South East Coast Ambulance Service NHS
NHS Foundation Trust

Clinical Preceptorship Procedure (Paramedics)

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) and other colleagues who require a period of supported development.

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 life-long 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.

1.2.3. As such, the Trust recognises that the principles of preceptorship can equally be applied to colleagues who require support to develop in the paramedic role. This may include, but is not limited to, experienced international paramedics with no recent experience of clinical practice within the United Kingdom (UK); paramedics who have gained clinical experience outside the NHS Ambulance Services; and 'return to practice' paramedics who have recently returned to the paramedic register.

1.2.4. The NHS Long Term Workforce Plan highlights that "Good quality preceptorship is key for the wider workforce" (NHS England, 2023).

1.2.5. The Trust Preceptorship Procedure has been developed to incorporate the underpinning principles from the Health and Care Professions Council (HCPC) Principles for Preceptorship (2023) and the National Health Service England (NHSE) Allied Health Professional Preceptorship Standards and Framework (2023). Although the framework focuses on preceptorship for paramedics, the principles and approach can also be used to support other Allied Health Professionals within the Trust.

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 replaced the previous preceptorship programme which had been in place since 2014.

1.4. This procedure will provide a clear framework to both the preceptee and the Trust for the support, guidance, deployment and scope of practice of preceptees working within 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 in a non-registered role 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'). Where the national programme has been partially completed elsewhere, this evidence will be added to the preceptee's ePortfolio on commencing preceptorship within SECAmb.

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'). Refer to HCPC website for more details about return to practice requirements.

1.6.5. Any other paramedic who is being supported through preceptorship ('Paramedic, Supported Development'). Note that, in line with the NHSE AHP Preceptorship Standards and Framework (2023) standard 1.3, any paramedic may request to commence the preceptorship programme as a Paramedic (Supported Development) and this should be discussed with their line manager through the appraisal process in the first instance.

1.7. For preceptees 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. This is discussed further in paragraph 2.2 below.

1.7.1. The Trust will not employ NQPs on a bank basis or equivalent (such as a secondary assignment alongside an alternative full-time role) due to reduced patient contact hours making it difficult to supervise the individual's progression and adequately support their development.

1.7.2. The Trust will not generally employ NQPs on a part time contract of less than 0.5 Whole Time Equivalent (WTE). This is to ensure sufficient clinical exposure to ensure skills maintenance and development. Where NQPs are employed on a basis of less than 0.5WTE, they may require an extension to their Preceptorship to complete all required elements and demonstrate competency.

1.7.3. Where an individual voluntarily leaves their NQP or Paramedic (Supported Development) role on a permanent (e.g. voluntary resignation, termination of contract) or temporary (e.g. internal / external secondment, career break / sabbatical) basis, their preceptorship will be paused until such time that they return to this role. In either case the preceptee will be shown as 'Withdrawn' on the ePortfolio, and the time they are away from their role will not be included within the length of their preceptorship. Preceptorship may be restarted at any stage on returning to the NQP or Paramedic (Supported Development) role.

1.8. 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 (in which case time undertaken on preceptorship elsewhere will be accepted towards the length of preceptorship within SECAmb).

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. This will be the date recorded on their

Electronic Staff Record (ESR) as the commencement date of their NQP or Paramedic (Supported Development) role.

2.2.1.1. Where a direct-entry NQP has not gained HCPC registration by the conclusion of their induction training and therefore is unable to start preceptorship, the Clinical Education department will complete a Staff Changes Form (SCF) to temporarily amend their scope of practice and associated pay to Emergency Care Support Worker until such time that they have gained their HCPC registration and are able to commence preceptorship. At this point a further SCF will be completed to reinstate them as an NQP – this will become the start date of their preceptorship. This temporary amendment in scope of practice does not infer any underlying qualification as an ECSW and in these cases if the individual is unable to gain their HCPC registration prior to the end of their probationary period there is no automatic right to continue working in the ECSW role.

2.2.2. The Trust has a separate Standard Operating Procedure (SOP) to identify the eligibility criteria, application method, and decision-making process for preceptees who wish to consider fast tracking through preceptorship. This aligns with the Clinical Preceptorship Procedure. It should be noted that the fast-tracking procedure is intended for individuals who have previous relevant experience in a paramedic (or equivalent) role, and that the vast majority of competent preceptees will benefit from completing the full 24-month preceptorship.

2.2.3. **Extension of preceptorship:** In exceptional circumstances where preceptees are unable to complete the competency requirements of the Consolidation of Learning Programme within 24 months due to personal circumstances (for example a prolonged period of absence) the preceptorship period may be extended. The Trust will provide light or alternative duties to support achievement of the competencies within the timeframe to avoid extension wherever possible. This will be discussed with the individual on a case-by-case basis and decisions made following the planned review meetings (6, 12, 18 and 23-month reviews).

2.2.3.1. Competency will be measured against the Consolidation of Learning Outcomes, which are determined nationally and recorded on the ePortfolio. A number of these require the preceptee to ‘demonstrate’ clinical competency and therefore should generally be completed within clinical practice (i.e. on an ambulance responding to patients). Where required, simulation activities and clinical conversations will be considered to assist with evidence where practice is restricted.

