Education and Training Committee, 3 March 2016

Research on preparation for practice among newly qualified professionals

Executive summary and recommendations

Introduction

In September 2014, the Education and Training Committee agreed to the commissioning of a large-scale research project on the role of the standards of education and training (SETs) in ensuring that newly qualified professionals are fit to practise. This forms part of the ongoing review of the SETs.

Following a competitive tendering process, a research team from the joint Faculty of Health, Social Care and Education at Kingston University and St George's, University of London, was selected and commenced the project in March 2015.

The aims of the research were as follows:

- To learn from previous relevant literature;

- To gather and analyse views among newly qualified professionals, educators, students, practice placement educators and employers on preparation for practice across the professions regulated by the HCPC;

- To draw on these findings in order to help assess the effectiveness of the HCPC standards of education and training in ensuring newly qualified professionals are fit to practise; and

- To develop recommendations for how the SETs and supporting guidance may be amended or strengthened to support preparation for practice.

The research comprised a literature review; online surveys of education providers, practice educators, and both experienced and newly qualified professionals; data collection events which included these same groups, as well as students and service users; and a 'consensus workshop'.

A copy of the final report is attached. The research findings, recommendations and the Executive's response in relation to the SETs and supporting guidance were considered by the Professional Liaison Group (PLG) for the review of the SETs in January 2016. The recommendations and comments from the PLG are now being incorporated in proposed revisions to the SETs and supporting guidance, a draft of which will be presented for consideration by the Committee in June 2016.

Decision

The Committee is invited to note this research report. No decision is required.

Background information

- Education and Training Committee, 11 September 2014. 'Research on preparation for practice'.
  http://www.hcpc-uk.org/assets/documents/10004815Enc03-Researchonpreparationforpractice.pdf

- Professional Liaison Group for the review of the standards of education and training, 19 January 2016. 'Theme: Research on preparation for practice'.
  http://www.hcpc-uk.org/assets/documents/10004EB3Enc04-Preparationforpracticeresearch.pdf

Resource implications

The resource implications associated with commissioning and managing this research were included in Policy and Standards departmental planning for 2014/15 and 2015/16.

Financial implications

The financial costs involved in commissioning this research were included in the Policy and Standards departmental budget for 2014/15 and 2015/16.

Appendices

None

Date of paper

19 February 2016

Preparation for practice: The role of the HCPC's standards of education and training in ensuring that newly qualified professionals are fit to practise

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Acknowledgements

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Executive Summary

Background

The HCPC is a regulator of 16 health and social care professions. Its role includes ensuring that education and training programmes meet standards of education and training (SETs) and that newly qualified professionals are fit to practise. These SETs apply to all 16 professions and cover the following areas: level of qualifications for entry to the register, admissions, programme management and resources, curriculum, practice placements and assessment.

To ensure that the SETs are contemporary and relevant they are reviewed regularly. It is as part of such a review that this research was commissioned.

Purpose and objectives of the project

The overall aim of this project is to explore 'preparation for practice' of newly qualified professionals who have completed pre-registration education and training programmes approved by the HCPC. Evidence gained from this project will inform and assist the HCPC in decision-making regarding the SETs (and supporting guidance) required when preparing newly qualified professionals to be fit to practise.

The project objectives were to:

- Identify the factors (including SETs and guidance), and how they combine and contribute towards ensuring 'fitness to practise'
- Determine how Higher Education Institutions (HEIs) implement, and measure as outcomes, the HCPC SETs within curricula
- Explore the views of healthcare managers, educators, experienced professionals and newly qualified regarding preparedness to practise (including the extent to which they meet the HCPC standards of proficiency)
- Explore the views of newly qualified professionals, educators, students, service users, patients, carers, practice placement educators, experienced professionals and employers on the appropriateness and completeness of current SETs and supporting guidance
- Determine the extent to which the pre-registration education programmes (incorporating HCPC SETs) prepare newly qualified professionals for the challenges of interprofessional working and public and patient involvement (PPI)
- Produce recommendations for how the SETs (and their supporting guidance and any other factors/key issues that contribute to fitness for practice) for newly qualified professional groups regulated by the HCPC, may be amended and/or strengthened.

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Methods

The study was undertaken using a four-stage, interdependent sequential mixed method approach, which includes both qualitative and quantitative methods of data collection and analysis. Following a literature review (stage 1), an online questionnaire survey (stage 2) was designed and circulated among our sample. The literature review and preliminary analysis of the questionnaire data informed the questions asked at the data collection events (stage 3), which included world cafés, focus groups and individual interviews. Finally, a consensus workshop (stage 4) with key informants was carried out.

Findings

The HCPC's definition of 'fitness to practise' is consistent with that of other professions and regulators. There is one issue, included in the General Medical Council's definition, and not elsewhere, that relates to the relationship between the practitioner and patient. Our research findings also revealed concern, often from service users, that some health and social care professionals are unable to relate to service users in an appropriate way.

Generally speaking newly qualified professionals were regarded as adequately prepared for practice albeit with some concerns about the ability of some to relate to service users and carers. There were also concerns about the impact of the variability of both the placement experience as well as the role and training of the practice educator.

The data suggests that the vast majority of respondents see the standards as either very important or important regarding ensuring fitness to practise, and that there was no appetite for additional SETs. Course directors are more likely to rate the standards as very important or important. For every standard 80% of course directors rated it as either important or very important. Both course directors and newly qualified professionals were most likely to rate the standards relating to 'practice placements' as important, with all being rated by 90% as very important or important.

The standards relating to 'programme management and resources' produced the lowest percentages of newly qualified professionals who rated them as very important or important.

Where issues were raised with the standards they tended to be a concern about how best to implement them. There was a recognition that SETs, that have to cover 16 professions, will need to be generic so as to provide sufficient flexibility rather than specific and prescriptive. It is the SoPs and the requirements of professional bodies which provide more profession specific criteria. Currently, however, some respondents reported that these different standards and requirements are not sufficiently joined up.

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SET 2.2 states that 'The admissions procedures must apply selection and entry criteria, including evidence of a good command of reading, writing and spoken English.' Our findings showed that there were variations in how 'good command' was interpreted and applied.

SET 2.4 states that 'The admissions procedures must apply selection and entry criteria, including compliance with any health requirements.' The findings revealed concerns about the lack of clarity on this and also that the HCPC does not make explicit mention of mental health.

SET 3.17 states 'Service users and carers must be involved in the programme.' The results have shown that some HEIs struggle to involve service users and carers effectively.

Despite the importance of effective collaboration between professions, there have been a number of difficulties for some HEIs in implementing interprofessional learning within the curriculum.

In terms of practice placements, the findings indicate huge variety in the placement experience. Key issues are the length of placements, the difficulties of matching theory and practice and lack of clarity of the role of practice educator.

SET 6.5 states 'The measurement of student performance must be objective and ensure fitness to practise'. Some respondents were concerned about how much objectivity was actually possible especially as the measurement of student performance 'must be objective'.

SET 6.9 includes the word 'aegrotat'. Many respondents were unclear of the meaning.

Recommendations

The findings presented the following recommendations to be considered by the HCPC.

Recommendation 1	The HCPC should consider adding a reference to the development of relationships with service users to their definition of fitness to practice
Recommendation 2	The HCPC should consider making an explicit mention of 'soft skills' within current SETs
Recommendation 3	The HCPC's SETs and guidance should include stronger links to SoPs and HCPC's standards of conduct, performance and ethics, and also the standards and requirements of

	professional bodies. Suggestions include: • URL link • Explicit link within the introduction to the SoPs and standards of conduct, performance and ethics, and professional body guidance
Recommendation 4	The HCPC to consider providing a minimal IELTS score for students whose first language is not English, seeking a place on HCPC regulated courses
Recommendation 5	The HCPC to make a clear link, in their SETs and guidance, to the document 'Health, disability and becoming a health and care professional'
Recommendation 6	The HCPC to make explicit mention of 'mental health' within the SETs or guidance
Recommendation 7	The HCPC to review practice educator training with a view to developing broad principles about the role of practice educators
Recommendation 8	The HCPC to consider the development of a 'how to' practice guide to complement the SETs and the guidance

Recommendation 9	Re-word the SET 6.5. Suggestions are:
	 • Replace 'must' with 'should aim to be'
	    ○ 'The measurement of student performance should aim to be objective and ensure fitness to practise'
	 • Replace 'objective' with 'fair', 'rigorous', or 'uniform'
	    ○ 'The measurement of student performance must be fair/rigorous/uniform and ensure fitness to practise'
	 • Keep 'objective' but include 'fair', 'rigorous' and 'uniform' too
	    ○ 'The measurement of student performance must be objective, fair, rigorous, uniform and ensure fitness to practise'

Recommendation 10	Recommendation 10: Define the word 'aegrotat' within SET 6.9 using the definition of aegrotat provided within the glossary. • E.g. 'Assessment regulations must clearly specify requirements for an aegrotat award (awarded to a student who cannot complete the degree due to illness) not to provide eligibility for admission to the Register'

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Chapter 1 Introduction

1.1 Introduction

The Health and Care Professions Council (HCPC) is a regulator of 16 health and social care professions. Its role includes ensuring that education and training programmes meet standards of education and training (SETs) and that newly qualified professionals are fit to practise. To ensure that the SETs are contemporary and meaningful they are reviewed regularly. It is as part of such a review that this project was commissioned.

This chapter outlines the context and background to the project. The chapter begins by providing information on the aim and objectives to the project. It then provides information on the background to the project; the definition of fitness to practise used by the HCPC and explains some of the key developments in health and social care. The HCPC's definition is used throughout this project.

Chapter two is a literature review that includes previous work (from other health and social care professions as well as those regulated by HCPC) on fitness to practise as well as an exploration of the different definitions of key concepts used within the literature.

A description of the data collection methods employed in the project are described in chapter three while chapter four outlines the project findings. Chapter five provides a discussion of the key issues including recommendations and the limitations of the project.

1.2 Aim

The overall aim of this project is to explore 'preparation for practice' of newly qualified professionals who have completed pre-registration education and training programmes approved by the HCPC. Evidence gained from this project will inform and assist the HCPC in decision-making regarding the SETs (and supporting guidance) required for preparing newly qualified professionals to be fit to practise.

1.3 Objectives

- Identify the factors (including SETs and guidance), and how they combine and contribute towards ensuring 'fitness to practise'
- Determine how Higher Education Institutions (HEIs) implement, and measure as outcomes, the HCPC SETs within curricula
- Explore the views of healthcare managers, educators, experienced professionals and newly qualified professionals regarding preparedness to practise (including the extent to which they meet the HCPC standards of proficiency)

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- Explore the views of newly qualified professionals, educators, students, service users, patients, carers, practice placement educators, experienced professionals and employers on the appropriateness and completeness of current SETs and supporting guidance
- Determine the extent to which the pre-registration education programmes (incorporating HCPC SETs) prepare newly qualified professionals for the challenges of interprofessional working and public and patient involvement (PPI)
- Produce recommendations for how the SETs (and their supporting guidance and any other factors/key issues that contribute to fitness to practise) for newly qualified professional groups regulated by the HCPC, may be amended and/or strengthened

1.4 Background

When assessing education programmes the HCPC employ a set of standards. These SETs cover the following areas: level of qualifications for entry to the register, admissions, programme management and resources, curriculum, practice placements and assessment. The SETs are common across all 16 professions regulated by the HCPC. In turn, a programme which meets the SETs allows a student who successfully completes that programme to meet the standards of proficiency (SoPs) - the threshold standards for safe and effective practice in each profession. If a student successfully completes the approved programme they are eligible to apply for registration with the HCPC (subject to health and character checks and payment of the registration fee).

Accompanying the SETs is guidance, which provides advice to education and training providers on how programmes will be assessed and monitored against the SETs. The focus of the SETs and guidance are on the outcomes of the education and training programmes i.e. the ability of those completing the programmes to practise safely and effectively.

HCPC reviews their SETs approximately every five years and were last updated in 2009. The project reported on here is one of three strands of work reviewing the SETs and supporting guidance. A second strand is research relating to interprofessional education while a third is internal HCPC research and stakeholder engagement activities to gather views on the SETs.

This project explores the role played by the SETs and supporting guidance in ensuring that education providers have the structures and systems in place to prepare students to be fit to practise at point of entry to the Register. The intention is to identify whether and how the SETs and/or supporting guidance should be strengthened and programmes modified as a result.

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It is not just education providers upon whom the SETs impact. They also have implications for students on HCPC approved courses, newly qualified staff as well as more experienced professionals. It is vital that any review of these SETs include this range of people.

Defining fitness to practise

The HCPC have separate definitions of fitness to practise for students and registrants i.e. staff who are qualified. Fitness to practise for students means 'have(ing) the necessary health and character so that they will be able to practise safely and effectively once they have become registered. It is also about students' ability to act appropriately with those they have come into contact with when they are training, including service users' (HCPC, 2011). Fitness to practise for registrants is defined as having the 'skills, knowledge, health and character in order to practise their profession safely and effectively' (HCPC, 2011). This project is focussed on the latter. The key differences between fitness to practise for students and registrants are that registrants need the skills and knowledge, as well as the health and character, to practise safely and effectively. The phrase 'newly qualified' will be used in the rest of this project to refer to registrants; this is a term more easily understood by stakeholders.

A distinction should also be made between being fit to practise with being fit for purpose. The latter is the responsibility of employers and is about whether an employer regards an individual as having the knowledge, understanding, skills and experience to make them suitable for any given role or to work within any given setting.

Inevitably this project raises issues touching upon the role that employers can play in enabling newly qualified staff to undertake their role. However, the focus of this project is on the HCPC SETs and supporting guidance - employers will always be responsible, e.g. via preceptorship, induction, training and supervision, in supporting newly qualified professionals in their transition into practice.

Chapter two provides a fuller exploration of definitions of fitness to practise used within the health and social care professions.

1.5 Key developments covered by the research

There are several factors driving the changes to the health and social care system and subsequently, the knowledge and skills required of health and social care practitioners. These include an ageing population, frequently with long term conditions, children born with complex conditions who can now be expected to reach adulthood, growing emphasis on chronic illnesses, greater focus on patient safety and quality care (Bainbridge, 2010).The long term care and support needed puts demand on the health and social care system and the skills required of the workforce. Other significant developments are the advent of consumerism, a more

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diverse and discerning population and the rising cost of health and social care. In addition, technology has advanced and roles are rapidly expanding, which not only broadens levels of autonomy but intensifies the demand for new knowledge and skills (Whiting, 2009).

Two particularly important developments, which were explicitly addressed in the project, are the need for interprofessional working and the requirement to engage effectively with service users and carers.

Interprofessional working
The consequences of inadequate collaborative working were highlighted in both the tragic case of Baby P (Laming, 2009) and the scandal at Mid Staffordshire Foundation Trust which resulted in the Francis Report (2013). Both reports illustrate how poor team-working and communication between professionals can have a hugely negative impact on the delivery of patient care. The Health and Social Care Act (2012), and the National Collaboration for Integrated Care and Support (2013), emphasise the need for effective collaborative working between professions to provide integrated, optimal and safe patient care. This has consequences for how health and social care professionals are prepared for practice. The delivery of modern healthcare is dependent on groups of trained professionals coming together as interdisciplinary teams (WHO, 2013).

Service user and carer involvement
No longer is it acceptable for people to be passive recipients of services; they want to be involved in decisions about their care and treatment. The Alliance of Health Care Regulators in Europe (AURE) has argued that service user and carer involvement in healthcare regulation should be regarded as good practice (Joint Health and Social Care Regulators' Patient and Public Involvement Group, 2010). This is echoed in the UK White Paper, 'Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century' (DH, 2007), which advocates greater service user and carer involvement. In recognition of the importance of service user and carer involvement, the HCPC commissioned research into developing a SET that would cover this issue (Chambers & Hickey, 2012); subsequently a SET was introduced specifying service user involvement in the design and delivery of courses. The recent Willis Report, which reviewed the education and training of care staff and nurses, recommended that Health Education England should seek to identify those forms of public and patient involvement that can support learning and incorporate the findings into standard and quality assurance processes.

1.6 Summary
The HCPC reviews its SETs, and supporting guidance, on approximately a five year cycle – the last time they were reviewed was in 2009. The focus of the HCPC's SETs and guidance are on the outcomes of education and training programmes i.e. the

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ability of those completing the programmes to practise safely and effectively. This research reviews the SETs and guidance against a backdrop of key developments driving the changes to the health and social care system and subsequently, the knowledge and skills required of health and social care practitioners. These key developments, and included in this research, are the need for interprofessional working and the requirement to engage effectively with service users and carers.

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Chapter 2 Literature review

2.1 Introduction

This chapter is a literature review which explores different definitions of fitness to practise, reviews previous research on fitness to practise, identifies factors that impact upon fitness to practise, and compares standards, guidance and approaches used by different professions to ensure fitness to practise.

The chapter also outlines the search strategy used for the review and provides a commentary on the methods employed in the literature reviewed. For the purpose of simplicity the literature review has been organised using the HCPC's headings for their SETs.

The outcomes of the review provided context to the project and informed the focus and content of the subsequent questionnaire, focus groups, world café events and individual interviews.

2.1.1 Search strategy

Literature was identified through systematic searches of the electronic databases Ovid Medline, Cumulative Index of Nursing and Allied Health (CINAHL) and Applied Social Science Index and Abstracts (ASSIA) and further manual examination of reference lists. The search of journal articles was narrowed according to the following criteria:

- date of publication from 2000 to 2015
- written in English,
- peer reviewed, and
- other relevant literature identified from the articles in the review.

These searches were carried out in April and May 2015.

Only articles, which were available free of charge were considered. Using advanced search facilities, the phrases 'fitness to practise', 'fitness for practice', 'suitability to practise' and 'preparedness to practise' were searched with each profession. The terms 'qualification', 'registration', 'regulation', 'education', or 'professional standard' were compared alongside each of the professions: 'speech and language', 'radiographer', 'prosthetist' or 'orthotist', 'practitioner', 'paramedic', 'orthoptist', 'dietitian', 'chiropodist' or 'podiatrist', and 'therapist'. The following terms were also considered, 'students, undergraduate', 'practice patterns', 'health knowledge' or 'attitude of health personnel'.

This advanced search method initially generated thousands of possible articles and these were shortlisted using Microsoft Excel, reduced by the limiting factors, listed above, and removal of duplicates. The accumulated articles deemed most relevant

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for the study: 266 from CINAHL, 574 from Medline, and 32 from ASSIA. Subsequently, a process of rigorous sifting followed with a screening of these articles by title and abstract. This process enabled the researchers to discard irrelevant articles, resulting in 40 unique papers from CINAHL, 44 from Medline and 31 from ASSIA.

The remaining journal articles identified for inclusion in the review were subject to detailed examination and appraisal. The methods and major findings of individual papers were summarised within a matrix table (see Appendix 1).

2.1.2 Search results

The literature search included other health and social care disciplines not under the HCPC umbrella (medicine, midwifery, nursing, pharmacy, physical therapy, public health, dentistry, mental health, audiology, respiratory therapy, physician assistance, general practitioners and support care) in order to widen our understanding of current knowledge. Although the majority of the research was focused in the UK (n= 53) this literature review also includes papers from other countries (Australia, Belgium, Canada, Germany, Hong Kong, Ireland, Israel, New Zealand, South Africa, South Korea, Sweden and United States).

The most frequently mentioned group of professionals was student nurses (n=38) who are registered and regulated in the UK by the Nursing and Midwifery Council (NMC), not the HCPC. The relatively large number of papers on nursing may be due to the size of the profession and visibility within the health care setting.

Importantly, the literature reviewed identified papers representative of HCPC professions: social work, physiotherapy, occupational health therapy, psychology, nutritionists, paramedics and speech language therapy. Of these, social work was the most heavily represented (n=23). Additional factors might include the relatively large size of the profession and public fears regarding system failures in management and professionalism. The high-profile examples have demonstrated the need for ensuring fitness to practise in safeguarding the public and service users. The tragic cases of Daniel Pelka and Keanu William have contributed to research-based recommendations to be made within the profession (Narey, 2014). Noticeably, nine of the HCPC's regulated professions do not appear in this search strategy and within these databases: arts therapy, biomedical science, chiropody, clinical science, hearing aid dispensers, operating department practitioners, orthoptics, prosthetics and radiography.

A challenge in examining the published research was the lack of a common definition for fitness to practise, making comparisons between reports difficult.

Most of the articles assessed students' perceptions of their own level of competency to practice (n=39). Previous students' and graduates' opinions were also uncovered

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(Bullock et al., 2013; Hartmann et al., 2013; Hylin et al., 2007). Newly qualified professionals were considered by a number of papers (Avis et al., 2013; Black et al., 2010; Caldwell et al., 2006; Caldwell et al., 2007; Derbyshire & Machin, 2011; Young, 2011) as were qualified and registered professionals (Findlay, 2012; Fraser, 2000a; Fraser, 2000b; Green et al., 2007; Hartigan et al., 2010; O'Connor et al., 2012; Paterson et al., 2007; Stanley et al., 2011; Tam et al., 2012). An obvious weakness in self-reflection of preparedness is the lack of objectivity in such assessments.

There were though, a number of articles that considered the perceptions of clinical educators (Bandali et al., 2012; Fraser, 2000a; Fraser, 2000b; Gibbs & Furney, 2013; Holland et al., 2010; McAllister et al., 2013; Reeves & Freeth, 2002; Wilson & Carryer, 2008), lecturers (Holland et al., 2010) and course directors (Boyd & Spatz, 2013). Additionally, some papers considered the input of supervisors or student mentors (Brintworth, 2014; Fraser, 2000a; Fraser, 2000b; Gunn et al., 2012; Holland et al., 2010; Young, 2011). A few papers also consulted service users and carers about the level of care they receive (Holland et al., 2010; Reeves & Freeth, 2002).

2.1.3 Research methodologies identified from current literature

Previous research has utilised a diverse range of data collection methods to uncover opinions of student preparedness for clinical practice (highlighted in Appendix 2). Focus groups, interviews and questionnaire approaches were common methods of highlighting experiences. A smaller number of papers employed other methods such as workshops, ethnography and examination of self-reflective diary entries (see Appendix 2). Other studies offered a longitudinal element (Black et al., 2010; Fineberg et al., 2004; Jackson et al., 2006; Rees & Raithby, 2012; Reeves & Freeth, 2002; Ross & Haidet, 2011; Tee & Jowett, 2009; Webster et al., 2010), comparing perceptions from different time frames; some studies used a mixed method approach.

Most studies were small-scale, analysing results from one or two institutions or studying one or two professions.

The variety of professions, countries covered and methodologies used means that any conclusions should be treated with extreme caution.

Analysis of this literature follows the same structure as the HCPC's grouping of SETs (see Appendix 3 for full list of SETs). Evidence is presented, critiquing the SETs and any challenges posed; there is overlap between the SETs as they implicate each other.

2.2 Fitness to practise

The literature explores definitions of 'fitness to practise' (Avis et al., 2013; Fraser, 2000a; Holland et al., 2010; Holstrom, 2014; Moriarty et al., 2011; Parker, 2006; Stanley et al., 2011; Unsworth, 2011). Much of the literature uses terminology without fully explaining what it means (Brintworth, 2014; Christiansen & Bell, 2010; Lauder et al., 2008; Tee & Jowett, 2009; Whiting, 2006; Wilson & Carryer, 2008). Furthermore there is a lack of agreement around definitions of fitness to practise (Grundy, 2011).

Fitness to practise represents an amalgamation of many factors contributing to the preparedness of an individual to confidently enter their chosen clinical profession with appropriate and expected levels of capacity, capability and expertise. How individuals achieve these rests with the Higher Education Institution (HEI) and the design of their courses. The HEIs need to ensure specific SETs of education and training to guarantee that each student is confident and competent at the point of graduation to become registered.

Appendix 4 presents definitions of 'fitness to practise' of various professional regulatory bodies. HCPC define fitness to practise as someone having the:

"Skills, knowledge, health and character in order to practise their profession safely and effectively' (HPC 2011)"

Fitness to practise is often defined in terms of what is 'unfit' – focusing on the negatives and the opposites of these actions. For example, when defining fitness to practise the HCPC (2003) uses language of 'impairment' and outlines situations when a registrant may be considered as 'impaired' by falling short of specified SETs. Holmström (2014, p.459) has criticised the HCPC for using reductionist language to what is deemed an absence of 'bad character' in relation to (un)professional behaviour. Unsworth (2011) critiques nursing students' fitness to practise mechanisms for focusing on academic achievements, as opposed to the students' personal competency levels. A holistic model for defining competency provides better indicators, as opposed to being broken down into a list of specified criteria (Fraser, 2000b). Moriarty et al. (2011) have suggested that student preparedness should not be viewed as an end product but instead a process of continual development.

Other Regulatory Body Definitions

The role of fitness to practise amongst all regulators in the UK is crucial as the NHS Executive (2000) has stated that there must be a 'modernising education and training to ensure that staffs are equipped with the skills they need to work in a complex, changing NHS'. Appendix 4 gives the definitions from the other regulatory bodies operating within the UK and provides a good comparative base for the definition provided by the HCPC. For some, these variations in measuring and

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defining fitness to practise highlight a need for uniformity across all regulatory bodies to ensure standards (Tee & Jowett, 2009). Currer (2009) has suggested that it is essential for a common definition of competencies to be developed. The need for a uniform approach has also been advocated by Meerabeau (2001, cited in Holland et al. 2010, p.463) who states that without an appropriate and agreed benchmark then judgements on whether expectations have been met will also vary.

Within recent years some other health regulatory bodies have reviewed fitness/preparedness to practice and the implications of this upon their professional standards.

The General Dental Council (GDC) assessed the extent to which new registrants pose a risk to patients and the public, collecting data from patient and public surveys, questionnaire, stakeholder events and a literature review (Pierce, Kavanagh & Das, 2013). While recognising that risk can never be totally removed from clinical situations, the report concluded that newly qualified dentists do not pose a risk to the public. The literature review highlighted that graduates are most confident in those areas in which they received most experience while training; oral surgery, orthodontics and endodontics were specific areas that newly qualified professionals reported low skill and confidence. The report recommends further research supporting newly qualified professionals within the workplace, specifically those from outside the UK transitioning to a new setting.

The General Osteopathic Council (GOsC) undertook an in-depth study with a questionnaire and focus groups, gathering the views of faculty staff and final year students. Results acknowledge the multifaceted nature of preparedness to practise; they assert that the 'bed-rock' of preparation comes from clinical knowledge and competence that is supported by interpersonal and communication skills (Freeth, McIntosh & Carnes, 2012). The GOsC explored the notion of "safe if not always effective" which has been used to determine if students are prepared to enter practice. However, they note that focusing on the extent to whether newly qualified professionals are 'safe' can lead to overlooking the importance of interpersonal skills. This report suggests that these interpersonal skills should be better implemented within the curriculum and there should also be a greater emphasis on support systems for newly qualified professionals.

The General Medical Council (GMC) reviewed the extent to which newly qualified doctors felt they were prepared for practice by studying different teaching styles in three different universities – Newcastle, Warwick and Glasgow (Illing et al., 2008). Results showed that they felt well prepared in basic clinical skills and communication but felt under-prepared for assessing more difficult cases, managing workloads and prescribing. A proffered solution was for students to gain more experiential learning and clinical practice, especially within their final year of study. The study acknowledged existing variation between placements. It suggested the need to

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develop a 'learning culture' within placement settings, where staff encourage the student's progression and learning routinely rather than only the educator contributing during specific time-frames. The report raised some concerns from educators that too much focus was being placed on 'softer skills', such as communication, leading to less dedication to skill development.

A subsequent study by Monrouxe et al. (2014), and commissioned by the GMC, looked at the extent to which current UK medical graduates are prepared for practice. They undertook a Rapid Review of the literature between 2009 and 2013, interviews with a range of stakeholders and longitudinal audio-diaries with Foundation Year 1 doctors. Some of the findings echo those of Illing et al. (2008) as most trainees were not prepared for adopting a holistic understanding of the patient or involving patients in their care. They were also not prepared for safe and legal prescribing, diagnosing and managing complex clinical conditions and providing immediate care in medical emergencies. The trainees were well prepared for some practical procedures but not others, and reasonably well prepared for history taking and full physical examinations.

The General Optical Council (GOC) conducted qualitative research with students to assess whether they feel prepared for practice (Council for Healthcare Regulatory Excellence, 2012). From this research the consensus was that generally students did feel well prepared, but suggested two improvements; the development of modules with clinical scenarios and additional placements to increase student exposure to unusual and unfamiliar conditions.

These bodies regulate different professions and therefore have slightly differing ideals regarding fitness to practise, some emphasising the necessity of clinical skills over interpersonal skills with others viewing them as equally important. Issues that emerged, from the reviews, as needing addressing were increased practical experience and greater support for staff post qualification. The need for interpersonal or softer skills also emerged as an issue; interestingly the report by the GMC suggested that there was too much emphasis on this while GOsC called for a greater emphasis. A key difference with the HCPC is that it regulates 16 professions rather than one. It follows that the HCPC has to ensure that its SETs and definition of fitness to practice are applicable to all 16 of these professions.

Appendix 4 shows various definitions of 'fitness to practice' across a range of professions. Common themes are that professionals who are 'fit to practise' can do so 'safely and effectively', which is included in the HCPC's definition. Other common themes are that the professional should have a level of 'competence', 'skills' 'performance' or 'knowledge' – the HCPC go with skills and knowledge. 'Health' is also a recurring theme – again this is included in the HCPC definition. 'Character' and an absence of misconduct or inappropriate behaviour are also frequently mentioned – the HCPC refer to 'character'. Not explicitly included in the HCPC's

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definition, and included in the GMC's definition, is the issue of being able to 'establish effective relationships with patients and maintain effective relationships with patients'. It could be argued that the HCPC's notion of a relationship between the practitioner and patient is implicit in the phrasing 'safely and effectively'.

2.3 Programme admissions

The admissions procedure is the first point of contact between the prospective student and the HEI. HCPC has outlined criteria to be considered during the admissions process – command of the English language, criminal conviction checks, appropriate academic and prior learning and disclosure of any health impairments. Largely, the literature had little to say on the relationship between the admissions procedure and fitness to practise. Lauder et al.'s (2008) cross-sectional survey of 777 nursing and midwifery students concluded that the HEI is best-placed to decide whether a student is, or is not, potentially capable to complete the course.

Key issues that emerged from the literature related to the ethics of having to disclose health issues, the declaration of previous criminal convictions and the compatibility of personal attributes with the requirements of a course.

