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A National Preceptorship Framework for Health Visiting

The First 2 Years

Author: Elaine McInnes
with Anne Page, Mary Marsh
August 2014

Developed by the Institute of Health Visiting
on behalf of Health Education England and the
Department of Health

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- supporting the development of universally high quality health visiting practice;
- so that health visitors can effectively respond to the health needs of all children, families and communities;
- enabling them to achieve their optimum level of health, thereby reducing health inequalities.

Acknowledgements

We would like to thank all those who made this work possible. We are indebted to the many practitioners, students, managers, lecturers and Local Educational Training Board (LETBs) representatives who kindly contributed their time and shared their experiences through the Preceptorship Framework review and focus groups process.

Tracey Biggs
Jacky Knapman
Rita Newland
Trish Kelly
Justine Rooke
Naledi Kline
Wendy Taman
Elizabeth Tinsley
Anna East
Sophie Hassell

We would also like to offer appreciation to the members of the profession and iHV who made a contribution to this work. In particular Professor Dame Sarah Cowley, Dr Cheryll Adams, Professor Ros Bryar, Martin Munro (policy advisor), Stef Watkins (proof reading), Sarah Morton and Fleur Seekins (content advisors).

This Framework was commissioned and supported by Health Education England and the Department of Health.
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Foreword

Dear Colleague

In 2010 the Department of Health asked for the health visitor workforce to be expanded by 4,200 FTE health visitors and Health Education England was asked in 2013 to commission training places across the country to help meet this target and focus on the delivery of the service offer to children and families, so that health outcomes can be improved.

Since 2010, we have all been working hard to increase the numbers of health visitors in post by training, retention and supporting returners. Of course this programme is not just about these numbers; it's around supporting the transition from student to qualified health visitor, newly qualified staff and returning health visitors to the workforce. This is our next challenge; we need to support and retain the health visiting workforce because they can provide inspiration for all of us; as individuals and teams, to implement on-going improvements to the health visiting service.

Health Education England (HEE) and the Department of Health have responded to what we have heard from health visitors and commissioned the Institute of Health Visiting (iHV) to produce a customised Induction and Preceptorship frameworks for Health Visitors entering the workforce as part of the health visitor Implementation Plan (DH, 2011). The frameworks sets out a vision and model for newly qualified health visitors to meet future health needs and provide a structure for integrating, retaining and developing new and returning health visitors to the workforce.

I would like to thank everyone who has shared their expertise so generously in the preparation of such a timely and valuable document for health visiting.

It is recommended that all employers begin to use them from September in preparation for national rollout early 2015.

Professor Lisa Bayliss-Pratt
Director of Nursing
Health Education England

A National Preceptorship Framework for Health Visiting

The First 2 Years

About the National Health Visitor Preceptorship Framework

Health Education England has tasked the Institute of Health Visiting with producing new, customised Induction and Preceptorship Frameworks for Health Visiting.

All organisations employing health visitors are recommended to implement the new frameworks.

The pilot version of the Induction Framework is available from early September 2014.

The pilot version of the Preceptor Framework is available from early September 2014.

These pilot versions have been developed with health visiting leaders and experts from across England and in consultation with students, newly qualified, return to practice, practice teachers and senior managers from the health visiting profession.

With the help from 9 organisations across England the new Frameworks are being evaluated and further developed from September 2014 to December 2014.

Final version frameworks will be available from January 2015.

Local areas are encouraged to commence their preparation for implementing the frameworks so that they are best placed to support their current intake of newly qualified health visitors.

The references are indented in the text for ease to the reader. Click on the bitly link to directly access the reference. If printing the framework, simply type in the bitly link into your browser to access the reference.

Please contact: Project Lead Elaine McInnes with any queries Elaine.McInnes@ihv.org.uk

Introduction

This framework is designed to outline the best practice standards for a high quality Preceptorship Programme for newly qualified Health Visitors and those returning to practice following a break.

Preceptorship aims to empower practitioners to develop their knowledge and skills acquired during the formal training process and to become confident and accountable members of the multi-disciplinary team. It also helps practitioners to understand coping strategies, coping styles and to build resilience.

The nature of preceptorship is to offer support and guidance to the preceptee in the first 2 years of practice.

In addition, every practitioner should have their organisation's support and encouragement to engage in continuing professional development, including access to centres of excellence such as the Institute of Health Visiting (iHV) for ongoing professional updates.

Preceptorship creates a learning environment within which newly qualified and return to practice health visitors can deliver the core components of the organisation's service offer, including the Healthy Child Programme and in so doing further contribute to the health and social care agenda.

Aims of the framework:

- To support the development of an effective preceptorship programme across all organisations employing health visitors.
- Through supporting preceptorship, develop an efficient professional environment for health visitors in practice.
- Provide the support for newly qualified health visitors/returning to practice to fulfil their role as an independent, autonomous and innovative health visitor, meeting the requirements for health visiting in England during their first 2 years of employment.
- To provide a consistent approach to preceptorship across the country.
- Through a robust supportive learning environment we aim to ensure that all children and their families get the early support they need as part of the Healthy Child Programme.

Figure 1: Definition

The preceptorship framework

Outlines the best practice standards that newly qualified/employed health visitors in England should expect during the first 2 years of their employment. It requires 'sign-up' from employing organisations to use the framework in developing locally agreed programmes for all newly qualified health visitors they employ, as part of the organisation's quality strategy.

Definitions of the roles of key people involved in the preceptor programme. See Appendix 1.

Why Preceptorship?

Policy Overview

New Service Vision

This new vision enhances the role of health visitors and places them at the heart of developing and providing services for families in the community.