2.2.3.2. Some of the competencies may be evidenced within alternative duties postings, and where applicable this will be encouraged. Alternative duties will be assessed as meeting the Consolidation of Learning Outcome

during the portfolio assessment process. Advice can be provided through the Clinical Education department in consultation with the HR Business Partner.

2.2.3.3. It is recognised that in order to gain experience and develop as a practitioner, both sufficient and sustained clinical practice is required. Therefore, the portfolio should be completed across the full length of preceptorship (see paragraph 3.8.5.1).

2.2.3.4. Irrespective of the number of clinical hours completed, there may be other circumstances where it is reasonable to extend the preceptorship period in order to provide additional support. The Clinical Education department will provide advice, support and guidance in this regard, and more information is included in section 2.9 below: 'Completing preceptorship'. In these circumstances an 'Individual Learning Agreement' may be put in place to document the support to be made available and expectations of all parties.

2.3. **Induction training:** All NQPs and other preceptees 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 preceptees will complete a TtP course).

2.3.1. For direct-entry NQPs this will generally form their first weeks of employment. Where required the emergency driving course or assessment (as appropriate) will also be completed at this time. As new employees there will also be the requirement to undertake operational 'onboarding' and a suitable induction to their Operating Unit (OU).

2.3.2. For in-service NQPs this will be prior to their start date of employment as a paramedic ('change of practice'), however may take place prior to receiving HCPC registration. The Clinical Education department will complete a Staff Changes Form (SCF) to confirm the date that the individual will start in the NQP role – until this date the individual will continue to work to their existing role and scope of practice.

2.3.3. Following the Transition to Practice course, most preceptees will progress immediately to their period of direct clinical support (see paragraph 2.5.1). The exception to this will be where a specific concern has been raised during the TtP course where the preceptee requires a bespoke period of support which may include supernumerary shifts, or where there has been a delay in being able to fulfil all requirements of their role for any reason (e.g. a delay completing the driving course) which requires the individual to remain supernumerary.

2.4. The Operations Manager for the preceptee will assign an Operational Team Leader (OTL) – the OTL will also function as the individual's preceptor and should be the first point of contact for support, mentorship and guidance as required. The preceptee will be advised of the name of their OTL as early as possible in their employment and prior to operational deployment (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).

2.4.1. In addition to their OTL, each preceptee will be allocated a named specialist cliniciac Practitioner or Critical Care Paramedic) within their Operating Unit (OU). The purpose of the specialist clinician will be as an initial point of contact for clinical supervision, support and development and they will act as a secondary preceptor; however, this support may also be provided by other clinicians within the OU as appropriate.

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

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

2.5.1.1. In order to balance support for the preceptee 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 preceptees 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 preceptees 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 preceptees 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 on the day to allow for staff sickness, absences or other unforeseen circumstances – however the confidence of the preceptee should be considered a factor in this decision. Where a preceptee has their duties changed 'on the day' to balance the skills mix this should be reported via Datix and should be considered an exception rather than an expectation.

2.5.1.2. It is recognised that whilst ideally a preceptee 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 preceptee.

2.5.1.3. With the exception of where there are specific restrictions on their practice, preceptees 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 preceptee to work with an experienced paramedic as part of a crew have been exhausted, preceptees 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). In order to maximise efficiency during shift planning, two preceptees may be deployed to work with an experienced paramedic, where the experienced paramedic becomes the supernumerary individual supporting both preceptees. In this case only there is no limit regarding how frequently this can occur.

2.5.1.4. In exceptional circumstances such as a Business Continuity Incident or Major Incident the preceptee 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.

2.5.1.5. During the initial 300 hours of direct clinical support, a preceptee is unable to book overtime regardless of the availability of shifts. This is to aid planning and reduce the need for ‘on the day’ changes, reduce overload on Practice Educators, reduce cognitive overload on preceptees and recognise the need for adequate rest periods to ensure resilience. Following this initial period and for the remainder of preceptorship, preceptees may book overtime in line with the Overtime Policy and Procedure, however are reminded of the importance of ensuring sufficient time between shifts to consolidate learning and avoid ‘burnout’.

2.5.2. The preceptee must not be deployed on a Single Response Vehicle (SRV) or expected to solo respond for the full duration of their preceptorship, other than in the circumstances described in paragraph 2.5.2.1.

2.5.2.1. It is recognised that in extreme circumstances it may be necessary for a preceptee to solo respond in order to provide a first response at a confirmed cardiac arrest, however this must not be planned either as part of an advanced roster or the result of on the day resourcing changes. Where a preceptee provides a solo first response to a confirmed cardiac arrest, they must be backed up as soon as possible and stood down if the nature of the call changes on route. This should be retrospectively

reported via Datix and a welfare check should be completed with the preceptee as soon as practicable following the call.

2.5.3. The preceptee must not supervise an inexperienced (less than three months operational experience) colleague of any clinical grade (i.e. Emergency Care Support Worker, Trainee Associate Ambulance Practitioner) at any stage during their preceptorship.