Health issues

Regarding the ethical issues surrounding disclosure of health status, Stanley and colleagues (2011) studied the extent to which students perceive that disclosure of disability or mental health problems may prevent acceptance onto courses. In this study of 60 practitioners and students for nursing, social work and teaching, results showed that three students did not disclose and a further eleven only partially disclosed information pertaining to a health condition due to fears of stigma and exclusion. The majority of students, however, were happy to make their disabilities known as it is essential in eliciting support where it may be required. Furthermore, the authors concluded that in order for equality and disabilities to be celebrated within the workplace they need to be acknowledged in the education setting (Stanley et al., 2011). The Equality Act (2010) makes it unlawful to discriminate against disability within education settings.

Criminal conviction checks

The HCPC's guidelines request for criminal convictions to be uncovered through the Disclosure and Barring Service (DBS) checks prior to admissions onto HEI programmes. Tee & Jowett (2009) studied nursing and midwifery students within one university setting and suggest that previous acts of criminality should be revealed through self-declaration as a means of promoting honesty and self-reflection. Convictions can expire after time has been spent. However, there is the view that both health and criminal convictions should be rigorously checked as a means of safeguarding the public (Burns et al., 2004) particularly as many service users of healthcare are vulnerable (Harris & Keller, 2005).

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Personal characteristics and attributes

A common theme across the literature was the compatibility of students' personal attributes with health professions, which is not currently explicitly addressed by the SETs. Holmström's (2014) literature review has suggested that attitudes ought to have equal weighting of importance as academic strengths. Specific individual qualities are referenced as imperative for healthcare professionals: sensitivity (McAllister et al., 2013), maturity, initiative and communication skills (Fraser, 2000a). Similarly, Beccaria et al. (2013) reviewed nursing through online surveys and focus groups totalling 85 respondents and have suggested a more holistic stance would recognise emotional competencies that are necessary within nursing. O'Connor et al. (2012) believe that it is necessary to contemplate the ways in which age and previous life experience may lead to greater motivation levels and development of an 'emotional IQ' – this was as a result of 20 individual interviews with representatives from physiotherapy and occupational therapy.

Through a systematic literature review Parker (2006, p.401), however, has deemed the process of screening individuals based on their personalities as 'counterintuitive' because it should not be assumed that students have emotional competencies at the point of entering onto courses. Instead Parker (2006) believes the focus should remain on academic rigour, specific skills and reasoning abilities.

Attitudes and beliefs was another issue raised in the literature. Students will always reflect a diversity of attitudes and beliefs – thus, judgements regarding the appropriateness of individual moral frameworks are by definition value-laden. While Whiting (2006) asserts that morality and behaviour are closely linked. His personal commentary focusing on the impact of student beliefs found that not all prejudices and racist attitudes will necessarily lead to unprofessional behaviour. This suggests that fitness to practise only becomes a concern when students are unable to suppress these attitudes (Whiting, 2006).

Other research suggests that compassion can also present challenges. Holmström (2014, 454) has suggested that while there are positives associated with selecting compassionate persons, there may be 'too much of a good thing' if students are then unable to control their emotions during difficult situations or periods of stress. Similar views have been echoed by McAllister et al. (2013) and Wilson and Carryer (2008), suggesting that being over sensitive and emotionally immature can hinder the ability to perform.

There are similarities here with the notion of person-centred care. Laird et al. (2015) note that people have a right to compassionate care and that knowing the service user, working with their values and beliefs as well as developing positive relationships are all common aspects of person-centred practice.

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2.4 Programme management and resources

Effective management of the course and utilisation of resources within HEIs is perceived by the HCPC as crucial in producing students who are fit to practice. Key issues emerging from the literature are effective management, the role of staff and availability of resources.

Effective management

Ho et al.'s (2008) literature review stresses the need for the course to be funded and organised in a structured and efficient manner. The role of academic staff in ensuring effective management is noted in the literature - the professional responsibility and subsequent behaviours of academics is equally important to the SoPs students are measured against (Currer, 2009). Successful courses (specifically in Interprofessional Education) require dedicated staff, passionate and committed to their discipline (Ho et al., 2008). Cook and Payne (2012) have acknowledged, however, the potential cost implications of recruiting staff who are outstanding in their roles.

Positive models of staff management have been developed and described in the literature. Cook and Payne (2012) propose the use of a 'Quality Circle' in which a feedback loop is created; supervision improves education at operational and strategic levels, in turn benefiting supervision. Co-operation amongst staff and between different faculties is appreciated in improving the organisation and delivery of healthcare profession courses (Vanier et al., 2013). A successful example of co-operation is outlined in Vanier and colleagues' 2013 multi-disciplinary review of curriculum from ten different institutions; the Welsh Association of Midwifery Lecturers was established, and tutorial staff valued the informal nature of communication and sharing of ideas.

Role of staff

Professional teaching staff employed in HEIs frequently have to juggle the demands of teaching, management and clinical practice. O'Connor, Cahill and McKay (2012, p.281) highlight the 'dual' nature of juggling teaching and management. Lecturers may also engage in clinical practice work, requiring further time commitments (Cook & Payne, 2012). Raque-Bogdan et al. (2012) have critiqued the lack of clinically active staff, supposing that without healthcare experience such lecturers may not be best placed to educate students.

Availability of resources

The availability of resources has been highlighted as useful in the development of students as competent professionals. Callaghan et al.'s (2008) focus groups of fourteen students from midwifery and social work stress the importance of utilising services, such as the library, to increase the validity and accuracy of information that students have at their disposal. Alongside this there is a need for developing an environment that supports and encourages students to progress their learning

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(Bullock et al., 2013). Callaghan and others (2008) identified barriers to availability of resources, books and electronic videos or recordings: traveling to the library, especially whilst on placement, may not be feasible, loan periods on books are often too short, and some students are simply not aware of the resources they can utilise. Caldwell et al. (2007), explored the role of technology in course development, noted limited use of electronic resources, possibly relating to inadequate IT skills or limited access to computers in their questionnaires completed by 85 respondents.

2.5 Curriculum

The appropriate content of courses is necessary in ensuring that students are adequately prepared, in terms of their proficiency and efficiency, for the challenges they will face when applying knowledge and skills within health and social care settings.

Key issues identified in the literature were a lack of agreement about what should be included within the curriculum, gaps in student knowledge and the balance between theory and practice.

Curriculum content

There is a notable lack of unanimity of what is and should be represented in 'core' curriculum (Black et al., 2010). Studies have noted the importance of teaching professionalism (Morrison, 2008), emotional competency (Wilson & Carryer, 2008), patient-centred approaches (Ross & Haidet, 2011) and 'legal literacy' (Preston-Shoot & McKimm, 2013, 272).

Kelly (1999, taken from Lauder et al., 2008) notes a 'hidden curriculum' in the development of university work; often lessons are learned by students without being explicitly and formally outlined in the curriculum. Lessons may be taught in an informal exchange of knowledge and ideas between the educator and the student. The hidden curriculum has been defined as 'the set of influences that function at the level of organisational structure and culture including implicit rule to survive in the institution such as customs, rituals, and taken for granted aspects' (Lemp & Seale, 2004, p.770)

'Mastery goals', gaining new knowledge, and 'performance goals', positive feedback on competencies, have been acknowledged by Madjar, Bachner and Kushnir (2012, 2) as effective in the monitoring of student progression in meeting targets and increasing abilities.

Gaps in student knowledge

The literature highlighted gaps within student knowledge, not adequately addressed by curriculum. Holland et al. (2010) observed low numerical skills from newly qualified students in nursing and midwifery through their in-depth study of 311 participants using questionnaires, focus groups, interviews and curriculum analysis.

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Other studies raised alarm over gaps in student understandings of disability and mental health (Rees & Raithby, 2012), understandings of what is regarded as abuse of elderly people (Lo, Lai & Tsi, 2010), and understandings of what constitutes domestic violence (Beccaria et al., 2013).

The literature highlighted that continuous research is an effective way to ensure that practice is best served and well informed (Caldwell et al., 2007). Analysis of their questionnaire sent to a mixed group of 85 health professions, Caldwell et al. (2007) found that 95% of students received training related to research methods during their education, providing a source of knowledge for their practical work. Furthermore, research is not a singular process; students should be enabled to review and question the relevance of literature and texts within their field and perhaps make suggestions for more applicable research, which will in turn bring a depth of knowledge (Bientzle, Cress & Kimmerle, 2013).

Linking theory and practice
Linking theory and practice is integral to achieving student learning; the curriculum needs to match effectively to the active learning undergone on placements. The inter-connection should be constant but open to change (Bellinger, 2010). Milligan (1998, cited by Girot, 2000, p.321) holds the view that both aspects of the course complement each other – analysing the experience of nurses they found that practical training allows the skills of students to 'function for today' while classroom education enables the learning to 'function for tomorrow'. Learning skills that have the ability to transcend through the career of professionals is beneficial in light of the constantly changing environment of healthcare. Woods et al.'s (2006) study of psychologists reported that practical performance fundamentally rests upon knowledge of basic science mechanisms. Achieving a constructive link between theory and practice places responsibility with education providers and practice placement providers and the promotion of a solid relationship between both (Moriarty et al., 2011; Holland et al., 2010).

Whilst evidence-based practice has been celebrated, time constraints have been acknowledged as a barrier to successful implementation (Caldwell et al., 2007). It takes a considerable amount of time for research to have practical implementation within the healthcare setting as procedures may have to be reviewed and altered in light of new evidence. Equally if a new way of working emerges within the professional setting then it takes time for the validity and efficacy of the new practice to be researched and published.

The literature highlighted the role vocational courses could play in cultivating more professionally competent students, who are fit to practise. Grundy (2001) praises National Vocational Qualifications (NVQs) for preparing students for practice in an effective manner. Similarly, Girot's literature review (2000, p.333) recognises diploma students as having the same capability as university graduates, and in some

cases being 'fitter' to practise. Hartigan et al. (2010) demonstrated, through focus groups of nursing students and staff, that the departure of courses away from apprenticeship models and towards healthcare teaching within universities may have catalysed concerns over fitness to practise as students hold fewer positions of responsibility.

The methods of teaching also relate to the linking of theory and practice. Gallagher (2010) endorses a 'vertical' approach for combining theory and practice, which is fostered through problem-based learning and utilisation of case studies, as opposed to more traditional methods of teaching knowledge in a separate environment from learning practical skills. The argument for a 'blended' approach - mixing online and face-to-face engagement to provide a successful interface of resources for both students and staff - has been proposed by Rowe, Frantz and Bozalek in their literature review (2012, p.217) for offering a link between theory and practice and improving competency skills. Hilton and Pollard's (2004) development of 'skills laboratories' presented an innovative combination of teaching methods aimed at improving midwifery students' clinical abilities; although acknowledging the huge time burdens involved in creating this learning environment.

2.5.1 Methods of teaching
Consideration and evaluation of fitness to practise also brings with it a focus on pioneering novel methods in delivering learning to students. It is apparent within education circles that teachers are passionate about engaging with inventive methods (Vanier et al., 2013). There is a need for different styles of teaching to be considered as students learn in diverse ways (Gunn, Hunter & Haas, 2012; Black et al., 2010).

McAllister et al. (2013, p.91) promote the concept of 'transformative learning', with the intention of questioning accepted norms and ideals by incorporating principles of social justice; perspectives are altered by 'a process by which learners call into question accepted ideas, frames of reference, or habits of mind'. Hingley-Jones and Mandin (2007, p.178) credit a more 'therapeutic model' of learning both on the surface-level and also in-depth; arguing that a systematic method of thinking allows for a consideration of contextual factors alongside the individual requirements of the patient.

Problem-based learning
Problem-based learning stimulates group discussion of case-studies; students can assess 'cases' within the safe setting of a classroom, allowing the chance to learn from any mistakes (Kiersma, Plake & Darbishire, 2011). Problem-based learning demonstrated a proven rise in the competency levels of 40 social work students in Rees and Raithby's questionnaire data (2012), as the learner is encouraged to consider the individual circumstance of each situation. The benefits of education through problem-based learning have been listed in the literature; students become

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active learners (Nelson, Sadler & Surtees, 2005) and motivation levels rise as self-reflective practices are encouraged (Gunn, Hunter & Haas, 2012). Role-play situations can help prepare students for the expectations of clinical settings (Billington, 2011); offering a link between theory and practice (Gunn, Hunter & Haas, 2012).

Virtual learning/simulation
Virtual learning and simulation have been hailed as the future of student education in the classroom environment (Hughes, 2004). The value of simulation is the perception that it reflects reality (Dow, 2008; Kiersma, Plake & Darbishire, 2011), affording the opportunity for student error within a controlled environment (Nelson, Sadler & Surtees, 2005). Simulation offers an important method to remove many barriers to practical learning including smaller numbers of patients, and placement opportunities and apprehension of students learning on 'live' patients (Bandali et al., 2008).

Other assets of virtual education have been discussed; consideration of wider social factors (Nelson, Sadler & Surtees, 2005), aiding critical and reflective thought processes (Barratt, 2010; Bandali et al., 2008). Dow's (2008) study of midwifery literature education involved computer simulated childbirth; students found the experience captivating, while educators saw the benefit in the ability to reproduce the same learning practice over time. Barratt (2010) also sees the benefits videos allow for staff to analyse their teaching styles, after conducting sixteen focus groups with nurses. Tee & Cowen's 2012 in-depth study of visual learning employed in a mentor training scheme in one specific university witnessed increased knowledge and empathy levels.

Virtual learning is not without criticism; arguments suggest that simulation can never fully replace the role of practice placements (Bellinger, 2010). The reality of human experience is that each situation is unique and reproductions can never create true accuracy (Dow, 2008; Bandali et al., 2008). Furthermore, there are huge cost associations with this learning method (Dow, 2008; Nelson, Sadler & Surtees, 2005). Issues regarding student access to virtual settings and IT skills have also created a barrier to development (Barratt, 2010; Nelson, Sadler & Surtees, 2005). Some educators may view virtual learning as a threat in that it may replace the need for them within the classroom setting (Dye, Gillon & Sales, 2009). Nelson, Sadler & Surtees's 2005 study of the use of computer-based virtual social work environments, within one university setting, reported that some students fell ill with cyber-sickness. Others caution that there is a lack of evidence of the impact of simulations on competencies (Rowe, Frantz & Bozalek, 2012; Bandali et al., 2008).

Feedback
An important aspect of teaching is for the tutor to relay feedback, stressing positives

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and contextualising negatives, to encourage student development through goal setting (Findlay, 2012). Frank feedback is welcomed by students as reports have shown this to have implications for raising confidence levels (Pal, Dixon & Faull, 2013; Wells & McLaughlin, 2014; Avis, Malik & Fraser, 2013). Girot (2000) believes feedback entails mutual exchange of views between tutor and student. Young's observational study of 53 midwives, supported with individual interviews and focus groups, found that third year students did not enjoy working without the opportunity to 'bounce ideas off colleagues' (2012, 826). Delivery of opinion can be complex and needs to be clear and direct in order to have the desired outcome (Wells & McLaughlin, 2014). Some have suggested that training may be necessary to better prepare tutors in this area (Findlay, 2012). Young (2012) argues that the most effective way of organising feedback is face-to-face conversation straight after the occurrence of events, allowing for the exchange of questions.

Some tutors, however, seek to evade feedback in person due to a fear of harming the student's confidence and the relationship that may be in place between the pair (Wells & McLaughlin, 2014). Bourke et al. (2014) see technology (sending emails and text messages) to be an honest method available to negotiate the feedback process as it avoids any awkward situations appearing face-to-face.

Self-reflection
Self-reflection has been recognised as a valuable addition to teaching. Benefits have included increased self-awareness (Black et al., 2010), development of reasoned judgment and confrontation of assumed knowledge (Holmström, 2014). For students, to reflect upon previous experience allows them to take action into the future – as found through McAllister's 2013 observational study of 25 mixed health professions. Young (2012) argues that students need to reflect on their practice placements in the safe and supportive environment of the classroom.

The most studied method of examining student self-reflection is the use of diaries and portfolios (Fraser, 2000b; Girot, 2000; Hughes, 2004). It should be noted that the value of self-reflection is based upon how well it is implemented and the strengths of the methods of training and assessment (Maloney et al., 2013).

2.6 Practice Placements
Practice placements are an essential part of students' learning, it gives them the opportunity to demonstrate their skills and prove themselves to be fit to practise. The influence of placement periods within course programmes has been regarded as highly valuable (Webster et al., 2010; Holland et al., 2010). Gains in student confidence have been noted (Webster et al., 2010) alongside growths in competence and knowledge acquisition (Sheepway, Lincoln & McAllister, 2014; Vanier et al., 2013).

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The literature identified key themes relating to practical skills, improving community engagement and issues relating to the length, timing and availability of placements.

Practical skills

Hartmann, Nadeau and Tufano's survey of 190 occupational mental health students (2013) observed improvement of holistic and emotional skills following practice placements. Practical learning is seen as a process of 'normalising' experiences (Conlon, 2014, 426); by contextualising every-day experiences through exposure. The process of doing and the hands-on nature of learning have proven to be successful in delivering successful student competencies (Gibbs & Furney, 2013); it requires an active and social experience of 'learning the ropes' (Black et al., 2010, 1767). Clinical learning allows for students to prepare for future situations by providing them with real examples to refer to (Young, 2012). In order for practice placements to successfully improve student skills it is necessary for them to be offered a wide range of experiences (Moriarty et al., 2011), including providing exposure to cultural diversity and multiculturalism (Kropf, 2003). Gunn, Hunter and Haas (2012) have also highlighted the need for a positive student attitude in embracing all aspects of the placement.

Michau and colleagues' 2009 study of paramedics on placement uncovered that students were often mistreated by existing members of staff and asked to perform duties outside of their level of competence. Black et al. (2010, p.1759) suggest that students need to be appropriately scrutinised as 'experience does not equal expertise'.

Non-statutory, voluntary and community placements

Increasingly, there are arguments supporting students collaborating with the wider community by engaging in non-statutory or voluntary placements. Bellinger (2010) suggests that these placement environments provide diversity in experience and the ability to increase learning. Holland et al (2010) assert that it is necessary to consider community-based practice due to the changing demands of healthcare, which requires a more contextualised and personal response (Holland et al., 2010). Community-based practice in this regard refers to the health or care professional going out and visiting the patient within their home or community setting, rather than only in the hospital. Mathias-Williams and Thomas (2002) found that 91% of social work students in their study anticipated working in community settings, be that voluntary or statutory, during their future work. Green et al. (2007) argue for an increased role of private sector placements.

Webster et al. (2010) and Paterson, Green and Maunder (2007) both examined statutory rural placements (in Australia and South Africa respectively, where traditional community groups may be located far from a hospital or a university). They found that community placements of this ilk produce greater student

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engagement, enjoyment and connection to student work, based on questionnaire data completed by 8 respondents.

Generally, non-statutory placements are critiqued for their high costs (Webster et al., 2010), associated transport and infrastructure problems, perceived cultural barriers and depleted resources (Paterson, Green & Maunder, 2007).

Length and timing of practice placements
Not all literature views practice placements in a positive light. Placements are criticised for their brevity, students feeling they would benefit from longer exposure (Webster et al., 2010; Mathias-Williams & Thomas, 2002). There is also a desire for placements to occur earlier in course programmes; the later they take place students find greater difficulty to integrate their learned skills (Gallagher, 2010). Often, there are insufficient placements available to offer to students, let alone to offer a breadth of experience, specifically in the case of paramedic students (Michau et al., 2009). Shortage is linked to funding availability, competition from increased student numbers and the decrease in patient availability (Michau et al., 2009).

2.6.1 Practice educators

Practice placement educators have an important role in preparing students for the reality of healthcare professional work. The HCPC defines a practice educator as 'a person who is responsible for a student's education', although the literature uses the term educator and mentor interchangeably[1]. The literature highlighted the role of practice educators in adopting a mentor relationship with students to help their development, outlining both positive and negative aspects of a mentoring role. It is acknowledged that different professions have particular definitions of 'mentorship.' The phrase here is used as a generic term to capture the idea of support being provided, by an individual or individuals, to newly qualified staff.

Positive factors
Educators often take on the role of a mentor in guiding students through the progression into the clinical working environment (Moriarty et al., 2011); mentors are obliged to 'bridge the gap' between education and practice (Hughes, 2004, p.274; Wells & McLoughlin, 2014, p.138). Support from practice educators can boost student development and experience (Webster et al., 2010; Holland et al., 2010). Darra (2006, p.458) discuss how mentors make the practice placement experience 'real' for students. Importantly, mentors must ensure that student competencies increase; Black et al.'s (2010) longitudinal study evidenced that therapists developed their understanding of self-awareness and communication skills with numerous stakeholders, including patients, peers and professionals.

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[1] In this project the term practice educator and mentor are considered synonymous.

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There is much literature on the relationship between mentor and mentee. Effective mentoring takes the form of role-modelling, where students use mentor behaviour as a prototype for their own conduct (Bellinger, 2010; Young, 2012). Students learn skills, such as decision-making, through a simultaneous process of observing and copying the behaviours of others (Young, 2012). Appropriate attitudes and character are learned by a process of repetition and practice (Holmström, 2014). Andrews & Roberts' 2003 study of nurses on placement found that students replicate good behaviour that is demonstrated by seniors. Ideally, the development of a relationship between the student and educator is based upon 'trust, patience, communication, knowledge, empathy and respect' (Hughes, 2004, 274). Mentors should provide a 'safety net' while students experience the reality of their role by consulting in decision-making (Young, 2012, 827). Steven et al.'s 2014 study of medical students' audio diary entries and follow up interviews found that relations between professional doctors and students can nurture learning, despite the unequal relationship between the two. The supervision process should be participative, the student is not passive (Hughes, 2004). Relationships must be sensitively and constructively managed, especially during periods of conflict (Bourke, Waite & Wright, 2014). Friendship between the mentor and mentee can impair the judgement of supervisors (Hughes, 2004) and they may experience personal failure if the mentee is not performing to the required standard (Wells & Mcloughlin, 2014). Findlay (2012) supports this view; relationships cannot be a barrier to receiving necessary feedback and a balance between comforting and supporting the student and encouragement them to step outside of their comfort zones is essential.

Successful mentoring is fostered through the establishment of a clear framework and guidelines to assist with the teaching role (Young, 2012; Darra, 2006). Systems must also be scrutinised to regularly review and assess their efficacy (Hughes, 2004). McCafferty's report (2005, p.30) outlines five necessary aspects of supervision: administration, teaching, helping, mediation and assessment. Additionally, Tee and Cowen (2012) observed constructive impacts of establishing a Student Practice Learning Advisor Service in nursing, to support the role of practice educators. Practice educators should be aware of the need to continue mentorship and support when students become newly-qualified as learning continues after the point of graduation (Fraser, 2000a). Avis, Malik and Fraser (2013) demonstrated that newly-qualified midwives actually felt more supported by mentors than they had done as students.

Mentors are not only encountered in the practice setting, for many students there is invariably crossover between different supervisors. Students ultimately derive assistance from numerous sources and people (Andrews & Roberts, 2003); throughout the duration of courses students deal with a range of people who operate at different levels and possess dissimilar working styles (Young, 2012). Mentoring is noted as occurring in an ad-hoc manner, as opposed to being organised via designated personnel (Avis, Malik & Fraser, 2013).

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Negative factors

Role-modelling is not celebrated uniformly across the literature. Patterson, Green & Maunder (2007) have suggested that where a lack of support is in place, students will become more pro-active and independent in their learning as a result of their focus groups with 13 dieticians. Bourke, Waite and Wright (2014) argue that students cannot develop independence skills if they are solely cloning and copying mentors.

The extent to which mentors succeed in guiding student education has been questioned. Many working professionals have existing constraints on their time due to high workloads and are unable to spare sufficient time for mentoring students (Bourke, Waite & Wright, 2014; Hughes, 2004). There is an argument that clinical settings are designed for professional work, not student learning (Andrews & Roberts, 2003). Furthermore, lack of financial or monetary incentive discourages professionals to be mentors (Bellinger, 2010). The post of mentor requires genuine enthusiasm and commitment (Bourke, Waite & Wright, 2014). Some educators are forced into taking on the role, even when teaching is not necessarily in their skill set or are not adequately prepared for the role (Andrews & Roberts, 2003). Students themselves can be an obstacle to fruitful relationships, as they may believe that having a mentor brands them as weak (Hughes, 2004).

Wells & McLoughlin (2014) argue that effective mentors should be able to overcome pressures and barriers. However, there is certainly a lack of uniformity in the performance of mentors, leading to varied student experiences (Andrews & Roberts, 2003). Continuity is also impeded by shift patterns which impact on the extent to which the student and mentor are able to meet, (Young, 2012). Poor mentors can have long-term impressions on students (Hughes, 2004); notably bad attitudes and disengaged work ethics (Paterson, Green & Maunder, 2007).

2.7 Assessment

Assessment offers the opportunity to evaluate whether the student graduating is indeed fit to practise. Key themes that emerged from the literature are the definition of competence and what issues should be considered in assessment. Assessing students is a charged and fraught process (Girot, 2000).

Defining competence

There is an absence of accord regarding the definition of competence (Girot, 2000; Grundy, 2001), which results in variations in the criteria used for assessment (Moriarty et al., 2011). Hartigan et al. (2010) call for an international definition of competence, Holland et al. (2010) request a common point of reference, and Currer (2009) suggests that all courses need to work in line with professional bodies to draw parallels with other institutions.

Inclusion within assessment

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The notion of 'professionalism' is considered during assessment. Parker (2006) judges professional expertise through a negative framework, comparing student behaviour against what is deemed to be improper conduct. Arguably, unprofessional conduct can be detected early within the course and measures can be set in place to reduce problems (Howe et al., 2010). Fraser (2000b) argues that students should be assessed in a holistic way - i.e. competencies should not be simplified and reduced to lists; rather the whole professional performance of the individual's abilities should be analysed.

A necessary part of assessment is the ability to recognise student failure and prevent them from graduating from the course; this is an obligation of public protection (Currer, 2009). Fraser's report into midwifery recounted staff testimonials that incompetent students were being allowed to pass as a result of inconsistencies within the assessment process, based on their in-depth and observational study of one university (2000b). Furthermore, recent public concerns regarding the practical abilities of newly qualified students have stressed the importance of rigorous assessment (Young, Brooks & Norman, 2007). However, Tam, Coleman and Kam-Wing (2012) argue that although some students may not achieve good results via performance testing they may still possess necessary professional qualities. While failure for some students may be a necessary option, it is important for HEI courses to have systems of support in place for struggling students which help them to overcome obstacles and achieve success (Gunn, Hunter & Haas, 2012). Failure then occurs when behaviour persists despite the existence of mechanisms to support the student (Parker, 2006).

Orr, McGrouther and McCaig's (2014) literature review uncovered high levels of ill-health and obesity amongst nurses. They proposed assessing professionals on their health as they are best placed to promote healthy lifestyle ideals.

Billington (2011) supports the introduction of Objective Structured Clinical Examination (OSCE) in assessment procedures; this method scrutinises competencies related to technicality, critical thinking, communication and the ability to view the patient as a whole. However, OSCE has been criticised for rewarding students who complete a larger number of tasks, irrespective of the quality in which they may be carried out (Woods et al., 2006). Objective assessment could be more consistent through circulation of a handbook for assessors to consult (Fraser, 2000b).

Service users can offer valuable insights into the assessment and training of students (Hingley-Jones & Mandin, 2007). Pal, Dixon and Faull's 2013 study of twelve support workers looked into the results of giving patients feedback forms to assess the performance of students. Students were able to improve their patient-care and communication skills, but some patients felt they were unable to answer forms honestly due to fear of receiving poor treatment if giving negative responses.

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Furthermore, students expressed embarrassment and feeling like a burden during the process of giving out forms, as they do not want to bother patients during sensitive times.

2.7.1 Student Confidence

There is a notable concern regarding student confidence levels after graduation and registration. Fraser's study of midwives concluded that often students express that they have high competence levels but lack confidence in their abilities (2000a). Similarly, Bullock et al. (2013) suggest that students feel under prepared when graduating and Caldwell et al. (2007) reported that a third of students were not self-assured in their capacity to perform well. Avis, Malik and Fraser (2013, p.1068) declared that a successful student must feel 'confident as well as competent' after analysis of diary entries and interviews with 35 midwifery students.

Various reasons for this lack of confidence can be identified in the literature. Matthias-Williams and Thomas' 2002 report into social work found that 47% of students felt they had not received enough training or experience to develop their skills and 88% of graduates disclosed concern about entering the workplace. Moriarty et al. (2011) have also noted a link between limited training and decreased confidence, on this occasion as a result of depleted resources available for personal development. It has also been suggested that assessors can demoralise students and impact upon confidence levels (Fraser, 2000a).

Low confidence among newly-qualified students can also occur as a result of the transition between education and professional work environments. Moriarty et al. (2011) discuss the dissimilarity between expected experiences and the reality that ensues. There have been reports of students who embellish their competency skills (Gallagher, 2010), which can result in a shock upon working. Falk and colleagues (2013) argue that the variation between experiences lies in the different expectations of staff. Transitioning into a role of responsibility is often difficult as students are largely protected by staff regarding the accountability of their actions (Hartigan et al., 2010; Avis, Malik & Fraser, 2013). Black et al. (2010, 1759-1760) suggest that the transition period could be aided by a continuation of learning the realities of 'actual' practice.

Some contend that the need to assess confidence levels is unnecessary as fear related to beginning work is a natural process for any student (Avis, Malik & Fraser, 2013). Confidence building is a process that occurs within the professional setting and Holland et al. (2010) believe it can take up to six months for a newly-qualified student to settle. Self-esteem and assurance occurs through developing communication skills (Black et al., 2010; Hartigan et al., 2010). Indeed, Mathias-Williams and Thomas's questionnaire of 35 social work students (2002) found that 91% of students felt communication is the skill most paramount to maintaining

confidence, compared to decision-making, report-writing, empowering and interviewing techniques.

2.8 Service user and carer involvement
HCPC (2003) have acknowledged the benefits associated with service user and carer involvement in preparing students for working with patients. Following research undertaken in 2012 (Chambers & Hickey 2012), the HCPC adopted a SET requiring service users to be involved in the design and delivery of courses.

Service users can have a significant impact within curriculum design and leading teaching sessions, offering reality to case-study examples and the opportunity for reflection within a safe environment (Rees & Riathby, 2012). However, Hingley-Jones and Mandin's study (2007) demonstrated how students often exhibit feelings of embarrassment when working with service users, leading to a feeling within students that their involvement within courses is unnecessary. Hingley-Jones and Mandin, however, have promoted the incorporation of service users within course design and the benefits that can be gained by placing patients at the centre of teaching.

For service user involvement to be effective there needs to be adequate training for educators, students and service users (Forrest et al., 2000). Chambers & Hickey (2012), in a review of the literature, identified the need for an appropriate culture, infrastructure and resources.

