EVALUATION of FLYING START NHS

FINAL REPORT

February 2010

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Flying Start NHS

Developing confident, capable health practitioners

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EXECUTIVE SUMMARY

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Flying Start NHS

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Introduction

In January 2006 "Flying Start NHS", a national web-based educational resource to support the transition from student to qualified practitioner for all newly qualified nurses, midwives and allied health professionals (NMAHP) joining NHS Scotland was launched. This summary brings together the findings from a two-year evaluation which focussed on the impact and effectiveness of Flying Start NHS in supporting the recruitment, confidence and skills development of newly qualified nurses, midwives and allied health professionals within NHS Scotland. The evaluation was carried out be a research team from the University of the West of Scotland, the University of Stirling, and the University of Dundee.

Design and Methods

The evaluation employed a multi-method approach using a range of methods to gather relevant data from a variety of individuals and sources.

Data collection

- Literature review
- One to one face to face or telephone interviews
- Nominal Group Technique event
- Focus group interviews

- Critical Incident Technique
- Identification and collection of secondary data
- Gricean analysis of on-line communication
- On-line survey

Participants

- Flying Start NHS Lead Contacts
- Flying Start NHS Coordinators
- Newly Qualified Practitioners
- Managers

- Practice Education Facilitators
- Mentors
- Final semester nursing, midwifery, and AHP students

Ethics

Ethical approval was granted by the University of the West of Scotland Research Ethics Committee and HEIs providing NMAHP education.

Procedure

The evaluation began with a scoping element using telephone interviews to elicit information from Flying Start NHS Leads contacts and Coordinators in each NHS Board. The findings from these interviews were used to develop a Nominal Technique Event. This phase was following by further data collection using focus group interviews with final year students in all institutions providing NMAHP education in Scotland, as well as newly qualified practitioners (NQPs) in each NHS Board. Telephone interviews were also carried out with mentors, PEFs, and mangers in each NHS Board. Finally an on-line survey was carried out in order to involve a larger number of newly qualified practitioners. Secondary data analysis involved a Gricean analysis of on line communication using the Flying Start website, identification and interrogation of relevant databases, and a literature review. A feedback event, which was attended by our European reference group, allowed feedback to key stakeholders from NHS Education Scotland and key individuals from the NHS Boards.

Participants

Data were collected from:

- NHS Flying Start Lead contacts or Coordinator: **-** 21
- Final year students: 50 nursing, 6 midwifery, 4 nursing and midwifery, 10 AHP: **-** 70
- NQPs (focus groups/interviews): 59 nurses, 4 midwives, 31 AHPs: **-** 94
- NQPs (survey): 237 adult nurses, 20 midwives, and 287 AHPs: **-** 547
- Mentors: **-** 22
- Practice Education Facilitators: **-** 12
- Managers: **-** 9

All NHS Boards input to the evaluation

Timescale

Because the evaluation was undertaken over 24 months (see table 1) with two months for final analysis and write-up, each part of the evaluation should be seen within the context of the time period in which it was carried out.

Table 1: Approximate timescales (shaded area represents timing of data collection)

	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	J
Interviews: Flying Start Lead Contacts & Coordinators			▓	▓																				
NGT Event: Flying Start Lead Contacts & Coordinators					▓																			
Focus Group & Interviews: Final Year Students			▓	▓	▓	▓	▓	▓	▓															
Focus Groups & Interviews: Newly Qualified Practitioners			▓	▓	▓	▓	▓	▓					▓	▓	▓	▓	▓	▓	▓	▓				
Gricean Analysis of On-Line Communication													▓	▓										
Identification of Secondary Data & Analysis			▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓								
Interviews: Mentors, Practice Education Facilitators, & Managers												▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	▓	
On-Line Survey: newly qualified practitioners																								▓

Ongoing development

The Flying Start NHS programme and its delivery have not been static over the time of the evaluation. The programme has been modified and evolved in response to the findings of the evaluation, feedback from key stakeholders, and the changing environment within the NHS. Significant changes have included short-term funding for each NHS Board to implement the programme, Master classes for PEFs and mentors, revision and development of the website to provide increased guidance and structure, enhanced input to HEIs, awareness raising and an 'expectation' in all NHS Boards that all NQPs will complete the programme.

Because of the time that has elapsed from the initial data collection, this summary will concentrate on findings from the on-line survey, and interviews with mentors, PEFs, and managers, although earlier data will be incorporated where relevant.

How the model works

♦ Flying Start is designed to be a generic programme suitable for all professions, from diploma to Masters degree, in all NHS Boards.
♦ Differences between areas in terms of the number and proximity of NQPs, the nature of work, and contact with experienced staff, mean that support requires to be tailored to individual circumstances.
♦ Some managers felt that the programme was repetitive and overly academic; others drew attention to the strengths of the Flying Start, and suggested that it would be useful for more experienced staff as well as NQPs, particularly learning activities such as equality and diversity.