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

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

2.6.1. The preceptee may supervise a pre-registration student at any stage, with the expectation that the student may only undertake clinical practice that the preceptee feels confident and competent to both practice independently and oversee in others. A preceptee can also sign to state they have witnessed an intervention be correctly performed by a student – but should not make judgements about the student's ability to perform the intervention in the future (without supervision).

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 preceptee as part of their rostered duties.

2.6.1.2. Scheduling teams should avoid booking direct entry pre-registration students onto supernumerary shifts with preceptees during their first 300 hours of direct clinical support working with another paramedic. Where this does occur the pre-registration 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 preceptee. All students are to be made aware of this as part of their Trust induction.

2.6.2. A preceptee who has completed their Practice Education (PEd) course and their first 12 months of preceptorship can provide guidance and support to learners by providing feedback over a sustained period and helping the learner to develop their practice. Preceptees in this group may be allocated a first-year student paramedic to support. This has previously been referred to as 'formative mentoring'.

2.6.3. The preceptee must not act as a summative ("sign off") mentor at any stage, although should complete the Practice Education (PEd) 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 PEd course will be able to sign off summative assessments for students, however preceptees may provide feedback to Practice Educators about a learner they are supporting.

2.7. **Progress reviews:** the preceptorship programme is designed to empower the preceptee to develop their practice and demonstrate their transition from novice to expert and should take place as a partnership between the preceptor and the preceptee. 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(s), 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 by either the preceptor or preceptee.

2.7.2. Formal reviews should take place at regular intervals as an opportunity for both the preceptor and the preceptee to identify specific development needs and generate a personal action plan if required. The review should take place between the preceptee and the OTL, and may also involve input from subject specialists to provide additional support. This could include the named specialist paramedic; Clinical Education Lead; or HR Business Partner as required. The overarching purpose of the review is to identify whether the preceptee requires any additional support or reasonable adjustments to remain on track and achieve completion of their preceptorship. They may take place in-person, virtually (for example using Microsoft Teams), or by telephone as appropriate to the needs of the individual. These will be identified as follows:

2.7.2.1. 6 months – probationary review meeting. If concerns are raised regarding the preceptee's progression at this stage this must be escalated to the Clinical Education department and the OTL must arrange for the preceptee's probationary period to be extended.

2.7.2.2. 12 months – mid-point review. At this stage consideration should be given to ensuring the Practice Education (PEd) course has been completed or booked.

2.7.2.3. 18 months – development review. This could take place alongside the preceptee's annual appraisal, or may take place separately.

2.7.2.4. 23 months – end of preceptorship review. This should take place in anticipation of the preceptee completing their preceptorship, and therefore needs to occur in good time for all administrative elements to be completed. See section 2.9 for more information on completing preceptorship.

2.7.3. Each review meeting must be documented using the current version of the Candidate Evaluation Form (see Appendix D) and a copy submitted to the Clinical Education department for review via Marval. This will subsequently be uploaded to the preceptee's ePortfolio as part of their record of development.

2.7.4. Informal reviews will take place more frequently (ideally no less than once per month) 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 a preceptee to provide immediate and objective feedback on the preceptee's actions during a single shift.

2.7.4.2. Personal evaluations and reflective practice completed by the preceptee to support their own development.

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

2.7.4.4. Clinical supervision, practice and discussion with Advanced and Specialist Paramedics within the preceptee's Operating Unit.

2.7.4.5. Informal meetings with the OTL (or another member of the OU leadership team) to discuss ongoing wellbeing and support.

2.7.5. Where there are concerns surrounding the development of a preceptee or their ability to meet the requirements of the Consolidation of Learning Programme, this should be discussed with the Clinical Education department at the earliest opportunity in order to ensure appropriate support can be made available.

2.7.5.1. **Delayed progression:** where a preceptee is not developing or progressing through their preceptorship as expected, early support is essential in order to identify any barriers to learning and to overcome these.

2.7.5.2. Support is available through a range of sources, including local peer support (for example a group of preceptees arranging a study day to support each other); facilitated sessions by OTLs or specialist paramedics

utilising OU Support time; and tutorials with the Clinical Education departments.

2.7.5.3. Where targeted support is provided, this should be documented within the 'contact logs' section of the preceptee's ePortfolio – this may include a copy of any action plans agreed or tutorial notes.

2.7.5.4. Where there are identified delays in progressing with preceptorship, it may be necessary to support the preceptee through the Capability Procedure – further information and prompts for doing so are within paragraph 2.9.2.4 of this procedure.

2.7.6. **Developmental Abstraction Requests for Training (DART):** Preceptees are entitled to be abstracted for up to seven 7.5 hour development days every year (52.5 hours per year in total) to undertake education or development activities. The abstraction of these development days will be authorised and planned in advance with Scheduling and the OTL in-line with normal shift planning. Consideration will be made to the impact of the resources left available to meet patient demand on the requested days similar to annual leave, and DART days will not be authorised during known periods of increased demand or reduced capacity (such as over Christmas, New Year or significant national events).

2.7.6.1. It is the responsibility of the preceptee 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. The planning and content of this day must be validated through completion of a NQP Development Abstraction Request for Training form to identify what activities will be undertaken and which Consolidation of Learning Outcomes will be achieved.

