South East Coast Ambulance Service NHS
NHS Foundation Trust

Clinical Preceptorship Procedure

Version:	V3.00
Name of originator/ author:	, Transition to Practice (Education) Manager

Procedure:	
Approved by:	Senior Management Team (by email)
Date approved:	31.10.17

Date issued:	31.10.17
Date next review due:	31st October 2020
Target audience:	Operational Staff
Replaces:	Clinical Preceptorship Procedure v2.00

Contents

1 Scope

1.1. This procedure details how South East Coast Ambulance Service NHS Foundation Trust (hereafter 'the Trust' or 'SECAmb') will provide preceptorship for the Newly Qualified Paramedic (NQP).

1.2. Preceptorship is defined by the Department of Health (2008) as:

1.2.1. A foundation period for practitioners at the start of their career to help them begin the journey from novice to expert, enabling them to apply the professionalism, knowledge, skills and competencies acquired as students into their area of practice, and laying a solid foundation for lifelong learning.

1.2.2. The journey from novice to expert is described by Benner (1984) as the progression that a healthcare practitioner undertakes as they develop their competence within a specific field (in this case paramedicine). The five levels and associated expectations are identified in Appendix A.

1.3. Since 2017 the national programme to assimilate experienced paramedics into band 6 on Agenda for Change has led to the development of a national programme of support for NQPs which is known as a Consolidation of Learning Programme (NHS Staff Council, 2016). Within SECAmb this will replace the existing preceptorship programme.

1.4. This procedure will provide a clear framework to both the NQP and the Trust for the support, guidance, deployment and scope of practice of NQPs working for the Trust.

1.5. Crucially, preceptorship should be seen as a model of enhancement which recognises new registrants as safe and competent but inexperienced practitioners, undertaking the first step in career-long development rather than addressing any deficit in training or ability (Council of Deans of Health, 2009).

1.6. This procedure will apply to all clinical staff after successful completion of a regulated professional education programme and subsequent registration with the Health and Care Professions Council (HCPC) who are:

1.6.1. Commencing their National Health Service (NHS) employment for the first time as a paramedic with no previous employment in a clinical role ('direct entry NQP') – this includes those who have been employed on a bank contract as a support worker during their studies.

1.6.2. Progressing from a non-registered clinical role within the Trust to work as a paramedic for the first time ('in-service NQP').

1.6.3. Transferring from another NHS ambulance service Trust but have not provided evidence of completion of the Consolidation of Learning Period prior to joining ('transferring NQP').

1.6.4. Returning to practice as a paramedic after a period of time away from the profession during which time their previous HCPC registration had lapsed ('returning paramedic').

1.7. For NQPs who are not employed on a whole time equivalent contract (e.g. reduced hours contracts) consideration should be given to providing greater support to meet the outcomes of this procedure in line with reduced exposure, however the required outcomes and timings should not be affected.

1.7.1. The Trust will not employ NQPs on a bank contract due to reduced patient contact hours making it difficult to supervise the individual's progression and adequately support their development.

1.8. It is also recognised that there is a small subset of staff who have started their preceptorship programme under a previous version of the procedure but are subject to the requirements of the new Consolidation of Learning Programme. These transitional staff will have special arrangements made which are detailed in appendix B.

1.9. The Trust recognises the importance of supporting all staff and particularly those who are inexperienced in order to promote high levels of staff engagement and subsequently the best possible standards of patient care.

2 Procedure

2.1. All Newly Qualified Paramedics (NQPs) employed by the Trust will commence on band 5 on Agenda for Change until successful completion of the preceptorship programme.

2.2. **Length of preceptorship:** Completion of the preceptorship programme will normally take a period of 24 months. The only exception to this will be those eligible for fast tracking or those who have commenced an equivalent Consolidation of Learning Programme elsewhere and can evidence their progress accordingly.

2.2.1. For the purposes of this procedure the commencement date of the preceptorship programme will be the date that the individual has successfully gained their HCPC registration and has been employed by the Trust as a paramedic. Note that the date of registration and date of employment are likely to be different and therefore both must be in place to commence preceptorship.

2.2.2. The procedure for fast tracking is still under development and will be published as an amendment to this procedure. However, it should be noted that this will only be applicable to those individuals who have

previous experience of working in the paramedic role or a direct equivalent. Other healthcare experience, even in an autonomous capacity (e.g. nursing, midwifery, technician), will not make an individual eligible.

2.2.3. In exceptional circumstances where NQPs are unable to complete the requirements of the Consolidation of Learning Programme within 24 months due to personal circumstances (for example a prolonged period of sickness or due to maternity) the preceptorship period may be extended. This should be managed on an individual basis to ensure the NQP receives the appropriate support to achieve the required outcomes and should only last for the length of time required to achieve these outcomes and no longer. Where this is the case the NQP will remain on band 5 until completion of the preceptorship programme.

2.3. **Induction training:** All NQPs employed by the Trust will complete a Transition to Practice (TtP) course prior to working operationally as a paramedic. The length and format of this course may vary depending on the needs of the individual and the Trust, however will be designed to fulfil all required induction components of the national Consolidation of Learning Programme (Key Performance Indicator target one: 100% of NQPs will complete a TtP course).

2.3.1. For direct-entry NQPs this will generally form their first weeks of employment and will incorporate both a Corporate Induction to the Trust and local induction to their Operating Unit / station. Where required the emergency driving course will also be completed at this time.

2.3.2. For in-service NQPs this will generally be prior to their start date of employment as a paramedic ('change of practice').

2.4. The Operations Manager for the NQP will assign an Operational Team Leader (OTL) – the OTL will also function as the NQP's preceptor and should be the first point of contact for clinical support, mentorship and guidance as required. The NQP should be advised of the name of their OTL as early as possible in their employment and in any case prior to their local induction (Key Performance Indicator target two: 100% of NQPs will be aware of the name of their OTL prior to the end of their TtP course).