The aim is to make sure that all families get the support they need as part of the Healthy Child Programme. 'A new vision for health visiting' was published in May 2012 (DH, 2011) with a government commitment to train an extra 4200 health visitors in England by 2015. This means that a large proportion of the workforce will be newly qualified practitioners. Whilst this is exciting for the profession, it also brings challenges of support and retention (DH 2011). **In order for the new service vision to be achieved, we must provide adequate support and ongoing development to enable the workforce to deliver this new vision.**

The Mid Staffordshire Report (Francis 2013) recommends that organisations must provide adequate recruitment, training and support for their staff. Providing a robust preceptor programme locally will enable the workforce to feel empowered and confident to deliver the highest care to the public. Safeguarding children is often an area in which newly qualified/return to practice health visitors require the most support. Organisations must protect the public and the welfare of new staff by providing adequate opportunities for new staff (and at a pace to reflect their personalised level of experience) to 'shadow' experienced staff in the safeguarding process. Lessons learned from serious case review tells us that multi-agency practitioners must feel equipped to deal with neglect and physical abuse at an early point and should work closely together (Brandon et al 2013). Recent evidence from research by Cowley et al (2013) drew attention to the variety and extent of skills needed. A further study showed that continuing professional development and variety within a health visiting career were both important in encouraging staff retention (Whittaker et al 2013). A structured post-qualification route is essential to ensure the effectiveness of the health visiting profession.

Appropriate and adequate organisational support and access to preceptorship and other development opportunities are essential to deliver a high quality service and to have maximum impact on improving outcomes for children, families and communities.

What will a successful local Preceptorship Programme achieve?

- An enhanced ability for the preceptee and the health visiting profession to develop clinical knowledge, skills and strategies to support vulnerable families quickly and to deliver health messages in challenging situations;
- A service that has responded to the new vision for health visiting and the "Six C's" by:
  - showing care, commitment and compassion in how they look after families;
  - finding the courage to do the right thing, even if it means standing up to multi-agency colleagues to act for the child or parent's best interests, in a complex and pressured environment;
  - being confident to communicate well at all times;
  - able to demonstrate high levels of professional competence.

What will a successful local Preceptorship Programme include?

- Experiential and active learning methods using strength-based, solutions-focused strategies and motivational interviewing skills to enable health visitors to work in a consistently safe way utilising the full scope of their authority.
- Opportunities for constructive feedback and challenge using advanced communication skills to facilitate reflective supervision.
- Strategies to equip health visitors to manage strong emotions, sensitive issues and undertake courageous conversations.

Every practitioner comes with their own life experiences and previous skills and knowledge.

Preceptorship should not be seen as a training course (i.e. is something that follows the education programme).

- The preceptee must be at the centre of developing their own preceptor programme tailored to their own level of need.
- It is based on experiential learning in the context of practice. It is the practical experience and use of expertise in the field that will develop preceptees into expert practitioners.
- To become advanced practitioners, health visitors need to possess the additional personal attributes and professional maturity that will enable them to move the health visiting profession forward (Baldwin 2013).
- Is aimed at the development of skills and the emotional confidence necessary to underpin autonomous practice (Maxwell et al (2011) and Ellis and Chater (2012).

"Alongside the action learning sets, the one-to-one preceptorship that I received helped me to identify and address any gaps in my knowledge. My preceptorship and time frame were fine tuned to me and were adjusted to suit my personal development. This meant that there were no feelings of being pressurised and I developed at my own pace. Excellent support".

(Newly qualified Health Visitor (NQHV) 2014).

An overview of a Preceptorship Programme:

Figure 2: Table to illustrate an overview of a Preceptorship Programme

1 month prior to qualification/return to practice/ new to area health visitors	First 3 months: induction period	6 weeks - 12 months in practice	1-2 years
Organisations should: Allocate preceptors for the number of new health visitors appropriately	**Please see:** iHV/HEE framework for Health Visiting Induction Framework	**Accessing:** 4-6 weekly preceptor meetings which include: ■ supervision ■ reflection ■ action learning	**Accessing:** ■ Peer supervision ■ Mentor support ■ Clinical/restorative supervision ■ Safeguarding supervision
Provide an induction pack prior to the arrival of new staff	Preceptee and preceptor meet in the first 2 weeks and arrange meetings 4-6 weekly for the year	Safeguarding supervision	CPD in line with the organisation
	Accessing safeguarding supervision	Managerial supervision	Working in line with the national career framework
		Building Community Capacity	Mentor training
		Developing leadership skills	Clinical/restorative supervisor training

For a guide to how Induction works, go to bit.ly/1qJ0RU2 where you can access the full Induction framework.

Outcomes of a Preceptor Programme:

Figure 3: Outcomes

For the Preceptee	For the Preceptor	For the Organisation
Development of a professional confidence	Personal growth through the development of new skills	The development of skilled confident practitioners
Increased job satisfaction leading to improved patient/client satisfaction	Professional development	Meeting organisational goals
The personal development of moving from expert to advanced practice	Job enrichment	Enhanced recruitment and retention
The development of personal responsibility for maintaining up-to-date knowledge	Their own lifelong learning	Reduced sickness absence
Professional socialisation into the working environment	Enhances future career aspirations	Enhanced staff satisfaction
Feels valued and invested in		Reduced risk of clinical incidents and near misses (Francis 2013)
Ability to share experiences and learn from each other		
Build resilience		
To gain the confidence in courageous conversations		

A 3 - stage model for developing a successful local Preceptor Programme

Organisations with existing programmes and policies will use this framework to review the local programme with the focus on best practice.