2.7.6.2. Where a development day is cancelled for any reason, it must be removed from GRS and the preceptee 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 (such as ALS and PHTLS courses); 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. Whilst DART days are not generally intended solely for completion of the ePortfolio, it is recognised that a preceptee may undertake self-directed learning and reflective activities during a DART day and record this development in their ePortfolio – in this case the OTL should review the ePortfolio following the DART day to ensure the expected activity has been completed.

2.7.6.4. Preceptee allocations of hours for DART abstractions (52.5 hour per year) will be based on the individual start date of preceptorship and will not roll over from one year to the next if unused. All DART abstractions must be recorded on GRS as 'NQP Dev'. Where preceptorship length is shortened through successful fast tracking, no DART abstractions will be authorised following the completion date of preceptorship. Where preceptorship length is extended, additional DART hours will be available on a pro-rata basis and only hours which have been accumulated to date may be booked.

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 must not be used.

2.8.1. Paramedic Preceptees 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. Formally started employment in the NQP or Paramedic (Support Development) role, **and**;

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

2.8.4. During the TtP course the preceptee will not be deployed 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, it is recommended they act as a 'lay responder' as they will not have any equipment in order to make additional interventions.

2.8.5. Upon successful completion of the TtP course the preceptee 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, refer to paragraph 2.2.1.1 regarding temporary amendment to scope 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 (see paragraph 2.3.2).

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

2.8.6.1. Preceptees 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 within the Emergency Operations Centre (EOC) and the local Urgent Care Hubs. Preceptees should use the EOC Clinical Callback Procedure in order to gain clinical support. For urgent support requests the Critical Care Desk is available, and during specific periods of high demand the Incident Command Hub may also be available.

2.8.6.2. It is acknowledged that as well as the support identified above, the Preceptee 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.

2.8.6.3. Preceptees must consult another Health Care Professional (other than another preceptee) prior to discharging a patient on scene.

2.8.6.4. Preceptees must consult another Health Care Professional (other than another preceptee) prior to deviating from national or Trust clinical or operational guidelines.

2.9. **Completing preceptorship:** as preceptees approach the end of their preceptorship they should be supported to ensure that all mandatory elements of preceptorship are complete in order to progress to the experienced (band 6) paramedic role in a timely manner.

2.9.1. Mandatory elements which must be evidenced in order to successfully complete preceptorship include:

2.9.1.1. All Consolidation of Learning Assessment Criteria evidenced (in other words, ePortfolio 100% complete).

2.9.1.2. Completion of a Trust-approved Practice Educator (PEd) course.

2.9.1.3. 24 months employment as an NQP or Paramedic (Supported Development), or approved Fast-Track

2.9.1.4. End of preceptorship candidate evaluation completed and no outstanding concerns identified (see paragraph 2.7.2.4 for further information). Note that although previous evaluations should be completed at the relevant times, if these are not recorded for any reason this will not prevent completion of preceptorship as long as the end of preceptorship evaluation is completed).

2.9.1.5. Any mandatory training requirements as identified in appendix B.

2.9.2. Once all mandatory elements have been completed, the Clinical Education department will submit a Staff Changes Form (SCF) to process the promotion to experienced (band 6) paramedic.

2.9.2.1. Where all mandatory elements are completed in sufficient time prior to the anticipated completion date of preceptorship, the SCF will be dated to take effect from the anticipated completion date. This is the expected timeframe which all preceptees will be supported to achieve.

2.9.2.2. Where any mandatory elements are not completed by the anticipated completion date, preceptorship will be extended only for as long as is required to successfully complete the mandatory elements. This will be supported by the preceptee's OTL and the Clinical Education department as required, including through the use of an individual learning action plan to provide bespoke support.

2.9.2.3. It is expected that any 'overdue' preceptee (a preceptee who has not completed their preceptorship by their anticipated completion date) will be supported by their OTL using the Trust's Capability Procedure – it is important to note that the Capability Procedure is designed to ensure colleagues are supported to achieve the expected high standards of performance, therefore this should not be considered a punitive action. It is an opportunity to identify any barriers to completion and ensuring appropriate support to overcome these.

2.9.2.4. Where a preceptee is not yet overdue (i.e. their anticipated completion date has not passed), however the ongoing reviews of their progress have identified that they are struggling to progress or achieve the expected standards, it is also likely to be appropriate to provide bespoke support through the Capability Procedure. Initiators for this will include

(but are not limited to) a specific concern raised by the preceptee's OTL or the Clinical Education department; a lack of engagement with the preceptorship process; repeated non-compliance with the requirements of the Preceptorship procedure; or being more than 30% behind their target progress on their ePortfolio while continuing in operational duties.

2.9.2.5. In extreme circumstances, where a preceptee is unwilling to engage with their preceptorship or deliberately and repeatedly fails to comply with the requirements of the Preceptorship Procedure, it may be necessary to begin disciplinary proceedings. This should be a last resort, since the preceptorship process is designed to be supportive and aid an individual's professional development, however the band 5 NQP and Paramedic (Supported Development) roles are intended to be progression roles only and therefore completion of preceptorship is a contractual requirement of all NQPs and Paramedics (Supported Development). Where this is required, it will be managed by the preceptee's line manager with input from the Clinical Education department and Human Resources team as required.