2.5. **Resourcing and deployment:** Operational shifts for NQPs will be planned by the Trust's scheduling department and will fulfil the requirements of preceptorship outlined within this procedure. NQPs will be allocated shifts in line with Trust requirements.

2.5.1. The NQP should work with an experienced paramedic who has completed their preceptorship for the first 300 consecutive hours of their clinical practice. The NQP must not be planned to work with any clinical grade below experienced paramedic for this front-loaded period of support.

2.5.1.1. In order to balance support for the NQP with operational requirements, there are two Key Performance Indicators for this front-loaded period of support. The first (Key Performance Indicator target three) is that NQPs must only be deployed to work with an experienced paramedic for the first 150 consecutive hours of clinical practice and has a target of 100%. The second (Key Performance Indicator target four) is that NQPs should only be deployed to work with an experienced paramedic for the next 150 consecutive hours of clinical practice and has a target of 75%. This means that although the advance shift planning of NQPs will require them to be rostered with an experienced paramedic for the first 300 hours, after the first 150 it may be possible to change this to allow for staff sickness, absences or other unforeseen circumstances. Where an NQP has their duties changed 'on the day' to balance the skills mix this should be recorded on the EOC End of Shift Report.

2.5.1.2. It is recognised that whilst ideally an NQP would work with the same experienced paramedic for the full duration of these 300 hours, current staffing levels and deployment methods are unlikely to allow for this. However, when planning shifts thought should be given to maintaining as much consistency as possible for the NQP.

2.5.1.3. With the exception of where there are specific exclusions on their practice, NQPs should not generally be deployed in a supernumerary capacity as it is neither operationally nor educationally beneficial. Nevertheless, where all other avenues for arranging the NQP to work with an experienced paramedic as part of a crew have been exhausted, NQPs may be deployed as an additional person on any shift – however this should form no more than 10% of their required hours (Key Performance Indicator target five).

2.5.1.4. In exceptional circumstances such as a Business Continuity Incident or Major Incident the NQP may be required to work during their shift with

staff other than those they have been rostered to work with, although every attempt should be made to ensure that the requirements of this procedure are maintained.

2.5.2. The NQP must not be deployed on a Single Response Vehicle (SRV) or expected to solo respond for the full duration of their preceptorship.

2.5.2.1. It is recognised that in extreme circumstances it may be necessary for an NQP to solo respond in order to provide a first response at a high priority call, however this must not be planned either as part of an advanced roster or the results of on the day resourcing changes. Where this is required it should be reported as part of the EOC End of Shift reports and every effort should be made to ensure a secondary response to the incident as soon as possible.

2.5.3. The NQP must not supervise an inexperienced Emergency Care Support Worker (who has been operational for less than three months) at any stage.

2.5.4. Following the initial 300 hours, an NQP may work with another NQP however may not act as a preceptor for that NQP and should not be considered an experienced clinician for discussions in terms of shared decision making.

2.6. **Supervising and mentoring pre-registration students:** the development of students is a fundamental aspect of the paramedic role which the NQP should be supported to progress towards during their preceptorship, however this should not detract from the NQP's own development.

2.6.1. The NQP may supervise a pre-registration student at any stage, with the expectation that the student may only undertake clinical practice that the NQP feels confident and competent to both practice independently and oversee in others.

2.6.1.1. This applies to both direct entry pre-registration students who attend shifts on a supernumerary basis and in-service pre-registration students who may be working with the NQP as part of their rostered duties.

2.6.1.2. Direct entry pre-registration students should avoid booking supernumerary shifts with NQPs during their first 300 hours of supported practice working with another paramedic. Where this does occur the preregistration student must attend in an observational capacity only and will not be permitted to perform any clinical skills allowing for the focus of support to be on the NQP. All students are made aware of this.

2.6.2. The NQP may not act as a formative mentor for students until they are 12 months post registration and have successfully completed the PEd1 course, which should normally be completed during the Transition to Practice course.

2.6.3. The NQP must not act as a summative mentor at any stage, although may complete the PEd2 course after 12 months and prior to completion of their preceptorship in anticipation of becoming a Practice Educator once working as an experienced paramedic. Only paramedics who have

completed both their preceptorship and the PEd2 course will be able to sign off summative assessments for students.

2.7. **Progress reviews:** the preceptorship programme is designed to empower the NQP to develop their practice and demonstrate their transition from novice to expert and should take place as a partnership between the preceptor and the NQP. Progression through the programme will be supported and reviewed using both ongoing assessment and discrete developmental milestones.

2.7.1. Ongoing assessment and support will be provided by the preceptor, who should be the first point of contact for any clinical support, mentorship or guidance. Where further support is required this should be escalated to the Clinical Education department (Transition to Practice team) by either the preceptor or NQP.

2.7.2. Formal reviews should take place at regular intervals as an opportunity for both the preceptor and the NQP to identify specific development needs and generate a personal action plan if required. These will be identified as follows:

2.7.2.1. 6 months – probationary review meeting. This will be undertaken by the OTL. If concerns are raised regarding the NQPs progression at this stage this must be escalated to the Clinical Education department (Transition to Practice team) and the OTL must arrange for the NQPs probationary period to be extended.

2.7.2.2. 12 months – mid-point review. This will be undertaken by Clinical Education and should ideally incorporate PEd2 training.

2.7.2.3. 18 months – appraisal review. This will be undertaken by the OTL and should incorporate the annual appraisal for the NQP.

2.7.2.4. 24 months – end of preceptorship review. This will be undertaken by Clinical Education and should culminate in a Staff Changes Form being submitted to formally end the preceptorship agreement and progress the individual from NQP to experienced paramedic. Only once the preceptorship has been completed will the NQP be promoted to experienced paramedic and their salary be increased to band 6 on Agenda for Change. The change to band 6 should take place with effect from the 24-month anniversary of the NQP's start of preceptorship. This may mean that the Staff Changes Form has to be backdated to prevent the NQP being penalised for any delays in the end of preceptorship assessment.