2.9 Interprofessional Education (IPE)
IPE was initially piloted in the UK in St. Bartholomew's Hospital in London, 1999 (Reeves & Freeth, 2002). Bandali et al. (2008, p.187) define IPE as learning 'with, from and about'; which encourages communication and settlement of disagreement between professions. Plaudits of the interprofessional approach include the World Health Organisation (WHO, 1988) and UK policy makers (Department of Health, 2001). Various benefits are identified in the literature as well as challenges to its effective implementation.

A major benefit claimed of IPE is the increased awareness of the duties associated with other health professional roles (Conlon, 2014; Ericson, Masiello & Bolinder, 2012; Ho et al., 2008; Fineberg, Wenger & Forrow, 2004) and a conscious understanding of the health care system as a whole (Hylin et al., 2007). Caldwell et al. (2006) have suggested that creating your own identity and professional role occurs in a natural and productive way when defining your own role through the context of others. Developing knowledge of the work and responsibility undertaken by others in the clinical arena leads to a fruitful knowledge exchange process – Preston-Shoot and McKimm (2013) note the increase in understandings, specifically related to law, as a result of IPE. Undertaking interprofessional working at the

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educational level crucially dispels negative attitudes and stereotypes concerning other disciplines (Derbyshire & Machin, 2011).

Some suggest that IPE improves student preparedness to practise (Bandali, Craig & Ziv, 2012) and that students become active learners through the process (Guile & Grifiths, 2001: Bellinger, 2010). Greater knowledge of professionalism has been linked to raising confidence levels amongst students (Conlon, 2014) and perceptions of the realities of interprofessional issues that may arise (McCafferty, 2005). Falk et al. (2013) have suggested that the learning experience becomes more valuable the closer students work alongside other professional roles. These views are supported by Levett-Jones et al. (2012), noting an upsurge in student commitment and engagement throughout the learning experience. Hylin et al. (2007), in their study of newly qualified professionals, found that, through IPE, students are notably more independent and responsible for their own actions as they have developed knowledge of the accountability of their professional role. Furthermore, many transferred skills from their IPE into their current practice.

IPE encourages peer-assisted learning within the professional setting. Relationships amongst peers, via social interactions and support networks, allow for effective learning and confidence levels to flourish (Christiansen & Bell, 2010). Students can benefit from their associates as they can exchange ideas without fear of judgement from educators or assessors (Thompson & Hilton, 2011); helping to influence decision-making (Young, 2012). Also, by developing relationships and friendships with others students, they progress their emotional competence, which is crucial for health practitioners. Caldwell et al. (2006) observed that 94% of newly-qualified professionals worked within a team, acknowledging the essential nature of peer relations.

IPE has been celebrated for its ability to conquer temporal-spatial problems, which may otherwise inhibit learning (Reeves & Freeth, 2002). All of the students are placed within a singular training ward, instead of spreading across the hospital setting to allow teaching and learning to occur together. This means that students can get an immediate response and assistance from other health professionals. Ultimately, greater interprofessional team work is likely to improve patient care as a result of improved communication and creating common goals (Conlon, 2014; Ho et al., 2008; Reeves & Freeth, 2002).

It has been suggested that the benefits of IPE are more notable within the practical setting than within the classroom (Derbyshire & Machin, 2011). However, studies of practice placements encouraging IPE (Fineberg, Wenger & Forrow, 2004; Reeves & Freeth, 2002) have recognised the short nature of IPE placements and the need for courses to be longer and include a greater number of professions for students to gain full awareness of the roles of all health professionals (Hylin et al., 2007).

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Problems associated with Interprofessional Education

Whilst the benefits of IPE have been witnessed across the literature, it has been criticised for a lack of commonality between standards of interprofessional learning (Zorek & Raehl, 2012).

There is a lack of consistency between professions regarding the benefits of IPE. Within interprofessional training it can be difficult to obtain equal representation of students from different professions (Derbyshire & Machin, 2011; Ho et al., 2008; Hylin et al., 2007); there may be large numbers of students for one profession and none or only a few from another. Medical students were repeatedly mentioned as reluctant to engage with IPE courses (Hylin et al., 2007; Reeves & Freeth, 2002). Time-table clashes are a key barrier in bringing different student professions together (Reeves & Freeth, 2002). Nurses repeatedly faced difficulties within IPE training, with many students perceiving team-work tasks to be the responsibility of nursing (Conlon, 2014; Bellinger, 2010; Reeves & Freeth, 2002) e.g. focusing on discipline-specific roles reinforces negative attitudes that prevent interprofessionalism from flourishing (Fineberg, Wenger & Forrow, 2004). Student resistance to fully collaborate their work with other professionals in some cases led to 'turf battles' between disciplines (Bandali et al., 2008, 184). Furthermore, some feel that their own role becomes less significant (O'Connor, Cahill & McKay, 2012. Goelen et al., (2006) contend that interprofessional training is expensive. The application of IPE would demand restructuring of current hierarchies and would place pressure upon existing staff to ensure efficacy (Ho et al., 2008; Reeves & Freeth, 2002).

Creating a climate willing to adapt to innovative IPE models is difficult when some assert that there is limited validated evidence that interprofessionalism is a useful endeavour (Ericson, Masiello & Bolinder, 2012; Bandali et al., 2008).

2.10 Conclusion

It is clear that there are similarities, across professional bodies and regulators, of the definition of fitness to practise. The issues of practising 'safely and effectively' recur. This is also true for the notion of the knowledge, skills, health and conduct of the individual. An issue included in the General Medical Council (GMC)'s definition, and not elsewhere, relates to the relationship between the practitioner and patient.

This chapter has demonstrated that many of the themes and issues in the HCPC's SETS also recur in the wider literature on fitness to practise. What emerges from the literature is debate about 'how' these themes and issues impact upon fitness to practise and 'how' they are best implemented.

The literature revealed several issues that were explored further within the data collection events.

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In terms of the HCPC SETS relating to programme admissions the key issues were;

- Whether or not applicants should have to disclose health and previous criminal convictions
- The extent to which particular personal attributes should be considered as a requirement for admission onto a course

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Issues pertinent to the programme management and resources SETs were;

- The role of effective management
- The role played by academic staff
- The extent to which service users were involved in programmes
- The resources available to students.

There were four main issues that relate to the curriculum SETs;

- The issue of what should be included in the curriculum
- The extent to which there was IPE
- The extent to which there were gaps in student knowledge and
- The extent to which theory and practice were adequately linked.

This latter issue of linking theory and practice was, in turn, linked with issues which are related to the practice placements SETS;

- The extent to which newly qualified staff have adequate practical skills,
- The type, timing and availability of placements and
- The role of mentorship and the practice educator.

Finally, in terms of those SETs relating to assessment, the key issues were

- How to define competence and
- What issues should be included in assessment.

It is important to note, that although these issues did inform the data collection events respondents were given the opportunity to raise other issues that were of relevance to them.

Also worth noting that not all of the professions included under the HCPC's regulatory umbrella have been researched in this way: arts therapy, biomedical science, chiropody, clinical science, hearing aid dispensers, operating department practitioners, orthoptics, prosthetics and radiography. Furthermore the research that has been undertaken has tended to be small scale and focused on single professions.

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Chapter 3 Methodology

3.1 Introduction

The study was undertaken using a four-stage, interdependent sequential mixed method approach (Creswell & Clark, 2011) which includes both qualitative and quantitative methods of data collection and analysis.

Following a literature review (stage 1), an online questionnaire survey (stage 2) was designed and circulated. The literature review and preliminary analysis of the questionnaire data informed the questions asked at the data collection events (stage 3), which included world cafés, focus groups and individual interviews. Finally, a consensus workshop (stage 4) with key informants was carried out.

The project was overseen by an advisory group. Membership of this group covered a variety of professions (social work, radiography, dietetics, speech and language therapy, paramedics, physiotherapy) academic staff, professionals currently in clinical practice, HCPC representatives as well as service users and carers. This group met three times during the course of the project and reviewed all data collection instruments and protocols, including the revised approach to data collection. Further information is provided below.

Each stage is explained in detail in the following paragraphs.

3.2 Stage 1: Literature review and development of a matrix

A literature review was undertaken following the criteria and procedures outlined in chapter two. The purpose was to identify the factors, mechanisms and challenges which impact upon fitness to practise, and to explore the different models and approaches used in previous research looking at fitness to practise issues for health and social care professionals.

The outcomes from the literature review were organised using a matrix which included the country where the research was carried out, data collection methods used, the professional areas and roles included, and the findings in terms of positive and negative factors that emerged. Strengths and limitations were also highlighted where relevant. A version of the matrix can be seen in Appendix 1.

The literature review informed the questions included in both the online survey (stage 2) and the data collection methods employed during the specific events (stage 3).

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3.3 Stage 2: On-line questionnaire survey
3.3.1 Questionnaire design and implementation

Due to the diverse range of professional roles and disciplines included among the recipients of the on-line questionnaire, two versions of the survey were needed to reflect the expected level of awareness and knowledge of the SETs. The first group of recipients were course directors[2] and professional leads in practice (this is a term used in health and social care to refer to an individual who has expertise skills and knowledge of their discipline and leads a team of professionals) who would be expected to work more regularly with the SETs and so have a greater knowledge than other participants. They were therefore asked to consider and evaluate all of the SETs as they are set out in HCPC documentation. Opinions on the supportive guidance and on potential improvements were also investigated. The second group consisted of service managers, practice educators, experienced and newly qualified professionals. Since these professionals would not be expected to work regularly with the SETs, a set of questions was developed that reflected key sentiments behind the SETs. In addition, they were asked to think of any other factors that could potentially have an impact (either positive or negative) on newly qualified professionals' fitness to practise.

Both versions of the questionnaire consisted of 7 sections: one each for the 5 sections of the SETs, one about the Guidance and one about other factors impacting on fitness to practise. In addition, both respondent groups had to answer initial demographic questions including professional role, discipline and their geographical area. The survey used a range of different question types, including multiple choice questions, free text boxes as well as 5 level Likert type responses.

When finishing the questionnaire a link to a further survey was provided where respondents were asked if the research team could contact them about attending subsequent data collection events and the final consensus workshop (stage 3 and 4 of the project). If respondents were interested in attending one or both of these events then they could provide the researchers with their contact details. This strategy allowed us to anonymously collect the survey answers, and simultaneously obtain participants contact details for the following stages of the study. The complete versions of the questionnaires can be seen in appendices 5 and 6.

Although not formally piloted due to the tight time scale of the project, both versions of the questionnaire were discussed and reviewed by the project advisory group.

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[2] The HCPC refer to 'Programme Leaders' rather than Course Directors. However the advice of colleagues from the Faculty of Health, Social Care and Education at Kingston University and St. George's University of London was that 'course director' was a more frequently used term within HEIs and so is the term used throughout this project.

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The questionnaire was implemented and placed on-line via LimeSurvey software, which is a highly effective method to reach a considerable number of people, being quick, cost effective, intuitive and flexible to use.

Questionnaires were distributed in the form of a unique web link together with a covering letter. A contact list of all the course directors providing courses which fall under the HCPC's regulatory umbrella was provided to the research team by the HCPC. A total of 650 emails with an invitation to take part in the survey were sent to course directors.

The course directors were also asked to forward an invitation letter with the questionnaire link to one of each of the following: a professional lead in practice, a practice educator, a service manager and an experienced professional from their discipline.

Newly qualified professionals were contacted using a contact list, again provided by the HCPC. They randomly selected 5000 out of approximately 15000 newly qualified professionals among those registered with the HCPC during the previous year. The 5,000 sample was put together by taking a third of the newly qualified professionals in each profession. The email addresses list was provided by the HCPC to the research team following a data protection agreement. Email addresses were kept on the computer of a member of the team, protected by a password until the completion of the project, and then deleted.

Following the first invitation email, a follow up process was adopted. A first reminder email was forwarded after one week of the questionnaire being sent, a second reminder with a deadline extension after one additional week, and a third and last reminder four weeks after. The deadline extension was deemed useful in light of a number of answers received from respondents, showing an interest in the research and a willingness to take part, but a difficulty related to the busy period of the year, with exam boards and staff vacations taking place.

3.3.2 Data analysis
Following the expiry of the deadline, the data to the closed questions were exported from LimeSurvey to an Excel spread sheet which was used to assist the quantitative analysis of the closed questions.

Data collected through the open questions were exported to a Word document and then manually coded using a thematic analysis approach (Braun and Clarke, 2006). Following initial coding the codes were grouped into concepts and categories. Two researchers from the team independently coded the qualitative data collected from the open questions, and only at a later stage compared the results. An additional researcher also worked on defining the concepts and the categories that emerged from the preliminary coding. The involvement of more than one researcher, working

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independently, on the qualitative analysis ensured credibility and trustworthiness of the results (Quinn-Patton, 2002).

3.4 Stage 3: Data collection events

Following the survey data collection, the next stage of the research involved the collection of further qualitative data with the aim to explore further some of the issues that emerged from the survey. A series of events were undertaken within seven regions across the UK, involving a cohort of HEIs and associated health and social care organisations who provide HCPC regulated courses. Service users and carers also took part. This stage included different types of data collection activities: world cafés, focus groups and individual interviews.

3.4.1 Venues' selection and participants' recruitment

The data collection venues were chosen according to the following rationale:
  I.   One Higher Education Institution was identified for each of the seven geographical areas considered, in order to ensure representation across the UK.
  II.   The site offered a substantial number of courses regulated by the HCPC.
  III.   The site was, relatively, easily accessible, in order to allow people from nearby universities and towns to take part in the events.

When it was not possible to arrange a venue within an educational institution, an alternative location was found. This happened in Scotland, where an independent meeting room was booked in the centre of Glasgow.

A range of approaches were used to recruit people for the stage 3 events. This became necessary in order to overcome the difficulty in recruiting a sufficient number and variety of people. In particular, the short time period of the project initially meant that all data collection events were scheduled for July and August; this left little time to give notice to potential participants and was at a time when students were not attending university and many university staff were on leave.

The following approach to recruitment was initially adopted:
  I.   Contacting survey respondents who expressed an interest in taking part and who left their contact details via the link provided at the end of the questionnaire.
  II.   Circulating the invitation via internal contacts within the educational institutions hosting the events.
  III.   Sending out personal invitations to course directors, whose contact details were available on the university's website, and asking them to cascade the invitation among academic and clinical colleagues and students.

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IV.   Circulating the invitation to service users and carers registered on the Centre for Public Engagement's contact list, and asking the educational institution hosting the events to do the same with their service users and carers' contact list. It was possible to reimburse travel expenses by public transport or personal vehicle.

Subsequently, however, additional approaches were used to ensure that, if possible, all of the professions regulated by the HCPC were included. As such we sent personal invitations to Hearing aid dispensers, Podiatrists, Prosthetists and Orthotists and Clinical Scientists, obtaining their contact details via university websites. When their inclusion in the planned events was not practicable, alternative arrangements were implemented: individual interviews in a location convenient to the interviewee or via telephone were conducted. Two additional focus groups were also organised, with service users and carers only, to ensure that their voice was heard.

Overall, we visited 10 different venues across 7 geographical areas. We conducted a total of 4 world cafés, 14 focus groups and 7 individual Interviews. Also we made additional trips to some regions to increase the number of participants.

Venues, disciplines and professional roles included in the data collection events are shown in table one.

Table 1: *Venues, disciplines and professional roles from data collection events*

Venue	Event	Participants		
		No.	Disciplines	Professional roles
Northern Ireland	1 World café	16	Radiography (x4) Physiotherapy (x4) Speech and Language Therapy (x2) Occupational Therapy (x1) Biomedical Science (x1)	Course director (x3) Lecturer (x7) Head of School (x1) Experienced professional (x2) Service user (x2) Carer (x1)
	1 Focus group	5	Physiotherapy (x1) Biomedical Science (x1) Speech and Language Therapy (x1) Radiography (x2)	Course director (x1) Lecturer (x1) Experienced professional (x1) Student (x2)
	4 Individual interviews	1	Physiotherapy (x1)	Service user (x1)
		1	Physiotherapy (x1)	Professional lead in practice (by telephone) (x1)

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		1	Physiotherapy (x1)	Professional lead in practice (by telephone) (x1)
		1	Dietitian (x1)	Professional lead in practice (by telephone) (x1)
London – University A	3 Focus groups	2	Non-medical prescribing (x1) Speech and Language Therapy (x1)	Course director (x2)
		3	Radiography (x2) Social Work (x1)	Experienced professional (x1) Practice educator (x1) Course director (x1)
		4	Radiography (x3) Art Therapy (x1)	Experienced professional (x2) Newly qualified professional (x1) Student (x1)
London – University B	1 World café	8	Paramedic (x3) Physiotherapy (x1)	Course director (x1) Experienced professional (x4) Service user (x3)
	1 Focus group	3	Paramedic (x2)	Course director (x1) Experienced professional (x1) Service user (x1)
	4 Individual interviews	2	Social work (x2)	Service manager (x2)
		1	Hearing Aid Dispenser (x1)	Course director (x1)
		1	Clinical scientist (x1)	Experienced professional (x1)
Scotland – University A	1 World café	4	Orthoptics (x1) Speech and Language Therapy (x1) Radiography (x1) Psychology (x1)	Course director (x2) Experienced professional (x2)
	1 Focus group	3	Occupational Therapy (x3)	Course director (x1) Student (x2)
Scotland – University B	1 Individual interview	1	Hearing Aid Dispenser (x1)	Course director (x1)

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North West – University A	2 Focus groups	4	Social work (x2) Art Therapy (x1) Speech and Language Therapy (x1)	Newly qualified professional (x2) Practice educator (x1) Professional lead in practice (x1)
		5	Speech and Language Therapy (x2) Social work (x1) Biomedical Science (x2)	Professional lead in practice (x2) Newly qualified professional (x1) Service manager (x1) Experienced professional (x1)
North West – University B	2 Focus groups	9	Prosthetics (x3) Occupational Therapy (x3) Biomedical science (x1)	Course director (x1) Service user (x3) Student (x4) Experienced professional (x1)
		2	Speech and Language Therapy (x1)	Service user (x1) Newly qualified professional (x1)
South West	2 Focus groups	6	Psychology (x1) Podiatry (x1) Physiotherapy (x1) Social work (x1) Occupational therapy (x2)	Course director (x4) Experienced professional (x1) Practice educator (x1)
		2	Paramedic (x2)	Experienced professional (x1) Lecturer (x1)
Yorkshire – University A	1 World café	6	Operating department practice (x2) Radiography (x1)	Course director (x1) Newly qualified professional (x1) Experienced professional (x1) Service user (x3)
	1 Focus group	5	Radiography (x1) Operating department practice (x1)	Course director (x1) Newly qualified professional (x1) Service user (x3)
Yorkshire – University B	2 Individual interviews	2	Orthoptics (x1) Operating department practitioner (x1)	Course director (by telephone) (x2)
Wales	1 Focus group	2	Biomedical Science (x2)	Course director (x1) Service user (x1)

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Table 2 shows the number of respondents by professional role.

Table 2: *Professional role of respondents*

Type of respondent	Number
Course director	23
Experienced professional	19
Service user	18
Student	9
Lecturer	9
Newly qualified professional	7
Professional lead in practice	6
Practice educator	3
Service manager	3
Head of School	1
Carer	1
Total	101

3.4.2 Event design and implementation

The data collection events were carried out following the principles of both problem solving and appreciative enquiry approaches. The combination of these two methodologies allowed us to consider the emerging issues in two respects. According to the problem solving approach, problems and weaknesses of the topics discussed are identified, and causes with possible solutions considered. In parallel, the appreciative enquiry principles enable a focus on the positive aspects of the issue considered, and to engage in dialogue about "what should be" in order to foster the positive potential of the topics under examination (Cooperrider & Srivastva, 1987).

World cafés, focus groups and interviews were audio recorded after receiving participants' permission, and complimented with written notes. The latter used as a precautionary measure to protect against any machine failure, and to enable the researcher to note non-verbal interaction and cues (Krueger & Casey, 2009).

Prior to the beginning of each data collection event, all participants provided written consent to participate in the study.

Following the analysis of the data collected through the on-line survey, content topic guides were developed for each type of event. The topic guides can be found in appendices 7, 8, 9 and 10.

An objective of the research was to develop a compendium of practice examples, in meeting the SETs, and therefore questions on effective practice were also asked.

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The decision to use a variety of methodologies derives from an awareness of the specific strengths and limitations of each individual method.

The **World Café** approach requires participants to move around tables in small groups. Each table has an assigned topic to be discussed, a host to introduce the questions and to facilitate the conversation (the role of the host was taken by a member of the research team) and a scribe who was to record the key themes emerging from the discussion and to feedback at the end of the session. This approach is particularly appropriate when the intention is to generate dialogue, encouraging the discussion by including various different groups or types of people, exploring the issues in-depth, stimulating innovative thinking, as well as identifying solutions within a large group of people (Elliot et al., 2005).

During a **Focus Group** participants were asked about their opinions, thoughts and perceptions on a specific topic. Questions are asked in an informal setting, and participants are encouraged to talk freely. This technique is particularly useful when seeking to explore and clarify views and concepts in more detail (Marshall et al., 1999).

Individual **semi-structured interviews** consist of various key questions that help to address the areas to be explored, but also allow the interviewee to drive the conversation in order to explore an idea or a response in more depth when needed. The flexibility of this technique enables researchers to address and elaborate information that are important to the participants but may not have been previously identified by the researchers, or considered as not pertinent at a preliminary analysis (Gill et al., 2008).

The data collection events were conducted by one or two researchers depending on the number of participants attending. The duration of the world café events ranged from two to three hours, all the focus groups and the interviews were between one and two hours.

3.4.3 Data analysis
A thematic analysis approach was used to analyse the data (Braun & Clarke, 2006). There are six phases to this approach, which need not be followed linearly. Phase one involves the researchers familiarising themselves with the data, by listening to data recordings and reading transcripts. Phase two involves coding. In this project we coded line-by-line. In terms of the mechanics of the line-by-line analysis, the advice of Corbin (1986) was followed, who suggested leaving a margin on the right hand side of the transcribed interview to enable codes to be written next to an incident in the data. The codes, however, tended to be substantive or conceptual rather than descriptive and so reducing the amount of work that needed to be done at phase three - searching for themes within the codes. The themes identified were also compared with those that emerged from the questionnaire. Phase four involves

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the researchers reviewing the themes to ensure that they 'fitted' with the data. Phase five involves defining and naming the themes to ensure they are concise and informative. Finally, phase six involves writing up the data, weaving the themes together to tell an informative story and contextualising with existing literature. A second researcher reviewed the coding to check for credibility and trustworthiness (Quinn-Patton 2002). It is also important to note that as the data collection progressed, the focus in data collection and analysis was on issues which had already emerged and which required further exploration. This is referred to as 'theoretical sampling' (Glaser 1992).

3.5 Stage 4: Consensus Workshop

The aim of the Consensus Workshop was to discuss the findings from earlier phases of the project and attempt to gain a consensus about any of the issues that emerged from the data collection in stages 2 and 3.

This final event involved key stakeholders e.g. survey respondents (who had expressed an interest) and those who took part in the data collection events across the UK were invited. An invitation letter to service users and carers registered at the Centre for the Public Engagement was also sent out. Service users and carers were reimbursed their travel expenses by public transport or personal vehicle. A member of the HCPC was also present.

In order to achieve a consensus, a modified Nominal Group Technique (NGT) (Hickey and Chambers 2014) was used. NGT is a suitable approach when a group of variable size is asked to focus on a problematic issue in order to generate solutions and come to a shared decision. This approach is time efficient, needs few financial resources, brings together experts on a particular topic and provides an opportunity for equal input from all participants (Hickey and Chambers 2014).

The main objectives of the consensus workshop were:
- To feedback the main findings from the earlier stages of data collections, namely the on-line survey, world cafés, focus groups and individual interviews.
- To develop solutions to the issues that emerged from the research.

The duration of the consensus workshop was 3 hours. A presentation of findings was carried out by the researchers and discussed with participants. This was followed by two breakout sessions (two groups of 4 and 5 participants ie 9 people) in which participants were asked to identify solutions to key questions. Each group was asked to feedback to the wider group from which there ensued further discussion. The session culminated in the developments of suggestions to address the issues that emerged from the research. Researchers took on the role of mediators, to facilitate the discussion and to ensure that all the key areas identified were covered within the session.

3.6 Ethical approval

The research design and the research instruments received the ethical approval from the Faculty Research Ethics Committee (FREC) prior to the beginning of the data collection.

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Chapter 4 Findings

4.1 Introduction

This chapter reports on the findings from the online survey, focus groups, world café events and interviews.

The chapter opens with a demographic description of respondents who completed the online survey, followed by an analysis of questionnaire responses. There then follows an analysis of the data from open-ended questions together with qualitative analysis of the world café, focus group and interview data. The focus groups, world café events and one-on-one interviews tended to explore issues raised in the questionnaires in more depth. As such the findings from the different data collection methods have, in the main, been grouped together to avoid unnecessary duplication. Where these findings are reported, it is made clear to the reader how the data were obtained. Finally, there is a section describing the information generated at the consensus workshop.

The world café, focus groups were mixed groups involving various professions and various types of respondents, therefore we cannot relate the quotes to particular professional groups and/or individuals.

4.2 Survey respondents

The aim of this project was to explore the views of a range of stakeholders in considering the preparedness to practise of newly qualified health professionals regulated by the HCPC. The questionnaire was circulated to healthcare managers, educators, practice placement coordinators, experienced professionals and newly qualified professionals.

Online surveys were distributed using the HCPC electronic database of registered professionals from their 16 regulated professions. As outlined in the methodology chapter, course directors and professional leads in practice were sent a different questionnaire to newly qualified and experienced professionals. After circulating the questionnaire there was initial response rate of 1195.

The following descriptions of the respondents are only those who completed the survey in full; totaling 878 useable responses.

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Figure 1: *Professional roles from online surveys*
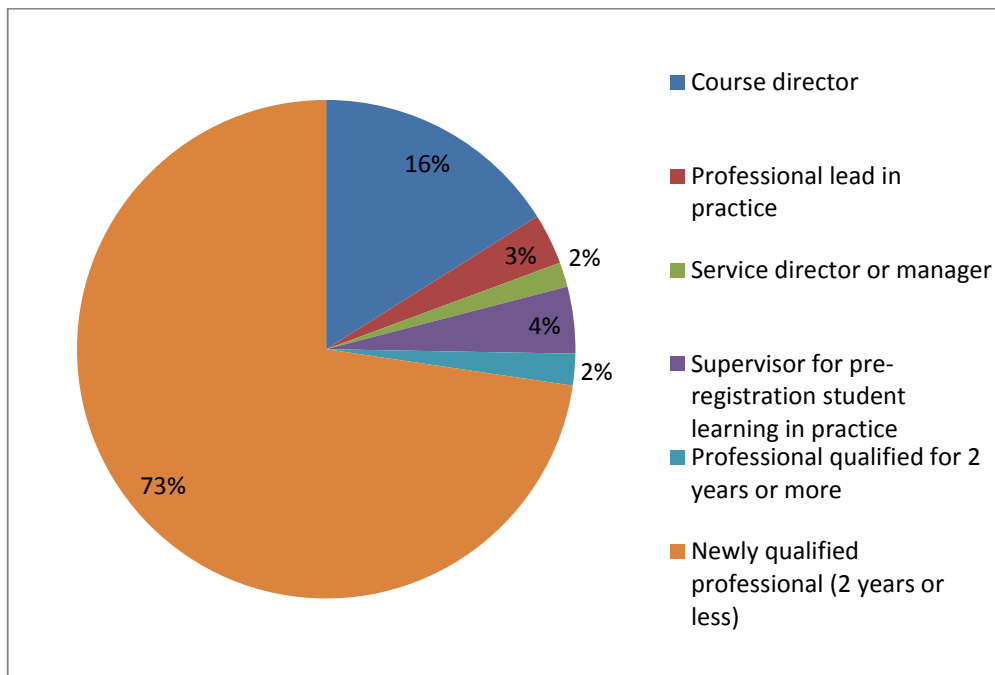
Figure one represents the role of each person who completed the survey. The results indicate that newly qualified professionals were the highest respondents (73%) followed by course directors (16%). Service directors or managers were the least represented (2%).

Figure 2: *Professions represented in online surveys*

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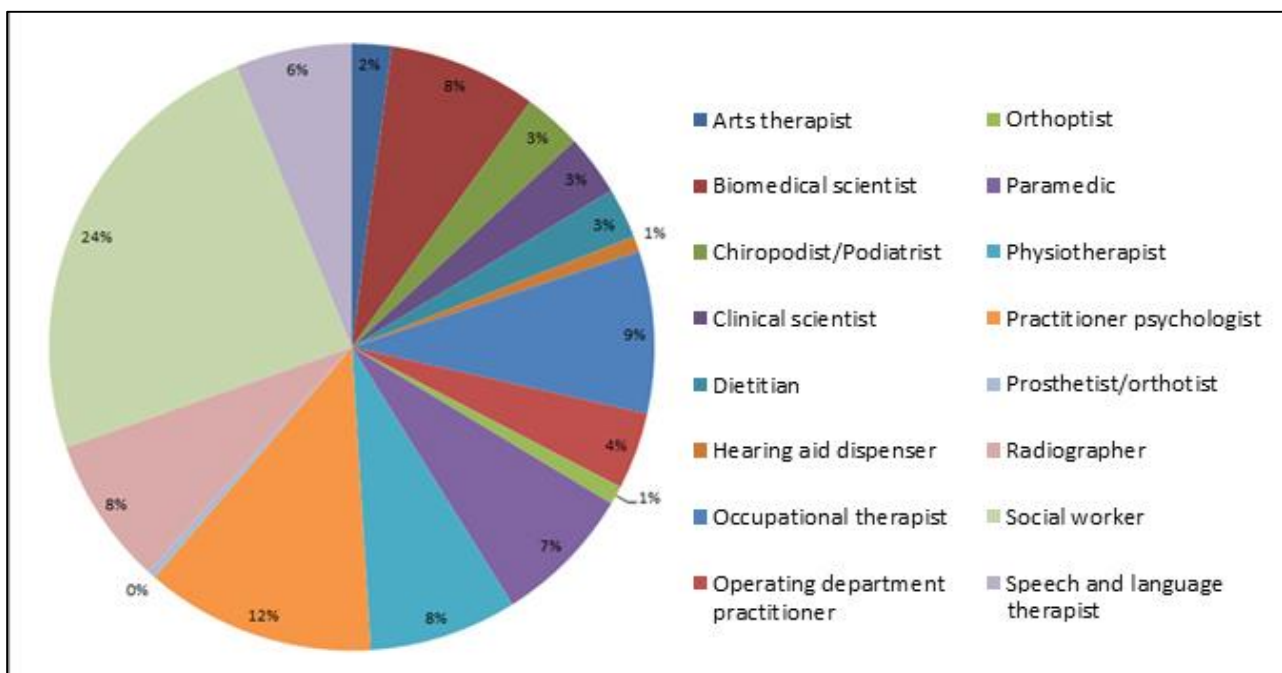
Clearly, some professions are more heavily represented than others. This is largely a reflection of the size of those professions and some, such as social work, which have a large number of courses across England. The biggest professional cohort of respondents came from social workers in England who made up nearly a quarter of respondents (23%)[3], followed by psychologists (13%). This figure for social workers in England is broadly comparable to the percentage of this profession on the HCPC's register (27%) (http://www.hcpc-uk.org/aboutregistration/theregister/stats/ - checked on 20/10/2015). The rest of the professions each made up 9% or less of the respondents.