3 Responsibilities

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

3.2. The **Chief Medical Officer** is to ensure that this procedure effectively provides the Preceptee 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 Consultant Paramedic (Education and Training).

3.3. The **Consultant Paramedic (Education and Training)** 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 Paramedics (Support Development), 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 preceptees 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 oversight and management of the Transition to Practice Programme and Preceptorship Programme will be delegated to the **Senior Education Manager**, which will be undertaken on a day-to-day basis by the nominated Clinical Education Lead.

3.4. The **Clinical Education Lead** will be responsible for:

3.4.1. Day to day management of the Transition to Practice and Preceptorship programme on behalf of the Consultant Paramedic (Education and Training).

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.

3.4.4. Providing educational support to preceptees and preceptors, in particular recognising individual learning needs and ensuring that preceptees are supported or signposted appropriately.

3.5. The **Director of Operations** will be responsible for ensuring that preceptees 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 preceptees and ensuring both the OTL and preceptee are made aware prior to the preceptee undertaking a local induction and starting operational practice.

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

3.6.3. Ensuring that the preceptee 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 preceptee 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 preceptee 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 preceptee 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.

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 preceptee's online ePortfolio.

3.7.5. Ensuring that the rostering of preceptees 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.

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).

3.7.9. Recognising and supporting preceptees with any individual or additional learning support needs, including neurodiverse learners, to ensure that they are supported with any reasonable adjustments which may be required to promote learning opportunities. This should be in conjunction with the Trust's inclusion time and completion of an 'Enable' (reasonable adjustments) passport should be considered.

3.8. The **Preceptee** 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 an ePortfolio of practice in line with HCPC and Trust guidance to demonstrate their achievements against the required competencies of the Consolidation of Learning Programme.

3.8.5.1. Note that completion of the ePortfolio should be in line with the guidance published by the Clinical Education department relating to standard and quality of entries, maintaining confidentiality, avoiding plagiarism, and demonstrating professional behaviours. The ePortfolio should be completed in a linear fashion throughout preceptorship (in other words completing approximately 25% every six months, rather than leaving long periods without development and then completing the entire ePortfolio towards the end of preceptorship).

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 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 (evaluating effectiveness)

4.1. All procedures have their effectiveness audited by the responsible Management Group at regular intervals, and initially six months after a new policy is approved and disseminated.

4.2. Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).

4.3. This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the policy is not working effectively.

4.4. All changes made to this procedure will go through the governance route for development and approval as set out in the Policy on Policies.

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

4.5.1. KPI 1: All preceptees to complete a Transition to Practice Course (compliance target = 100%).

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

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

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

4.5.5. KPI 5: preceptees should be deployed as part of a crew for the first 300 hours and not on supernumerary basis (however may be deployed as two NQPs with a supernumerary experienced paramedic) (compliance target = 90%).

4.5.6. KPI 6: preceptees must consult another Health Care Professional prior to discharging a patient on scene (compliance target = 100%).

4.5.7. KPI 7: preceptees must not be deployed on a Single Response Vehicle (SRV) or expected to solo respond for the full duration of their preceptorship, other than for the specific exception defined in this procedure (first response to confirmed cardiac arrest) (compliance target = 100%).

4.6. 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 Consultant Paramedic (Education and Training) or their delegate with input from all key stakeholders.

5 Associated Documentation

5.1. Health and Care Professions Council (2023). *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.

5.3. South East Coast Ambulance Service NHS Foundation Trust (2022). *Clinical Preceptorship Procedure: Fast Track SOP.* Crawley: SECAmb.

5.4. South East Coast Ambulance Service NHS Foundation Trust (2022). *Managing Health and Attendance at Work Policy and Procedure, v3*. Crawley: SECAmb.

5.5. South East Coast Ambulance Service NHS Foundation Trust (2023). *Overtime Policy, v3.* 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. Health and Care Professions Council (2023). *Principles for Preceptorship.* London: HCPC.

6.6. NHS England (2023a). *Long Term Workforce Plan*. London: National Health Service.

6.7. NHS England (2023b). *Allied Health Professions (AHP) Preceptorship Standards and Framework.* London: National Health Service.

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

7 Glossary and definitions

7.1. Anticipated Completion Date – the planned date on which the preceptee is expected to complete their preceptorship, subject to completion of all required elements. Note that where all required elements are not completed, the actual completion date will be extended beyond the anticipated completion date.

7.2. Direct Clinical Support – the period of time a preceptee will spend working directly alongside an experienced paramedic to ensure that support is available immediately (note that support is not synonymous with supervision). For the purposes of this procedure this will usually be the first 300 hours of clinical practice.

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

7.4. Indirect Clinical Support – the period of time a preceptee will have access to remote clinical support (including a supportive scope of practice). For the purposes of this procedure this will be the remainder of preceptorship following the period of direct clinical support.

7.5. 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.