1. Preparation **2.** Embedding **3.** Sustainability

Stage 1. Preparation of a Preceptor Programme

Preparation is key to the success of a preceptorship programme. Forward planning by organisations to allocate preceptors to preceptees should occur in advance of the new practitioners starting in practice. Deciding which model of preceptorship to use depends on the local organisational structure, geographical spread and most importantly the number of new practitioners arriving.

Preceptorship Models
The Nursing Midwifery Council (NMC) suggests a period of preceptorship when moving to a new and different role. During the induction period the new health visitor should be introduced to their preceptor and be ready to start a preceptorship programme. During this period the new health visitor should work through a self-directed programme with a named preceptor.

Models available for organisations to consider are:

- 4-6 weekly meetings 1:1 with a practice teacher (PT)/HV;
- 4-6 weekly facilitated by a HV/PT- group (recommended up to 8 NQHVs);
- Combination of both.

Essential - Daily support from a buddy to offer peer support and allow the newly qualified health visitor time to discuss issues relating to work placements/ personal issues and role development. There is no fixed routine to meeting the buddy, this is an arrangement to be developed as required. See appendix 1 for the definition of a buddy.

The Preceptorship process
The preceptor should be identified in advance by the health visitor team leaders. Practice teachers should also be involved in the process. The practice teacher in the practice area should be available to assist in addressing individualised learning needs. The induction period encompasses the first 3 months in practice but the preceptor process should start within the first month in post.

New staff come with different backgrounds, knowledge and skills and should be at the heart of shaping their own preceptor journey. This will allow the preceptee to become self-managing, with a view to them becoming autonomous practitioners. This would allow peer supervision to develop and clinical supervision to start at the end of year 1. An important point to note is the necessity of the preceptee keeping an ongoing reflective log with minimal formal paperwork.

Outcomes for the first 2 years

The table below gives an overview of outcomes to be achieved but every practitioner is different and individuals may move between the sections at different times.

Figure 4: Example table of the outcomes of a Preceptorship Programme

6 weeks to 3 months	3-6 months	6-12 months	1-2 years
■ Allocated caseload in line with Universal service ■ Not to have sole responsibility for safeguarding families in the first 6 months ■ Shadow/co-work with safeguarding families if appropriate ■ Attend safeguarding meetings with co – worker ■ Attend safeguarding supervision with co-worker ■ Have met with named preceptor by week 2 in post and agreed a learning contract within preceptorship period driven by the preceptee ■ Health visiting offer explained ■ Public Health Outcomes Framework and 6 High Impact Indicators explained ■ Identified meetings with preceptor with protected time to attend ■ Placed in a team that is providing adequate support/ peer supervision ■ Begin to develop an awareness of assessment of health needs as you start looking and analysing the caseload from day 1 ■ Attend strategic meetings with stakeholders such as Children Centre liaisons, GP liaison and Midwife meetings ■ Start a reflective portfolio ■ Access to a buddy	■ Gaining confidence within consolidation period as a newly qualified health visitor ■ Supported by preceptor and team to undertake more complex case management ■ Progress to holding Universal Plus and Partnership Plus cases independently if appropriate ■ Shadow/co-work with safeguarding families ■ Attend safeguarding meetings with co –worker ■ Attend safeguarding supervision ■ Access support/supervision/ Action Learning sets in line with requirements of the Healthy Child Programme, Public Health Outcomes Framework, and 6 High Impact Areas ■ Maintain a reflective portfolio ■ Access to a buddy	■ Undertake full caseload responsibilities, inclusive of Universal Plus, Partnership Plus and safeguarding cases ■ Undertake required continuing professional development in line with your organisations' training plan and in line with the implementation of the health visiting core offer ■ Attend safeguarding supervision ■ Develop Leadership Skills-shadowing /inputting into organisational steering/ task and finish groups ■ Access Building Community Capacity programmes ■ Access to a buddy	■ Access clinical/restorative supervision ■ Undertake required continuing professional development training plan and in line with your organisations' training plan in line with the implementation of the health visiting core offer ■ Attend safeguarding supervision ■ Work in line with the national career framework ■ Access to local career information/enhanced /specialist roles ■ Identify special interests ■ Opportunities to explore interests ■ Access leadership continuous professional development ■ Access coaching ■ Undertake mentor training course or become a 'buddy' ■ Active role in the team, leading parts of the meetings, increasing responsibility

Roles and Responsibilities

The Preceptor - Prerequisite for Preceptors:

The preceptor will have sufficient knowledge of the practitioner's programme leading to registration to identify and support current learning needs. The preceptor will have a minimum of 1 year's post registration (ideally 2 years) experience as a health visitor in their current role and keep themselves up to date with current health visiting theory and evidence as well as new ways of working.

Whilst there are no formal qualifications associated with being a preceptor, the NMC considers that individuals will need preparation for the role. Mentorship training is advisable to ensure an understanding of learning styles and having the ability to assess the preceptees' development. Those considering becoming a preceptor should discuss this with their line manager or the organisations' workforce development team. Such preparation will ensure the preceptor demonstrates the attributes required, that is they:

- Have sufficient knowledge regarding health visitor education and practical experience (including the content of the health visiting return to practice programme) and to be able to identify the preceptees current learning needs.
- Are able to support the preceptee in applying knowledge to practice using a strengths-based compassionate approach.
- Understand how preceptees integrate within a new practice setting and what problems this can present for the individual and the team.
- Can act as a resource to facilitate the preceptees professional development.
- Understand that, from the moment a practitioner is first admitted to the register, they are professionally accountable for all their own actions and omissions – the preceptor cannot be accountable on their behalf.
- Have time to reflect and access support and supervision to develop their self-compassion (i.e. with the child and family at the centre).