However, we have aimed to strengthen the voices of these disciplines through our interview data. There are also profession-specific themes that emerged from the findings, which are discussed in later sections in this chapter.

Figure 3: *Geographical location from online surveys*
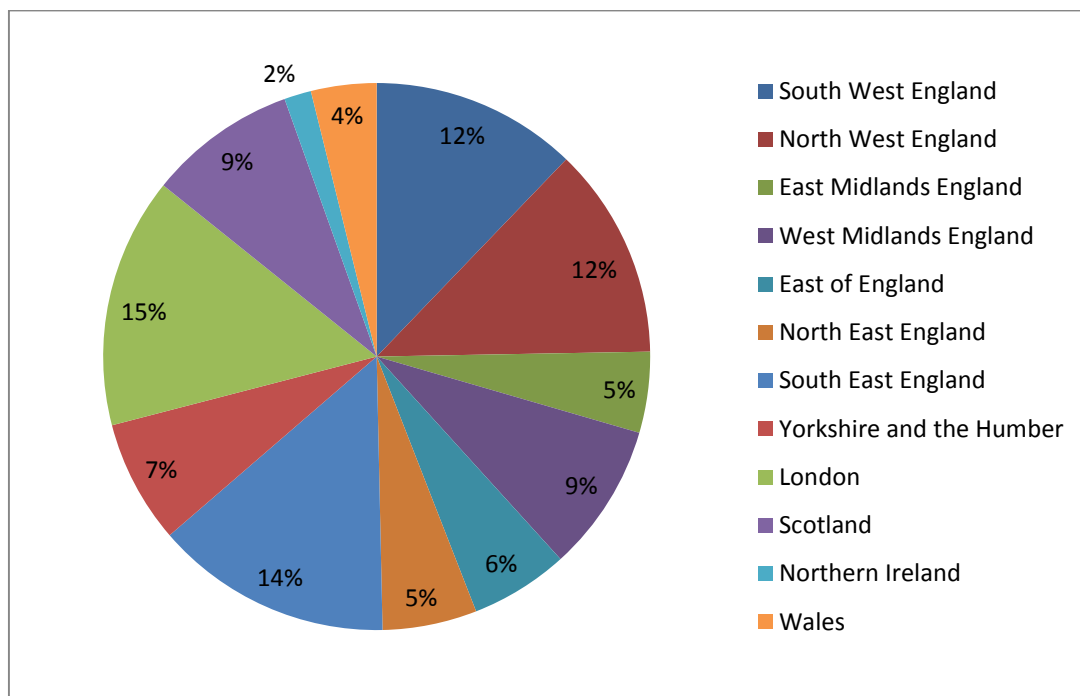
Figure three shows the geographical location of respondents. We found the respondents to be largely equally distributed across the UK. The highest area of respondents was in London (15%), followed by South East England (14%), North-West England (13%) and South-West England (12%). The rest of the regions each made up 9% or less of respondents with Northern Ireland having the smallest proportion of respondents (2%).

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[3] The HCPC only regulates social workers in England.

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A note on the questionnaire data

It was noted in chapter two that two, slightly different, questionnaires were used. The first was sent to course directors and professional leads in practice. The second was sent to newly qualified professionals, professionals qualified for two years, pre-registration students and service managers. The former group were asked about each of the HCPC's SETs (as they would work with them on a regular basis) while the latter were asked about only some SETs, or aspects of the SETs, which would be relevant to them. The two questionnaires can be found in appendices 5 and 6.

For ease of comparison during this chapter, the findings from both surveys are presented within the same graphs. Both groups were asked to rank each SET (or re-worded version) from 'very important', 'important', 'less important', 'not important' and 'not sure'. After initial analysis of the results it was clear that the vast majority of the respondents viewed most SETs as either 'very important' or 'important'. To make the analysis more meaningful we grouped these two rankings together in order to highlight any discrepancies from the trend.

As course directors produced the higher response rate in the first survey and similarly with newly qualified professionals in the second survey, for ease of discussion in the subsequent findings we will use these titles to refer to the different surveys.

4.3 Programme admissions

The questionnaire asked respondents to rate the importance of the SETs relating to programme admissions (2.1-2.7). Figure four shows the combined category of 'very important' and 'important' answers from both questionnaires.

Figure 4: *Practice placement SETs considered very important/important*
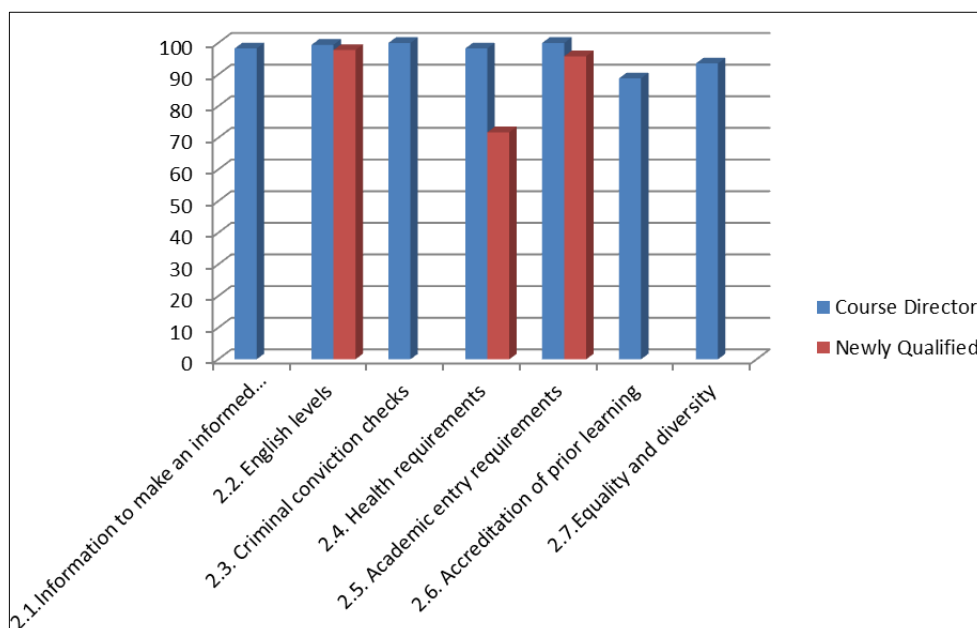
Figure four shows that both groups perceive the SETs relating to programme admissions to be important. All but one SET is regarded as important by 80% or more of the respondents, suggesting there is an agreement that effective admissions criteria have an important impact upon the fitness to practise of future professionals.

4.3.1 Command of English

Both groups rated SET 2.2 as important, 99.4% of newly qualified professionals and 97.7% of course directors; 'The admissions procedures must apply selection and entry criteria, including evidence of a good command of reading, writing and spoken English'. Similarly, interviews highlighted the importance of acknowledging good levels of written and spoken English.

4.3.1.1 Defining 'good command' of English

Course directors revealed that their entry requirements relating to language are set by the university. Most currently use International English Language Testing System (IELTS) scores to determine the eligibility of applicants onto the programme – with different courses and different universities applying different benchmarks. Some have felt that the SETs documentation could provide better clarity on how the HCPC determines 'good command' of English and what criteria may be included in this. Command of English as a language is commonly viewed as essential for full integration within the course and vital for becoming fully prepared and ultimately the health professional's ability to communicate effectively with service users in producing high-quality care.

'*I would hate to see a student come on the programme and be struggling and not be able to engage effectively in classes and discussion because of language.*' (Scotland - focus group)

'*We have recently been validated and one of the conditions was the IELTS… The level that we had our standard at the HCPC weren't happy with, so we've had to change that. It was too low in their opinion; it was at 6.5 but it needed to be at 7… I would like the SET to be more precise because my interpretation of the guidance is that they just need good English… But this was not reflected when I had the revalidation*' (Yorkshire - world café)

Defining command of English has been broadened by some to encompass aspects of communication and interpersonal skills, attributes that are essential to becoming a fully prepared health professional. Good communication is visible though behaviour and body language, which some have suggested should be incorporated within this SET as different cultures may communicate differently.

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'*Not English as the language but communication and being able to talk to people that can't communicate well takes inter-personal skills, rather than just speaking the language*'

'*It's about body language, it's about expression, it's about everything*' (North West – focus group)

'*Some people assume that it's a language thing but I think it's not so much that but instead how they communicate with you… It's the body language and all of that*' (London – world café)

Region-specific considerations have been expressed as well. An example is that in one HEI students are often sent to rural practice placements where varying dialects may confuse a student's understanding of English if they are not yet proficient.

'*Rather than English first language being a challenger maybe accents and dialects have been a problem*' (South West – focus group)

People have also noted that the SET should not be too focused on 'spoken English' but programme admissions should be mindful of the 'written English', which is currently considered in the SET 2.2. Written skills and communication can be very important in the workplace.

'*You don't get that instilled about just how important your notes are. I don't think that was ever mentioned to me in my training about how important it was legally*' (London – world café)

Some respondents, however, have cautioned against setting the bar too high. It is expected that English levels will improve throughout the duration of a course and so restriction at the level of entry may be harsh.

'*It should be as high as we can possibly have it because of the communication issues linked to hearing aid audiology*' (London – individual interview with course director of hearing aid dispenser)

'*It's not expected that at the start they will have proficiency with the language that they will have by the end*' (Scotland - world café)

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Not all arguments proposed a tightening of regulation regarding high levels of English with some respondents expressing that English abilities may not directly impede fitness to practise. While command of English may be very important, prospective students fluent in other languages may be extremely valuable.

'*We do teach bi-lingualism and multi-lingualism and we talk about the benefits to society and to development and all the rest of it. Having a bi-lingual workforce is part of that.*' (Scotland - world café)

Universities are encouraged to take international students due to the high fees that they pay.

'*There are pressures to have more international students because of the fees*' (Scotland – individual interview with course director of hearing aid dispenser)

4.3.2 Health requirements

The outlying result, within the admission SETs, is SET 2.4: 'The admissions procedures must apply selection and entry criteria, including compliance with any health requirements'. While 92.8% of course directors acknowledge the importance of this SET only 71.8% of newly qualified regarding this as very important or important. 24.3% of newly qualified professionals saw this element of criteria as 'less important' and a further 3.1% saw it as 'not important'.

These results do not suggest that the SET should be removed or is un-important per-se. Instead, with regards to the broader question of preparedness to practise some have debated the extent to which health is or is not relevant.

'*Health requirements are important, but I don't see them as important as the other criteria*' (Questionnaire response – South West – course director for practitioner psychology)

4.3.2.1 Variations between health admission SETs

While there has been acknowledgement of physical impairment and disability preventing some from completing courses, others have felt that disclosure of illness in the admissions process can be an unfair barrier to course entry.

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> '*In one area you could be completely not fit for practice and in the other area you could be amazing… There's no distinction between that*' (Northern Ireland – world café)

Course directors from different regions and disciplines reported concerns about admitting students with severe sensory impairments. There have been suggestions for the HCPC to set clearer guidance on the topic, which is in line with their own health policies at the point of registration. Some have felt there to be a conflict between 'fit for practice' and 'fit to complete a university course'; although these boundaries are blurred as a large element of university education is spent in the practical setting.

> '*Obviously, if you've got a condition that would impede your ability then there's no point letting you onto the course and then them not being able to work at the end of it*' (North West - focus group)

> '*As I understand it courses have to, the law requires us to take people who are able to complete our course. Not people, who in our judgement, will then be judged to be fit to practise. That's a second hoop that has to be gone through… HCPC was saying "well you have to make decisions about your course and we will make decisions about that student when the time comes for them applying to registration". So as far as I'm concerned really what we have to do is try and assess students to complete our programme.*' (Scotland – world café)

> '*We offer the opportunity for people to study for a degree, not the chance to work in that profession. It might be incorrect for us to decide you can't get this degree because you can't become a physio, there might be other reasons why people would want to get a degree in physio… We can only make our decisions to whether the student is fit to finish the course, with an element of practice*' (Northern Ireland – world café)

> '*Essentially it's about their employability… We need to make sure that we're not wasting their time*' (Northern Ireland – world café)

Assessing health impairments at the admissions stage has difficulties.

> '*I don't think that the HCPC helps education providers at all in regards to health checks; we are very much left to our own devices… That continues to be an issue, the lack of clarity*' (Northern Ireland – world café)

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Disabilities impact upon individuals in different ways, meaning that strict and regimented policies may be unfair. Further to this, defining 'health' has been debated within the results, specifically the inclusion of mental health and whether this impacts upon a person's fitness to practise. Specific courses may have their own reasoning for preventing people with specific disabilities from entering onto the programme. For example, speech and language therapy may require applicants to themselves have good communication ability. However, examples have been highlighted of making reasonable adjustments on courses to allow students with disabilities to become competent practitioners. Some respondents also suggested that a student who themselves lives with a disability may have a greater knowledge and understanding of how best to treat patients similar to themselves.

'*One person with the same disability on paper is different from another person with the same disability on paper*' (Scotland - world café)

'*So much about disability is contextual*' (Scotland - world café)

'*The courses are very, very demanding and we have had a number of issues with students who have been stepping on and off courses because of mental health issues*' (North West - focus group)

Furthermore, a person's health may in fact change during the course, meaning that their fitness to practise could too change. It may be unfair to prevent a prospective student if their health may alter over time.

'*Health does fluctuate. How do you then cancel someone out of the course? It gets very messy*' (Northern Ireland – world café)

4.3.3 Interviews
Not all courses have the same interview procedures. Some do not interview prospective candidates, which has been criticised by others.

'*I don't do an interview unless they are a non-traditional adult, mature, you know they don't actually have the entry requirements but they have life experience and they were applying to my course… Other than that we don't*' (Scotland – world café)

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> '*My university didn't interview and it meant that people dropped out because they found that they didn't have adequate communication skills. If they would have been interviewed them they would have found that out*' (North West – focus group)

There are perceived benefits to not interviewing all prospective students because students are not expected to be fit for practice at entry to the programme; skills should be developed throughout the duration of the course.

> '*If it becomes too prescriptive at the point of admission then it doesn't pay much attention to the middle and the end result of registration and producing a student fit for practice*' (South West – focus group)

Some believe that the HCPC should enforce interviews because otherwise there is not pressure for courses to conduct them, which may impact on the calibre of students.

> '*We used to interview candidates and we stopped doing that because there's no requirement from the HCPC. I think that's a real shame, for paramedics or any other profession. I think that we will start interviewing again. I believe that the NMC make it mandatory and I think we should too. I think that is coming as a result of the Mid-Staffordshire Report*'

> '*Definitely some face-to-face contact, sitting down to observe the people coming on the programme. It's seeing how well they will fit on the programme, whether they will be disruptive*' (South West – focus group)

4.3.4 Life experience

Some respondents discussed whether there is a place for life experience to be considered within the admissions SETs.

> '*Is there a difference between a master's student and a BA student? Having just recruited for 9 NQSW's, 8 of them has a master's degree. That says something in itself doesn't it? It would be interesting to do research around that, whether it's to do with the experience they come with before they do the course? I do think that the younger ones on the BA course don't have quite as much experience, not as mature. This does filter through in terms of the way that they deal with placements and interviews*' (London – individual interview with service manager for social work)

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Life experience has been noted, by some, as a crucial element contributing to being an adequately prepared professional.

'*That life experience of being able to speak to someone on an appropriate level*' (London – world café)

4.4 Programme management and resources

The questionnaire asked respondents to rate the importance of the SETs relating to programme management and resources (3.1-3.17). Figure five shows the combined category of 'very important' and 'important' answers from both questionnaires.

Figure 5: *Programme management and resources SETs considered very important/important.*
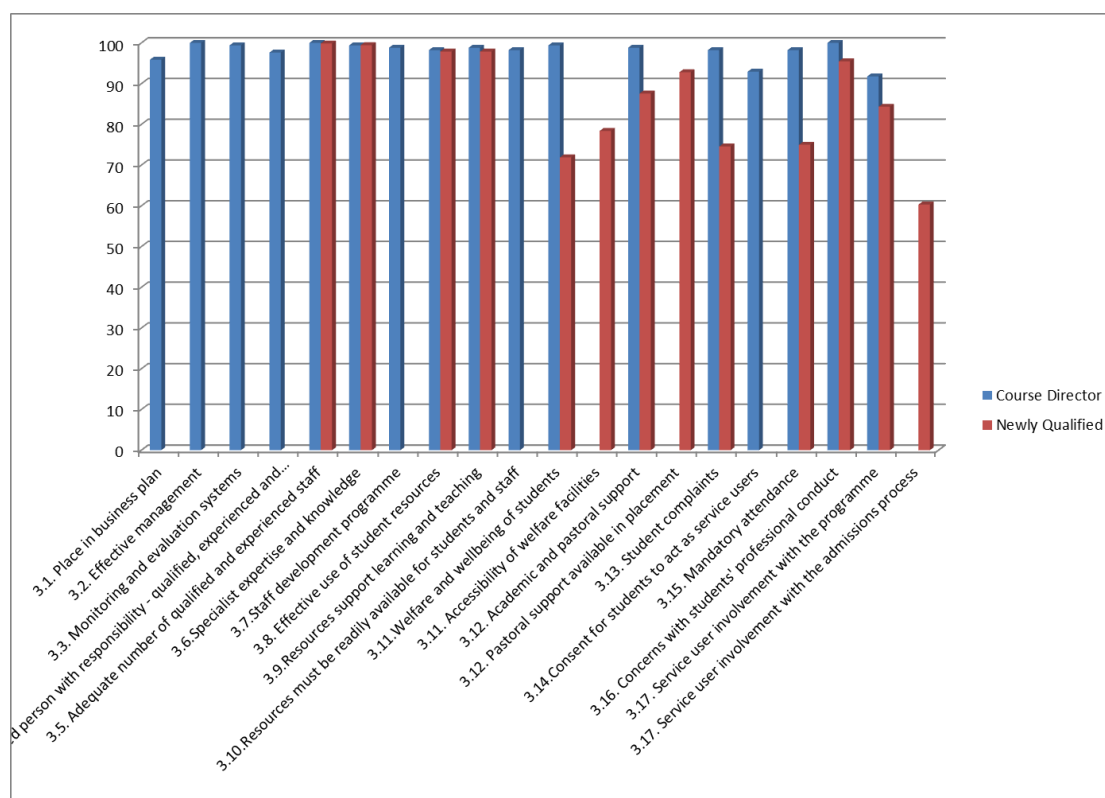
For course directors all of the SETs relating to programme management and resources are deemed as very important or important by 90% or more of the respondents. For many of the SETs, however, newly qualified people were less likely to regard them as important.

Both groups give SETs 3.5, 3.6, 3.8 and 3.9 equally high percentages for very important and important. SETs 3.5 and 3.6 relate to the amount of staff and their

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levels of skill and knowledge. Both 3.8 and 3.9 are concerned with the amount and availability of student resources.

Newly qualified professionals are less likely to rate the SETs 3.17, 3.11, 3.13 and 3.15 as important for fitness to practise. 3.17 refers to service user and carer involvement in education, 3.11 welfare facilities, 3.13 student complaints, and 3.15 mandatory attendance.

4.4.1 Students participating as service users

SET 3.14 states 'Where students participate as service users in practical and clinical teaching, appropriate protocols must be used to obtain their consent'. This relates to students acting as service users during education and role-play situations. 92.9% of course directors believed that this SET was either very important or important.

5.3% of course directors, however, believed this SET to be either less important or not important to all. When questioned on their reasoning for low importance a common response was that the option to sit out these valuable learning experiences could actually negatively impact upon a student's fitness to practise. Some people from the professions of social work and psychology believe that students should be expected to act as service users throughout their education, regardless of consent, as it is integral to both courses.

'*3.14 it is simply role play. It is something that students would expect to do when coming on a course of this nature*' (Questionnaire response – North East – course director for social work)

'*This requirement has always seemed to me rather perverse because any student who does not give consent freely cannot be taught, and therefore cannot stay on the programme*' (Questionnaire response – London – course director for practitioner psychology)

'*I just query the use of obtaining consent from students for participation as service users. It is a basic part of social work theory that all are potentially service users. They must participate. It is part of their training. Asking for consent seems odd*' (Questionnaire response – South East – course director for social work)

The guidance acknowledges profession-specificities by stating that 'the level of involvement of students will vary between programmes and profession to profession'.

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4.4.2 Mandatory attendance

The notion of mandating and monitoring attendance has been debated and the appropriateness of SET 3.15 contested. The SET reads 'Throughout the course of the programme, the education provider must have identified where attendance is mandatory and must have associated monitoring mechanisms in place'. There was much discussion about the lack of specificity as to 'where' attendance is compulsory and whether the HCPC should offer more clarity about which elements of the course are essential for students to attend.

Course leaders have expressed a view that the current SET does not allow them to enforce mandatory attendance because it is not specific enough. Furthermore, some would like regulatory backing for situations when students question mandatory attendance.

'*There is no guidance for this from the HCPC and this means that students think that it is not necessary to attend… We monitor through gateways. It is working but it would be good to be better guided by the HCPC so that students can be told in writing if they are falling short. We say that 100% attendance is mandatory in the university but it is difficult to achieve*' (Yorkshire – individual interview with course director for operating department practitioner)

'*I don't want to be told what to do by the HCPC but at the same time would the HCPC be happy if we said students don't have to turn up to any lectures as long as they still pass exams? I assume not. The student response will be "where does the HCPC say that I need to be there?" and they don't. It protects service users when we can say that students have attended a certain amount of time at university. It's a difficult thing to impose because it's not written in stone. If the HCPC set a figure then there's a line in the sand there… It makes it really clear to the students from day one. I deliberately shy away from talking about attendance because I don't have a robust answer for students.*' (South West – focus group)

4.4.2.1 Attendance on placement vs. attendance in education

There appeared to be an agreement that all practical elements of education should be compulsory and course leaders would follow-up lack of attendance with strict measures. Students generally would be made to repeat practice placements if they had not met the compulsory hours of practical experience.

'*If you miss the practical you have to re-do it. It's felt, and this is from the students too, that if they don't achieve all of that time then they wouldn't have met all of their learning outcomes. Having a student missing two weeks would really give them a disadvantage*' (Northern Ireland – world café)

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'*I think everyone is on the same hymn sheet when it comes to attendance at placement*' (Scotland – world café)

Attendance within the educational environment, however, was debated. Some felt that the ethos of university education should encourage students to be adult learners and therefore students should not be forced to attend lectures. Some also suggested that students can now do learning online. This online learning has enabled students to be successful on courses when they may live a distance from campus or have competing priorities and demands on their time.

'*The notion of mandatory attendance does not fit with HEI/Adult learning principles 100%. It is possible to learn through self-direction or directed study without being in a lecture, class room, seminar*' (Questionnaire response – South West – course director for operating department practitioner)

'*The practicalities of enforcing it are problematic and if we are going to be inclusive and have widening access to students who may have a small family and they might be working very hard at night but they aren't always able to come in during the day and as long as they are doing okay.*' (Scotland – world café)

One suggestion was to reword the SET, making it clear where attendance is essential and where it is not.

'*There's a problem with the word mandatory… Mandatory there isn't necessarily a consequence if you don't do it… I think it's important to have adequate attendance but I don't think that we should record attendance at lectures… I don't see why they should attend lectures when they can get the material elsewhere. There are certain things, practical elements, where they should attend… So the wording should be careful and accurate enough to allow for that. Full attendance isn't possible and it isn't even desirable in certain contexts*' (Northern Ireland – focus group).

Conversely, people have suggested that simply making attendance mandatory may not actually mean that students are actively learning.

'*You could have mandatory attendance and he's just turned up and signed in but has he actually learned anything? [laughter]*' (Northern Ireland – world café)

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4.4.3 Service user and carer involvement

SET 3.17 states that 'Service users and carers must be involved in the programme'. This SET is fairly new and was implemented from September 2014 for all programmes regulated by the HCPC.

91.8% of course directors ranked the SET as very important/important. The results hint that service user involvement, in some HEIs at least, was common practice before the SET was introduced. These results, echoed in the interview data, suggest that service user and carer involvement is closely linked to fitness to practise.

'*Social work service user involvement is really strong. Lots of involvement and input into the programmes that means that you are getting programmes fit for purpose*' (South West – focus group)

In the survey for newly qualified professionals we asked two different questions relating to service user involvement. One question asked the importance of service users and carers being involved with programme development; a second asked about the importance of service user and carer involvement in the admissions process. For the latter, opinions have been divided, producing the lowest percentage of respondents who regarded a SET as very important or important – 60.3%. 38% percent of newly qualified professionals felt that this is less important or not important.

4.4.3.1 Value of service user and carer involvement

The value of service user and carer involvement has been noted within interviews and focus groups. Course leaders outlined the many different ways that service users and carers can be involved in contributing to education and training, including within the admissions process.

'*Students absolutely love seeing people with the condition coming in… One gentleman came in and the students hung on every word that he said, they loved it*' (Northern Ireland – world café)

'*Individuals come and talk to you and then you know that you're doing something that is helping them and changing things. It's the authenticity, you might read it in a book but it's different. It's more realistic*' (North West – focus group)

The process is one that service users enjoy being involved in.

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> '*We're all quite vocal, as you're discovering! Our opinions are the best! [laughter]*' (London – world café)

4.4.3.2 Where should service users be involved?

Currently the HCPC does not specify in which aspect of a programme service users should be involved. The guidance explains that service users 'must be able to contribute to the programme in some way'. Where service users should be involved within course programmes has been debated. Some have appreciated the current open nature of the SET, which allows individual courses to make their own judgment of where and when to involve service users.

> '*We felt at the moment the SET was adequate because we don't want it to be too restrictive, we want to be able to use a range of methods to engage with service users*' (Northern Ireland – world café)

Others, however, have suggested that the SET should be more specific and courses should involve services at all levels of the programme in order for their participation to be valued and meaningful – rather than a tick box, tokenistic, exercise and so that they can see the full progression of the student.

> '*It's relevant but it's only a tiny part of what we do. It just feels like a drop in the ocean. It just feels a bit tokenistic*' (South West – focus group)

> '*What incentive is there for universities to have you involved at every stage? There isn't one. It costs them money and time, so many courses at the moment just tick the box that you're involved at some point. I think that there needs to be more incentivisation because some people only do the minimum*' (North West – focus group)

4.4.3.3 Getting service users involved: risks, representativeness and resources

Responses also revealed problems and challenges relating to service user involvement. Issues of resources required were raised.

> '*Because of the nature of service user issues in mental health field, getting significant involvement is a real challenge, which presents some real ethical issues. Therefore meeting this requirement could tend towards the tokenistic*' (Questionnaire response – South West – course director for practitioner psychology)

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Others noted that there were risks involved.

> '*It's like a can of worms. They're people, they need managing and a certain level of competence to do the job that you're asking them to do*' (Yorkshire – World Café)
>
> '*There are risk assessments of bringing someone really ill onto campus, who's responsible?*' (Northern Ireland – world café)

Finally there was the issue of representativeness. The paramedic below noted the lack of a representative 'service user' who encounters the profession.

> '*Our patients [paramedics] come from such a wide background, from minor injury to major trauma. So we deal with such a wide range of people so one patient with one medical condition does not mean much. Our patients and their carers often want such different things from our service. So in that sense I just question the benefit in many ways*' (South West – focus group)

A variation on the representativeness issue was raised by the respondent below, who noted that some service users have an 'axe to grind' and are not representative of wider service users.

> '*I've found it to be not very valuable. I think because the people that you get tend to have an axe to grind or something they feel very passionately about that guides them. They tend not to look at the bigger picture and that's what we're looking at, we're not just designing a programme just for that one person. They've not been representative. They're not reliable for turning up either and actually getting them to be involved. We've had patients invited on the advisory board and no one has ever showed up.*' (Scotland – world café)

4.5 Curriculum

The questionnaire asked respondents to rate the importance of the SETs relating to curriculum (4.1-4.9). Figure six shows the combined category of 'very important' and 'important' answers from both questionnaires.

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_Figure 6__: Curriculum SETs considered very important/important_
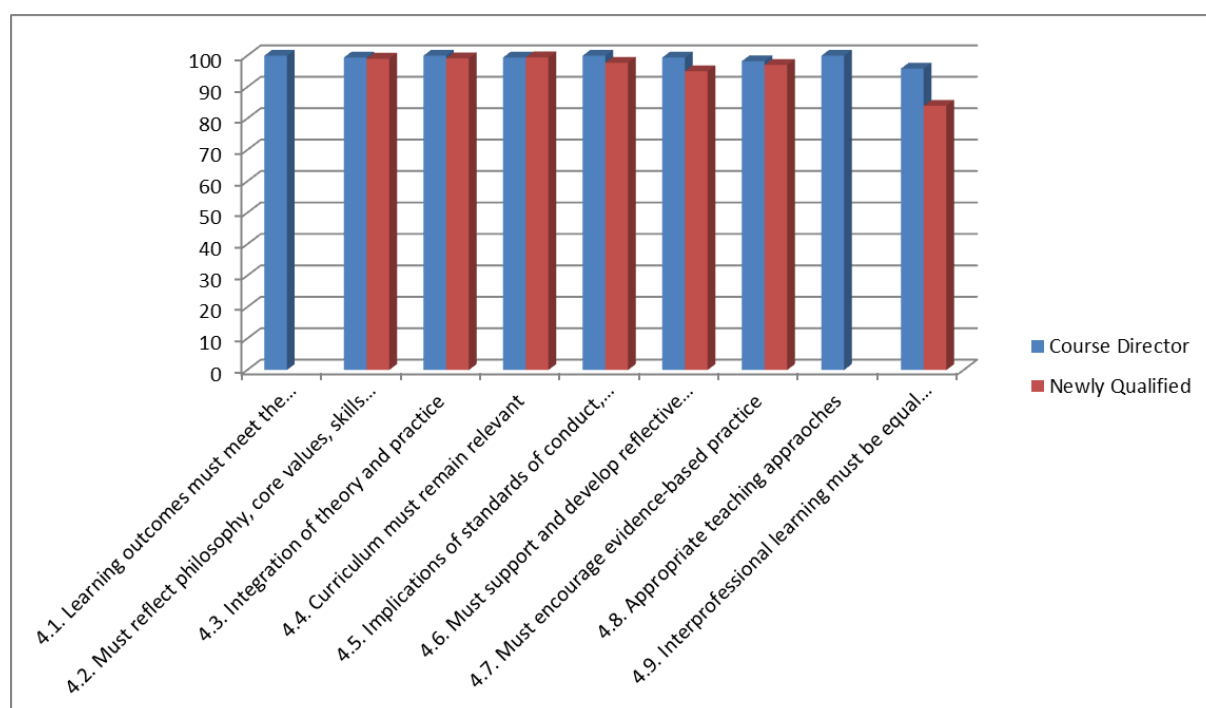
Figure six shows that both groups have 90% and above of respondents rating the curriculum SETs as very important or important aside from SET, 4.9, where 80% of newly qualified respondents rated this as very important or important.