7.6. Paramedic (Supported Development) – an individual who, whilst not newly qualified, may be newly registered with the Health and Care Professions council or otherwise unfamiliar with contemporaneous paramedic practice in the United Kingdom NHS Ambulance Services.

7.7. Preceptee – the subject of the preceptorship programme – for the purposes of this procedure is synonymous with Newly Qualified Paramedic (NQP) and / or Paramedic (Supported Development).

7.8. Preceptor – an individual who has been identified and tasked to provide clinical support, mentorship and guidance to a Preceptee.

7.9. Preceptorship – a period of support for a competent but inexperienced practitioner – in most cases this will last for a period of 24 months for paramedics.

7.10. 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 Ambulance Practitioner or Ambulance Technician).

8 Financial Checkpoint

8.1 This document has been confirmed by Finance to have financial implications and the relevant Trust processes have been followed to ensure adequate funds are available.

9 Equality Analysis

9.1. The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

9.2. Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.

9.3. A copy of the completed and approved EA is included on the following pages.

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: Schedule of mandatory education and training activities

The following is a list of training and education activities which have been mandated either internally or externally for Newly Qualified Paramedics to complete during their preceptorship.

B1.1. Spotting the Sick Child eLearning course – available at www.spottingthesickchild.co.uk

B1.2. Trust Key Skills Programme and Statutory and Mandatory eLearning courses – note that these are administered on an annual basis, therefore it is recognised that a preceptee may not yet have completed Key Skills / Statutory and Mandatory eLearning for the financial year in which they complete their preceptorship and this should not prevent or delay completion.

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 (updated September 2023).

Ref	Section	Learning outcome	HCPC SOP (2023)
A	**Clinical**		
A1	Patient advocacy and experience		
A1a		*Demonstrate the ability to communicate effectively and appropriately with patients and carers.*	2.1; 7.1; 7.2; 7.3; 7.4; 7.5; 7.6; 7.7; 7.8; 8.1
A1b		*Evidence understanding of informed patient consent.*	2.7; 7.4; 7.5; 7.6
A1c		*Demonstrate understanding of the need to encourage and facilitate patient involvement in management, planning and control of their own health and illness.*	8.1; 11.5; 13.17; 15.1; 15.3
A1d		*Capture patient conceptions, concerns and expectations, recording these where appropriate to patient care.*	2.5; 8.5; 12.5; 12.13
A2	Confidence in examination and clinical decision making		
		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.	13.2; 2.5; 13.5; 12.10; 13.4
A2a		*Identify relevant psychological and social factors to understand current problems.*	12.20; 15.2; 12.13; 8.5; 12.9; 12.14
A2b		*Evidence the ability to perform a physical examination according to the medical model.*	4.2; 13.12; 12.5; 12.6; 12.10; 13.18; 13.2; 13.4; 13.5; 13.6; 13.7; 13.19; 2.5
A2c		*Evidence the ability to perform a comprehensive mental state examination and risk assessment.*	4.2; 13.12; 12.5; 12.6; 12.10; 13.18; 13.2; 13.4; 13.5; 13.6; 13.7

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.*	4.2; 4.6; 4.7; 4.9; 4.10; 12.1; 12.4; 12.6; 12.8; 13.3; 13.6; 13.16; 12.5; 12.10; 2.5; 1.1
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*	4.7; 4.9; 4.10; 13.17; 7.4; 8.1; 12.10; 11.5; 12.6; 13.16; 2.5; 1.1
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*	7.4; 7.8; 13.14; 13.16; 14.5; 15.3; 1.1
A2g	*Demonstrate the ability to monitor and follow up changes in patient condition in response to treatment, recognising indicators of patient response*	4.2; 4.3; 12.2; 11.2; 12.10; 12.11; 13.15; 12.11; 13.7; 4.6; 12.7
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.*	1.1; 12.6; 13.3; 1.4; 2.5; 13.18; 4.5; 4.7; 12.3; 14.1; 12.7; 12.8; 12.10
A2i	*Recognise when data is incomplete and work safely to minimise risk where such limitations are encountered.*	14.5; 1.5; 14.3
A2j	*Recognise when a clinical situation is beyond scope of practice and seek appropriate support.*	1.1; 2.10; 8.2; 2.12; 4.4; 13.13
A2k	*Demonstrate safe practice with regards to drug administration, intervention, management, storage and documentation.*	2.5; 9.3; 13.7; 4.3; 12.10; 13.13; 9.1; 12.11; 14.2
A2l	*Demonstrate familiarity with pharmacodynamics and pharmacodynamics of Trust formulary.*	12.11
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; 1.4; 1.5; 4.9; 4.4; 14.3; 14.1; 14.5