2.7.3. Each review meeting must be documented using the NQP Evaluation Form and a copy uploaded to the NQP's portfolio.

2.7.4. Informal reviews will take place more frequently and may take a variety of forms in order to incorporate the principles of 360 degree assessment, whereby information is gathered from multiple sources to evaluate progression. Methods of informal review may include, but will not be limited to:

2.7.4.1. Single Shift Snapshot Assessments – these can be completed by any member of staff working with an NQP to provide immediate and objective feedback on the NQP's actions during a single shift.

2.7.4.2. Monthly evaluation of Confidence, Knowledge and Support.

2.7.4.3. 'Ride out' shifts where the OTL joins the NQP on shift on a supernumerary basis to provide support and direct feedback.

2.7.5. Where there are concerns surrounding the development of an NQP or their ability to meet the requirements of the Consolidation of Learning Programme, this should be discussed with the Clinical Education department (Transition to Practice team) in order to ensure appropriate support can be made available.

2.7.6. NQPs are entitled to be abstracted for two 7.5 hour development days every quarter to undertake education or development activities, with the exception of quarter three (Q3) where only one development day may be taken. The abstraction of these development days will be authorised and planned in advance with Scheduling and the OTL. Consideration will be made to the impact of the resources left available to meet patient demand on the requested days similar to annual leave. The content of this day must be validated through completion of a NQP Development Abstraction Request for Training form to identify what activities have been undertaken and which Consolidation of Learning Outcomes have been achieved.

2.7.6.1. It is the responsibility of the NQP to arrange the contents of the development day; select an appropriate date in line with the above requirements; and ensure that it is educationally beneficial.

2.7.6.2. Where a development day is cancelled for any reason, it must be removed from GRS and the NQP will be expected to make the hours up in operational shifts in line with agreed policies.

2.7.6.3. Development days may include: Trust organised training courses (including ALS and PHPLS courses; Key skills training; Practice Educator training); externally provided training courses (including relevant online / eLearning courses on the condition that the expected duration of the course can be verified); relevant conferences; and opportunities to undertake supernumerary shifts with specialist practitioners.

2.8. **Scope of practice:** scope of practice depends on level of training, professional registration and current operational status. It is important to note that scope of practice is set by the Trust and is independent of what training the individual has received – clinical interventions or skills which are not approved by the Trust or specifically included within the current scope of practice may not be used.

2.8.1. NQPs are registered practitioners in their own right working to the HCPC standards of proficiency.

2.8.2. Information about the scope of practice is listed within the Scope of Practice and Clinical Standards Policy. There is also further information in the Referral, Discharge and Conveyance Policy and the Urgent Care Handbook.

2.8.3. In order to work to the paramedic scope of practice individuals must have:

2.8.3.1. Successfully completed the Transition to Practice (TtP) course, **and**;

2.8.3.2. Registered with the Health and Care Professions Council (HCPC), **and**;

2.8.3.3. Not have any current restrictions on practice by the Trust or HCPC.

2.8.4. During the TtP course the NQP will not be expected to work to the paramedic scope of practice and will not wear anything on their uniform to identify them as a paramedic. Any supernumerary shifts undertaken should be on an 'observation only' basis and should the individual come across an incident in their own time they will act as a 'lay responder' as they will not have any equipment in order to make additional interventions.

2.8.5. Upon completion of the TtP course the NQP will automatically start working to the paramedic scope of practice as long as they are registered with the HCPC. Where registration has not yet been confirmed, the individual will revert to the Emergency Care Support Worker (ECSW) scope of practice until such time as registration has been confirmed at which point a Staff Changes Form (SCF) must be submitted to confirm the effective date of this change of practice.

2.8.5.1. The exception to this is in-service NQPs who will continue working to their existing scope of practice until an SCF has been submitted to confirm the effective date of their change of practice to NQP.

2.8.6. **Shared decision making:** this is recognised as best practice in reducing risk and promoting high standards of patient care. The Trust supports shared decision making as best practice for all clinical staff. NQPs are recognised as being competent but inexperienced practitioners and therefore should have a lower threshold for utilising shared decision making. In particular:

2.8.6.1. NQPs must consult another Health Care Professional (other than another NQP) prior to discharging a patient on scene.

2.8.6.2. NQPs must consult another Health Care Professional (other than another NQP) prior to deviating from national or Trust clinical or operational guidelines.

2.8.6.3. NQPs must have access to an experienced Health Care Professional for decision making support at all times to allow for the principles of 'no decision in isolation'. Within SECAmb this will be provided through the clinical desk and paramedic practitioner desk within the Emergency Operations Centre (EOC) using the EOC Clinical Callback Procedure. For urgent support requests the Incident Command Hub will also be available.

2.8.6.4. It is acknowledged that as well as the support identified in paragraph 2.8.6.3, the NQP may also consult with other Health Care Professionals, including but not limited to: General Practitioners; Out of Hours services; HCP-led community teams; the duty OTL; other experienced paramedics. The nature and outcome of any consultation must be fully documented on the Patient Clinical Record including the name of the person consulted.

3 Responsibilities

3.1. The **Chief Executive Officer (CEO)** will be ultimately responsible for this procedure which will be delegated to the Director of Human Resources.

3.2. The **Director of Human Resources** is to ensure that this procedure effectively provides the Newly Qualified Paramedic with an appropriate programme that supports them in line with the definitions and recommendations above in conjunction with the Operations Directorate and delegates this responsibility on a day to day basis to the Head of Clinical Education.