4.5.1 Theory and practice

SET 4.3 states that 'Integration of theory and practice must be central to the curriculum'. In the interviews this revealed itself as a theme that has a huge influence on whether students are well prepared to practise.

'_Going in you can't assess a situation appropriately without knowing particular avenues you want to take and what options you've got – it's crucial I think having a knowledge base_' (North West – focus group)

'_You've got something to hook it onto, rather than just having a little ball by itself_' (North West – focus group)

However, not everyone felt that the curriculum adequately bridged the gap between the two.

'_It was very academic and there wasn't a lot of linking the academic to the actual practical_' (North West – focus group)

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'*It was almost a clash between what was needed on the academic side and what you needed to go out as a practitioner*' (North West – focus group)

'*What that's meant is that theory and practice don't match, so a student in their second year may go on an adult placement but have no adult theory… Placement providers have complained that they are having to teach theory to students as well because they haven't had the theory. In terms of what you do about it, to me I think the move towards problem-based learning is the biggest strength*' (North West – focus group)

'*At my uni there was a big focus on theory… But the main OT core skills were not a focus*' (Questionnaire response – North East – newly qualified occupational therapist)

4.5.2 Evidence-based practice

SET 4.7 states that 'The delivery of the programme must encourage evidence-based practice'. Whilst this was rated highly in questionnaire data, some respondents in the interviews felt that, in the workplace, using only evidence based practice was not such a simple option.

'*You have to get the balance, you have to say this is what is being done at the moment and this is where we are heading towards. If the other hasn't been proven not to be working then we can't totally throw it out either*' … '*You can't come out and say you can only teach what is evidence-based, you'd be so limited! You have to acknowledge that and that it's a work-in-progress and everything is going to change over time*' (Northern Ireland – world café)

However, not everyone saw current practice and evidence-based practice to be in conflict.

'*They [evidence-based and current practice] are not mutually exclusive and they rely on each other. It is really about reflective practice for health care professions*' (London – individual interview with service manager for social work)

'*Nothing is a tablet of stone, it must be altered if it's wrong. That's good reflective practice isn't it?*' (North West – focus group)

In certain professions it is difficult to achieve evidence-based practice when techniques may not be simply measured or quantified.

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> '*There would be a disparity around evidence-based in psychology because evidence-based is a lot around CBT because this is something that is measurable and quantifiable. But actually if you come from a different school of thought you can't measure that then it's difficult to say that you've got evidence-based practice*' (Northern Ireland – world café)

4.5.3 Interprofessional education

SET 4.9 is the anomaly within the curriculum data. This SET reads 'When there is interprofessional learning the profession-specific skills and knowledge of each professional group must be adequately addressed'. 15.5% of newly qualified professionals believe that this SET is less important or not important to fitness to practise 3.5% of course directors view the SET as less or not important.

The wording of the SET is such that it does not require courses to have interprofessional learning. Our research demonstrated that not all universities have access to a wide range of professions and so are unable to integrate learning across all professions. In such examples, interprofessionalism may be verbally encouraged by lecturers but sometimes it is only in practice where the student is able to engage with other professions.

4.5.3.1 Value in interprofessional education

A key benefit of interprofessional education, noted by some respondents, is the greater understanding acquired of the roles of others.

> '*It's absolutely essential that the interprofessional nature is in there somewhere because otherwise you're in your own little world of thinking 'I'm just an OT', then suddenly you go out into the placement and you're like 'WOW! Who are all these other people? What's happened here?"* (Scotland – world café)

Another major benefit was that collaborative work contributes to better patient-centred care.

> '*It's about understanding the patient's journey and your point within that journey*' (Scotland – world café)

> '*We don't want patients to have to start their pathway from the beginning each time they see a new health professional*' (Scotland – world café)

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4.5.3.2 Balancing profession specific skills and knowledge with IPE

When course lengths are not particularly long there have been suggestions that interprofessional learning detracts from the core skills and knowledge, specific to professions, that must be taught.

'*I think in practice this is a very difficult SET to achieve. Students are trying to orientate to their own profession-specific skills and knowledge and it is only possible to provide a cursory introduction to profession specific skills and knowledge when conducting interprofessional learning*' (Questionnaire response – London – course director for arts therapy)

'*You need to be grounded in your own profession first… But the course is so big now and they have to cover so much that there isn't a huge room anymore, perhaps if we moved back to a four-year programme we could embrace it better. It's important but there are other priorities, your own profession is more important*' (Northern Ireland – world café)

4.5.3.3 Making IPE happen

In its existing SET, the HCPC recognises that it may not be possible for interprofessional learning to occur on all courses and for this reason it is not currently a requirement within the SETs. This is complicated, however, by the SoPs that students must meet, which state that they are required to work in an interprofessional manner. Difficulties have been noted as a lack of all professions willing to be involved in the process. The HCPC is exploring this through separate research which aims to look at the scope for a more positive SET which would require IPE to take place.

'*Without the medics being involved there is still the hierarchy, they have been a massive barrier to the progression of interprofessional education. Until we get everyone sat around the table it won't be effective*' (Scotland – world café)

'*The medics facilitating were not informed about the different professions and this lead to a very frustrating event with limited efficacy despite it being highlighted as an integral part of learning*' (Questionnaire response – East Midlands – newly qualified practitioner psychologist)

'*Certain professions think that they don't need interprofessional working. I found that strange because you always work better when you understand the role of other people*' (Yorkshire – world café)

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Student experiences have, in some cases, found IPE unbeneficial to their learning.

'*In my opinion the sessions were completely unbeneficial, with sessions focusing on a health perspective and considering how to address senior medical practitioners. I came away feeling frustrated and considering my time could have been better used*' (Questionnaire response – East England – newly qualified social worker)

'*I had an issue with interprofessional learning. In my first year we got people from all different disciplines in the classroom, we got all these different people from the hospital who can see or probably will see the same patient. We did a project about how to coordinate a building project. It was ridiculous! ... I just thought "why aren't we doing a patient pathway?"*' (Yorkshire – world café)

It has also been raised that there is an insufficient amount of interprofessional working actually occurring within practice and so students are unable to pick up the necessary skills.

'*I don't get much of a sense that there is much interaction between professions while they are on placement*' (Northern Ireland – world café)

4.6 Practice placements
Our questionnaires asked respondents to rate the importance of the SETs relating to practice placements (5.1-5.13). Figure seven shows the combined category of 'very important' and 'important' answers from both questionnaires.

Figure 7: *Practice placement SETs considered very important/important*
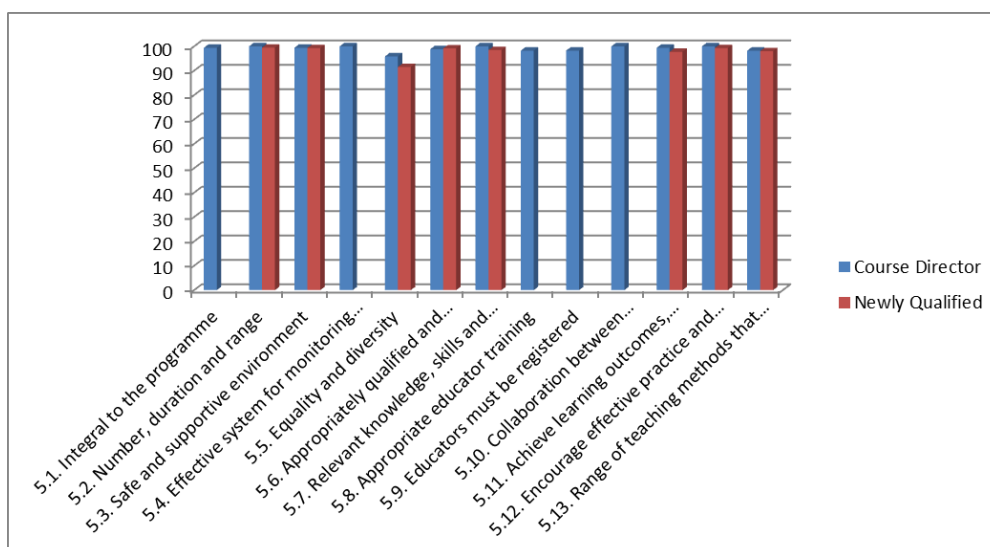
All of the SETs related to practice placements are ranked as very important or important by 90% or more by both groups of respondents.

4.6.1 Number, duration and range of placements

SET 5.2 is ranked as the highest by newly qualified professionals, with 99.4% ranking it as very important or important. Similarly 100% of course directors believe it to be very important/important. It is worth noting that only 3 respondents believed it as less important/not important and 1 was not sure. Across both groups only 4 people did not see this SET as important, stressing how crucial it is for university courses to deliver on this.

4.6.1.1 Variation between placements

The SET reads 'The number, duration and range of practice placements must be appropriate to support the delivery of the programme and achievement of the learning outcomes'. Without more prescriptive guidelines there is, inevitably, variation of practice placements between courses, between universities and between individuals. Interview data has highlighted what some participants saw as the negative implications of placement variation.

'*If you don't have a broad range of placements then it can be a bit of a shock when you come out*' (North West – focus group)

'*In regards to amount of placement I think it would be appropriate to have a minimum percentage stated within it. You could technically put someone on placement for a 3 year course for only a week. That needs to be addressed because it is the placements that get those clinicians up to a level where they can do the job*' (London – world café)

'*I think there's something needed within the SETs about that diversity of placements and structure*' (London – world café)

'*Variation in quality of placements (and placement supervisors) was a huge factor in my training so I think that these should be assessed more rigorously, not just the students*' (Questionnaire response – London – newly qualified practitioner psychologist)

There has also been a debate regarding the benefits of both a specialised approach to placements and a generalised approach. Some have called for students to spend a greater amount of time in one area of their professional practice so that they feel more comfortable and confident in that area when graduating. However, others have

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stated the benefits of instead having a number of placements in different areas so that all bases are covered, with the opportunity to then specialise when working.

> '*I think that the large blocks that we did were better perhaps having a couple of weeks here and a couple of weeks there because it allows your confidence to grow. Every time you go to a new department perhaps you're a little bit quiet at first then you grow into the area and you get to know the people that you're working with*' (Yorkshire – world café)

> '*I got a good, broad range of a big hospital and various disciplines within it and smaller hospitals where it tends to be a bit more personal with the team. So I got a good, broad background in all of the different sides as disciplines within the hospital*' (Yorkshire – world café)

If students are not experiencing an adequate number of varied placements then they may not have the opportunity to learn valuable practical skills. Variety between placements has highlighted that some students gain hands-on experience, whilst others may simply observe the practical setting.

> '*Different trusts have different priorities and depending on their management will depend on how much hands-on experience that the student will have. Some do an awful lot more than in other places. You need to gain the trust of the trusts [laughter]… If they're not allowing the person that opportunity then the student is de-skilling*' (Northern Ireland – world café)

4.6.1.2 Issues with practice placements

Current workplace demands within the NHS have restricted the availability of placement opportunities and many universities have noted a struggle to sufficiently provide a varied experience for all students. Many people feel that placements are not long enough.

> '*My colleagues who have attended a different university had three placements that were 30-40 days in length, this did not enable them to gain experience of having a caseload and the challenges the practice environment brings*' (Questionnaire response – North West – newly qualified social worker)

Specific placement pressures have been highlighted within the debate. Within social work a recurring issue was the need to have statutory placements during the course.

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As it stands it is not required for courses to give all students a statutory placement and it may not be logistically feasible. However, some students who do not have any statutory experience are unable to find employment after graduating - ultimately they are deemed by employers as unfit to practise without this relevant experience. Some respondents suggested that the HCPC should provide more stringent regulation to ensure that such scenarios do not occur.

'*Every student should be given the opportunity to have a statutory placement during the three years. By not having this they are not given the learning experience that others may have. I was not given a statutory placement and as a consequence I left university not feeling ready to start work. I am also finding it difficult to gain this experience due to not being able to get a social work job because I cannot evidence any statutory work. In this respect the university failed to prepare me for practice*' (Questionnaire response – South West - newly qualified social worker)

Orthoptic students on placements are sometimes located within high-street optician stores and they can be located anywhere across the country, which creates problems in how they can be monitored.

'*Quality assurance on placements is not possible, we simply can't visit them all because they could be located anywhere in the UK*' (Yorkshire – individual interview with course director for orthoptics)

Also, regional logistical problems have been noted about the availability of placements.

'*There are not enough extended practitioners practising in Scotland. That's a big struggle*' (Scotland – world café)

4.6.2 Role of practice educators
The HCPC uses the term 'practice educators' to describe the person who is responsible for a student's education during their period of clinical or practical experience. Other professions and institutions may use other terms, such as 'clinical educator'.

Practice educators are covered in the SETs 5.7, 'Practice placement educators must have relevant knowledge, skills and experience', 5.8, 'Practice placement educators must undertake appropriate practice placement educator training', and 5.9, 'Practice

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placement educators must be appropriately registered, unless other arrangements are agreed'. All of these SETs ranked highly in the questionnaire results.

4.6.2.1 Benefits of practice educators

Practice educators have an important role in ensuring that students are prepared for practice. Our results have highlighted the many positive effects that a good practice educator can have.

'*Clinical educators are totally responsible for ensuring that students are fit to practise*' (Northern Ireland – individual interview with professional lead in practice for physiotherapy)

Practice educators are important mentors and help to build confidence within students.

'*I was closely supervised and they were there all of the time but they weren't standing over my shoulder. It allowed me to push a little bit further*' (Yorkshire – world café)

4.6.2.2 How trained or qualified should practice educators be?

However, not all practice educators influence students in a positive light and examples of poor practice have been raised as an issue that can inhibit successful student learning. Specifically the marking of student performance has been noted as inconsistent across practice educators.

'*Some educators/assessors mark really harsh where as others give high marks. It doesn't appear consistent, more just down to luck of your educator*' (Questionnaire response – West Midlands – newly qualified physiotherapist)

'*There are discrepancies in placement marking due to placement educators subjective views of students and the level they should be attaining which I believe is unfair and can impact badly on student progression*' (Questionnaire response – North West - newly qualified occupational therapist)

'*I find the quality of practice educators (placement based) incredibly variable and their independence in grading final portfolios allows for large disparity in the grading process… I find that as students we were massively disempowered as we were encouraged not to complain or question poor or unprofessional practice by placement-based practice educators… I really do think that placement educators*

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need further training and monitoring' (Questionnaire response – South East – newly qualified social worker)

Students feeling powerless was a notion that occurred repeatedly.

'*Practice educators should be monitored extremely as they are human. All human practice educators have capacity to oppress students. Students are in a powerless position and structural oppression applies… I have experienced bullying and oppressive practice educators… No support from university. In my experience it was just business for them. No social work values were shown by university. Disappointed*' (Questionnaire response – West Midlands – newly qualified social worker)

'*Lack of support on placement when there is a breakdown of communication between yourself and your educator. Instead of looking to other possible causes, university tutors sided with my educator as they felt they were peers and blamed myself for the issues*' (Questionnaire response – East England – newly qualified occupational therapist)

Incentives for individuals to take up the title of a practice educator seem to have diminished. Some have even suggested that for people to take up the role leaves less time for practice in a period where services are already short-staffed.

'*With the changing nature of the social work and social care workforce you run the risk of excluding some exceptional practitioners to act as practice educators*' (Questionnaire response – North West – course director for social work)

Training practice placement educators is a contested issue. The HCPC's SET 5.8 does not specify how educators must be trained and some have still found this difficult to achieve.

'*Less important to have actual practice placement educator training as long as the educator is suitably experienced*' (Questionnaire response – North East – professional lead in practice for physiotherapy)

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> '*If there wasn't a qualified mentor then there would still be a qualified member of staff who would unofficially be there to mentor you but not be able to sign your paperwork. They can still do a testimony that they can give to the mentor*' (Yorkshire – world café)

4.7 Assessment

Our questionnaire asked respondents to rate the importance of the SETs relating to assessment (6.1-6.11). Figure eight shows the combined category of 'very important' and 'important' answers from both questionnaires.

Figure 8: Assessment SETs considered very important/important
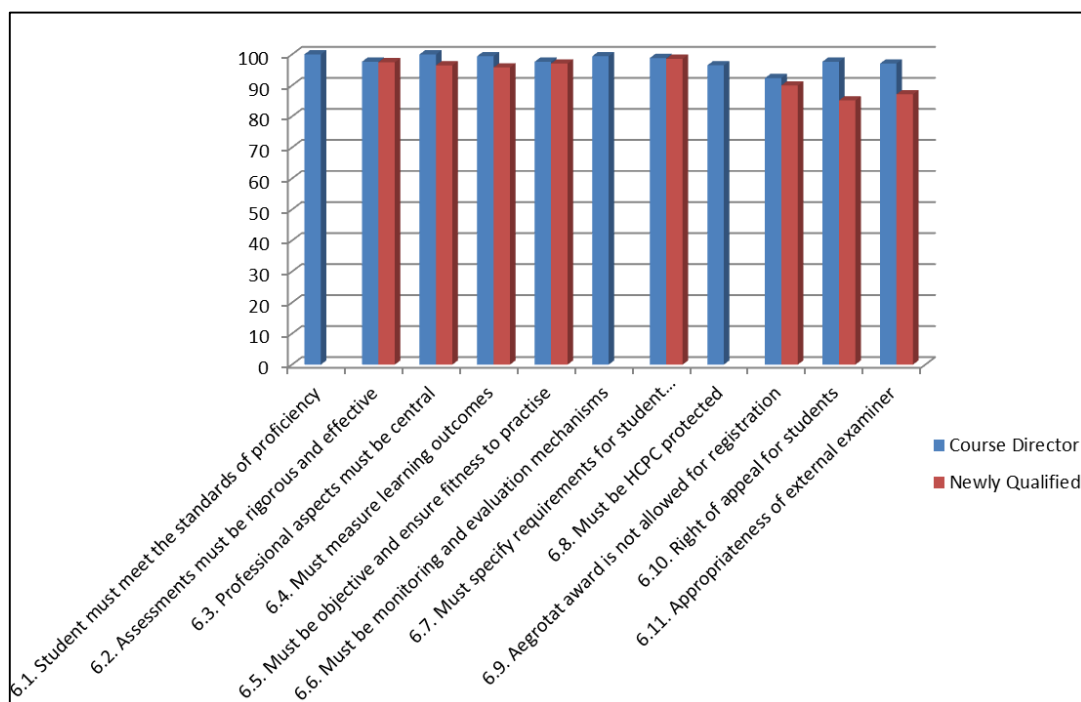
The assessment SETs were rated as very important or important by over 80% of respondents in ensuring fitness to practise. For course directors this rises to 90%.

4.7.1 Can an assessment be 'objective'?

SET 6.5 states 'The measurement of student performance must be objective and ensure fitness to practise'. While this SET was regarded as important by the vast majority of both groups, questions have been raised regarding the appropriateness of the word 'objective'. It has been suggested that the notion of objectivity is in many ways impossible to achieve as human nature will always contain elements of subjectivity. The pursuit of an objective assessment was noted as particularly difficult within the practical setting.

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'*Objective assessment is difficult to achieve with human factors: better to emphasise fairness and reliability*' (Questionnaire response – East England – course director for occupational therapy)

'*If we are looking at someone's attitude it will be subjective*' (South West – focus group)

'*I would question what it means that the assessment process is objective and unpick smaller aspects of it*' (Questionnaire response – London – newly qualified practitioner psychologist)

The data, however, also gathered suggestions for helping ensure that assessments can be objective. Assessments are not carried out in isolation, they are made up of a number of assessments, and there will never be one individual assessor.

Suggestions have been made for a possible re-wording of SET 6.5.

'*I think that the term "objective" here is ambiguous. Would the terms systematic and rigorous capture it better?*' (Questionnaire response - West Midlands – course director for physiotherapy)

'*Fair, rigorous, consistent, non-biased*'

'*Uniform*'

'*Maybe it needs a mash of words that have relevance*' (London – focus group)

4.7.2 Aegrotat award

SET 6.9 has raised some confusion both in the questionnaire data and also in interviews. The SET states 'Assessment regulations must clearly specify requirements for an aegrotat award not to provide eligibility for admission to the Register'. People are not always aware of the definition of 'aegrotat'. There have been suggestions for the HCPC to replace this word from the SETs.

'*It's a new concept to me. I had to look it up on Wikipedia so I may not have understood the SET properly*' (Questionnaire response – London - professional lead in practice for arts therapy)

'*If we don't understand it and we are in the profession then loads of people aren't going to understand it. They need to get rid of that word and replace it. I've never*

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seen this word in all of my profession; maybe if you're in a university then it is used all of the time' (London- individual interview with service manager for social work)

4.8 What is not covered by the SETs?

Our results highlighted key issues relating to fitness to practise that are not currently addressed within the HCPC's SETs.

4.8.1 Personal characteristics and attributes

Many people suggested that an element missing from the current SETs is the mention of what is termed here 'personal attributes and characteristics'. These are often regarded as a vital part of being fit to practise.

'*Personal values is all about what the HCPC is about in terms of protecting the public*' (South West – focus group)

'*It doesn't say about good communication skills or good listening skills, something that will actually help you be a good practitioner*' (North West – focus group)

There was mention from service users of times they have received poor treatment due to inappropriate professional attitudes.

'*I don't know what it is why they ignored the patients. There is an attitude that they are the boss, so they will deal with you whenever they're ready. Not, you're the consumer and I have to look after you. They're not deferent to the patients, it's as if they're doing the patient a favour and the patient should be happy. If you went into a business or a shop, you wouldn't be treated like that. The whole thing is the wrong way around*' (Northern Ireland – individual interview with service user of physiotherapy)

The benefit of professionals having desirable characteristics has been discussed as a way of delivering patient-centred care.

'*I've found that they are a lot more able to treat you like a person… Most of the time the treatment is specifically tailored for me. I want to see that extended to the general population of patients… If you can treat everybody with privacy in mind then some of the criticism that the NHS gets will actually decline because a lot of it is they feel humiliated in some way not the actual treatment that they get. It's about treating the individual*' (London – world café)

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It has been suggested that a SET should be introduced to cover a person's character. Some suggested that such a SET be included as part of the assessment SETs.

'Personality is never, never assessed. Physical we can work with that but someone's personality that is so entrenched and that's so difficult to work with. Someone can be academically brilliant but they have a personality impediment'

'There's nothing in the SETs to look at that'

'You need inter-personal understanding' (Northern Ireland – world café)

Others have discussed personal attributes as lacking within the admissions section.

'It [admissions] doesn't say about good communication skills or good listening skills, something that will actually help you be a good practitioner' (North West – focus group)

However, not all people see personal characteristics as essential to making a good practitioner.

'The bottom line for me isn't the empathy it's about their competence. As long as they are a good physio and adequate with their interactions with patients. I would put skills first every time, whether I like the guy or not' (Yorkshire – world café)

4.8.2 Peer support

The benefits of peer support, while a student, have been noted within the survey results and the interview data.

It has been suggested that newly qualified professionals could offer support and guidance to students to help them be better prepared.

'I was coming in to talk to the new students about what it's actually like. Part of it is with the lecturers there and then we send them off and ask the students if they've got any questions. We talk about money, what jobs you can get, when you really shouldn't be out partying because it's not appropriate on placement, and Facebook that's a huge thing… It was brilliant for us, we had a private, closed group. It might

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even be "oh what room are we in?"… Normally within 2 minutes somebody would have answered' (Yorkshire – world café)

Current students in elder years could also provide support to younger students.

'*I think current students mentoring new students is really good. Not so much as filling paper work in but just there for advice*'

'*If a first year student was having difficulty with anything relating to the patient, knowing how to conduct something, then a senior student a third year would be asked to go down to whichever area the struggling person was on and then go and mentor the student through the procedure… You're not a formal mentor because you're not qualified but you're there with more experience to help someone who is struggling*' (Yorkshire – world café)

4.8.3 Clinically active staff
Many participants noted the value that clinically active staff can have in creating a richer education environment and better preparing students for practice. A member of teaching staff who maintains their clinical skills can easily draw on real-life examples throughout their teaching.

'*I think it would be good for the tutors to maybe go back into practice to give them real life examples*' (North West – focus group)

'*It's looking at it from below, looking up and thinking "you understand this because you've been through this"* (London – world café)

'*During my 3 year degree it was apparent how tutors did not have the opportunity to revisit and practice social work outside the classroom arena*' (Questionnaire response – North West – newly qualified social worker)

It is not currently specified within the SETs that education staff should be clinically active. This may be due to the fact that it would prevent good lecturers from teaching. It has been noted that it is problematic for all staff to be clinically active and is not always necessary.

'*I can see the pros and cons of the debate, it gives more flavour but if your staff aren't clinically active then that gives them more time for scientific research which is*

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> *also good. I think that it's good to have a mix of both*' (Yorkshire – individual interview with course director for orthoptics)

4.9 How aware are people of the SETs?

Within the interviews respondents were asked whether they were aware of the SETs prior to the data collection events. We did not raise this within the survey data. Our results revealed that course directors have a greater knowledge of the SETs than any other group. This is to be expected as the courses for which they are responsible have to meet the SETs.

> '*In terms of programme re-approval processes then you come to live and breathe the standards. I've always found them to be very clear, very explicit… We have to take some of them maybe a wee bit further because of our professional body guidance but I've never found them to be at conflict*' (Scotland – world café)

Students revealed that they are less aware of the SETs, having a better understanding of the HCPC's SoPs, which are profession-specific.

> '*As a student you don't look at these*'

> '*I think they are probably more likely to be aware of the standards of proficiency*' (Scotland – world café)

As it was mostly only course directors who were aware of the SETs, prior to events we circulated copies and during interviews gave time and opportunity for other participants to read the SETs in order to formulate their own opinions.

4.10 Other issues

From the data collection events a range of other issues emerged. These were the usefulness of the SETs, the extent to which the SETs should be generic or profession specific, what contributes to fitness to practise, the extent to which newly qualified staff are fit to practise, managing expectations of practice and support for newly qualified staff.

4.10.1 SETs are useful

The data indicates that the vast majority of people believe the current SETs to be important in contributing to professionals being fit to practise.

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'*In general I find the SETs very positive although there are some places where the guidance is needed to fully understand what the SET is trying to achieve. I've found the guidance in particular very good*' (Yorkshire - individual interview with course director for orthoptics)

'*I actually think the SETs are very good; I don't have any major issues with them. I was actually relieved that they were sensible most of the time… These are actually very well worded and that allows a little bit of flexibility*' (Scotland - World Café)
'*I found it very helpful when I was designing my programme… before it was closed down with the regulations of the time, they were too specific in some places and were being interpreted in very different ways around that specificity and that's how we get into trouble. So this I had no issues with that, to me this was like a breath of fresh air compared to the old regulations*' (Scotland – world café)

It has been suggested, however, that it is how the SETs are put into practice that is important.

'*They're only as good as the people putting them in place*' (Scotland – World Café)
'*It's a personal responsibility for the student and every person that is wanting to practise, to ensure that they meet the requirements. So you can only do so much*' (Scotland – world café)

'*It is not about the factors and issues that go beyond these listed. It is about ensuring that the factors already stated actually happen… Of which they do not in some cases*' (Questionnaire response – London – newly qualified social worker)

4.10.2 Generic or specific SETs?
Many respondents noted that it is a necessity for the SETs to include some degree of flexibility as they must cover a range of professions, regions and learning establishments.

'*You might pick up something that would work for one profession but not for another*'
'*Because there's so many involved*' (Scotland – world café)

A consequence, however, is that sometimes the SETs are perceived as 'vague'.

'*They are generally very, very vague. That may be necessary when they are applying to however many professions*' (North West – focus group)

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> '*There's a vagueness to it but it's a necessary vagueness because of the breadth of professions that it's covering*' (London – focus group)

> '*If you went any more specific you would probably be reading War and Peace*' (London – world café)

One participant also suggested that the generic SETs do not need to be as prescriptive as they are for doctors and nurses, where more is expected.

> '*It's whether the HCPC should be more prescriptive like other regulatory bodies are. Generally the HCPC professionals seem to cause less trouble, I'm not making judgements on that it's just that the volumes of complaints are so less because the public expects a bit more for doctors and nurses*' (London – world café)

It should be noted that where problems have been discussed they are often profession-specific. One suggestion is that the HCPC should ensure that the SETs dovetail with the guidelines and requirements of professional bodies.

> '*There needs to be a statement that these work in partnership with, or to work along with professional body guidelines. They should inform each other almost*' (Scotland – world café)

It has also been suggested that the SETs could be better linked to the HCPC's SoPs and other documentation to strengthen their relevance and guidance.

> '*One of my colleagues who is an OT [Occupational Therapist] lead went to a HCPC conference last year and she brought back a lot of little booklets. The other day I went to where the pile of booklets was to see if there was one of these [SETs] and there wasn't. She said "oh no, I didn't bring any of those, I just brought the others [SoPs]… So that probably tells the story, that she didn't actually see these as relevant*' (North West – focus group)

4.11 What is 'fit to practise'?
In questioning whether newly qualified professionals are prepared for practice, respondents highlighted areas that made a newly qualified professional proficient and 'fit to practise'.

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> '*What we look for is clinical reasoning, systematic problem-solving, these are the abilities that can be carried from one placement setting to the next*' (Northern Ireland – individual interview with professional lead in practice for physiotherapy)

> '*Practice placements are the most challenging set of standards for us but I don't think that makes them the most useful for preparing students to be fit for practice*' (Yorkshire – individual interview with course director for orthoptics)

> '*Adequate practice, good communication skills to assess the patient (which will give good treatment), adequate theory*' (North West – focus group)

> '*If you look at the six Cs then that tells you everything you need to know. You need confidence and competence, being able to care, courage for your own convictions. If someone can't develop all of these, it's not just being able to site them, then you shouldn't be able to pass. If you can't sign someone off to that effect then you should be signing someone off*' (Yorkshire – world café)

> '*It's about having a problem and thinking what do you need? What questions do I need to ask? What is my management of that?*'

> '*It does come down to the speed that they can make decisions and the knowledge and expertise that they have in different areas, the ability to think on the spot, problem-solving capacity, ability to lead others and conflict resolution*' (London – world café)

4.11.1 Are newly qualified professionals fit to practise?
Largely the results suggested that newly qualified professionals are fit to practise.