A3b	*Recognise risks to self, colleagues, patients and others and take appropriate action to minimise/eliminate them.*	1.1; 1.4; 1.5; 4.9; 4.4; 14.3; 14.1; 14.5; 2.2; 14.4 3.1; 8.5
A3c	*Demonstrate compliance with clinical governance processes*	9.2; 11.3; 11.4
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*	2.2; 2.5; 2.6; 5.1; 5.2; 5.3; 5.4; 5.5; 5.6; 5.7
B1.0b	*Demonstrate understanding of capacity and consent, evidencing how these are established in practice.*	2.8; 2.7; 6.5; 7.5; 7.8
B1.0c	*Demonstrate understanding of discrimination in its various forms and how it can be challenged.*	15.2; 12.14; 2.5; 7.3; 7.5; 5.1; 5.2; 5.3; 5.4; 5.5; 5.6; 5.7
B1.0d	*Demonstrate an ability to maintain appropriate boundaries.*	2.6; 2.11
B1.0e	*Consistently behave with integrity and sensitivity and in line with Trust and professional (HCPC) values*	2.1; 2.4; 2.6; 4.8; 5.1; 6.1; 7.5; 4.1
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.*	2.1; 2.2; 2.4; 2.10; 2.5; 5.1; 5.2; 5.3; 5.4; 5.5; 5.6; 5.7 6.1; 8.1; 8.3; 8.5; 8.10; 13.15; 15.3
B1.1	Communicate appropriately and effectively	
B1.1a	*Demonstrate appropriate and effective communication with colleagues, service users and carers.*	2.1; 7.1; 7.2; 7.3; 7.4; 7.5; 7.6; 7.7; 7.8; 8.1; 4.4
B1.1b	*Able to evidence partnership working with colleagues individually and as part of a team*	7.1; 8.1;8.2; 8.3; 8.4; 10.2
B1.1c	*Demonstrate understanding of the need for responsible use of social media and networking media.*	6.4; 6.5; 2.4; 2.1; 6.2
B1.2	Report concerns about safety.	
B1.2a	*Understand the systems available to report concerns about the safety or wellbeing of service users.*	2.3; 1.5; 6.3; 8.5; 14.2; 14.3

B1.2b	*Demonstrate understanding of how to follow up concerns and if necessary escalate them appropriately*	2.3
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*	2.7; 2.2; 7.3; 2.10; 2.5; 5.1; 5.2; 5.3; 5.4; 5.5; 5.6; 5.7
B2.1b	*Be aware of own behaviour, unconscious bias and its effects on others*	2.1; 4.1; 8.3; 12.9; 5.1; 5.2; 5.3; 5.4; 5.5; 5.6; 5.7; 7.3; 7.5; 8.10
B2.1c	*Identify and take action when own or others behaviour undermines equality and diversity.*	2.2; 2.4; 5.6; 2.10; 2.13
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.*	2.5; 5.1; 5.3; 5.4; 5.5; 5.7; 7.3; 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; 1.3; 2.9; 13.12; 13.13; 13.14; 13.15; 13.16; 13.17; 13.18; 13.19; 13.20; 13.1; 13.2; 13.3; 13.4; 13.5; 13.6; 13.7; 2.10; 2.12; 8.9; 12.1; 12.2; 12.3; 12.4; 12.5; 12.6; 12.7; 12.8; 12.9; 12.10; 12.11; 12.12; 12.13; 12.14
B3.1b	*Demonstrate understanding of how to seek advice appropriately when at the limits of scope of practice.*	1.1; 1.2; 1.3; 4.4; 1.4; 1.5; 3.3; 3.4
B3.1c	*Provide evidence of maintenance and continued development of knowledge and skills*	1.3; 2.4; 4.8; 13.1; 13.8; 13.9; 13.10

B3.1d	*Demonstrate the ability to work within limitations of professional competence and scope of professional practice*	1.1; 1.3; 2.9; 13.12; 13.13; 13.14; 13.15; 13.16; 13.17; 13.18; 13.19; 13.20; 13.1; 13.2; 13.3; 13.4; 13.5; 13.6; 13.7; 2.10; 2.12; 8.9; 12.1; 12.2; 12.3; 12.4; 12.5; 12.6; 12.7; 12.8; 12.9; 12.10; 12.11; 12.12; 12.13; 12.14
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; 4.4; 8.9; 8.2; 8.4; 14.3; 15.3; 12.3; 4.8
B3.2b	*Evidence the ability to understand issues arising from supervision of others*	8.9; 4.8
B3.2c	*Demonstrate effective and appropriate supervision of others.*	8.9; 8.11; 5.10; 4.8
B3.3	Manage risk	
B3.3a	*Demonstrate awareness of risk and the ability to identify and minimise it.*	1.4; 1.5; 14.1; 14.2; 14.3; 14.4; 14.5
B3.3b	*Take responsibility for managing own health, seeking help and support where necessary*	14.1; 3.1; 3.2; 3.3; 3.4; 1.1; 1.2
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*	2.2; 2.4; 2.5; 2.9; 4.1; 2.1; 15.1; 2.13
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*	15.1; 15.3; 7.8; 2.2; 2.4; 2.5; 2.9; 4.1; 2.1; 15.1; 2.13
B4.2	Be honest and trustworthy	
B4.2a	*Personal and professional behaviour must justify the public's trust and confidence in individual and profession*	1.2; 2.1; 2.2; 2.4; 2.5; 2.9; 3.4; 4.1; 8.1