3.3. The **Head of Clinical Education** will be responsible for:

3.3.1. Overseeing both the Transition to Practice and Preceptorship Programme.

3.3.2. Ensuring that staff engaged in preceptorship are supported and appropriately educated for the role.

3.3.3. Reviewing the training needs of both Newly Qualified Paramedics (NQPs) and those acting as preceptors and ensuring appropriate educational opportunities are made available through the Trust's existing Clinical Education programme.

3.3.4. The development of objectives that will be used by NQPs in line with national requirements of the Consolidation of Learning Programme and ensure these align with the appropriate Knowledge and Skills Framework competencies and HCPC Standards of Proficiency for Paramedics.

3.3.5. The management of the Transition to Practice Programme and Preceptorship Programme will be delegated to the **Transition to Practice (Education) Manager**.

3.4. The **Transition to Practice (Education) Manager** will be responsible for:

3.4.1. Day to day management of the Transition to Practice and Preceptorship programme on behalf of the Head of Clinical Education.

3.4.2. Evaluating and developing the programme in line with national requirements and best practice.

3.4.3. Auditing adherence to the procedure against the Key Performance Indicators contained within and reporting compliance to all stakeholders.

3.5. The **Director of Operations** will be responsible for ensuring that NQPs are rostered appropriately and that evidence of this can be audited on an organisational and individual basis.

3.6. The **Operations Manager** will be responsible for:

3.6.1. Identifying an appropriate Operational Team Leader (OTL) for all NQPs and ensuring both the OTL and NQP are made aware prior to the NQP undertaking a local induction and starting operational practice.

3.6.2. Ensuring that all NQPs who are new joiners to the Trust undertake an appropriate local induction in line with current Trust requirements.

3.6.3. Ensuring that the NQP is abstracted from operational shifts as necessary to meet the requirements of this procedure.

3.6.4. Ensuring that the OTL has time to undertake the role of preceptor and the NQP has time to meet with their OTL for reviews as required.

3.7. The **Operational Team Leader** (line manager) will be responsible for:

3.7.1. Acting as a preceptor for the NQP throughout the duration of their preceptorship – supporting them to meet the objectives of their role and providing clinical support, mentorship and guidance as required.

3.7.2. Referring the NQP to other avenues of support as required – this may include (but is not limited to) specialist practitioners within their own team; other OTLs within the Operating Unit; Occupational Health and welfare support services; and the Clinical Education Department (Transition to Practice team).

3.7.3. Undertaking the mandatory review meetings as identified in this procedure paragraph 2.7.2.

3.7.4. Maintaining accurate documentation and ensuring this is added to the NQP's online portfolio.

3.7.5. Ensuring that the rostering of NQPs complies with the requirements of this procedure (including 'on the day' changes made to resourcing due to, for example, sickness).

3.7.6. Escalating any issues or concerns to the Clinical Education department (Transition to Practice team).

3.7.7. Promoting the Trust's values, culture and vision.

3.7.8. Maintaining their own competence and providing evidence of Continual Professional Development (CPD).

3.8. The **Newly Qualified Paramedic** (NQP) will be responsible for:

3.8.1. Taking ownership of their own personal development journey.

3.8.2. Maintaining a good relationship with their Operational Team Leader, other experienced paramedics and the Clinical Education department to further their own knowledge and understanding.

3.8.3. Reflecting on their clinical practice and behaviours and seeking guidance when required.

3.8.4. Attending and engaging in the mandatory review meetings as identified in this procedure paragraph 2.7.2.

3.8.5. Maintaining a portfolio of practice in line with HCPC and Trust guidance to demonstrate their achievements against the required competencies of the Consolidation of Learning Programme.

3.8.6. Promoting the Trust's values, culture and vision and behaving as an ambassador for the Trust, demonstrating professionalism in all engagements.

3.8.7. Working within their scope of practice and the limits of their professional competence.

3.8.8. Engaging with educational opportunities provided by the Trust, including statutory and mandatory training.

3.8.9. Exercising the duty of candour and being open when mistakes may have been made.

3.8.10. Ensuring continued registration with the HCPC.

3.8.11. Informing their preceptor and the Clinical Education department (Transition to Practice team) of any period of suspension from the workplace, practice restriction, current or ongoing period of disciplinary warnings or sanction from any regulatory body or employer (including the Trust).

4 Audit and Review

4.1. This procedure is to be audited for compliance against the following Key Performance Indicators (KPI):

4.1.1. KPI 1: All Newly Qualified Paramedics to complete a Transition to Practice Course (compliance target = 100%).

4.1.2. KPI 2: All Newly Qualified Paramedics will be aware of their named Operational Team Leader prior to the end of the Transition to Practice Course (compliance target = 100%).

4.1.3. KPI 3: Newly Qualified Paramedics will only be deployed to work with an experienced paramedic for the first 150 consecutive hours of clinical practice (compliance target = 100%).

4.1.4. KPI 4: Newly Qualified Paramedics will only be deployed to work with an experienced paramedic for the next 150 consecutive hours of clinical practice (compliance target = 75%).

4.1.5. KPI 5: Newly Qualified Paramedics should be deployed as part of a crew for the first 300 hours and not on supernumerary basis (compliance target = 90%).

4.2. This procedure will be reviewed every three years or sooner if new legislation, codes of practice or national standards are introduced. The procedure will be reviewed by the Head of Clinical Education with input from all key stakeholders.

5 Associated Documentation

5.1. Health and Care Professions Council (2014). *Standards of Proficiency – Paramedics.* London: HCPC.

5.2. South East Coast Ambulance Service NHS Foundation Trust (2015). *Scope of Practice and Clinical Standards Policy.* Crawley: SECAmb.

6 References

6.1. Benner, P (1984). *From novice to expert: excellence and power in clinical nursing practice*. Menlo Park CA: Addison-Wesley.

6.2. Council of Deans of Health (2009). *Report from the preceptorship workshops retreat.* Bristol, 27 May 2009 (unpublished).

