptorship has been identified. There is a project now underway to scope and identify preceptorship needs in relation to monitoring, delivering and evaluation the organisation's preceptorship programme.
L	From April 2015 monthly monitoring on the 'School of Oncology Balance Score Card' has commenced reviewing uptake of preceptorship within induction period for new registrants. Conduct evaluation of preceptees experience and an analysis of gaps in support and training as part of the trust learning needs analysis.
O	Please note attrition rates are a total for nurses and midwives. Midwifery data is not currently available for number on programme and completed. The trust is currently looking at a multi-professional Proctorship policy currently in draft format.
P	Preceptorship is on the agenda at the Professional Nurse Forum. Preceptorship is recognised as being intrinsic to the support and development of registered nurses and is being considered as part of the Shape of Caring recommendations.
Q	Currently working on our recruitment and workforce data to improve planning. Also working on preceptorship programme to align with mentorship to increase recruitment and retention and in preparation for revalidation.
R	Limited preceptor input at the moment. Aiming to provide more support and training but currently slow off the ground. Named preceptor lead is very new in post and is currently researching development of our programme.
S	Our preceptorship programme is always being reviewed but we would like to include action learning sets going forward. It was not easy to obtain the information re newly qualified nurses recruited to the trust from current ESR set up and I think this may need to be reviewed; along with better electronic records of completion. We will continue to develop the ward based practice facilitator role and plan to evaluate this. The accuracy of the reporting of completion of preceptorship is within their role. All newly qualified nurses are expected to start preceptorship programme so on data page - it is assumed that all nurses started programme, electronic records are not kept and paper copies are not consistent. To the best of my knowledge and using data from leavers lists all staff who commenced the programme still worked in the trust beyond 6 months and have therefore completed preceptorship. Competency assessments are being developed in collaboration of nurses specialists. We plan in the future to review our preceptorship programme in line with our neuro module that is offered by our HEI partners - Edge Hill. All new staff nurses are offered the opportunity to complete the degree level neuro module within 12 months.
U	Our preceptorship programme is an interprofessional programme for all band 5 staff new to the trust, we have just revised the programme and will send you the current teaching package.
V	Our preceptorship programme is currently undergoing development in order to meet Health Education England's standards for preceptorship. Changes include; courses

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	tailored to new registrants, a new preceptorship portfolio, additional support for preceptors and preceptees and an in house training day for preceptors.
W	Our programme is currently under review & we are extending preceptorship from 6 months to 12. There are going to 4 contact days over this period with the PEF to introduce action learning etc. so the 4-6 weekly visits will stop unless there are concerns raised.

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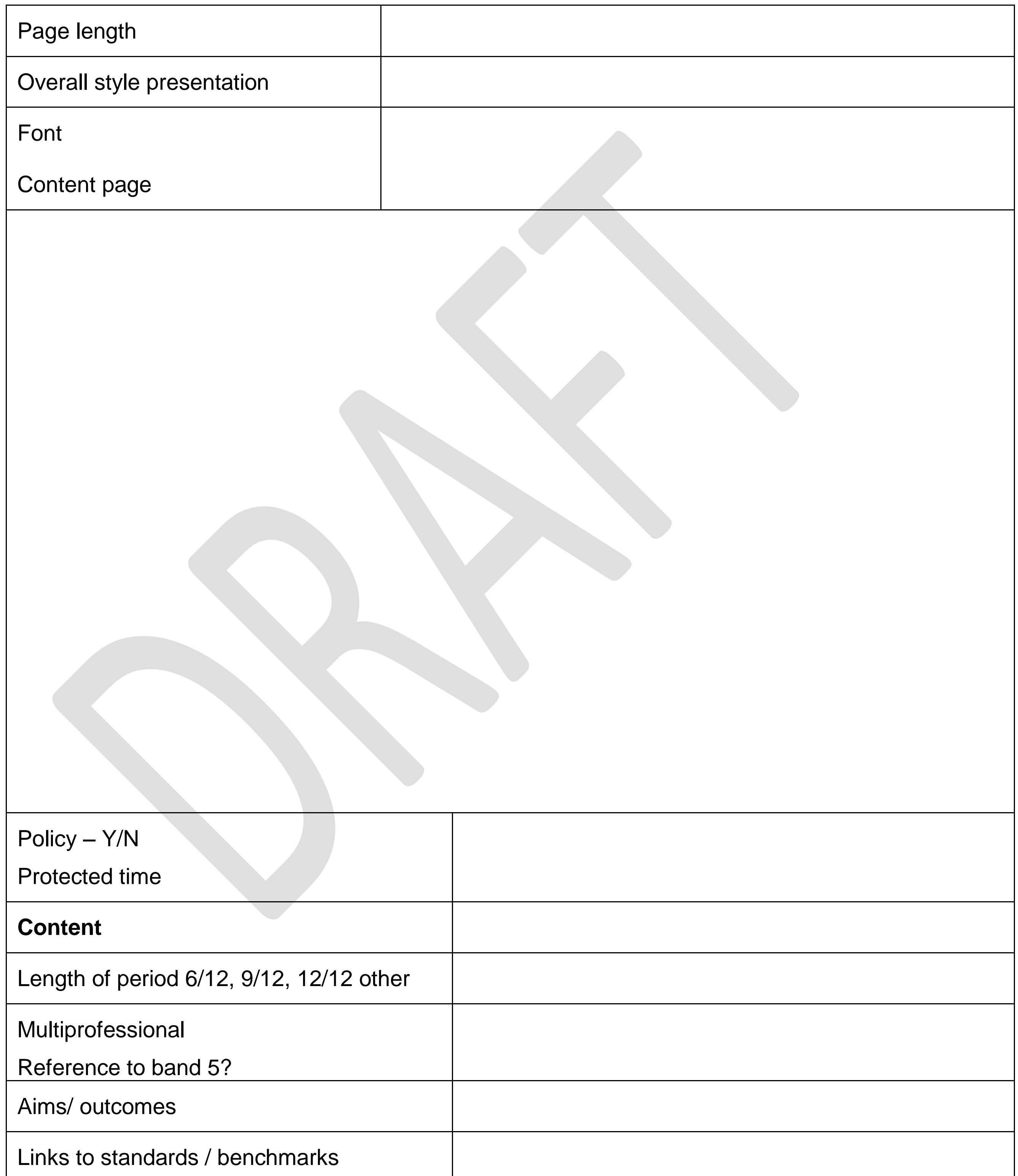
Appendix V: Content analysis Proforma

Trust Number



Page length	
Overall style presentation	
Font Content page	

Policy – Y/N Protected time	
Content	
Length of period 6/12, 9/12, 12/12 other	
Multiprofessional Reference to band 5?	
Aims/ outcomes	
Links to standards / benchmarks	

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Evaluated / Audited	
Documentation covers	
Accountability	
Career development	
Communication	
Dealing with conflict/managing difficult conversations	
Delivering safe care	
Emotional intelligence	
Leadership	
Quality Improvement	
Resilience	
Reflection	
Safe staffing /raising concerns	
Team working	
Medicines management (where relevant)	
Linked to 6C's or other?	
Action learning, group reflection or discussion are included in the preceptorship process	
LLL/CPD	
Assessment	

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