> '*They're better prepared for changes and ensuring that they are looking for changes in the future*' (South West – focus group)

> '*Generally students are very good at interpersonal skills… In terms of communication they're probably stronger because we ask them to do a lot of presentations*' (North West – focus group)

> '*I was very confident in my university that I was adequately prepared for practice but speaking to others they were not*' (North West – focus group)

However, some felt that the standard of newly qualified professionals is not good enough.

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'*My observation would be that students are definitely not as ready for practice when they qualify as they used to be… I think in terms of preparation for students then that can cause quite a lot of frustration for them because they come out feeling that in order to give a quality service you have to have endless time for each patient – life is not like that*'

'*I think that another reason why newly qualified aren't as ready to practise is partly to do with the way that we do placements*' (North West – focus group)

'*It's the clinical thinking, they haven't got that quick recognition of clinical reasoning to deal with a busy environment. You need to give them a lot more time and support to work through things*' (London – world café)

'*I still felt like a student, it's very busy, you're just thrown into the deep end… I was a little bit overwhelmed to be honest*' (London – focus group)

4.11.2 Managing expectations of practice

Many respondents felt that the expectations of students should be managed before graduating, so that they are aware of the role of a newly qualified professional. Repeatedly professional staff voiced that newly qualified professionals are not expected to know everything.

'*They should bear this in mind during their education – the registration is not seen as the end point*' (London – individual interview with course director for hearing aid dispenser)

'*There is a different level of thinking 'I really, really don't know what I'm doing*' and '*I'm not quite sure what I'm doing but I'm hoping I'll be able to bluff it for the first year or so' [laughter]*' (Scotland – world café)

'*Warning about that initial step and normalising that fear*' (North West – focus group)

'*When you go out you can never fully prepare for all of the patients you might see*' (North West – focus group)

Some newly qualified professionals have been over-confident when entering the workplace as a result of a miss-judging their own expectations.

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'*A lot of students over pressurise themselves and in the workplace no one expects them to know it all. Occasionally we get over confident students and we need to tell them to pull back*' (North West – focus group)

'*I think for anyone when we lose that sense of fear there's a danger of being over-confident because of the nature of the job and the unknown of what the patient will be*' (South West – focus group)

4.11.3 Supporting newly qualified professionals

Some respondents suggested that universities could better support students in their transition from student to practitioner. Specifically students may feel anxious approaching graduation and registration and may seek some assistance in applying for jobs. It has been suggested that the HCPC could regulate better support during the point of graduation and the point of starting employment, so newly-qualified professionals do not 'de-skill' during this period.

'*The challenge comes in keeping up the momentum from final year into the real world*' (Northern Ireland – individual interview with professional lead in practice for physiotherapy)

'*I was going to just say at the end of the degree I think once we've submitted our work and our final academic piece of work we were more or less dropped, so to speak*'

'*In that period there is an opportunity then because the rest of the year is so packed with all of the academic stuff and placements but that period is free*'

'*It's a missed opportunity*' (North West – focus group)

'*Universities (and practice educators) need to focus on the transition period between university and getting a job – preparing them. Just before the registration, certainly in the last year*' (London – individual interview with service manager for social work)

'*We finished in August and then didn't start 'til mid-September so you're already de-skilling then*' (Yorkshire – world café)

As part of this process it has been suggested that newly qualified professionals should have a period of transition when they first enter into the workplace. References were made to 'mentorship', 'preceptorship' and 'continued professional development'.

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'All newly qualified staff should undergo some form of mentoring in their first year of practice, it's like any transition and they will need support for it' (Yorkshire – individual interview with course director for orthoptics)

'Something like a preceptorship – someone's got your back while you're still learning' (Yorkshire – world café)

'One issue I personally faced was the transition from student to newly qualified. I wasn't treated as a newly qualified once I was 2 months into my practice. I had 10 child protection cases and 11 child in need cases with 3 months of being newly qualified. This burnt me out… Newly qualified need to shadow qualified workers with no case load for at least 2 months. Then slowly introduce manageable cases' (Questionnaire response – North West – newly qualified social worker)

'We've designed a preceptorship programme. I want it to be the standard one for clinical scientists.' (London – individual interview with clinical scientist)

These systems are recognised as beneficial for newly qualified staff to continue their learning in a supported way before becoming fully autonomous and responsible. There were, however, individuals with reservations about the use of some terms.

'I personally think that the preceptorship of 1 year is too long when students are coming straight out of a course. We need to think of it as more of a transition than a preceptorship' (Yorkshire – individual interview with course director for operating department practitioner)

4.12 Summary of findings

The survey suggested that the current SETs were regarded as important by the majority of respondents. However, open questions and data collection events did though reveal many suggestions for enhancing some SETs and some questions about how to implement the SETs. It was not possible to cover all of these issues in the consensus workshop and an assessment was made about what were the key issues. A key issue to emerge was that of the 'theory practice gap.' Two important components of this were the placement experience, in particular the variety and quality of the experience, and the role played by the practice educator. Another key issue was that of the 'personal characteristics' of a student and qualified professional. This notion of 'personal characteristics' can be hard to define, encompassing a variety of issues from interpersonal skills through to the extent to which an individual is 'caring and compassionate.' However defined it seems to be crucial to providing patient centred care and was an attribute that should be demonstrated by all practitioners. Finally, there were some respondents who were

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concerned about SET 6.5 "*The measurement of student performance must be objective and ensure fitness to practice*"; in particular they were concerned about how objectivity could be achieved.

4.13 Consensus workshop

The final stage of data collection was a consensus workshop focusing on the evidence collected via the surveys, focus groups, world cafes and interviews. The aim of the day was not necessarily to collect new opinions but to discuss existing views in a framed debate and to develop solutions to the issues that emerged.

Following a presentation outlining the background to the research and the key findings that had emerged, the participants were divided into two breakout groups to discuss four key issues:

1. Variety and quality of placements
2. Role of the practice educators
3. Can assessments ever be 'objective'?
4. Importance of personal characteristics

Participants in the workshop were a mix of service users, academic staff, professional leads in practice, and HCPC staff. The group discussions were facilitated by staff involved in the research project (see Appendix 11 for full results).

4.13.1 Group discussion

The two groups agreed that there was no need to introduce new SETs to address any of the issues. Generally the groups were satisfied with the SETs and felt that they adequately prepared newly qualified professionals to practise. The participants felt that the discussion points could be captured by existing SETs by providing links to HCPC guidance, professional body recommendations and providing good practice examples.

4.13.2 Variety and quality of placements

The groups concluded that SET 5.2 could be better linked to SETs 4.1, 4.2 and 4.3 from the curriculum section. Ensuring that the learning outcomes were better linked to the curriculum could ensure better integration between theory and practice. This could help to reduce the variation between different placements and ensure better learning outcomes. It was acknowledged that different professions have different 'core' curriculums which are advised by their individual professional bodies. If the HCPC were to work alongside professional body guidance then they could produce more specific regulation on what the 'number, duration and range' of placements would look like for each profession.

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4.13.3 The role of the practice educators

The groups concluded that the definition of 'practice educator' needs to be reviewed. It was agreed that due to staffing pressures it would be logistically difficult to set out specific time allocations for mentors. Also, students receive guidance from a whole range of people in the practical setting. For these reasons the definition of practice educator has become blurred. Both groups believed that the HCPC could provide better guidance on how to be a good mentor and could supplement this with good practice examples.

4.13.4 Can assessments ever be 'objective'?

There was debate between the groups on this issue and they did not reach an agreement. While one group felt that the word 'objective' should be removed and replaced, the other felt that it was essential for it to remain in the SET. The second group felt that there are ways of managing the assessment process to reduce subjectivity: measuring the student on numerous occasions, using learning outcomes and having a number of assessors. The first group felt that true objectivity is not possible and the word should be replaced in the SET with 'holistic', so that the whole of the student is judged rather than a specific set of competencies. Both agreed that assessors need better guidance on how to achieve this SET effectively.

4.13.5 Importance of personal characteristics

The groups concluded that there was no need for this to become a new SET and that it could be included within SETs 4.2 and 6.3. Participants felt that professional qualities will differ from profession to profession and introducing a new SET may be difficult. They did agree, however, that communication and interpersonal skills should apply to all health and care professionals. Therefore, they felt that there was scope for these elements to be included within the current SETs and/or guidance. It was acknowledged that these 'soft skills' are addressed within the profession-specific SoPs, and so it was suggested that a better link between the two documents may address this issue, e.g. a URL linking the two documents.

For all of the issues raised within the consensus workshop the participants agreed that these issues would not be resolved by creating new SETs. This finding concurs with previous data that respondents are satisfied with the current SETs. The consensus workshop, however, did suggest that the SETs need to be better linked to the other guidance provided by the HCPC, and also better linked to suggestions from professional bodies in order to help address specific problems. Where people may struggle with visualising certain SETs it was repeatedly mentioned by participants that good practice examples would '*bring the SETs to life*'.

4.14 Conclusion

The findings from this project echoes similar themes to that identified within the literature regarding what elements are relevant in producing a professional fit to practise. Specifically the role of the SETs in contributing to the preparation of newly

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qualified professionals has been explored within this research. The positive aspects related to the SETs and issues for their implementation have been discussed.

The data suggests that the vast majority of respondents see the SETs as either very important or important in ensuring fitness to practise. Course directors are more likely to rate the SETs as very important or important. For every SET 80% of course directors ranked it as either important or not important. Newly qualified professionals are more likely to rate SETs lower. Although 80% or more of newly qualified professionals also saw all SETs - beside six (2.4, 3.11, 3.11, 3.13, 3.15, 3.17) – as either very important or important. These results suggest that the SETs are crucial for determining fitness to practise.

Both course directors and newly qualified professionals saw 'practice placements' as the most important section relating to fitness to practise, with all being ranked by 90% as very important or important. Specifically the number, duration and range of placements and the role of practice educators were highlighted as determining the success of individual professionals.

Programme management and resources was the SET that produced the lowest percentages of very important or important from newly qualified professionals. Specifically SET 3.17 relating to service users and carers raised issues for how it can be appropriately implemented. Only 60% of newly qualified professionals believed that involving service users and carers within the admissions process was very important or important. However, 84% of newly qualified professionals saw involving service users and carers within teaching, assessment and evaluation as very important or important. There appears to be a lack of communicated value in the benefits of service user and carer involvement.

Where issues were raised regarding the SETs they were usually profession-specific. The results highlighted awareness that the SETs covered 16 professions and it was therefore essential for them to remain open. The perceived 'vague' nature of the SETs was deemed as essential to allow each profession the capacity to tailor the SETs specifically to their course. However this then makes the SETs general and open to critique of being unable to provide adequate guidance. The findings suggested that this could be overcome by greater collaboration between the HCPC and professional bodies. There appears to be general support for the current SETs, which could be supported and supplemented by better links and providing good practice examples.

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Chapter 5 Discussion and Recommendations

5.1 Introduction
The HCPC reviews its SETs on a regular basis. The project presented here is one of three strands of work reviewing the SETs and supporting guidance. A second strand is research into IPE while a third is internal HCPC research and stakeholder engagement activities to gather views on the SETs.

This project explored the role played by the SETs and supporting guidance in ensuring that education providers have the structures and systems in place to prepare students to be fit to practise at entry to the Register. These findings should be considered together with findings from the other strands of work.

5.2 SETs are regarded as important in terms of ensuring fitness to practise of newly qualified staff
All but six of the SETs were ranked as either very important or important by 80% or more of the questionnaire respondents. Just six SETs (2.4, 3.11, 3.11, 3.13, 3.15, 3.17) were rated as important or very important by less than 80% of newly qualified professionals. Newly qualified professionals in particular were less likely to view the group of SETs related to programme management and resources as important or very important.

The results show that course directors were generally more inclined to view the SETs as very important or important compared to newly qualified professionals. This may be because course directors have more exposure to the SETs throughout the process of course approval and design.

Both course directors and newly qualified professionals saw the group of SETs relating to practice placements as important. This was echoed within the interview data, with many believing that the success of students feeling adequately prepared was largely dependent upon their experiences within placement and their ability to integrate theory and practice. These results are consistent with the literature highlighting the importance of practice placements (Holland et al., 2010). Placements can improve students' knowledge, skills and competence levels (Sheepway, Lincoln & McAllister, 2014; Vanier et al., 2013) but also their confidence (Webster et al., 2010)

5.3 The HCPC's definition of fitness to practise is consistent with that of other professional bodies and regulators
The issues of practising 'safely and effectively' recur in various definitions of fitness to practise. Knowledge, skills, health and the conduct of the individual are also frequently mentioned. There is one issue, included in the GMC's definition, and not elsewhere, that relates to the relationship between the practitioner and patient. Some might suggest that this notion of a relationship between the practitioner and patient is

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implicit in the phrasing 'safely and effectively'. The data suggested that respondents would prefer a more explicit statement.

This issue is worth mentioning here given that a theme which emerged from the research findings, often from service users, was that some health and social care professionals are unable to relate to service users in an appropriate way.

This is clearly a complex and multi-faceted issue, with some respondents suggesting this is due to the character of the professional making them unsuitable for a given profession while for others it was about the behaviour of the professional and how they treated service users. There are also a range of words, not always consistent, which are used to describe these 'softer' activities such as 'caring and compassionate'. The literature highlighted considerations of sensitivity (McAllister et al., 2013), maturity, initiative and communication skills (Fraser, 2000a). It has been suggested that these attributes could be described as 'emotional intelligence'. Laird et al (2015) refer to person-centred care including knowing the service user, working with their values and beliefs as well as developing positive relationships. This touches on a point discussed at some of the data collection events about the extent to which such attributes are innate or can be taught.

Specifically, the inclusion of personal characteristics and attributes within the SETs is a highly important debate that should be considered by the HCPC. Many respondents believed the character of a person to be highly important in determining the fitness to practise of a newly qualified individual, and that this was not covered adequately in the SETs. The SETs do mention 'values and ethics' and 'professional behaviour' but many respondents did not think this quite captured the notion of 'caring' or 'emotional intelligence'. The SoPs do address this issue, and a recommendation (see Recommendation 4) is to make stronger links between the SET and SoP documents.

However, the HCPC may want to consider whether this issue of the relationship between the professional and the service user should be included in their definition of fitness to practise.

Recommendation 1: The HCPC should consider adding a reference to the development of relationships with service users to their definition of fitness to practice

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Recommendation 2: The HCPC should consider making an explicit mention of 'soft skills' within current SETs

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5.4 Generic and flexible SETs vs specific and prescriptive SETs

A decision was made to adopt generic (rather than profession-specific) SETs which covered all 16 professions rather than a specific group of SETs for each profession. Some SETs were criticised for being 'vague'. However, it was recognised by many respondents that if the SETS are to cover 16 professions then this necessitates them not being too prescriptive, allowing for flexibility amongst the different professions. Furthermore, some respondents pointed out that it was the SoPs which were profession specific and that it was important the SETs were not viewed in isolation but rather as part of a range of standards.

Professional bodies also provide their individual professions with guidance on how to manage certain aspects of their courses in relation to fitness to practise. Course directors have found the input of professional bodies to be highly important and have designed their courses by mapping HCPC regulations against the recommendations of professional bodies. The exercise of joining both of them could be eased if there were greater collaboration between the organisations. The SETs document does make some links to the SoPs and to professional body curriculum frameworks, for example 4.1 and 4.2; but there were suggestions these links could be stronger. Similarly, SET 4.5 does make a link to the HCPC's standards of conduct, performance and ethics; but again there could be a stronger link so that newly qualified professionals are aware of appropriate behaviours. The HCPC could acknowledge that professional bodies are the place to seek specific professional guidance.

Recommendation 3: The HCPC's SETs and guidance should include stronger links to SoPs and HCPC's standards of conduct, performance and ethics, and also the standards and requirements of professional bodies.

Suggestions include:
- *URL link*
- *Explicit link within the introduction to the SoPs and standards of conduct, performance and ethics, and professional body guidance*

5.5 How SETs are implemented

Although the SETs are regarded as important, this does not mean that they are devoid of issues. There is concern about 'how' some of these SETs are implemented. It has been suggested that SETs remain sufficiently broad and flexible to appropriately reflect each of the 16 professions. A consequence of generic SETs sometimes HEIs would like information on how to adhere to or implement the SETs.

The guidance, for the same reasons, also has to be broad.

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5.5.1 Command of English

There was some debate about the ambiguity of the phrase 'good command' (of English) within SET 2.2. The guidance expands on this SET outlining that entry criteria 'should be appropriate to the level and content of the programme' and acknowledges the communication aspects related to this SET by referring to the SoPs that should be met by each student. Yet ultimately it is 'for you to decide'. The level of English did not arise within the literature that we surveyed but was a pertinent issue within our results.

Our results show that language is highly regarded within health and care professions, as it is the means by which effective communication can take place between the practitioner and the service user. Arguably it is more important for some disciplines (e.g. speech and language therapy) than others and in areas when professionals are interacting with patients who have learning disabilities. The guidance states that students must be able to fully engage with the course from the outset. Given that students could possibly be sent onto placement within their first semester patient care should not be compromised by inadequate levels of English. There have been concerns from the General Medical Council (GMC) and Royal College of General Practitioners about doctors without a sufficient command of the English language (http://www.theguardian.com/society/2015/oct/28/two-eu-doctors-disciplined-for-inadequate-english).

Although no data were collected on this issue, it is acknowledged that course directors are often under pressure to accept international students, as they generate income for universities. This pressure may lead to some course directors accepting students with poor command of English. With regulatory backing on a minimum level of proficiency from the HCPC, course directors would be in a stronger position to resist financial pressures.

The HCPC, like other regulators, do require people trained in other countries, and seeking registration to practice in the UK, to acquire a particular IELTS score (8 for speech and language therapists and 7 for all other professions).

The GMC now require that people, from Europe and elsewhere, wishing to be employed as doctors in the UK get a score of at least 7.0 in each testing area of the IELST (speaking, listening, reading and writing), and an overall score of 7.5 (http://www.gmcuk.org/doctors/registration_applications/13680.asp).

A similar requirement has been specified by the NMC, stating an overall score of 7 is required for all non-EU trained applicants to the nurses or midwives part of the register (https://www.healthcareers.nhs.uk/i-am/outside-uk/information-overseas-nurses).

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However, the scores referred to above apply to people who are already qualified via courses undertaken overseas. Some respondents in this project suggested that it would be helpful if the HCPC could set a minimum score of IELTS that all health and care professionals should obtain *before* being allowed entry onto a course. Indeed, some respondents said that the HCPC had provided them with guidance on this issue, suggesting that a score of 6.5 was appropriate. It seems that there is some confusion about the guidance currently provided by the HCPC. Setting a minimum standard, prior to entry to the course, would provide a sense of uniformity across institutions and reduce variation within patient experiences. The minimum level could reflect the opportunity for language skills to develop whilst the student is on the course.

Recommendation 4: The HCPC to consider providing a minimal IELTS score for students, whose first language is not English, seeking a place on HCPC regulated courses.

5.5.2 Health requirements

Debates on the issue of health are laden with complexities and as such an amendment to the SET 2.4 would not be advised. It is important to note that the HCPC has recently provided guidance on this topic, ensuring their responsibility to remain fair to registrants with disabilities (HCPC, 2015). The report entitled 'Health, disability and becoming a health and care professional' advises students and all those involved with healthcare education – specifically navigating the complex nature of health requirements during the process of admissions. Prospective healthcare students can make use of the document to guide their decision as to whether their own health is a barrier to fitness to practise or not. It would be valuable for the HCPC to make a clear link to this document within the SETs so that people are aware of the resource and the support it offers.

During project interviews most debates focused around the extent to which physical disabilities could prevent a practitioner being able and fit to practise. On a number of occasions the mental health of an individual was raised as a potential barrier to full engagement with courses. Clearly, the HCPC would not want to be discriminatory or deter potentially excellent candidates from applying to courses. Indeed, the HCPC states that courses should not be discriminative within their admissions process. Stanley et al. (2011) have studied the element of personal disclosure of health and found that some people are less likely to disclose mental health issues due to fear of exclusion and stigma. It could be suggested that having lived experience of mental illness might strengthen an individual's ability to engage and relate to service users. That said the SET, guidance and the report mentioned above do not make explicit mention of mental health/mental illness - the focus is on physical health. It is essential for mental health to be acknowledged within HCPC documentation and

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subsequently university admissions so that students can have access to necessary support systems.

Recommendation 5: The HCPC to make a clear link, in their SETs and guidance, to the document 'Health, disability and becoming a health and care professional'

Recommendation 6: The HCPC to make explicit mention of 'mental health' within the SETs or guidance

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5.5.3 Service user and carer involvement

SET 3.17 is related to the involvement of service users. The problems around this SET are exacerbated because it is a new SET and some institutions do not have much experience in 'how to do it'. The results have shown that some struggle to involve service users effectively. Some have felt that the current SET is too demanding in that service users 'must' be involved given that students are interacting with patients throughout their practice placement experience. Chambers and Hickey (2012) have noted the importance of culture, processes and resources. However, our results have demonstrated that other institutions have succeeded in involving service users throughout courses. Service users and students alike have enjoyed high levels of satisfaction from the process. Clear benefits can be drawn from service user involvement in delivering education. Service users can get a feeling of empowerment (Frisby 2001, Masters et al 2002, Happell and Roper 2003, Rees et al 2007, Skinner 2010) and a sense of altruism (Brown and Macintosh 2006, Haffling and Hakansson 2008). The involvement of service users can help challenge student assumptions and stereotyping (Dogra et al. 2008, Rush 2008, Anghel and Ramon 2009, Branfield 2009, Schneebeli et al. 2010, Thomson and Hilton 2011), and contribute towards a more positive view of service users (Lathlean et al. 2006, Simpson et al 2008). Rees & Raithby (2012) have noted how service users add a sense of reality to the education.

5.5.4 Interprofessional education

The requirement for more effective collaboration between professions has been noted by the introduction of The Health and Social Care Act (2012), and the National Collaboration for Integrated Care and Support (2013) and various benefits of IPE have been articulated in chapter two. However, for some there have been difficulties implementing interprofessional learning within the curriculum. IPE is crucial to learn with and about the roles of others, in order to understand the individual's own professional role (Conlon, 2014; Ericson, Masiello & Bolinder, 2012; Ho et al., 2008; Fineberg, Wenger & Forrow, 2004). The benefits of this can be seen directly with improved patient-centred care through creating common goals (Conlon, 2014; Ho et

al., 2008; Reeves & Freeth, 2002). This is echoed by the views of service users from our results in that collaboration between health professionals can stop the 'revolving door' process.

Some believe that interprofessional education takes place within practice placements therefore there is no need for it to be taught within the education setting. However, our data has suggested that interprofessional collaboration is not always evidenced within current practice placements. There have been logistical issues for some institutions in finding space within course timetables to facilitate interprofessional teaching. Some are restricted by the small number of other health professions that are taught within their universities. The literature has also discussed the difficulties of obtaining equal representation across professions (Derbyshire & Machin, 2011; Ho et al., 2008; Hylin et al., 2007). This has led to a number of examples of taught modules on interprofessionalism, not adding much value to the student's experience and becoming more of a tick box exercise to fulfil this SET.

5.5.5 Management of practice placements

The management of practice placements is a key issue. Many students and newly qualified professionals have commented on variety of the placement experience. Placements are integral in developing student confidence and preparation. These variations exist between regions, institutions, organisations, and practice educators. Working with professional bodies (sharing their standards and regulations) and providing good practice examples could go some way to alleviating these variations. Results specifically highlighted the varying lengths of placements. The more exposure students gain on placements the more benefits they will acquire (Mathias-Williams & Thomas, 2002). Our results have shown that many placements are regarded as too short, meaning that students do not have long enough to settle and feel comfortable within a setting before they leave their placements. It should be noted that the length of practice placements is dependent on the nature of the course and the availability of placements within that region.

An issue also arose relating to the matching of theory and practice between the taught curriculum and what is learned on placement. Gallagher (2010) found that students struggle with their ability to integrate their learned skills within the practical setting. Due to the challenges of gaining placement opportunities it is not possible for course directors to map the theoretical learning from the classroom directly to the practical placement elements. Michau et al. (2009) have studied the reasons for shortages of placements, linked to funding, increased student numbers and decreasing patient availability. This has meant that students have struggled to consolidate their learning of the theory with lived examples. Our results have shown that some students are having the same practical experience across different placements, rather than being exposed to new areas of practice. This can limit practical skills developing and lead to some student feeling unprepared for practice.

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The role of practice educators is crucial for the successfully preparing students for practice. Educators can take on the role of a 'mentor' and can bridge the gap between education and practice (Hughes, 2004; Wells & McLoughlin, 2014). Their role is to guide students and develop their practical competencies. It has been noted by Black et al. (2010) that student self-awareness and communication skills are developed strongly through mentorship. Our results have highlighted both positive and negative examples of practice educator behaviours, which can have lasting impressions on the student. It has been recognised within the literature that practice educators may struggle within their role as they already face numerous time pressures and high workloads (Bourke, Waite & Wright, 2014; Hughes, 2004). This can have an impact on the amount of time educators are available to support and facilitate student learning.

The HCPC require practice educators to be qualified, trained and registered within the SETs. However, the lack of uniformity across mentors' activity and behaviour raised questions within the project regarding variability. A specific issue arose surrounding the definition of a 'practice educator'. Some take on this role after two years' experience as a qualified professional, sometimes our respondents claimed with little training. A standardised level of training for all HCPC practice educators could create a more consistent student experience. This could include reviewing practice educator training across all professions. It has been suggested that dedicated time be included within practice educator's job descriptions in order to truly develop a relationship with students.

Recommendation 7: The HCPC to review practice educator training with a view to developing broad principles about the role of practice educators

5.5.6 Addressing the 'how' issue

Project participants would welcome advice on 'how' to implement the SETs to a high standard and suggested the sharing of practice examples – these could inform a future publication (see Appendix 12). This could be a publication available on-line of practice examples, where specific institutions have addressed different SETs effectively in the form of a 'how to'. The intention of a valuable publication would be to identify possible pathways for HEIs through the SETs. It would be up to individual institutions to determine the extent to which they adopt or adapt the examples.

Recommendation 8: The HCPC to consider the development of a 'how to' practice guide to complement the SETs and the guidance

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5.6 Suggestions to reword SETs

SET 6.5

Throughout the project there was considerable debate surrounding the use of the word 'objective' within SET 6.5, 'the measurement of student performance must be objective'. Objective assessment has been encouraged within the literature, with calls for universities to adopt Objective Structured Clinical Examination (OSCE) in assessment procedures. This method considers technicality, critical thinking, communication and the ability to assess patients (Billington, 2011).

Many respondents called into question whether any form of assessment can ever be truly objective and have suggested for the wording to be changed in this SET. Participants have claimed that there will always be an element of subjectivity, specifically within the practical setting. However, others have claimed that objectivity should be sought for at all times to ensure fairness. Proponents believe there are methods to ensure objectivity: by following learning outcomes, completing numerous assessments, and by consulting the opinions of others. This SET has consequences for the experience of students; some have felt that assessments have been biased and unfair. Fraser (2000b) has suggested that a holistic method of assessment be used, so that the whole of student performance is considered rather than a specific list of competencies measured in isolation.

Both the words 'must' and 'objective' have been considered for possible alteration. Suggestions have been made to include other terminology to supplement the word objective. Considering the debate from our project findings the notion of assessment objectivity was considered within discussions at the consensus workshop. However, the group were unable to reach a collective decision surrounding the inclusion of the word 'objective'. As a result they offered three different suggestions to alter SET 6.5, listed below. We are aware that not all of the suggestions may be implemented due to contradictions, but feel that this is something for HCPC to consider.

Recommendation 9: Re-word the SET 6.5. Suggestions are:

- *Replace 'must' with 'should aim to be'*
  - *'The measurement of student performance should aim to be objective and ensure fitness to practise'*
- *Replace 'objective' with 'fair', 'rigorous', or 'uniform'*
  - *'The measurement of student performance must be fair/rigorous/uniform and ensure fitness to practise'*
- *Keep 'objective' but include 'fair', 'rigorous' and 'uniform' too*
  - *'The measurement of student performance must be objective, fair, rigorous, uniform and ensure fitness to practise'*

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SET 6.9

SET 6.9 raised confusion surrounding the word 'aegrotat'. Many respondents were unaware of its definition and as such struggled to understand the meaning of the SET. It was noted that if course directors cannot understand this, then it was unlikely that students would. In order to improve clarity we would recommend that the HCPC provide the definition within the guidance relating to this SET, rather than only within the glossary.

Recommendation 10: Define the word 'aegrotat' within SET 6.9 using the definition of aegrotat provided within the glossary.

- *E.g. 'Assessment regulations must clearly specify requirements for an aegrotat award (awarded to a student who cannot complete the degree due to illness) not to provide eligibility for admission to the Register'*

5.7 Conclusion

The findings of this project are mostly consistent with the relevant literature surrounding preparedness to practise. HCPC's definition of fitness to practise is similar to those given by other regulatory bodies. Newly qualified professionals were, generally, regarded as adequately prepared to practise. There were some concerns about the ability of some newly qualified professionals to relate to service users and carers, and also the impact of the variability of both the placement experience and the role and training of the practice educator.

The results from the project have shown that all of the HCPC's SETs are important in preparing newly qualified professionals for practice. Nor was there any evidence that there should be any additional SETs. There is a recognition that for the SETs to cover the 16 professions currently regulated by the HCPC they must remain generic and flexible.

However, there were some enhancements that could be made to the SETS and guidance. There were some SETs, and also guidance, that could be reworded to ensure greater clarity. Better links could be made between various documents relating to the SETs. And there were some SETs where respondents could benefit from more prescription on how such a SET could be met. Finally, it was clear that, for some SETs, respondents wanted knowledge on 'how' they might meet SETs; they wanted to access and share real life examples of how different HEIs went about addressing SETs. The development of such examples would provide a valuable source of support for HEIs in delivering the SETs and supplement HCPC existing guidance on how best to provide successful education programmes and ultimately produce students that are fit to practise.

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5.8 Limitations of the research project

The project was conducted over a seven month period. It included representation from all 16 professions regulated by the HCPC. This involved seven different regions of the UK and utilised an array of data collection methods. The nature and the scope of this project have provided useful insights regarding fitness to practise. It aims to improve the experiences of HEI staff, students, service managers, practice educators, experienced and newly qualified professionals. However, we acknowledged from the outset that the size of the study would result in challenges for the research team. As with most research, the project was not without limitations.