6.3. Department of Health (2008). *A High Quality Workforce: NHS Next Stage Review*. London: Department of Health.

6.4. Dreyfus, H L and Dreyfus, S E (1986). *Mind over Machine: the power of human intuition and expertise in the age of the computer*. Oxford: Basil Blackwell

6.5. NHS Staff Council (2016). *Implementation of the new Band 6 Paramedic Profile in Ambulance Trusts in England.* London: Department of Health.

7 Glossary

7.1. Experienced paramedic – a qualified paramedic who has successfully completed their preceptorship and is employed and working at band 6.

7.2. NQP (Newly Qualified Paramedic) – an individual who has completed a recognised programme of education and registered with the Health and Care Professions Council but has no or limited experience of working independently as a paramedic.

7.3. Preceptee – the subject of the preceptorship programme – for the purposes of this procedure is synonymous with Newly Qualified Paramedic (NQP).

7.4. Preceptor – an individual who has been identified and tasked to provide clinical support, mentorship and guidance to a Newly Qualified Paramedic (NQP).

7.5. Pre-registration student – an individual undertaking a recognised programme of education to become a paramedic but who has not yet completed that programme and / or registered with the Health and Care

Professions Council. Pre-registration students may also hold an employed role within the Trust (e.g. Emergency Care Support Worker, Associate Practitioner or Ambulance Technician).

Appendix A: The Journey from Novice to Expert (Benner, 1984)

Level	*1*	*2*	*3*	*4*	*5*
Description	**Novice**	**Advanced beginner**	**Competent**	**Proficient**	**Expert**
Career development stage	Undergraduate / pre-registration student	Newly Qualified Paramedic (NQP) at point of registration	NQP at 12 month development review	Paramedic at completion of preceptorship	Highly experienced paramedic / specialist paramedic
Knowledge	Minimal 'textbook' knowledge with no application to practice.	Working knowledge of key aspects of clinical practice.	Good working and background knowledge of own clinical practice areas.	Depth of understanding of own discipline and surrounding areas of practice.	Authoritative understanding of discipline and deep tacit understanding across all areas of practice.
Contextual perception	Tends to see actions in isolation.	Sees actions as a series of stages.	Sees actions at least partially in terms of longer term goals.	Sees overall picture and how individual actions fit within it.	Sees overall picture including alternative approaches.
Autonomy	Needs close supervision or instruction.	Able to achieve some tasks using own judgement but support needed for overall task.	Able to achieve most tasks using own judgement.	Able to take full responsibility for own work and supervise others.	Able to take full responsibility for going beyond existing standards and creating own interpretations.
Standard of work	Requires close supervision to ensure satisfactory standard.	Competent in straightforward tasks but requires support for more complex tasks.	Achieves basic standards although may lack refinement.	Fully acceptable standard achieved routinely.	Excellence achieved with relative ease.
Coping with complexity	Little or no conception of dealing with complexity.	Appreciates complex situations but only able to achieve partial resolution independently.	Copies with complex situations through deliberate analysis and planning.	Deals with complex situations holistically – confident in decision making.	Holistic grasp of complex situations – able to apply intuitive and analytical approaches as needed.

Adapted from the Dreyfus model of skills acquisition (Dreyfus and Dreyfus, 1986).

Appendix B: Candidates currently completing preceptorship under version two of the Clinical Preceptorship Procedure

1 Scope

A1.1. It is recognised that there are a small subset of existing staff who are subject to the requirements of the national Consolidation of Learning Programme but who have commenced their preceptorship under the previous version of the clinical preceptorship procedure (v2.0) prior to the development of this version.

A1.1.1. This affects approximately 150 direct entry Newly Qualified Paramedics and approximately 70 in-service Newly Qualified Paramedics who have commenced employment in this role since September 2016.

A1.2. The Trust recognises the need to provide these individuals with the same degree of clinical support, guidance and mentorship as all NQPs whilst acknowledging that their progression through the Consolidation of Learning Programme will be altered by the transition from the existing to the new preceptorship programme.

A1.3. Crucially, it is essential that these staff should not be penalised for the period of time they have not had access to the programme and not expected to stop undertaking assignments which they have previously been able to undertake (for example mentoring students and solo responding) unless there are concerns raised by either the individual or their OTL.

A1.4. Therefore, the following variations to this procedure apply solely to staff who have commenced their preceptorship between 1st September 2016 and 31st October 2017.

2 Variations

A2.1. Individuals who have already started working on Single Response Vehicles (SRVs) will continue to do so except in cases where either the individual or their OTL has raised concerns, in which case a personal action plan should be developed with the individual concerned.

A2.2. Individuals who are not currently qualified as a Practice Placement Educator or working towards this should be abstracted to undertake a PEd1 course at the earliest opportunity.

A2.3. The preceptorship for these staff will last for the full 24 months, measured from the date the individual started working as a paramedic (this may be the first date of employment, or the date that preceptorship was formally started where HCPC registration was delayed for any reason). At the

completion of preceptorship the individual will automatically move to band 6 on Agenda for Change.

A2.4. During their preceptorship these individuals will be entitled to the full range of support as all NQPs through their Operational Team Leader. This will include support with demonstrating their performance against the Consolidation of Learning Competencies required to successfully complete the Preceptorship Programme.

A2.4.1. Where required the Trust will provide abstractions for these individuals to undertake additional training and support to meet these competencies – this must be supported by a personal action plan to document the requirements as part of the Trust's appraisal processes.

Appendix C: National Consolidation of Learning Programme: Competencies and Outcomes

The following chart shows the required Consolidation of Learning Outcomes mapped against the Health and Care Professions Council (HCPC) Standards of Proficiency for Paramedics.