Responsibility of the first Line Manager

Line Managers are required to:

- Ensure adequate numbers of staff are able to provide preceptorship: involves attention to staff numbers/ workload and experience.
- Monitor the implementation of the preceptorship mechanisms. See appendix 2 for an example evaluation questionnaire which can be completed by the preceptor and preceptee on the first meeting and on completion of preceptorship.
- Provide support and protected time to preceptors undertaking the role.
- Evaluate the quality of the preceptorship process within the locality.
- Document on the personal files that preceptorship has been undertaken.
- Ensure adequate protected time for both preceptor and preceptee.
- Ensure that preceptees are allocated a caseload within reason and with their agreement.

Organisational Considerations

Preceptors must have the capacity to offer the level of support outlined above. If this is not possible, the preceptor should decline the role. Preceptors must understand the nature of their role and be committed to the values underpinning a preceptorship programme.

As a preceptee you can expect:

- Your preceptor will be identified for you in advance of you starting your new post.
- To have protected time for preceptorship meetings.
- Your preceptor to have a minimum of 1 year's experience (ideally 2 years) within their role and speciality and to understand the potential anxieties associated with being new in post.
- Your preceptor relationship will remain confidential unless specific management issues are identified. The nature of your preceptor meetings will only be disclosed with your prior knowledge.
- To be supported in practice to explore the emotional impact of practice.
- To identify support and development needs by setting learning objectives in partnership with the preceptor.
- To access peer support and social support as well as preceptor meetings.
- To be encouraged to participate in reflection and critical thinking.
- To have the opportunity to change preceptor if required.
- To take ownership for the completion of the programme.
- To receive support in the form of regular and planned meetings with the preceptor for 12 months and a final, closing meeting at the end of that period.

Team support

- Wherever possible, new health visitors should be placed in teams where they will be adequately supported throughout the induction and preceptorship period, and where there is an absence of frequent staff movements.
- Support and training may be required for team members to ensure they understand and can meet the needs of newly qualified health visitors.
- New health visitors should not work remotely and the ability to return to the base at the end of each day for debrief is required.
- The team should facilitate the gradual increase of their workload as and when the team leader and new practitioner feel it is appropriate to do so.
- The team should not allocate sole responsibility for safeguarding cases in the first 6 months. Safeguarding cases should be handed over gradually and in agreement with the new practitioner.
- During the first 6 months, teams should provide adequate and timely support/shadowing opportunities for safeguarding cases at a level appropriate to the individual new practitioner.

Confidentiality

Preceptorship is a confidential two way process. However, the preceptor has a duty to report to management any practice that may put clients, staff or preceptee at risk. This duty is in accordance with NMC standards of conduct, performance and ethics (NMC, 2009).

Meetings can be documented (paperwork agreed locally) and confidentiality maintained by preceptor unless concerns are raised and require to be escalated.

Stage 2. Embedding the preceptor programme

Embedding the preceptor programme involves regularly undertaking reflective practice and building up resilience to ensure good health as well as access to supervision on a regular basis. Having an action plan defined by a learning contract will enable the preceptee to take ownership of their development.

Agree a learning contract - see appendix 3.

The learning contract should adhere to the following key principles:

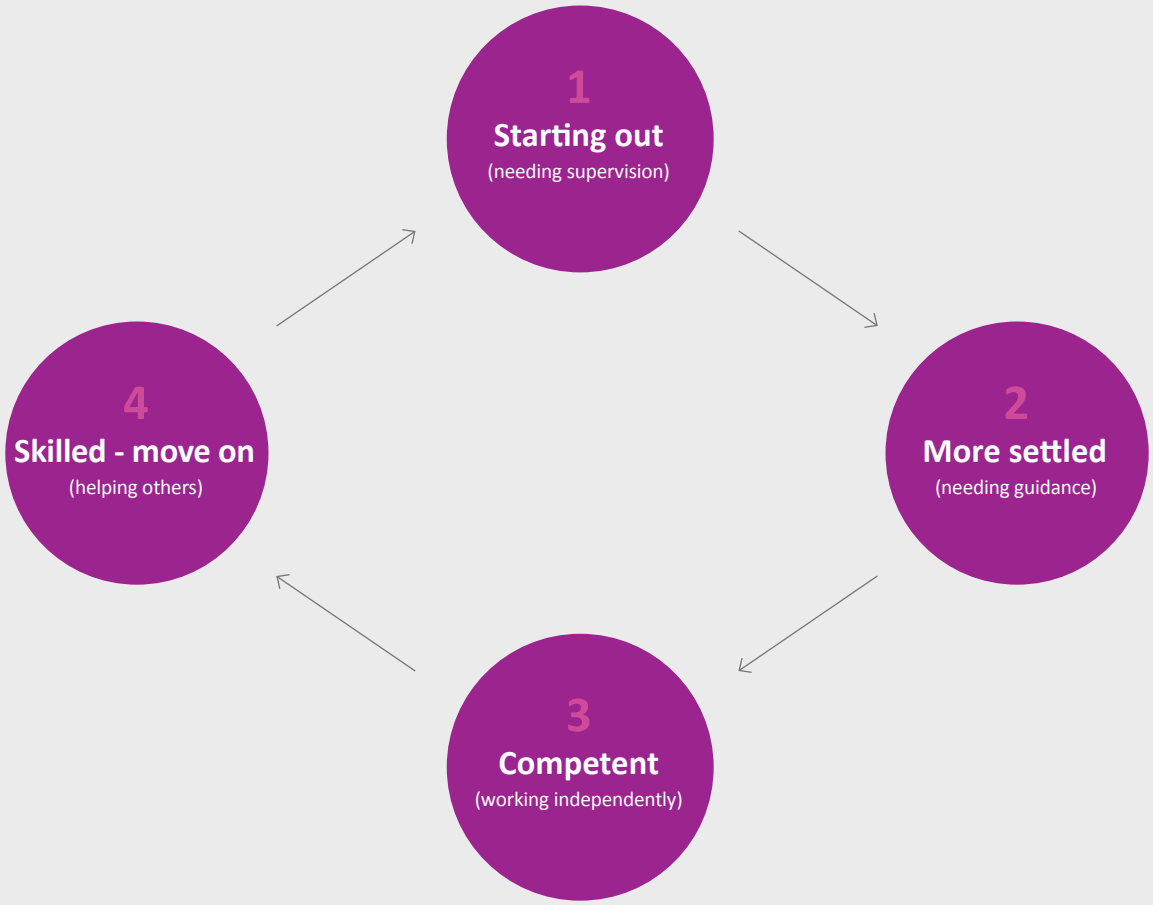
- The contract should set out the frequency that preceptee and preceptor will meet.
- The plan should enable newly qualified and newly appointed preceptees to agree how they will meet with their preceptor. This could include opportunities to shadow their preceptor in the clinical practice area.
- At the first meeting, agreement should be reached on the boundaries and objectives to be met during the period of preceptorship. Driven by the preceptee.
- Any opportunities for shadowing and development within the inter-professional team should be relevant to your area of practice.
- Agree a range of methods which may support the the growth and development of preceptees. This may include observation, question and answer, shadowing and reflective diary records.
- Determine any relevant clinical outcomes which require supervised practice to achieve development.
- The preceptee and preceptor will complete a final assessment and both will sign that the preceptee has successfully completed a preceptorship period.
- Complete the evaluation of preceptorship at the end of the programme.