5.8.1 Developing the questionnaires

The aim of the project was to collect the opinions from a wide range of participants. The HCPC allowed us access to a large sample of contact information for newly qualified professionals and course directors (programme leads). Given the background and expected knowledge of the different cohorts the Project Advisory Group to circulate two different questionnaires. An advantage of this approach is that we could specifically tailor the questions for the different audiences and reduce the overall length of the questionnaire (for the newly qualified professionals), thus increasing the potential completion rate. However, using two different questionnaires did not allow for a direct comparison for each individual SET.

In developing the questionnaire we were faced with a dilemma on how best to address the issue of fitness to practise. We did not ask newly qualified professionals, within the questionnaire, the extent to which they felt prepared when entering practice. Instead, we asked respondents to rank each individual SET in relation to fitness to practise (ranging from very important to not important at all). This allowed for a direct mapping of the SETs against fitness to practise. We supplemented this quantitative data with discussions of definitions of 'fitness to practise' and specifically asked newly qualified professionals to share their experience of the transition from student to professional within our data collection events.

5.8.2 Respondents of the online survey

We received more results from the survey circulated to newly qualified professionals than that to course directors. This was expected as newly qualified professionals represent a much larger population and we had more contact information for this group. However, due to the smaller amount of data from the other respondents strong comparisons across the sub-groups were not possible.

5.8.3 Number of respondents in data collection events

As the data collection period fell between the summer months (June-September, 2015) university staff and students alike were often unavailable to attend. This resulted in fewer participants than originally planned for in the project proposal. The low numbers of attendees meant that, on numerous occasions, rather than collect data via world café events we instead used focus groups. Alongside this, to ensure

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representation across the professions and to cater for those who could not attend the organised data collection events we conducted telephone interviews. Despite these challenges we believe that 98 participants in the data collection events, alongside the 878 completed online surveys, provide a strong basis for the findings reported in this project.

5.8.4 Service user and carer involvement in data collection events

Whilst a number of service users and carers did contribute to data collection events, their representation was not as large as we had hoped. Originally we sought to have exclusive service user focus groups. However, the use of mixed focus groups resulted in rich discussion between service users and carers and students and staff. On reflection, the participation of service users and carers may be improved in future studies by paying them for their involvement (in addition to their travel expenses).

5.8.5 Student involvement in data collection events

Given the time of the year many students were unable to attend the data collection events due to clinical placements or the annual university break. Furthermore, findings from the project indicate that current students have little awareness of the SETs and their role in shaping student education. Instead they appear to have a greater knowledge of the HCPC's SoPs. This meant that they struggled to engage with questions focussed directly on SETs. Despite this we did capture the views of students, asking them about their experiences of being a student and the key things that impact on their preparedness to practise.

5.8.6 Naming data quotations

The project was multi-professional and also involved students, service users and carers. This approach makes it difficult to capture the individual voices within the qualitative data (focus groups and world cafés). A limitation is that when collecting and reporting these data it proved impossible to attribute quotes to any specific profession or individual. However, we were able to achieve this within the open-ended question results of the online survey and the individual interviews.

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Appendix 1: *Example of literature review matrix table*

Research	Country	Professions involved	Area considered	Methods	Positive factors	Negative factors	Strengths/ Limitations
ASSIA_03 Pal, L. et al., 2014	United Kingdom	Palliative and support care.	Practice placements	Questionnaire given to patients and then results discussed with students. Interviews and focus groups (12 students).	User feedback as a learning strategy – method of reflection and self-evaluation. User involvement – gain insight into the lived experience of illness. Over time, seeking feedback enhanced general confidence in communicating with patients. Receiving feedback from tutors, and positive patient feedback, overwhelmingly positive. Reassurance, increase in confidence. Negative feedback spurred changes in behaviour. Integration of theory into daily work.	Little evidence of education development – largely reliant on instinct. Barriers to giving feedback forms – embarrassment, brevity of relationships with patients, language barriers, and not wanting to burden families. Usually only receive feedback in negative situations. Patients fear that negative feedback may impact future care. – Unequal power balance.	Strength: few other studies in the literature utilise user feedback being cared for by students. Limitations: validity of responses – selection bias.
ASSIA_04 Bourke, L, Wright, C.	Australia	Health professionals	Practice placements	Review of 39 mentoring papers	Mentoring should be engaged in willingly. 'Good mentor':	Cross-gender and cross-ethnicity mentorship occurs	Strength: a recommended model for

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| & Wright, J., 2014 | | | The role of mentoring in the rural setting | | empathetic, good role model, available, interested, and non-judgemental. 'Good mentee': willing to accept criticism, ability to set own agenda, reassess their performance and follow through on suggestions. Most studies focus on benefits to mentee but there are equal benefits to the mentor – rekindle excitement. 'Nurturing model' – safe and open environment. Technology mediated interactions (emails texts) provide an honest form of feedback. Rural practice is more interprofessional. Allows people to reach career goals. | less often. The 'cloning model' does not allow for individual growth. High workload of professionals restricts time for mentoring. Less choice of potential mentors. Mentoring time is unpaid- needs genuine commitment. Needs to be careful conflict resolution so as not to permanently damage the professional relationship. | mentorship based on a review of the literature.

Limitation: the proposed model has not been tested. |

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Appendix 2: *Literature review data collection matrix table*

Profession		Author	Method used	Number of participants	Country
HCPC registered	Social Work	Bellinger (2010)	Literature review		United Kingdom
		Currer (2009)	Report	24 documents	United Kingdom
		Green et al. (2007)	Questionnaire	947	United States
		Hingley-Jones & Mandin (2007)	Evaluation form	80	United Kingdom
		Holmström (2014)	Literature review		United Kingdom
		Kropf (2003)	Literature review		United States
		Mathias-Williams & Thomas (2002)	Questionnaire	35	United Kingdom
		McCafferty (2005)	Report		United Kingdom
		Rees & Raithby (2012)	Questionnaire and focus groups	40	United Kingdom
		Tam, Coleman & Kam-Wing (2012)	Questionnaire	341	Canada
	Physiotherapy	Bientzle, Cress & Kimmerle (2013)	Observational	76	Germany
		Gunn, Hunter & Haas (2012)	Interview	10	United Kingdom
		Maloney et al. (2013)	Survey	34	Australia
		Thomson & Hilton (2011)	Focus groups and interviews	37	United Kingdom
	Occupational Health Therapy	Hartmann, Nadeau & Tufano (2013)	Survey	190	United States
	Psychology	Raque-Bogdan et al. (2012)	Survey	22 programmes	United States
		Woods et al. (2006)	Observational	50	Canada
		Young, Brooks & Norman (2007)	Observational	24	Canada
	Dietetics	Paterson, Green & Maunder (2007)	Focus group and questionnaires	13	South Africa
	Paramedics	Michau et al. (2009)	Questionnaire	84	Australia
	Speech and Language Therapy	Brumfit et al. (2001)	Literature review		United Kingdom
		Sheepway, Lincoln & McAllister (2014)	Data analysis of assessment tool	73	Australia
Not	Nursing	Andrews & Roberts (2003)	Literature review		United Kingdom

HCPC registered		Barratt (2010)	Focus groups	16	United Kingdom
		Beccaria et al. (2013)	Online survey and focus groups	85	Australia
		Billington (2011)	Questionnaire	Does not say	United Kingdom
		Boyd & Spatz (2013)	Online questionnaire	36 institutions	United States
		Christiansen & Bell (2010)	Focus groups	54	United Kingdom
		Derbyshire & Machin (2011)	Interviews	8	United Kingdom
		Girot (2000)	Literature review		United Kingdom
		Hartigan et al. (2010)	Focus groups	28	Ireland
		Nelson, Sadler & Surtees (2005)	Report	1 university	United Kingdom
		Orr, McGrouther & McCaig (2014)	Literature review		United Kingdom
		Tee & Cowen (2012)	Report	1 university	United Kingdom
		Unsworth (2011)	Report	56 HEIs	United Kingdom
		Webster et al. (2010)	Questionnaire	8	Australia
		Wilson & Carryer (2008)	Focus groups	15	New Zealand
	Medicine	Howe et al. (2010)	Report of exam board data	118	United Kingdom
		Madjar, Bachner & Kushnir (2012)	Questionnaire	143	Israel
		Morrison (2008)	Literature review		United Kingdom
		Parker (2006)	Literature review		Australia
		Steven et al. (2014)	Audio diary entries, focus groups and interviews	22	United Kingdom
		Whiting (2006)	Personal commentary/Literature review		United Kingdom
	Midwifery	Avis, Malik & Fraser (2013)	Diary entries, interviews and questionnaires	35	United Kingdom
		Brintworth (2014)	Online survey	263	United Kingdom
		Cook & Payne (2012)	Literature review		United Kingdom
		Darra (2006)	Literature review		United Kingdom
		Dow (2008)	Literature review		United Kingdom
		Fraser (2000a)	Observational, interviews and documentary analysis	330 7 institutions	United Kingdom
		Fraser (2000b)	Observational, interviews and	1 institution	United Kingdom

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				documentary analysis		
		Hunter et al. (2004)	Literature review		United Kingdom
		Young (2012)	Observational, focus groups and interviews	53	United Kingdom
	Pharmacy	Gallagher (2010)	Literature review		Ireland
	Physical Therapy	Black et al. (2010)	Reflective journals and interviews	11	United States
		Gibbs & Furney (2013)	Interviews	15	United States
		Ross & Haidet (2011)	PPOS??	49	United States
	Dentistry	Bullock et al. (2013)	Questionnaire and telephone interviews	21	United Kingdom
	Mental Health	Conlon (2014)	Workshops and evaluation forms	150	United Kingdom
	General Practitioning	Findlay (2012)	Interviews	5	United Kingdom
	Support Care	Pal, Dixon & Faull (2013)	Interviews and focus groups	12	United Kingdom
Mixture	Medicine and respiratory therapy	Bandali, Craig & Ziv (2012)	Likert scale, interviews and focus groups	195	Canada and Israel
	Allied health	Bandali et al. (2008)	Literature review		Canada
	Nursing (n=19), social work (n=26), occupational therapy (n=29), physiotherapy (n=10)	Caldwell et al. (2006)	Questionnaire	85	United Kingdom
	Nursing (n=19), social work (n=26), occupational therapy (n=29), physiotherapy (n=10)	Caldwell et al. (2007)	Questionnaire	85	United Kingdom
	Midwifery (n=2), social work (n=6),	Callaghan et al. (2008)	Focus groups	14	United Kingdom

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	post-registration health (n=6)				
	Medicine (=89), nursing (n=102), physiotherapy (n=43)	Ericson, Masiello & Bolinder (2012)	Questionnaire	234	Sweden
	Medicine (n=113), nursing (n=234), physiotherapy (n=65), occupational therapy (n=42)	Falk et al. (2013)	Questionnaire	454	Sweden
	Medicine (n=33), social work (n=38)	Fineberg, Wenger & Forrow (2004)	Survey	177	United States
	Medicine (n=42), nursing (n=53), physiotherapy (n=54)	Goelen et al. (2006)	Observational	149	Belgium
	Nursing and midwifery	Grundy (2001)	Literature review		United Kingdom
	Nursing and midwifery	Hilton & Pollard (2004)	Literature review		United Kingdom
	Medicine, nursing, social work	Ho et al. (2008)	Literature review		Canada
	Nursing and midwifery	Holland & Lauder (2012)	Literature review		United Kingdom
	Nursing and midwifery	Holland et al. (2010)	Questionnaire, interviews, focus groups, curriculum evaluation	311	United Kingdom
	Nursing and midwifery	Hughes (2004)	Literature review		United Kingdom
	Nursing (n=148),	Hylin et al. (2007)	Questionnaire	348	Sweden

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medicine (n=100), physiotherapy (n=72), occupational therapy (n=28)				
Medicine, nursing, pharmacy, dentistry	Kiersma, Plake & Darbishire (2011)	Literature review		United States
Nursing (n=727) and midwifery (n=50)	Lauder et al. (2008)	Survey	777	United Kingdom
Nursing, pharmacy, medicine	Levett-Jones et al. (2012)	Literature review		Australia
Nursing, dietetics, public health, occupational therapy, paramedics	McAllister et al. (2013)	Observational, focus groups, interviews	25	Australia
Social Work, nursing, teaching	Moriarty et al. (2011)	Literature review		United Kingdom
Physiotherapy (n=10), occupational therapy (n=10)	O'Connor, Cahill & McKay (2012)	Interview	20	Ireland
Medicine (n=1154), social work (n=638)	Preston-Shott & McKimm (2013)	Questionnaire	1792	United Kingdom
Nursing, medicine, occupational therapy, physiotherapy	Reeves & Freeth (2002)	Observational, focus groups, interviews, questionnaires	104	United Kingdom
Physiotherapy, nursing, medicine,	Rowe, Frantz & Bozalek (2012)	Literature review		United Kingdom, United States,

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	social work, occupational therapy, pharmacy, paramedics				Canada, Australia and South Korea
	Nursing (n=21), social work (n=20), teaching (n=19)	Stanley et al. (2011)	Interviews	60	
	Nursing and midwifery	Tee & Jowett (2009)	Report	1 university	United Kingdom
	Audiology, medicine, nursing, nutrition, occupational therapy, pharmacy, physiotherapy, psychology, social work, speech therapy	Vanier et al. (2013)	Literature review		Canada
	Nursing and midwifery	Wells & McLoughlin (2014)	Literature review		United Kingdom
	Dentistry, medicine, nursing, occupational therapy, pharmacy, physical therapy, physician assistant, psychology, public health, social work	Zorek & Raehl (2012)	Report	21 documents	United States

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Appendix 3: *The SETs*

Programme Admissions	2.1	The admissions procedures must give both the applicant and the education provider the information they require to make an informed choice about whether to take up or make an offer of a place on a programme.
	2.2	The admissions procedures must apply selection and entry criteria, including evidence of a good command of reading, writing and spoken English.
	2.3	The admissions procedures must apply selection and entry criteria, including criminal convictions checks.
	2.4	The admissions procedures must apply selection and entry criteria, including compliance with any health requirements.
	2.5	The admissions procedures must apply selection and entry criteria, including appropriate academic and/or professional entry standards.
	2.6	The admissions procedures must apply selection and entry criteria, including accreditation of prior (experiential) learning and other inclusion mechanisms.
	2.7	The admissions procedures must ensure that the education provider has equality and diversity policies in relation to applicants and students, together with an indication of how these will be implemented and monitored.
Programme management and resources	3.1	The programme must have a secure place in the education provider's business plan.
	3.2	The programme must be effectively managed.
	3.3	The programme must have regular monitoring and evaluation systems in place.
	3.4	There must be a named person who has overall professional responsibility for the programme who must be appropriately qualified and experienced and, unless other arrangements are agreed, be on the relevant part of the Register.
	3.5	There must be an adequate number of appropriately qualified and experienced staff in place to deliver an effective programme.
	3.6	Subject areas must be taught by staff with relevant specialist expertise and knowledge.
	3.7	A programme for staff development must be in place to ensure continuing professional and research development.
	3.8	The resources to support student learning in all settings must be effectively used.
	3.9	The resources to support student learning in all settings must effectively support the required learning and teaching activities of the programme.
	3.10	The learning resources, including IT facilities, must be appropriate to the curriculum and must be readily available to students and staff.
	3.11	There must be adequate and accessible facilities to support the welfare and wellbeing of students in all settings.
	3.12	There must be a system of academic and pastoral student support in place.

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	3.13	There must be a student complaints process in place.
	3.14	Where students participate as service users in practical and clinical teaching, appropriate protocols must be used to obtain their consent.
	3.15	Throughout the course of the programme, the education provider must have identified where attendance is mandatory and must have associated monitoring mechanisms in place.
	3.16	There must be a process in place throughout the programme for dealing with concerns about students' profession-related conduct.
	3.17	Service users and carers must be involved in the programme.
Curriculum	4.1	The learning outcomes must ensure that those who successfully complete the programme meet the standards of proficiency for their part of the Register.
	4.2	The programme must reflect the philosophy, core values, skills and knowledge base as articulated in any relevant curriculum guidance.
	4.3	Integration of theory and practice must be central to the curriculum.
	4.4	The curriculum must remain relevant to current practice.
	4.5	The curriculum must make sure that students understand the implications of the HCPC's standards of conduct, performance and ethics.
	4.6	The delivery of the programme must support and develop autonomous and reflective thinking.
	4.7	The delivery of the programme must encourage evidence-based practice.
	4.8	The range of learning and teaching approaches used must be appropriate to the effective delivery of the curriculum.
	4.9	When there is interprofessional learning the profession-specific skills and knowledge of each professional group must be adequately addressed.
Practice placements	5.1	Practice placements must be integral to the programme.
	5.2	The number, duration and range of practice placements must be appropriate to support the delivery of the programme and the achievement of the learning outcomes.
	5.3	The practice placement settings must provide a safe and supportive environment.
	5.4	The education provider must maintain a thorough and effective system for approving and monitoring all placements.
	5.5	The placement providers must have equality and diversity policies in relation to students, together with an indication of how these will be implemented and monitored.
	5.6	There must be an adequate number of appropriately qualified and experienced staff at the practice placement setting.
	5.7	Practice placement educators must have relevant knowledge, skills and experience.
	5.8	Practice placement educators must undertake appropriate practice placement educator training.
	5.9	Practice placement educators must be appropriately registered, unless other arrangements are agreed.

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	5.10	There must be regular and effective collaboration between the education provider and the practice placement provider.
	5.11	Students, practice placement providers and practice placement educators must be fully prepared for placement which will include information about an understanding of: - The learning outcomes to be achieved; - The timings and duration of any placement experience and associated records to be maintained; - Expectations of professional conduct; - The assessment procedures including the implications of, and any action to be taken in the case of, failure to progress; and - Communication and lines of responsibility.
	5.12	Learning, teaching and supervision must encourage safe and effective practice, independent learning and professional conduct.
	5.12	A range of learning and teaching methods that respect the rights and needs of service users and colleagues must be in place throughout practice placements.
Assessment	6.1	The assessment strategy and design must ensure that the student who successfully completed the programme has met the standards of proficiency for their part of the Register.
	6.2	All assessments must provide a rigorous and effective process by which compliance with external-reference frameworks can be measured.
	6.3	Professional aspects of practice must be integral to the assessment procedures in both the education setting and practice placement setting.
	6.4	Assessment methods must be employed that measure the learning outcomes.
	6.5	The measurement of student performance must be objective and ensure fitness to practise.
	6.6	There must be effective monitoring and evaluation mechanisms in place to ensure appropriate standards in the assessment.
	6.7	Assessment regulations must clearly specify requirements for student progression and achievement within the programme.
	6.8	Assessment regulations, or other relevant policies, must clearly specify requirements for approved programmes being the only programmes which contain any reference to an HCPC protected title of part of the Register in their named award.
	6.9	Assessment regulations must clearly specify requirements for an aegrotat award not to provide eligibility for admission to the Register.
	6.10	Assessment regulations must clearly specify requirements for a procedure for the right of appeal for students.
	6.11	Assessment regulations must clearly specify requirements for the appointment of at least one external examiner who must be appropriately experienced and qualified and, unless other arrangements are agreed, be from the relevant part of the Register.

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Appendix 4: *Definitions of fitness to practise*

Regulatory body	Definition of fitness to practise	Professions represented
General Medical Council (GMC)	1. To practise safely, doctors must be competent in what they do. They must establish and maintain effective relationships with patients, respect patients' autonomy and act responsibly and appropriately if they or a colleague fall ill and their performance suffers. 2. But these attributes, while essential, are not enough. Doctors have a respected position in society and their work give them privileged access to patients, some of whom may be vulnerable. A doctor whose conduct has shown that he cannot justify the trust placed in him should not continue in unrestricted practice while that remains the case. 3. In short, the public is entitled to expect that their doctor is fit to practise, and follows our principles of good practice described in *Good Medical Practice*.	Doctors
Nursing and Midwifery Council (NMC)	Being fit to practise requires a nurse or midwife to have the skills, knowledge, good health and good character to do their job safely and effectively. All qualified nurses and midwives must follow The Code: Professional standards of practice and behaviour for nurses and midwives. Every nurse and midwife will be required to apply for revalidation every three years, demonstrating to us that they are fit to practise safely and effectively. We will investigate if an allegation is made that a nurse or midwife does not meet our standards for skills, education and behaviour. If necessary, we will act by removing them from the register permanently or for a set period of time.	Nurses and midwives
General Dental Council (GDC)	There may be doubts about a dental professionals' fitness to practise due to: • health; • conduct, including convictions and cautions; or • performance.	Dentists, clinical dental technicians, dental hygienists, dental nurses, dental technicians, dental therapists, and orthodontic therapists
Care Council for Wales	The main purpose of the Care Council's fitness to practise process is to make sure those on the Register (registrants) have the skills, knowledge and character to practise their profession safely and effectively.	Social workers (in Wales)

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(CCW)	Taking action when a registered worker (registrant) does not meet the standards set in the Code of Practice for Social Care Workers will mean better services for those using social care and improve the general public's confidence in social care services. - See more at: http://www.ccwales.org.uk/fitness-to-practise-2014/#sthash.CxzK0wco.dpuf	
General Optical Council (GOC)	They can investigate allegations about a registrant's fitness where there is evidence of: • poor professional performance, such as failure to notice signs of eye disease; • physical or mental health problems affecting their work; or • inappropriate behaviour, such as violence or sexual assault, being under the influence of alcohol or drugs at work, fraud or dishonesty, or a criminal conviction or caution.	Opticians (optometrists and dispensing opticians)
General Pharmaceutical Council (GPhC)	We consider a pharmacy professional fit to practise when they can demonstrate the skills, knowledge, character and health required to do their job safely and effectively. We describe fitness to practise as a person's suitability to be on the register without restrictions. In practical terms, this means: maintaining appropriate standards of proficiency ensuring you are of good health and good character, and you are adhering to principles of good practice set out in our various, standards, guidance and advice. All registrants must complete a fitness to practise declaration with their registration renewal which they complete once per year. This declaration requires registrants to inform us if there is any reason why their fitness to practise is impaired. A pharmacy professional's fitness to practise can be impaired for a number of reasons including misconduct, lack of competence, ill-health and through having been convicted of a criminal offence. In addition to this declaration registrants are required to let us know within 7 days if their status changes at any point during the year. Registrants are also required to complete continuing professional development, demonstrating their commitment to keeping up to date with developments in pharmacy practise.	Pharmacists and pharmacy technicians
Northern Ireland Social Care Council (NISCC)	Concerns about a social care worker's conduct or practice may be reported to NISCC by employers, members of the public or other professionals. Information is also referred to us by partner regulators, the Regulation & Quality Improvement Authority, the police and the court service. We will only take action in those cases where evidence of serious misconduct is identified such as: • Failure to provide proper care • Theft of money or property • Assault	Social workers (in Northern Ireland

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	• Physical or verbal abuse • Intimidation of a service user, carer or colleague • Engagement an inappropriate relationship or making sexual advances towards a service-user or carer	
Pharmaceutical Society of Northern Ireland (PSNI)	The Pharmaceutical Society NI (the organisation) describe fitness to practise as a pharmacist's suitability to be on the register without restrictions. This means: maintaining appropriate standards of proficiency ensuring they are of good health and good character, and are adhering to principles of good practice set out in the standards, guidance and advice issued by the Pharmaceutical Society NI. Reasons which may impair a pharmacist's fitness to practise include ill-health, lack of the ability to competently practise as a pharmacist or findings of misconduct including convictions of a criminal offence.	Pharmacists (in Northern Ireland)
Scottish Social Services Council (SSSC)	The Fitness to Practise team investigates concerns about the good character, conduct and competence of a person applying for registration or a person already registered and takes action where necessary.	Social workers (in Scotland)

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Appendix 5: *Questionnaire for Course Directors*

HCPC questionnaire survey for Course Directors and Professional Leads in Practice

Hello and thank you for taking part in our survey!

This research assesses the role and effectiveness of the Health and Care Professions Council's standards for pre-registration education and training (SET) and supporting guidance, in ensuring newly qualified professionals are fit to practise. The research has been commissioned by the Health and Care Professions Council (HCPC) and it is being undertaken by The Faculty of Health, Social Care and Education, run jointly by Kingston University and St George's, University of London.

As defined by the Health and Care Professions Council, we refer to "Fitness to practise" as having the skills, knowledge and character to practise the profession safely and effectively. However, "Fitness to practise" is not just about professional performance. It also includes acts by a registrant which may affect public protection or confidence in the profession. This survey should take approximately 15 minutes to complete. You can decide to save your responses and resume answering the survey at a later time.

By returning this questionnaire you are consenting to participate in this research. Be assured that your personal information will be treated confidentially.

1. Please indicate, by clicking on the appropriate box, which ONE of the following best describes your professional status. *

I am a course director in Higher Education	
I am a professional lead in practice	
I am a service director or manager	
I facilitate pre-registration student learning in practice	
I am a professional qualified for 2 years or more, but not a professional lead or someone who facilitates student learning in practice	
I am a newly qualified professional (2 years or less)	

2. Please indicate, by clicking on the appropriate box, which one of the following professions you are a course director or a professional lead in practice. *

Arts therapist (art/drama/music)	
Biomedical scientist	
Chiropodist/Podiatrist	
Clinical scientist	
Dietitian	
Hearing aid dispenser	

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Occupational therapist	
Operating department practitioner	
Orthoptist	
Paramedic	
Physiotherapist	
Practitioner psychologist	
Prosthetist/orthotist	
Radiographer	
Social worker	
Speech and language therapist	

3. Please indicate, by clicking on the appropriate box, in which one of the following geographical regions (as defined by HCPC) you are currently working. *

South West England	
North West England	
East Midlands England	
West Midlands England	
East of England	
North East England	
South East England	
Yorkshire and the Humber	
London	
Scotland	
Northern Ireland	
Wales	

PROGRAMME ADMISSIONS

4. Below are listed the SETs about programme admissions. Please indicate, by clicking on the appropriate box, how important you think each of them is in ensuring newly qualified professionals are fit to practise.

SETs	Very important	Important	Less important	Not important	Not sure
2.1 The admissions procedures must give both the applicant and the education provider the information they require to make an informed choice about whether to take up or make an offer of a place on a programme.					
2.2 The admissions procedures must apply selection and					

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entry criteria, including evidence of a good command of reading, writing and spoken English.				
2.3 The admissions procedures must apply selection and entry criteria, including criminal convictions checks.				
2.4 The admissions procedures must apply selection and entry criteria, including compliance with any health requirements.				
2.5 The admissions procedures must apply selection and entry criteria, including appropriate academic and / or professional entry standards.				
2.6 The admissions procedures must apply selection and entry criteria, including accreditation of prior (experiential) learning and other inclusion mechanisms.				
2.7 The admissions procedures must ensure that the education provider has equality and diversity policies in relation to applicants and students, together with an indication of how these will be implemented and monitored.				

5. If you have responded not important or less important to any of the standards above, please explain why you think they do not help ensure students are prepared for practice.

6. If you indicated you are 'not sure' about the importance of any of the standards above, please explain, for each standard, the reason why you are unsure.

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PROGRAMME MANAGEMENT AND RESOURCES

7. Below are listed the SETs about programme management and resources. Please indicate, by clicking on the appropriate box, how important you think each of them is in ensuring newly qualified professionals are fit to practise.

SETs	Very important	Important	Less important	Not important	Not sure
3.1 The programme must have a secure place in the education provider's business plan.					
3.2 The programme must be effectively managed.					
3.3 The programme must have regular monitoring and evaluation systems in place.					
3.4 There must be a named person who has overall professional responsibility for the programme who must be appropriately qualified and experienced and, unless other arrangements are agreed, be on the relevant part of the Register.					
3.5 There must be an adequate number of appropriately qualified and experienced staff in place to deliver an effective programme.					
3.6 Subject areas must be taught by staff with relevant specialist expertise and knowledge.					
3.7 A programme for staff development must be in place to ensure continuing professional and research					

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development.					
3.8 The resources to support student learning in all settings must be effectively used.					
3.9 The resources to support student learning in all settings must effectively support the required learning and teaching activities of the programme.					
3.10 The learning resources, including IT facilities, must be appropriate to the curriculum and must be readily available to students and staff.					
3.11 There must be adequate and accessible facilities to support the welfare and wellbeing of students in all settings.					
3.12 There must be a system of academic and pastoral student support in place.					
3.13 There must be a student complaints process in place.					
3.14 Where students participate as service users in practical and clinical teaching, appropriate protocols must be used to obtain their consent					
3.15 Throughout the course of the programme, the education provider must have identified where attendance is mandatory and must have associated monitoring mechanisms in place.					
3.16 There must be a process in place throughout the programme for dealing with concerns about students' profession-related conduct.					
3.17 Service users and carers must be involved in the programme.					

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8. If you have responded not important or less important to any of the standards above, please explain why you think they do not help ensure students are prepared for practice.

9. If you indicated you are 'not sure' about the importance of any of the standards above, please explain, for each standard, the reason why you are unsure.

CURRICULUM

10. Below are listed the SETs about curriculum.

Please indicate, by clicking on the appropriate box, how important you think each of them is in ensuring newly qualified professionals are fit to practise.

SETs	Very important	Important	Less important	Not important	Not sure
4.1 The learning outcomes must ensure that those who successfully complete the programme meet the standards of proficiency for their part of the Register.					
4.2 The programme must reflect the philosophy, core values, skills and knowledge base as articulated in any relevant curriculum guidance.					
4.3 Integration of theory and practice must be central to the curriculum.					
4.4 The curriculum must remain relevant to current practice.					
4.5 The curriculum must make sure that students understand the implications of the HCPC's standards of conduct, performance and ethics.					
4.6 The delivery of the programme must support					

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and develop autonomous and reflective thinking.					
4.7 The delivery of the programme must encourage evidence-based practice.					
4.8 The range of learning and teaching approaches used must be appropriate to the effective delivery of the curriculum.					
4.9 When there is interprofessional learning the profession-specific skills and knowledge of each professional group must be adequately addressed.					

11. If you have responded not important or less important to any of the standards above, please explain why you think they do not help ensure students are prepared for practice.

12. If you indicated you are 'not sure' about the importance of any of the standards above, please explain, for each standard, the reason why you are unsure.

PRACTICE PLACEMENTS

13. Below are listed the SETs about practice placements.

    Please indicate, by clicking on the appropriate box, how important you think each of them is in ensuring newly qualified professionals are fit to practise.