Ref	Sect.	Learning outcome	HCPC SOP
A	**Clinical**		
A1	Patient advocacy and experience		
A1a		*Demonstrate the ability to communicate effectively and appropriately with patients and carers.*	2.4; 8.1; 8.2; 8.3; 8.4; 8.5; 8.9;
A1b		*Evidence understanding of informed patient consent.*	2.7; 8.7
A1c		*Demonstrate understanding of the need to encourage and facilitate patient involvement in management, planning and control of their own health and illness.*	9.3
A1d		*Capture patient conceptions, concerns and expectations, recording these where appropriate to patient care.*	8.4; 10.1; 12.2
A2	Confidence in examination and clinical decision making		

A2	*Evidence the ability to elicit a patient history appropriate to the clinical situation, which may include, presenting complaint, history of presenting illness, past medical history, social history, family history, medications, allergies, review of systems, risk factors and other appropriate targeted history.*	4.1; 13.1; 13.6; 14.9; 14.10; 14.11; 14.15; 14.17
A2a	*Identify relevant psychological and social factors to understand current problems.*	13.10; 14.14;
A2b	*Evidence the ability to perform a physical examination according to the medical model.*	14.3; 14.10; 14.11; 14.12; 14.13;
A2c	*Evidence the ability to perform a comprehensive mental state examination and risk assessment.*	13.10; 14.3; 14.10; 14.11; 14.14;
A2d	*Evidence the ability to Interpret and weigh the findings from the consultation (Subjective and objective) in order to determine the need for further investigations and/or appropriate direction of patient management.* *No deviation from guidelines without discussion with a senior clinician.*	4.1; 13.8; 13.9; 13.10; 12.6; 14.8; 14.16;
A2e	*Evidence the ability to formulate and implement a management plan in collaboration with the patient, carers and other healthcare professionals. Ensure the input of a senior clinician is secured prior to any deviation from guidelines*	4.2; 9.3; 12.6; 13.11; 14.1; 14.6; 14.7; 14.8;
A2f	*Evidence the ability to provide adequate information (as agreed with a senior clinician if appropriate) to patients and carers to enable them to recognise and act upon deterioration or unanticipated response to treatment*	4.3; 8.7; 9.3; 14.8;
A2g	*Demonstrate the ability to monitor and follow up changes in patient condition in response to treatment, recognising indicators of patient response*	4.2; 4.5; 14.2; 14.6; 14.7;
A2h	*Demonstrate the use of clinical judgment to select most likely diagnosis in relation to evidence gathered, seeking senior advice to inform diagnosis or when treatment is outside of guidance and protocols.*	4.1; 4.2; 13.7; 14.16; 14.18;
A2i	*Recognise when data is incomplete and work safely to minimise risk where such limitations are encountered.*	1.1; 14.16;
A2j	*Recognise when a clinical situation is beyond scope of practice and seek appropriate support.*	1.1; 4.6;

A2k	*Demonstrate safe practice with regards to drug administration, intervention, management, storage and documentation.*	2.6; 10.1; 13.11; 14.4; 14.5;
A2l	*Demonstrate familiarity with pharmacodynamics and pharmacodynamics of Trust formulary.*	13.11;
A3	Risk management	
A3a	*Recognise potential clinical risk situations and take appropriate action, including seeking advice from a senior clinician in order to mitigate risk.*	1.1; 1.3;
A3b	*Recognise risks to self, colleagues, patients and others and take appropriate action to minimise/eliminate them.*	1.4; 15.1; 15.3; 15.5; 15.7;
A3c	*Demonstrate compliance with clinical governance processes*	12.5; 12.7;
B	**Professional practice**	
B1	Professional behaviours	
B1.0	Promote and protect the interests of service users and carers	
B1.0a	*Exhibits dignity and respect to service users*	2.1; 2.3; 2.4; 2.8; 5.1; 5.2; 6
B1.0b	*Demonstrate understanding of capacity and consent, evidencing how these are established in practice.*	2.7; 8.7;
B1.0c	*Demonstrate understanding of discrimination in its various forms and how it can be challenged.*	2.5; 5.2; 6; 8.6; 8.8;
B1.0d	*Demonstrate an ability to maintain appropriate boundaries.*	2.2; 2.4; 2.8; 3.1; 9.4;
B1.0e	*Consistently behave with integrity and sensitivity and in line with Trust and professional (HCPC) values*	2.2; 2.3; 3.1; 4.4;
B1.0f	*Behave as an ambassador for the Trust, acting professionally and behaving considerately towards other professionals, patients and carers. Act as a positive role model.*	3.1; 3.4; 9.1; 9.6;
B1.1	Communicate appropriately and effectively	
B1.1a	*Demonstrate appropriate and effective communication with colleagues, service users and carers.*	2.4; 8.1; 8.5; 8.6; 8.7; 14.22;

B1.1b	*Able to evidence partnership working with colleagues individually and as part of a team*	8; 9.1; 9.2; 9.4; 9.5; 9.6;
B1.1c	*Demonstrate understanding of the need for responsible use of social media and networking media.*	2.2; 3.1; 7.2; 14.22;
B1.2	Report concerns about safety.	
B1.2a	*Understand the systems available to report concerns about the safety or wellbeing of service users.*	15.1; 15.2;
B1.2b	*Demonstrate understanding of how to follow up concerns and if necessary escalate them appropriately*	15.1;
B2	Equality and diversity	
B2.1	Principles of equality and diversity	
B2.1a	*Recognise the importance of everyone's rights, in accordance with legislation, policy and procedures*	5.1; 6;
B2.1b	*Be aware of own behaviour, unconscious bias and its effects on others*	6;
B2.1c	*Identify and take action when own or others behaviour undermines equality and diversity.*	2.1; 2.2; 6;
B2.1d	*Demonstrate an understanding in practice of diversity issues and their impact on patient care, including issues such as: Cultural issues; Barriers to communication and associated ethical issues; Impact of protected characteristics e.g.; age, disability, transgender, sexuality; Health inequalities.*	5.2; 8.8;
B3	Work within the limits of knowledge and skills	
B3.1	Working within limits	
B3.1a	*Demonstrate understanding of own knowledge and skills and limits of own scope of practice.*	1.1; 4.4; 12.1; 13.4; 14.2;
B3.1b	*Demonstrate understanding of how to seek advice appropriately when at the limits of scope of practice.*	1.3; 2.8; 4.5; 4.6; 4.8; 9.4; 13.3;
B3.1c	*Provide evidence of maintenance and continued development of knowledge and skills*	3.3; 4.7; 11.1; 11.2; 14.18; 14.19; 14.21;
B3.1d	*Demonstrate the ability to work within limitations of professional competence and scope of professional practice*	1.1; 3.1; 4.4; 9.6;