Lifelong Learning

Entering the register with NMC means every practitioner must demonstrate they are retaining their fitness to practice whether they are newly qualified or starting a new post/role.

This means every practitioner must keep themselves regularly updated. Access the local intranet for local policy updates as well as national support networks such as the Institute of Health Visiting (iHV). Learning can be seen as a perpetual circle and you may need to join the cycle again at **stage 1** as you come across different aspects of practice during your career. This will probably occur many times in your life as you move on and change roles.

Figure 5: Illustration of Lifelong Learning – adapted from Kolb (1984)



Building Resilience

As well as the increase in workforce numbers, the new service vision gives the profession a fresh focus, and aims to develop a better skilled and more resilient workforce who positively impact not only their own health and wellbeing, but consequently that of the children, families, and communities they serve (Maben 2013).

Resilience is adopting a compassionate approach to "bounce forward" to a more normal state of functioning in the presence of adversity (Grains Research and Development Corporation 2013). It requires us to be in touch with our vulnerability and be compassionate to ourselves as well as others. The opportunity to explore feelings and name stress can foster hope which is essential to resilience (Menzies Lyth 1988).

A compassionate culture promotes attuned, trusting relationships which builds emotional resilience and improves outcomes for children and families.

Resilience is influenced by four key interacting factors including:

- Professional Identity
- Leadership and organisational culture
- Models of support
- Education and training

Figure 6: Some of the key **components which build resilience** are outlined in the diagram below – adapted by A Pettit (2014). iHV Building Resilience in the workforce.

Supervision

- Clinical supervision is an essential part of clinical governance to improve professional standards and has been clearly identified by the Department of Health and key partners as important for professionals to deliver the Health Visitor Implementation Plan 2011-2015 (DH 2011).

- All organisations should provide clinical supervision to support professionals working with complex caseloads. Supervision will enable the practitioner to develop a deeper reflection on their practice issues and team dynamics. Through supervision the health visitor will develop skills to contain their emotions and build resilience to manage all families they work with. This helps to address the risk of stress in the management of complex cases and provide clarity, direction and support. Ideally this should be underpinned by compassionate, strengths-based approaches which build resilience in families.

There are a number of different types and models of supervision within health visiting:

- Clinical supervision
- Safeguarding
- Managerial
- Restorative

All organisations offer safeguarding supervision as a mandatory part of practice and your preceptorship will also incorporate managerial supervision. Clinical/restorative supervision will follow on when the preceptorship period ends.

Preceptor Meeting Frequency

Aim: The meeting should provide a platform for supervision and peer support while providing the opportunity to engage in didactic reflection and self-directed professional development.

Figure 7: An example meeting frequency

Timetable	Activity
Week 1 of qualifying/returning to practice	Contact with your preceptor Arrange an initial meeting for week 2 to align development goals
Week 2	Face-to-Face meeting with your preceptor to align development goals **The plan based on SLOT (see appendix 3):** **Strengths –** What areas of practice do I already feel competent/ confident in? **Learning needs –** What area of practice do I need to know more about? **Opportunities –** How can I exploit my strengths and meet my learning needs? What can my work for the next period include to do this? **Threats –** What is it that I am most worried about/what might hold me back/how can I overcome?
Week 6	First preceptor meeting
Week 6 to 49	Meetings arranged for every 4-6 weeks for 2 hrs with protected time. Preceptor highlights the importance of preceptorship and being protected time. 80% attendance expected throughout the year.
Week 50- 52	Meeting to summarise and evaluate the learning in the first year (see appendix 2) Paperwork to line manager, preceptor and preceptee for their portfolio. Plan support for year 2 e.g. mentor/peer supervision/clinical supervision

Structure of a meeting.
Here are a few points you may wish to note when planning local preceptor meetings:

- Action plan (planning what you will do and how you will do it and why)
- Recovery action plan (in the event of a life event: personal/bereavement/traumatic experience)
- Outcome-focused – what will success look like
- Time available and how you want to use it
- Ground rules for working together
- Date/timescale for review
- Decisions/duration/frequency of meetings
- Agree a strategy for closure, strategy for escalating concerns (if relationship not working) or identification of poor practice
- Accountability and illustrating accountability