B4.2b	*Must demonstrate understanding of the need to fulfill information requirements in regards to conduct and competence*	1.2; 1.1; 2.4; 2.9; 2.1; 2.13; 3.4
B4.3	Maintain work records	
B4.3a	*Evidence the ability to keep full, clear and accurate records.*	9.1; 9.3
B4.3b	*Evidence the ability to keep records secure and prevent inappropriate access.*	9.2; 9.3; 6.2; 6.4; 6.5
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.*	2.5; 2.7; 6.1; 6.3; 6.5;
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.*	2.2; 2.6; 5.1; 5.2; 5.3; 5.4; 5.5; 5.6; 5.7; 7.4; 15.3
C	**Continued Professional Development (CPD)**	
	Maintaining knowledge base	
C1	Standards of CPD	
C1a	*Provide a continuous, up-to-date and accurate record of CPD activities*	2.4; 4.8; 9.2; 10.1; 11.3
C1b	*Demonstrate understanding that CPD activities are a mixture of learning activities relevant to current or future practice*	2.4; 4.8; 1.3;
C1c	*Evidence that the CPD undertaken has contributed to the quality of their practice and service delivery*	1.3; 11.2; 13.8; 2.4; 11.4;
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*	2.4; 11.2; 11.3; 10.1; 10.2; 11.4; 13.8; 13.9; 13.10
C1e	*Demonstrate the ability to apply knowledge, evidence, guidelines and audit to benefit patient care and improve professional practice.*	11.1; 11.2; 11.3; 11.4; 11.5; 11.6;
C1f	*Maintain a personal CPD portfolio*	1.3; 10.1; 2.4; 9.1; 13.9; 13.10
C1g	*Upon request, present a written profile or portfolio (own work, contemporary and supported by evidence) which demonstrates how CPD standards are being met.*	2.4; 9.1

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; 8.6; 8.7; 8.8; 8.9
D1b	*Evidence the ability to reflect on own clinical practice and behaviour*	10.1; 1.02; 1.3; 3.4
D1c	*Demonstrate understanding of how to provide constructive feedback as well as be open to receiving such feedback from others.*	2.1; 4.8; 8.11; 10.2; 11.6
D1d	*Demonstrate a constructive relationship with mentors and others engaged in own learning*	8.11; 4.8
D1e	*Understand how to raise concerns in an appropriate manner during the programme*	7.1; 6.3; 2.3
D1f	*Be an effective role model and ambassador for the Trust*	8.1
D1g	*Take ownership of own personal journey through the consolidation programme*	1.2; 1.4; 4.8; 13.1; 4.1; 4.5; 13.15
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*	8.9; 14.1; 2.7; 2.11; 6.1; 7.1; 7.4; 2.2; 2.1; 2.5; 2.6; 7.4; 7.8; 8.1; 8.3; 8.4;
D2b	*Demonstrate the ability to work collaboratively as part of a team as well as an independent practitioner*	2.1; 4.1; 8.2; 8.3; 8.1
D2c	*Evidence being able to work in a multi-disciplinary team*	8.4
D2d	*Share learning of skills, knowledge and experience where appropriate*	4.8; 8.7; 8.8; 8.9; 8.11
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.*	4.8
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.*	4.8; 4.7; 10.1

F	**Wellbeing and resilience**	
F1	Self awareness	
F1a	*Evidence awareness of and engage with Trust wellbeing services and advice where appropriate.*	3.2; 3.3; 3.4
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.*	1.2; 2.1; 3.1; 3.2; 3.3; 3.4; 10.1; 10.2; 14.1; 14.2; 14.3; 14.4; 14.5; 14.6
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*	14.1; 14.2; 14.3; 14.5; 1.1; 3.2
F1d	*Understand the need to limit work or stop practicing where own performance or judgment is affected by adverse health or wellbeing.*	3.3; 3.1; 4.1; 3.2; 3.4; 14.1; 14.5
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.*	13.9; 13.1; 10.1;
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.*	10.1; 10.2; 13.1; 2.1; 1.3; 4.8
G2	Shared values	
G2a	*Demonstrate compassion, caring and communication*	2.5; 2.2; 2.6; 7.1; 7.2; 7.3; 7.4; 7.5; 7.6; 7.7; 7.8
G2b	*Demonstrate empathy, dignity and respect, intelligent kindness, integrity and sensitivity.*	2.5; 2.2; 8.5;
G2c	*Recognise the different values and beliefs and the ability to adapt personal behaviours and approach accordingly.*	5.1; 5.2; 5.3; 5.4; 5.5; 5.6; 5.7; 2.5; 2.2; 15.2

G2d	*Demonstrate awareness of own behaviour and its effect on others*	2.5; 2.6; 3.4; 2.1; 8.1
G2e	*Involve the patients in decisions made about them.*	2.5; 8.1; 7.4; 7.5; 7.6; 15.3;
G2f	*Be accountable for own actions and accept responsibility*	1.1; 1.2; 2.9; 4.1
G2g	*Demonstrate understanding and practice of the Trust's Duty of Candour*	2.13; 2.11; 2.2

Appendix D: Forms

All forms currently in use are available from the Clinical Education / Preceptorship pages of the Trust intranet 'The Zone'. This includes:

- Candidate evaluation form v4
- Personal evaluation form v2
- Development Abstraction Request for Training (DART) form v4