B3.2	Delegate appropriately	
B3.2a	*Evidence the ability to delegate tasks appropriately to colleagues, with the ability to identify the appropriate knowledge, skills and experience needed to undertake these safely and effectively.*	1.2; 4.7; 9.1; 9.4; 9.6; 13.5;
B3.2b	*Evidence the ability to understand issues arising from supervision of others*	4.7; 13.5;
B3.2c	*Demonstrate effective and appropriate supervision of others.*	4.7; 9.6; 13.5;
B3.3	Manage risk	
B3.3a	*Demonstrate awareness of risk and the ability to identify and minimise it.*	1.4; 15.2; 15.3; 15.4; 15.5; 15.6; 15.8;
B3.3b	*Take responsibility for managing own health, seeking help and support where necessary*	3.2; 3.4; 3.5; 15.4; 15.6;
B4	Professional standards	
B4.1	Be open when things go wrong	
B4.1a	*Act in an open and honest manner when something has gone wrong with the care or treatment provided*	2.1; 2.5; 2.8; 3.1; 15.1;
B4.1b	*Understand how best to support service users or carers who wish to raise concerns about their care or treatment in a helpful, open and honest manner*	2.1; 2.8; 4.3; 7.3; 8.7; 15.1;
B4.2	Be honest and trustworthy	
B4.2a	*Personal and professional behaviour must justify the public's trust and confidence in individual and profession*	2.1; 2.2; 2.8; 3.1; 3.4; 4.4; 9.1;
B4.2b	*Must demonstrate understanding of the need to fulfill information requirements in regards to conduct and competence*	1.2; 2.2; 2.8; 3.1; 3.4;
B4.3	Maintain work records	
B4.3a	*Evidence the ability to keep full, clear and accurate records.*	10.1;
B4.3b	*Evidence the ability to keep records secure and prevent inappropriate access.*	7.2; 10.2;
B4.4	Ethical and legal issues	

B4.4a	*Identify and address ethical and legal issues that may impact on the patient and their care. Such issues will include: Ensuring patients' rights are upheld and protected; Maintaining confidentiality; Obtaining informed consent; Providing appropriate care and advocacy for vulnerable persons; Response to complaints.*	2.3; 2.7; 7.1; 7.3;
B4.4b	*Ensure that practice takes place within an ethical framework of: accepting that the patient has control; striving to achieve the best outcome; seek to do least harm; make decisions that can be judged as fair to all those involved.*	2.1; 2.4; 6; 9.3;

C	**Continued Professional Development (CPD)**	
C1	Maintaining knowledge base	
C1	Standards of CPD	
C1a	*Provide a continuous, up-to-date and accurate record of CPD activities*	2.2; 3.3; 12.4; 12.5;
C1b	*Demonstrate understanding that CPD activities are a mixture of learning activities relevant to current or future practice*	3.3;
C1c	*Evidence that the CPD undertaken has contributed to the quality of their practice and service delivery*	12.1; 13.2; 14.21;
C1d	*Evidence how CPD undertaken can benefit the service user. Demonstrate the ability to critically evaluate and reflect on own practice, in order to identify own learning and development needs and to identify and utilise learning opportunities*	11.1; 11.2; 12.7; 13.2; 14.19; 14.20; 14.21
C1e	*Demonstrate the ability to apply knowledge, evidence, guidelines and audit to benefit patient care and improve professional practice.*	12.1; 12.3; 12.4; 12.5; 12.7;
C1f	*Maintain a personal CPD portfolio*	2.2; 3.3; 10.1; 11.1; 14.20;
C1g	*Upon request, present a written profile or portfolio (own work, contemporary and supported by evidence) which demonstrates how CPD standards are being met.*	2.2; 10.1;

D	**Leadership**	
D1	Personal leadership	
D1a	*Evidence how personal leadership and judgment can be used to make informed decisions and meet the standards required for consolidation of learning programme and paramedic status, demonstrating how others are involved in own learning.*	1.1; 13.5;
D1b	*Evidence the ability to reflect on own clinical practice and behaviour*	3.3; 3.4; 11.1; 14.21;
D1c	*Demonstrate understanding of how to provide constructive feedback as well as be open to receiving such feedback from others.*	3.1; 3.5;
D1d	*Demonstrate a constructive relationship with mentors and others engaged in own learning*	3.3; 4.7;
D1e	*Understand how to raise concerns in an appropriate manner during the programme*	8.1;
D1f	*Be an effective role model and ambassador for the Trust*	3.1;
D1g	*Take ownership of own personal journey through the consolidation programme*	1.2; 3.3; 10.1; 14.2;
D2	Teamwork	
D2a	*As a new health professional, demonstrate the ability to work appropriately with others and in partnership with service users, professionals, support staff and others*	2.1; 3.1; 8.9; 9.1;
D2b	*Demonstrate the ability to work collaboratively as part of a team as well as an independent practitioner*	3.1; 4.4; 9.1; 9.2;
D2c	*Evidence being able to work in a multi-disciplinary team*	9.1; 9.2; 9.6;
D2d	*Share learning of skills, knowledge and experience where appropriate*	3.5; 4.7; 12.1; 12.2; 12.5;
E	**Practice based education (mentorship)**	