SETs	Very important	Important	Less important	Not important	Not sure
5.1 Practice placements must be integral to the programme.					
5.2 The number, duration and range of practice placements must be appropriate to support the delivery of the programme					

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and the achievement of the learning outcomes.					
5.3 The practice placement settings must provide a safe and supportive environment.					
5.4 The education provider must maintain a thorough and effective system for approving and monitoring all placements.					
5.5 The placement providers must have equality and diversity policies in relation to students, together with an indication of how these will be implemented and monitored.					
5.6 There must be an adequate number of appropriately qualified and experienced staff at the practice placement setting.					
5.7 Practice placement educators must have relevant knowledge, skills and experience.					
5.8 Practice placement educators must undertake appropriate practice placement educator training.					
5.9 Practice placement educators must be appropriately registered, unless other arrangements are agreed.					
5.10 There must be regular and effective collaboration					

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between the education provider and the practice placement provider.					
5.11 Students, practice placement providers and practice placement educators must be fully prepared for placement which will include information about an understanding of: – the learning outcomes to be achieved; – the timings and the duration of any placement experience and associated records to be maintained; – expectations of professional conduct; – the assessment procedures including the implications of, and any action to be taken in the case of, failure to progress; and – communication and lines of responsibility.					
5.12 Learning, teaching and supervision must encourage safe and effective practice, independent learning and professional conduct.					
5.13 A range of learning and teaching methods that respect the rights and needs of service users and colleagues must be in place throughout practice placements.					

14. If you have responded not important or less important to any of the standards above, please explain why you think they do not help ensure students are prepared for practice.

15. If you indicated you are 'not sure' about the importance of any of the standards above, please explain, for each standard, the reason why you are unsure.

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ASSESSMENT

16. Below are listed the SETs about assessment.

Please indicate, by clicking on the appropriate box, how important you think each of them is in ensuring newly qualified professionals are fit to practise.

SETs	Very important	Important	Less important	Not important	Not sure
6.1 The assessment strategy and design must ensure that the student who successfully completes the programme has met the standards of proficiency for their part of the Register.					
6.2 All assessments must provide a rigorous and effective process by which compliance with external-reference frameworks can be measured.					
6.3 Professional aspects of practice must be integral to the assessment procedures in both the education setting and practice placement setting.					
6.4 Assessment methods must be employed that measure the learning outcomes.					
6.5 The measurement of student performance must be objective and ensure fitness to practise.					
6.6 There must be effective monitoring and evaluation mechanisms in place to ensure appropriate standards in the assessment.					

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6.7 Assessment regulations must clearly specify requirements for student progression and achievement within the programme.					
6.8 Assessment regulations, or other relevant policies, must clearly specify requirements for approved programmes being the only programmes which contain any reference to an HCPC protected title or part of the Register in their named award.					
6.9 Assessment regulations must clearly specify requirements for an aegrotat award not to provide eligibility for admission to the Register.					
6.10 Assessment regulations must clearly specify requirements for a procedure for the right of appeal for students.					
6.11 Assessment regulations must clearly specify requirements for the appointment of at least one external examiner who must be appropriately experienced and qualified and, unless other arrangements are agreed, be from the relevant part of the Register.					

17. If you have responded not important or less important to any of the standards above, please explain why you think they do not help ensure students are prepared for practice.

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18. If you indicated you are 'not sure' about the importance of any of the standards above, please explain, for each standard, the reason why you are unsure.

19. Please indicate to what extent do you agree with the following statement:

The Standards of Education and Training ensure that newly qualified professionals are appropriately prepared for practice.

Strongly agree	
Agree	
Neither agree or disagree	
Disagree	
Strongly disagree	

20. Please indicate the extent to which guidance on standards of education and training is useful in providing clarity on the SETs

Very useful	
Fairly useful	
Undecided	
Not very useful	
Not at all useful	

21. In what way(s), if any, do you think the guidance could be improved?

Submit questionnaire

Thank you very much for completing this questionnaire.
If you have any comments or queries then please contact Gary Hickey, Co-Investigator working on this project.

Email: gary.hickey@sgul.kingston.ac.uk
Tel: 020 8725 2242

In addition to this questionnaire we will run data collection events across the UK and a workshop in London between June and August 2015.

These events will help us to learn more about your opinions and beliefs regarding the factors impacting on the preparation for practice of newly qualified professionals. If you want to express an interest in taking part please click on the following link. You will be then be asked few questions about your contact details – this should take just a couple of minutes. This will allow us to keep your contact details separated from the anonymous questionnaire you just submitted.

Link for the second questionnaire

Thank you again for your help with our research!

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Appendix 6: Questionnaire for newly qualified, experienced professionals, pre-registration student supervisors and service directors/managers

HCPC questionnaire survey for newly qualified, experienced professionals, pre-registration student supervisors and service directors/managers

Hello and thank you for taking part in our survey!

This research assesses the role and effectiveness of the Health and Care Professions Council's standards for pre-registration education and training (SET) and supporting guidance, in ensuring newly qualified professionals are fit to practise. The research has been commissioned by the Health and Care Professions Council (HCPC) and it is being undertaken by The Faculty of Health, Social Care and Education, run jointly by Kingston University and St George's, University of London.

As defined by the Health and Care Professions Council, we refer to "Fitness to practise" as having the skills, knowledge and character to practise the profession safely and effectively. However, "Fitness to practise" is not just about professional performance. It also includes acts by a registrant which may affect public protection or confidence in the profession. This survey should take approximately 15 minutes to complete. You can decide to save your responses and resume answering the survey at a later time.

By returning this questionnaire you are consenting to participate in this research. Be assured that your personal information will be treated confidentially.

1. Please indicate, by clicking on the appropriate box, which ONE of the following best describes your professional status. *

I am a course director in Higher Education	
I am a professional lead in practice	
I am a service director or manager	
I facilitate learning for pre-registration students in practice	
I am a professional qualified for 2 years or more, but not a professional lead or someone who facilitate student learning in practice	
I am a newly qualified professional (2 years or less)	

2. Please indicate, by clicking on the appropriate box, which one of the following best describes your profession. *

Arts therapist (art/drama/music)	
Biomedical scientist	
Chiropodist/Podiatrist	
Clinical scientist	
Dietitian	
Hearing aid dispenser	
Occupational therapist	

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Operating department practitioner	
Orthoptist	
Paramedic	
Physiotherapist	
Practitioner psychologist	
Prosthetist/orthotist	
Radiographer	
Social worker	
Speech and language therapist	

3. Please indicate, by clicking on the appropriate box, in which one of the following geographical regions (as defined by HCPC) you are currently working. *

South West England	
North West England	
East Midlands England	
West Midlands England	
East of England	
North East England	
South East England	
Yorkshire and the Humber	
London	
Scotland	
Northern Ireland	
Wales	

In questions 4 to 8 we are interested in understanding which factors about a programme, in your opinion, are important in the preparation to practise for newly qualified professionals. Please note we are not asking you to rate how well, or otherwise, these factors were managed by your university while you were studying.

PROGRAMME ADMISSIONS

4. Please indicate, by clicking on the appropriate box, how important you think each factor about programme admissions listed below is in ensuring newly qualified professionals are fit to practise.

	Very important	Important	Less important	Not important	Not sure
Making sure students prior to starting the course, have a good command of reading, writing and spoken English-language.					

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Before starting the course adequate consideration is given to any health requirements (such as vaccinations and occupational health assessment).					
The programme has an academic and professional entry level, including those relating to literacy and numeracy, appropriate to the level and content of the programme.					

PROGRAMME MANAGEMENT AND RESOURCES

5. Please indicate, by clicking on the appropriate box, how important you think each factor listed below is in ensuring newly qualified professionals are fit to practise.

	Very important	Important	Less important	Not important	Not sure
The quality of the teaching provided.					
Lecturers have relevant and specialist knowledge.					
Accessibility of student resources such as handbooks and module guides, information technology, text and journals, equipment and materials, specialist and skills lab.					
Appropriate opening hours of student facilities such as counselling service and health service.					
Ease of gaining access to those student facilities.					
Opportunity to contact academic and pastoral support in the theoretical setting.					

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Opportunity to contact academic and pastoral support in the practice placement setting.					
Existence of a student complaint service.					
Existence of a monitoring mechanism for ensuring compulsory attendance of students.					
A process for dealing with concerns about students' profession-related conduct.					
Involvement of service users and carers in the programme development, including teaching, assessment and evaluation.					
Involvement of service users and carers in the admission process.					

CURRICULUM

6. Please indicate, by clicking on the appropriate box, how important you think each factor listed below is in ensuring newly qualified professionals are fit to practise.

	Very important	Important	Less important	Not important	Not sure
Integration of theory and practice within both the theoretical and practical parts of the programme.					
Relevance of the curriculum and of the teaching provided.					
Ensuring the programme reflects changes and developments in the profession.					
Appropriate teaching of the standards of conduct, performance and ethics throughout the programme.					

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	Very important	Important	Less important	Not important	Not sure
Supporting students' autonomous and reflective thinking (through discussion groups, practice simulation, personal development plans, practice placement reviews).					
Encouraging evidence based practice.					
Inclusion of interprofessional learning as part of the curriculum.					

PRACTICE PLACEMENTS

7. Please indicate, by clicking on the appropriate box, how important you think each factor listed below is in ensuring newly qualified professionals are fit to practise.

	Very important	Important	Less important	Not important	Not sure
Inclusion of an adequate number, duration and range of practice placements as part of the programme.					
A safe and supportive environment in the practice placement settings.					
Placement providers must have transparent equality and diversity policies in relation to students.					
Adequate number of qualified and experienced staff supporting students at the practice placement settings.					
Support of qualified and experienced practice placement educators.					

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Students, practice placement providers and educators are fully informed about all aspects of practice placements (including timings and durations, learning outcomes to be achieved, expectations of professional conduct, assessment procedures).					
Encouraging safe and effective practice, independent learning and professional conduct.					
Consideration of the rights and needs of service users and other professionals working in the practice placement settings.					

ASSESSMENT

8. Please indicate, by clicking on the appropriate box, how important you think each factor listed below is in ensuring newly qualified professionals are fit to practise.

	Very important	Important	Less important	Not important	Not sure
Rigorous and effective assessment process.					
Inclusion of professional aspects of practice as an integral part of the assessment procedures both in the education and practice placement settings.					
Assessment procedures able to effectively and objectively measure learning outcomes.					
Clarity about how students are assessed.					
Clarity about what is expected from students at each stage of the programme.					

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Clear understanding of who is eligible to apply for registration with the Health and Care Profession Council following programme completion.					
Clear procedure for the right of appeal for students.					
Appointment of at least one external examiner appropriately experienced and qualified.					

9. Please tell us about other factors and issues which in your opinion should be addressed in the SETs.

10. Aside from the SETs, please tell us about any other factors which in your opinion have a POSITIVE impact on newly qualified professionals' fitness to practise.

11. Aside from the SETs, please tell us about any other factors which in your opinion have a NEGATIVE impact on newly qualified professionals' fitness to practise.

Submit questionnaire

Thank you very much for completing this questionnaire!
If you have any comments or queries then please contact Gary Hickey, Co-Investigator working on this project.

Email: gary.hickey@sgul.kingston.ac.uk
Tel: 020 8725 2242

In addition to this questionnaire we will run data collection events across the UK and a workshop in London between June and August 2015.

These events will help us to learn more about your opinions and beliefs regarding the factors impacting on the preparation for practice of newly qualified professionals. If you want to express an interest in taking part please click on the following link. You will be then be asked few questions about your contact details – this should take just a couple of minutes. This will allow us to keep your contact details separated from the anonymous questionnaire you just submitted.

Please click here

Thank you again for your help with our research!

Appendix 7: *Topic guide for mixed focus group*

Focus groups – Course Directors, practice educators, experienced professionals, newly qualified professionals, service managers, students

Welcome and thank you coming along today.

We are researchers from the Faculty of Health, Social Care and Education at Kingston University and St George's, University of London. We are working on a project, funded by the Health Care Professions Council, to assess the role, and effectiveness, of the Health and Care Professions Council's (HCPC's) standards for pre-registration education and training (SET) and supporting guidance, in preparing newly qualified professionals for practice. So today we want to explore your views on the role of the Health and Care Professions Council's standards of education and training in ensuring that newly qualified professionals are fit to practise.

The purpose of today is not to come to a consensus so please feel free to disagree with each other and give alternative views. Though if you agree with each other then that is fine as well. The purpose is to explore your views and experiences. There are no right or wrong answers. I stress - it is your views and experiences we are after.

We have a mixture of people here today; Course directors, service managers, professional leads in practice, experienced professionals, newly qualified professionals and students. It's important that we hear from everyone who has something to say, so please do let people have their say.

We would like to record this meeting. This is so we can accurately capture your views and analyse the data. The recording will be transcribed but all of the participants here will be anonymised as will any mention you make of particular places or people. Is everyone OK with that? As this is being transcribed it is helpful if just one person speaks at a time.

1. Are there any SETs which you wish to share your views about – either positive or negative?
- How relevant do you think it is to ensuring that newly qualified staff are prepared for practice?

   Negative only
   - How clear do you think this SET is?
   - What, if any, changes, would you make to this SET?
   - Have you got any suggestions for rewording or replacing this SET?
   - NB Probe on SETs raised by the survey

   Positive only
   - What is it about this SET that you like?

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- *NB* Probe on SETs raised by the survey

2. Are there any areas which you think are not covered adequately by the SETs?
- *NB* Probe on any areas that emerge from the survey

3. Are there any aspects of the guidance which you wish to share your views about – either positive or negative?

   Negative only
   - What, if any, changes, would you make to this aspect of the guidance?
   - What are your views on the clarity of this aspect of the guidance?
   - Have you got any suggestions for rewording this?
   - *NB* Probe on issues raised in the survey

   Positive only
   - What is it about this aspect of the guidance that you like?
   - *NB* Probe on issues raised in the survey

4. How well prepared for practice do you think newly qualified staff are?
- What are your thoughts about the role of clinical/practice educators?
- Are there any ways in which you think students/newly qualified staff could be better supported?

5. How well prepared do you think newly qualified staff are for interprofessional working?
- What suggestions do you have for any improvements?

6. How well prepared do you think newly qualified staff are for service user and carer involvement?
   - What suggestions do you have for any improvements?

7. Can you think at any examples of good practice which cover one of the area addressed in the SETs (e.g. admission, curriculum, practice placement, assessment…)? You can think about something you personally did, or that has been done in your university and you think it is worth to be shared.

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Appendix 8: *Topic guide for service user focus group*

Focus groups – Members of the public

Welcome and thank you coming along today. My name is Gary Hickey and this is x.

We are researchers from the Faculty of Health, Social Care and Education at Kingston University and St George's, University of London. We are working on a project, funded by the Health Care Professions Council, to assess the role, and effectiveness, of the Health and Care Professions Council's (HCPC's) standards for pre-registration education and training (SET) and supporting guidance, in preparing newly qualified professionals for practice. So today we want to explore your views on the extent to which newly qualified professionals are fit to practise.

The purpose of today is not to come to a consensus so please feel free to disagree with each other and give alternative views. Though if you agree with each other then that is fine as well. The purpose is to explore your views and experiences of newly qualified staff and how prepared they are for practice. There are no right or wrong answers. I stress - it is your views and experiences we are after.

It's important that we hear from everyone who has something to say, so please do let people have their say.

We would like to record this meeting. This is so we can accurately capture your views and analyse the findings. The recording will be transcribed but all of the participants here will be anonymised as will any mention you make of particular places or people. Is everyone OK with that? As this is being transcribed it is helpful if just one person speaks at a time.

1. What is your opinion about the skills and competence of health/social care staff?
    - Are there any differences between newly qualified staff and more experienced staff? If so, what are these differences?
    - Are there any ways in which you think students/newly qualified staff could be better supported?

2. Much care provision involves a range of professions. How well do you think these professions work together?
    - What suggestions do you have for any improvements?
    - Are there any differences between newly qualified staff and more experienced staff? If so, what are these differences?

3. What do you appreciate the most when dealing with health and care professionals? Can you think at any examples of good practice form newly qualified staff that you would like to share? Why do you think this was an example of good practice, what made it particularly valuable?

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Appendix 9: *Topic guide for world café events*

World Café

Welcome and thank you coming along today.

We are researchers from the Faculty of Health, Social Care and Education at Kingston University and St George's, University of London. We are working on a project, funded by the Health Care Professions Council, to assess the role, and effectiveness, of the Health and Care Professions Council's (HCPC's) standards for pre-registration education and training (SET) and supporting guidance, in preparing newly qualified professionals for practice. So today we want to explore your views on the role of the Health and Care Professions Council's standards of education and training in ensuring that newly qualified professionals are fit to practise.

The purpose of today is not to come to a consensus so please feel free to disagree with each other and give alternative views. Though if you agree with each other then that is fine as well. The purpose is to explore your views and experiences. There are no right or wrong answers. I stress - it is your views and experiences we are after.

We have a mixture of people here today; Course directors, service managers, members of the public, experienced professionals and students. It's important that we hear from everyone who has something to say, so please do let people have their say.

We have four tables. On each table there will be a question for you to discuss. We will split you into x groups and ask you to spend 10 minutes at each table discussing the question before moving on – we will let you know when your 10 minutes is up. At each table there will be someone taking notes and a facilitator who will help keep the conversation on track. At the end we will spend 10 minutes feeding back key points raised at the various tables.

1. From the responses collected through the survey it was suggested that the following SETS were problematic/particularly useful (list). What are your thoughts?
   - *NB* Probe on any areas that emerge from the survey

2. From the responses collected through the survey it was suggested that the following aspects of guidance were problematic (list). What are your thoughts?

Points 1. and 2. are quite well investigated already. I suggest to keep asking the question and record what emerge, but without probing areas emerged from the survey.

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3. Can you think at any examples of good practice which cover one of the area addressed in the SETs (e.g. admission, curriculum, practice placement, assessment…)? You can think about something you personally did, or that has been done in your university and you think it is worth to be shared

4. How well prepared do you think newly qualified staff are for interprofessional working?

5. How well prepared do you think newly qualified staff are for service user and involvement?

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Appendix 10: *Topic guide for individual interviews*

Interviews – professional leads in practice of social work and physiotherapy

Welcome and thank you coming along today.

We are researchers from the Faculty of Health, Social Care and Education at Kingston University and St George's, University of London. We are working on a project, funded by the Health Care Professions Council, to assess the role, and effectiveness, of the Health and Care Professions Council's (HCPC's) standards for pre-registration education and training (SET) and supporting guidance, in preparing newly qualified professionals for practice. So today we want to explore your views on the role of the Health and Care Professions Council's standards of education and training in ensuring that newly qualified professionals are fit to practise.

The purpose is to explore your views and experiences. There are no right or wrong answers. I stress - it is your views and experiences we are after.

We would like to record this meeting. This is so we can accurately capture your views and analyse the findings. The recording will be transcribed you will be anonymised as will any mention you make of particular places or people. Are you OK with that?

1. Are there any SETs which you wish to share your views about – either positive or negative?
- How relevant do you think it is to ensuring that newly qualified staff are prepared for practice?

   Negative only
   - How clear do you think this SET is?
   - What, if any, changes, would you make to this SET?
   - Have you got any suggestions for rewording or replacing this SET?
   - *NB* Probe on SETs raised by the survey

   Positive only
   - What is it about this SET that you like?
   - *NB* Probe on SETs raised by the survey

2. Are there any areas which you think are not covered adequately by the SETs?
- *NB* Probe on any areas that emerge from the survey

3. Are there any aspects of the guidance which you wish to share your views about – either positive or negative?

Negative only
- What, if any, changes, would you make to this aspect of the guidance?
- What are your views on the clarity of this aspect of the guidance?
- Have you got any suggestions for rewording this?
- *NB* Probe on issues raised in the survey

Positive only
- What is it about this aspect of the guidance that you like?
- *NB* Probe on issues raised in the survey

4. How well prepared for practice do you think newly qualified staff are?
   - What are your thoughts about the role of clinical/practice educators?
   - Are there any ways in which you think students/newly qualified staff could be better supported?

5. How well prepared do you think newly qualified staff are for interprofessional working?
   - What suggestions do you have for any improvements?

6. How well prepared do you think newly qualified staff are for service user and carer involvement?
   - What suggestions do you have for any improvements?

7. Can you think at any examples of good practice which cover one of the area addressed in the SETs (eg admission, curriculum, practice placement, assessment…)? You can think about something you personally did, or that has been done in your university and you think it is worth to be shared.

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Appendix 11: *Consensus workshop results*

Discussion topic	Key points

1. The variety and quality of practice placements has been shown to be crucial for the fitness to practise of newly qualified professionals. At the moment, there seems to be an issue about the effective control that an education provider is able to have on the quality standards of its practice placement providers. Therefore newly qualified professionals could be more or less prepared depending on the practice placement provider they were assigned to as students.
- Standard 5.2 already exists.
- It has been suggested that the HCPC should add a standard focused on this issue.
- How would you word this standard?
	• The standard 5.2 is appropriate and does not need changing.
	  - Could be better linked to the standards 4.1, 4.2 and 4.3.
	  - We can't look at SETs in isolation; the guidance should suggest that they should all be considered together.
	• Placements should link theory and practice.
	• Social work students need to have a statutory placement in order to gain employment.
	• Difficulties associated with guaranteeing practice placements – could teaching partnerships offer a solution?
	  - Need to look at service provision and the provision of jobs after students graduate.
	• The HCPC should give specific regulation on the 'number, duration and range' for each profession.
	• Placements should meet national curriculum requirements – in line with professional bodies.
	• Regional variations between placements exist.

2. On the practice placement another key aspect of the student successfulness seemed to be the role of the practice educator. It is considered particularly important that the practice educator is in the position to dedicate a good quality time to the student, for giving them feedback and for discussing problematic areas and strengths. In order to be able to do this, the practice educator must have sufficient time outside the day to do work. This is not always feasible due to heavy workloads and work place organisation. It has been suggested that the SET should regulate this aspect, in order to facilitate the practice educator in his relation with the employer.
  - How would you formulate a new
	• This is addressed in the standards of proficiency across all professions.
	• Should be addressed within the programme management section.
	• Need more resources available to achieve this.
	  - Currently not logistically possible to provide dedicated time for mentoring students. How could you then measure and enforce it?
	• Need to look at other models and good practice examples.
	• Needs to be a better definition of 'practice educator'
	  - There is a definition in the glossary of the guidance but it is still not clearly defined.
	• Some students do not get supervision from someone in their profession.

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SET addressing this issue?	• Boundaries are now so blurred that supervision comes in all different forms.
	• Training from the HCPC on how to be a good mentor. There needs to be similar documentation across professions.
3. The SET 6.5 states that 'The measurement of student performance must be objective and ensure fitness to practise'. Concerns have been raised about the word 'objective'. Specifically, it has been suggested that since 'objectivity' is not reachable, a more suitable word should be used. - How could an alternative wording be in your opinion?	• There is a triangulation of evidence that occurs to produce 'objectivity'.
	• Should the word 'objective' by changed to 'holistic'? Need to look at the whole of the student rather than a break-down of things to be assessed.
	• Progressive assessment = to be objective we need to look at the quality of evidence.
	• Capability and competence mean different things.
	• Could replace the word 'must' with 'aim to be'.
	• It is possible to be objective when you assess student outcomes – there are very clear guidelines.
	• Training assessors will help them to be objective.
	• Having a number of assessors reduces subjectivity.
	• It is not a single 'measurement', students are constantly being observed and measured to achieve objectivity.
4. From the literature review and from our data collection events, it has strongly emerged that a health and social care professional should have certain personal and professional characteristics and exhibit certain behaviours. These characteristics are often expressed in terms of how someone cares, interacts and empathises with the individual, and are described under the umbrella of 'soft skills'. This was particularly evident from the opinions expressed by service users. - In which section do you think this should be included? (Admission, curriculum, assessment) - What might this SET look like?	• It is hard to quantify 'soft skills'.
	• The term 'emotional intelligence' could be included in a current standard or within the guidance.
	• SET 6.3 'professional aspects' needs to include interpersonal skills.
	• Necessary professional attributes are different for each profession, couldn't produce a new SET appropriate for all professions.
	- Communication is highly important for all.
	- Biomedics and clinical scientists aren't interacting with service users in the same way.
	• Could link to SET 4.2 'values and ethics'.
	• These attributes are looked at more closely in the standards of proficiency.
	- These standards need to be better linked

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	to the SOPs generally. Within the introduction section?
	• Can you teach these elements of personality or is it inherent within a person?
	- Need to have a basic sense of wanting to be in the profession – "a seed that can grow and needs to be nurtured".
	- Interactive teaching and training can definitely help.
	• Would be useful to provide good practice examples.

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Appendix 12: *Compendium of practice examples*

	Practice example
Admissions	Workforce planning and working alongside the Welsh government; the amount of places on the course matches the projected number of biomedical scientists required. Designed to keep the workforce buoyant. Removes placement and employment competition.
Admission interviews	Values-based recruitment with different tasks throughout the day. That alleviates some of the anxiety because if applicants are not confident with one aspect they can excel in another. They do a written task on NHS values, which is very reflective. Then they watch a video to see how they react to that. Then there's a group interview and then an individual interview.
	Multiple mini interviews. There are 7 stations and the applicant comes in and they are asked a question and sit in the station for 5 minutes. Interviewers don't talk they just sit and listen, applicants do that 7 times and then leave. Interviewers ask them a variety of questions. Interviewers don't come together to talk about their decisions, scores are added up. So there are 7 individual opinions of a person. There are red flags, so if someone says something that is unacceptable then it gets red flagged. There is an actress as well, so the actress comes in and sits down and does a demonstration and the applicant has to respond to it. It really puts them on the spot. It's purely about testing their values and what would they do in a situation when they are presented with someone who has done something wrong? Would they be honest about it?
	Involve NHS partners in interviews. Also, get current students to 'interview' prospective students.
	Students watch a video and are then put into groups for discussion. Service users are involved and invited to make comments. They very quickly forget that they are being observed and true traits come through (looking for care and compassion).
	Service users design a reflective written piece that asks students to think about a time they needed help or a time that they were most vulnerable. This is marked by criteria designed by the service users.

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	Practice example
Health requirements	All students undertake an occupational health assessment in the induction week. Develop a full picture of the student's health and if they require any vaccinations. If anything arises then the course leader works with the student and student support to put measures in place.
Service user involvement	Database of patients, all given training on how to be an educator.
	'Ryan Harper Experience' – students placed with a family for 24 hours to experience a day in the life of coping with that illness
	Each unique patient encountered the educator visits their home environment and films them to gain a sense of their experience. These videos are kept in an archive for whenever students may need to draw on examples. Have videos dating back 20-30 years.
	Service user and carer consultative group who are involved at every stage: admissions, curriculum, teaching, assessment and reviewing and monitoring.
	'Lived Experience Group' – they coordinate themselves but attend meetings and respond to requests from the university and students.
	Comensus – money is allocated for service user involvement and it is done on a large scale. Service users design and teach a module for 80 to 100 students. There's been a book published with the help of service users.
	Professional patient interactions – two days a week of practising on a patient in the education setting. Followed by focus groups and discussions of the lived experience. Students see the same patients over a period of 4 weeks, they get to know each other and the sessions are relaxed.
	Worked with a hospital administrator to recruit service users. Her role was to look after patient satisfaction, so she was good at getting people involved.
	The same service users are involved at admissions, lectures and assessment. Able to see the student's progression.

	Practice example
Service user involvement	Advocacy in Action – involves a range of stakeholders and service users. They help to design the module and arrange and organise the class activities. Training is given before teaching and there is a de-briefing afterwards. Service users are treated as experts and are offered feedback on their performance. Students are able to interview service users one on one.
Carer involvement	Mother and son came in for the same teaching module; the son was the patient and the mother was the carer. The son was positive about his experience but the mother was emotionally damaged. After the workshop students' write a post-it-note of what they felt most important from the session.
Curriculum	One workshop session within the final year surrounding the idea of reality in practice. Students work in teams and simulate managing a clinic. Students learn that they cannot spend an infinite amount of time with one patient.
	One module the lecturer pre-recorded the lectures so students listened to them beforehand – PowerPoint and recorded voice sent by email. When students got to the lecture they were split into small discussion groups. Students had twice the amount of learning; it was all very interactive and clever.
	Reflective practice. 1st year portfolio combined with a 500/600 word reflective piece. 2nd year written piece of work at the end of a 15 week placement.
Theory and practice	Developed a manual called 'Independent Learning Activities' for scenarios that students may not be able to experience on placement, so students still had the resource.
Inter-professional education	Interprofessional is built up throughout the course. 1st year module with over 800 students and the tutorial groups are mixed so that they mix with other professions – the tutor may not be from the student's profession either. 2nd year module 'working in teams' explores the impact of collaboration on patient-centred care. 3rd year module 'teams in practice', staff create scenarios and students work together in simulation exercises. 4th year module around organisations, policy, practice and how the governance of organisations impact professions.
	Assignment to present with a group of 4 or 5 different professionals reflecting on the journey of an individual patient.

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	Practice example
Inter-professional education	Simulation exercises with service users.
	Students split into multi-professional groups and a service user explains their individual story. The students discuss and ask the service user questions, they realise they often have different questions to ask.
Placements	'Transition placement' – for 2 weeks the placement educators are asked to pretend the students are newly qualified staff but then to provide extra support and feedback.
Practice educators	Students involved in the training of practice educators. Students gave a presentation on their experience of placements, things that had been helpful and things that had not been helpful.
	Practice educator assessed student's skills right from the start and then regularly, to allow the student more and more independence. Rather than just assessing at the end.
Practice educator training	Trainers' forum held 4 times a year. All trainers and academic staff involved. Meet to discuss problems, things that have gone well.
Practice placement coordinators	Ensure students are not going through the programme and only having one type of placement opportunity.
	Coordinators attend periodic staff meetings, update the placement staff about the curriculum, involved in assessment, offer support for learning outcomes, and generate discussions about equity in assessment. If there are any issues then the lecturer will go out to visit the placement. The coordinator is usually a lecturer so they know the curriculum and know what will be expected of the student in practice. Regular discussions to see what is working and what is not. They have a real understanding of both sides.
	The placement coordinator is a link between the university and the hospital. He is employed by the hospital but he also lectures for the university and coordinates the students into the right placements. Once the student qualifies he then coordinates the preceptorship and advancements and further training. There is a cohesion as it's all done through the same person.

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	Practice example
Assessment	Case studies used in biomedical science. Allows the student to think of it as a patient rather than a sample.
Peer support	Peer teaching – the 3rd year students will teach the 1st year students. The 1st years can ask for advice and the 3rd years can get feedback on their communication skills.
	Newly qualified professionals come in to talk to students about what is expected of them.
	Buddy system – older years act as mentors to 1st years throughout their degree and then continued into 1st year as a newly qualified. The student is reviewed by the buddy and they are a means of getting advice.
Continued professional development	Newly qualified social workers go through an Assessed and Supported Year in Employment, formal preceptorship before they become a 'social worker'.
	Service users go out on visits to give CPD talks.

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