Figure 8: An example of the structure for a preceptor meeting

Times	Structure of a preceptor meeting
2 hours of protected time between preceptor and preceptee(s)	Ground rules set by the members Members will attend regularly, on time and be prepared to contribute Members will be responsible for maintaining a personal reflection log Preceptor to provide members with contact details if additional advice is required between meetings Minimal records need to be kept Reiterate that confidentiality relating to supervision is vital Late starters to the group (if this is the preferred method) have the same number of sessions with additional one-to-ones when the group disperses Members evaluate on day 1, verbally after 6 months, and provide a written reflective account and evaluation at 12 months Phones should be switched off as this is protected time to be valued as important to protect against burnout.
Group Meetings/1:1 meetings	
1st hour:	Reflective supervision either one-to-one or group supervision The focus is on the members becoming self-managing with the view to becoming independent from the preceptor after 12 months. This will allow peer supervision to develop
2nd hour:	Action learning session driven by the preceptee Celebrate examples of good practice Members bring concerns, worries and areas where education is needed and members co facilitate action learning See figure 9 for examples

Topics to discuss during a preceptor meeting

It is important for the preceptee to take ownership of action learning. This table is only to provide a few examples.

Figure 9: Examples of Topics for discussion during preceptorship meetings (adapted by Naledi Kline GSTT and Sharin Baldwin Ealing Clinical Academic Hub).

Improving Services:	
Ensuring Patient Safety Critically Evaluating Encouraging Improvement and Innovation Facilitating Transformation	HCP e - Learning modules. Core 7 identified by iHV (www.iHV.org.uk). Child health promotion/surveillance/public health role/ Building community capacity
Multi-agency Partnership working Understanding Local Authority structure and commissioning	PHE/DH 6 early years High Impact Areas (2014)
Issues and scenarios around safeguarding children, e.g. Domestic Violence, Mental Health, Drug and Alcohol misuse Preparation of child protection conference reports and preparation of self for conference attendance	Record-keeping and documentation (NMC 2008) Accountability
Leadership Skills:	**Development of self:**
Developing Self Awareness Managing Yourself Continuing Personal Development Acting with Integrity Conflict management	Emotional/psychological state of readiness/Empowerment of practitioners Developing motivational interviewing skills
Management of team work:	
Time management Planning Managing Resources Managing People Managing Performance Communication	Prescribing scenarios

Stage 3. Sustainability of the individual's accountability

The sustainability phase should enable the preceptee to prepare for revalidation of their NMC registration and to provide continued protection of the public.

Themes for Continuing Professional Development (CPD)

The National Health Visiting Service Specification (NHS England 2014/15) outlines the requirements for commissioned services in line with the Healthy Child Programme (encompassing Public Health Outcomes framework) and the 6 High Impact Areas (below).

This should enable a practitioner to understand and become familiar with the associated themes for Continual Professional Development taking account of any local variation.

- Transition to Parenthood and the Early Weeks
- Maternal Mental Health (Perinatal Depression)
- Breastfeeding (Initiation and Duration)
- Healthy Weight, Healthy Nutrition (to include Physical Activity)
- Managing Minor Illness and Reducing Accidents (Reducing Hospital Attendance/Admissions)
- Health, Wellbeing and Development of the Child Age 2 – Two year old review (integrated review) and support to be 'ready for school'

Action Learning

(maximum 8 NQHV).

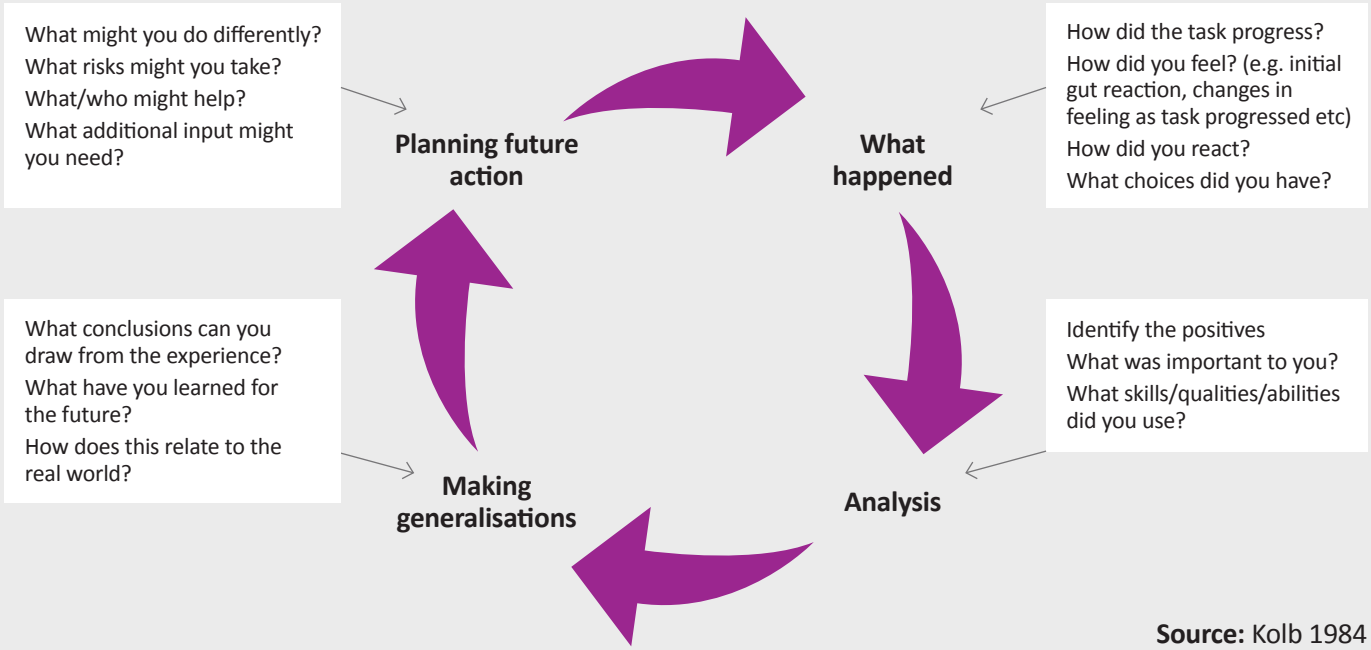
- Newly qualified Health Visitors may wish to access an action learning group facilitated by a Practice Teacher or Practice Educator to support them during their preceptorship.
- Action learning is a process of shared learning and reflection supported by colleagues. This could form part of the preceptorship programme.
- The group work together to focus on issues raised by the preceptees using the process questioning and challenging in a facilitative way.