E1	Becoming a Practice Educator (mentor)	
E1a	*Understanding the role and responsibility of mentoring and of being a mentor through observation, training, delivery and mentoring.*	4.7
E1b	*Facilitate problem solving, give constructive feedback, provide peer support, demonstrate coaching skills, and commence observed feedback. Provide a reflective case study including feedback from the learner recognising own limitations and those of others.*	4.7; 11.1;
F	**Wellbeing and resilience**	
F1	Self awareness	
F1a	*Evidence awareness of and engage with Trust wellbeing services and advice where appropriate.*	3.2; 3.4; 3.5;
F1b	*Be able to maintain fitness to practice: Understand the need to maintain high standards of personal and professional conduct; Understand the need to maintain personal health; Adopt strategies for physical and psychological self-care, critical self-awareness and maintain a safe working environment; Recognise the need to engage in incident debriefing to learn lessons, reflect and address future patient management and safety.*	1.1; 1.2; 3.1; 3.2; 3.4; 3.5; 15.1; 15.3; 15.4; 15.5; 15.6;
F1c	*Understand that you must not do anything or allow someone else to do anything that you have good reason to believe will put the health and safety of a service user in danger. This includes your own actions and those of others*	1.4; 3.2; 15.1; 15.2; 15.5;
F1d	*Understand the need to limit work or stop practicing where own performance or judgment is affected by adverse health or wellbeing.*	4.4; 15.3; 15.5;
G	**Reflection and giving feedback**	
G1	Receiving feedback and reflecting	
G1a	*Effectively demonstrate insight into own professional and clinical practice by providing evidence of reflection on: Incidents encountered during shift; Any adverse incidents, complaints or grievances; Following a specific event or experience.*	11.1; 11.2;

G1b	*Avoid becoming defensive, honing the ability to receive constructive feedback which may or may not be negative, using the reflective practice and insight gained to further develop clinical practice: Actively seek feedback from peers, mentors and patients; Evidence of how a change has been made as a result of feedback.*	3.1; 3.3; 11.1;
G2	Shared values	
G2a	*Demonstrate compassion, caring and communication*	2.1; 2.3; 8;
G2b	*Demonstrate empathy, dignity and respect, intelligent kindness, integrity and sensitivity.*	2.1; 2.3; 8.4;
G2c	*Recognise the different values and beliefs and the ability to adapt personal behaviours and approach accordingly.*	2.1; 5.1; 8.6;
G2d	*Demonstrate awareness of own behaviour and its effect on others*	2.1; 2.4; 3.1; 9.1;
G2e	*Involve the patients in decisions made about them.*	8.7; 9.1; 9.3;
G2f	*Be accountable for own actions and accept responsibility*	1.3; 2.8; 3.1;
G2g	*Demonstrate understanding and practice of the Trust's Duty of Candour*	

Equality Analysis Record

1. Trust policies and procedures should support the requirements of the Equality Duty within the Equality Act:	• Eliminate discrimination, harassment and victimisation; • Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; • Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.	When designing the processes in your document, have you taken care to support the requirements of the Equality Act? **Yes**

2. When considering whether the processes outlined in your document may adversely impact on anyone, is there any existing research or information that you have taken into account?	For example: • Local or national research • National health data • Local demographics • SECAmb race equality data • Work undertaken for previous EAs	If so, please give details:

3. Do the processes described have an impact on anyone's human rights?	If so, please describe how (positive/negative etc):

4. What are the outcomes of the EA in relation to people with protected characteristics?

Protected characteristic	Impact	Protected characteristic	Impact
Age	Neutral	Race	Neutral
Disability	Neutral	Religion or belief	Neutral
Gender reassignment	Neutral	Sex	Neutral
Marriage and civil partnership	Neutral	Sexual orientation	Neutral
Pregnancy and maternity	Neutral	**Date EA was undertaken: 09/10/17**	

5. Mitigating negative impacts:

If any negative impacts have been identified, an Equality Analysis Action Plan must be completed and attached to the EA Record. A template for the action plan is available in the Equality Analysis Guidance on the Trust's website. Please contact inclusion@secamb.nhs.uk for support and guidance.

Document Control

Manager Responsible

Name:	
Job Title:	Transition to Practice (Education) Manager
Directorate:	Clinical Education Department, Directorate of Human Resources

Committee/Working Group to approve	Senior Management Team	
Version No. 3.0	Final	Date: 31/10/17

Draft/Evaluation/Approval (Insert stage of process)

Person/Committee	Comments	Version	Date
Joint Partnership Fprum	Approved	3.0	30.10.17
Joint Partnership Forum	Options paper requested	Draft 4.2	29/08/17
NQP Working Group	Options discussed and agreed	Draft 5.1	22/09/17
Trust-wide consultation	Para 2.8.4 spelling correction Para 2.8.6.4 'bronze' removed CLO updated to latest version	Draft 5.5	05/10/17
Joint Partnership Forum	Para 2.5 – reference to Relief Policy removed.	Draft 5.7	30/10/17
Senior Management Team		Draft 5.8	31/10/17

Circulation

Records Management Database	Date: 31.10.17
Internal Stakeholders	
External Stakeholders	

Review Due

Manager	Danny Dixon	
Period	Every three years or sooner if new legislation, codes of practice or national standards are introduced	Date: 31st October 2020

Record Information

Security Access/Sensitivity	Official (Public Domain)
Publication Scheme	Yes
Where Held	Records Management database
Disposal Method and date:	

Supports Standard(s)/KLOE

	Care Quality Commission (CQC)	**IG Toolkit**	**Other**

Criteria/KLOE:	Name core service area and CREWS elements		