Professional Portfolio

- As part of the professional registration all registrants are required to continue to develop their own "knowledge, skills and competency beyond that of registration through continuing professional development" (NMC, 2008).
- A professional portfolio should contain information related to professional/educational development, career development and personal development (Bowers & Jinks 2004).
- The emphasis is on a positive professional development portfolio that documents your skills, responsibilities and supports your development for the future.
- There is no prescribed or correct way to construct a portfolio but there is consistency in the type of material that they should include. One way is to choose a reflective model e.g. Kolb. See appendix 4 for an example framework and other reflective models.

Figure 10: An example of a Reflective Cycle

Kolb's Model for the Learning Cycle



Source: Kolb 1984

The evidence in a portfolio may include any of the following:

Figure 11: An example of contents of a professional portfolio

Contents of a professional portfolio	
Reflective logs	Completion of course attended linked to HV service specification and 6 high impact areas
Documentation	Observation and shadowing to support Constructive feedback
Evidence of prescribing updates	In service / course training certificates
Personal development plans	References

Additional reading and useful web links

1. Institute of Health Visiting **www.ihv.org.uk**
2. HCP e-learning modules **bit.ly/1qJDM2d**
3. The Preceptorship Charter (iHV 2013) **www.ihv.org.uk**
4. Community Practitioners and Health Visitors Association **bit.ly/Zg0dTO**
5. Royal College of Nursing **bit.ly/1qe4aUg**
6. NHS Leadership Academy. The Edward Jenner programme. This accessible programme is a free online learning and development package designed to give you confidence and competence in your new role.

   You can view the website here: bit.ly/1uuNoQb
7. YouTube/TEDxTalks. Easy to digest video clips on current and relevant updates in health visiting. **bit.ly/1uxVGrd**
8. 'A Health Visiting Career' (DH, 2011) sums up the evidence for the induction and preceptorship process and explains that health visitors, like nurses, develop skills and understanding over time through a sound educational base combined with many, varied experiences.

   You can view the full document here: bit.ly/Wd7Ic4
9. The Public Health Outcomes Framework or PHOF (Public Health England, 2010) and the NHS Outcomes Framework (DH, 2014) include a range of outcomes. The expectation is that an effective 0-5 years public health nursing team will improve children's health and help prevent ill health through delivering public health interventions.

   You can view the full documents here: bit.ly/1uB1luN bit.ly/1qd0CAE
10. The Health Visiting Offer - Family focussed provision
    The Health Visitor Implementation Plan (DH, 2011) sets out what all families can expect from their local health visiting service.

    You can view the full document here: bit.ly/1Bqc0MS
11. Recent evidence from research by Professor Sarah Cowley et al (2013) shows that health visiting has an impact on key aspects of early intervention such as alleviating post-natal depression and providing parenting support through home-visiting, the health visitor-client relationship and needs assessment.

    You can view the full document here: bit.ly/1pK2stt
12. The National Health Visiting Service Specification (NHS England, 2014/2015) outlines in detail how the expanded and revitalised health visiting service will deliver the Healthy Child programme by providing expert advice, support and interventions to families with children in the first years of life. The document includes the evidence base from neuroscience and developmental psychology for early intervention, showing how what happens during the early years, starting in the womb, has lifelong effects on many aspects of health and wellbeing, educational achievement and economic status and highlighting the crucial role of health visitors in reducing inequalities.

    You can view the full document here: bit.ly/1ppSMOD

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Appendix 1.

Definitions	
The preceptorship framework	Outlines the best practice standards that newly qualified/employed Health Visitors in England should expect during the first 2 years of their employment. It requires 'sign -up' from employing organisations to use the framework in developing locally agreed programmes for all newly qualified health visitors they employ, as part of the organisation's quality strategy.
Practice Teacher	Has undertaken an approved practice teacher qualification and has greater responsibility for assessment of students beyond the level of initial registration. They are held accountable that the student has/has not met NMC standards of proficiency in practice.
Preceptor	An NMC registered practitioner who has been given additional formal responsibility to support a newly qualified health visitor through preceptorship (DH 2010).
Mentor	Is required to have one year's experience and to be trained in line with NMC recommendations (2008) having undertaken a mentoring qualification.
All of the above must attend annual updates and triennial review. Their names will be held on a local mentor register (NMC 2008a).	
Buddy	An NMC registered practitioner who is available to provide informal support on a daily basis
Preceptee	The newly qualified Health Visitor who engages in preceptorship (DH 2010).

Accountability and being accountable are principles that every qualified Health Visitor must uphold. Every Health Visitor must be able to evidence that through their practice they can keep the public safe without supervision. They must abide by the code (NMC, 2014) in relation to illustrating that they are accountable for both their actions and omissions.

Appendix 2:
Example Preceptee and Preceptor Evaluation Templates

Preceptee	Strongly disagree	Disagree	Agree	Strongly agree	Comments Please give any examples
I was able to link preceptorship with my personal learning objectives.					
I was able to identify my learning needs with my preceptor.					
Preceptorship is a partnership between preceptor and preceptee.					
Preceptorship enabled me to receive feedback from my preceptor.					
Preceptorship provided the opportunity for reflection.					
12 months is a suitable time period for preceptorship.					
The preceptorship period allowed me to progress from expert to specialist.					
I was able to benefit from my preceptor's knowledge.					
I was able to benefit from my preceptor's experience.					
I felt supported by my colleagues throughout the preceptorship period.					
My line manager supported my preceptorship programme.					
The 2 hour time slot for preceptorship meetings is appropriate.					
Other comments: We would welcome any constructive feedback that you can provide to improve this process for future health visiting workforce: ■ Were there any other areas that could have been covered? ■ Was there any duplication between this process and your line manager?					

Preceptor	Strongly disagree	Disagree	Agree	Strongly agree	Comments Please give any examples
I have a sound understanding of how preceptorship relates to other forms of support within the Trust, i.e. induction, clinical supervision.					
I was able to plan the preceptorship programme in partnership with my preceptee.					
Preceptorship provided the opportunity for reflection as to how my preceptee was settling into their role.					
12 months is an appropriate length of time for preceptorship.					
I have observed my preceptee's progress from expert to specialist practitioner.					
Preceptee utilised their preceptor's knowledge with regard to the Trust.					
Preceptees utilise their preceptor's experience as a clinical practitioner.					
The preceptee has used preceptorship in addition to other forms of support within the Trust.					
My line manager is aware of my role as a preceptor.					
My line manager is supportive of my role as a preceptor.					
Preceptorship provided time out for the preceptee to consider their learning needs at regular intervals.					
The 2 hour time slot for preceptorship meetings.					

Please give examples of the three main issues that have been addressed during this preceptorship period.
(e.g. communication, team working, time management)

1. **2.** **3.**

Other comments:
We would welcome any constructive feedback that you can provide to improve this process for future health visiting workforce:

- Were there any other areas that could have been covered?
- Was there any duplication between this process and your line manager?

Appendix 3:
Example of a Learning Contract

Preceptorship Learning Contract

Name of Preceptor

Job title

Name of Preceptee

Job title

1. Sessions will be agreed by both parties.

Frequency of sessions: Once every ..... week/s

Duration of sessions: ..... hour/s

2. Agreement signatures

	Preceptee	Preceptor
Signature	.....	.....
Date	.....	.....

Learning Contract based on SLOT

Strengths – What areas of practice do I already feel competent/confident in?

Learning needs – What area of practice do I need to know more about?

Opportunities – How can I exploit my strengths and meet my learning needs?
What can my work for the next period include to do this?

Threats – What is it that I am most worried about/what might hold me back/how can I overcome?

Appendix 4: Reflective Narrative Template

A structured reflection based on Kolb's learning cycle

Think about a situation from clinical practice

1. What happened?
How did the task progress? How did you feel? (e.g. initial gut reaction, changes in feeling as task progressed etc)
How did you react? What choices did you have?

2. Analysis
Identify the positives What was important to you? What skills/qualities/abilities did you use?

3. Making generalisations
What conclusions can you draw from the experience? What have you learnt for the future?
How does this relate to the real world?

4. Planning future action
What might you do differently? What risks might you take? What/who might help?
What additional input might you need?

Kolb DA (1984) *Experiential learning: experience as the source of learning & development*.
Upper Saddle River, NJ; Prentice-Hall

Johns' Model of Structured reflection

Looking in	Looking out
Find a space to focus on self.	Write a description of the situation surrounding your thoughts and feelings.
Pay attention to your thoughts and emotions.	What issues seemed significant?
Write down those thoughts and emotions that seem significant in realising desirable work.	**Aesthetics** What was I trying to achieve? Why did I respond as I did? What were the consequences of that for the patient/others? How were others feeling? How did I know this?
	Personal How did I feel in this situation? What internal factors were influencing me?
	Ethics – moral knowledge How did my actions match my beliefs? What factors made me act in an incongruent way?
	Empirics –scientific What knowledge did or should have informed me?

The framework uses five cue questions which are then divided into more focuses to promote detailed reflection.

Description of the experience:
Phenomenon – describe the here and now experience
Casual – what essential factors contributed to this experience?
Context - what are the significant background factors to this experience?
Clarifying – what are the key processes for reflection in this experience?

Reflection:
What was I trying to achieve?
Why did I intervene as I did?
What were the consequences of my actions for:
Myself?
The patient / family?
The people I work with?
How did I feel about this experience when it was happening?
How do I know how the patient felt about it?

Influencing factors:
What internal factors influenced my decision - making?
What external factors influenced my decision - making?
What sources of knowledge did / should have influenced my decision - making?

Evaluation:
Could I have dealt with the situation better?
What other choices did I have?
What would be the consequences of these choices?

Learning:
How do I now feel about this experience?
How have I made sense of this experience in light of past experiences and future practice?
How has this experience changed my ways of knowing?
Empirics - scientific
Ethics - moral knowledge
Personal - self awareness
Aesthetics - the art of what we do, our own experiences

Ref: Johns, C. (2000) *Becoming a Reflective Practitioner: a reflective and holistic approach to clinical nursing, practice development and clinical supervision*. Oxford: Blackwell Science

There are many other reflective models available such as:
Boud D, Keogh R & Walker D (1985): Promoting reflection in learning: A model. IN
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