Timing

♦ There was significant variation, both within and across organisations, in the time lag prior to enrolling on Flying Start.
♦ There was evidence that NQPs are now enrolling more quickly than they did in the past.
♦ Three managers, and final year students in one focus group interview, suggested that Flying Start should be introduced prior to registration in order to support NQPs *through* the transition from student to registered practitioner rather than being perceived as an additional challenge immediately following transition.

Structure

♦ NQPs reported that they found self-directed study difficult and required support, both to manage their time and through the provision of feedback on their progress.
♦ NQPs reported confusion relating to completion, and dissatisfaction with the lack of monitoring.
♦ Mentors drew attention to the flexibility of the programme, and suggested that guidance was necessary.
♦ One in five respondents who had been in employment for less than six months had completed some activities associated with at least one of the ten learning units; a proportion had completed some concluding activities
♦ Activity in terms of undertaking learning activities and completing concluding activities increased amongst NQPs who had been in employment for 6-12 months and 12-18 months.
♦ Some NHS Boards have chosen to recognise completion.
♦ Where recognition of completion had been put in place NQPs reported that they felt that the programme itself, and their efforts, were recognised.

Support

♦ There was evidence that Flying Start was most successful if there was an ethos of support at all levels from senior management to mentors, and an understanding of the purpose of the programme, and what NQPs were required to do to complete it successfully.
♦ Managers PEFs and mentors drew attention to the need for support for NQPs undertaking the programme.
♦ Some NQPs raised concerns about the lack of understanding that some mentors had of Flying Start NHS, and drew attention to the competing demands mentors have, and how this can influence their commitment to supporting NQPs through the programme.

- Managers and PEFs, reported that they were familiar with the Flying Start Programme, although some variation in level of knowledge was found amongst mentors.
- NQPs who worked closely with their mentors, either on the same shift, or had regular meetings, reported feeling supported and in turn more motivated.
- Nurses and midwives reported that they often met with their mentors if on the same shift, whereas AHPs tended to request meetings.
- A higher proportion of NQPs working in the community reported that the support that they received from the mentors, managers, and peers was *good* compared to those employed in acute settings.
- A higher proportion of midwives, compared to nurses, or AHPs reported that the support they received from their mentors had been *good*.
- Despite a series of workshops and information sessions being delivered to support mentors in their role, no differences associated with 'time in post' or 'time since enrolling' on Flying Start were identified in reported satisfaction with support provided by mentors or line managers.
- Some mentors felt that NQPs in their area were well supported, others were less confident.

Protected time
- Although NQPs reported that protected time was 'technically' available, they were often unable to take it for a number of reasons including wards being too busy.
- A majority of NQP reported that they undertook the activities associated with Flying Start NHS at home, in their own time.
- NQPs who reported that they had protected time for Flying Start, and were able to take the time, reported greater satisfaction with the support provided by their mentors and managers.

The on-line peer community
- Final year students and NQPs reported having mixed feelings about on-line learning, with a significant proportion expressing a preference for face-to-face communication.
- NQPs reported that they found accessing a computer at work difficult, and at times inappropriate if patients and carers required attention.
- Many reported that they tended to download and print information from the website.
- A majority NQPs who had explored the discussion forum reported that they had not engaged with it any further.
- One hundred and twenty-four respondents reported that they had posted threads or read threads posted by other NQPs. Of these less than half reported having found it *useful*.

The impact of Flying Start NHS on confidence and skills development

- Seven out of ten NQPs rated *learning the job* as their most important development need followed by *becoming a member of the team* and *orientation/induction to the clinical area*.
- The learning units with the highest level of activity were Communication, Clinical Skills, and Teamwork.
- Between half and three-quarters of the NQPs who were either currently working on the learning activities associated with each learning unit, or had completed the concluding activities, indicated that they had found it useful in terms of their **clinical skills development**.
- A slightly higher proportion of respondents who had *completed* the concluding tasks indicated that they felt that the learning units had been useful in terms of their clinical skills development compared to those who were still working on them.

- The learning units rated as useful in the development of clinical skills by the highest proportion of NQPs who had completed them were Clinical Skills, Safe Practice, Reflective Practice, and Communication.
- Between four out of ten and half the NQPs who were either currently working on the learning activities associated with each learning unit indicated that they had found it useful in terms of increasing their **confidence**.
- A higher proportion of respondents who had completed the concluding tasks for each learning unit indicated that they felt that the activities had been useful compared to those who were still working on them. The learning units rated as useful in engendering confidence by the highest proportion of NQPs who had completed them were, Safe Practice, Clinical Skills, and Reflective Practice.
- PEFs indicated that they thought Flying Start would ease transition for NQPs, although they acknowledged NQPs' desire to focus on their practical experience.
- Managers, PEFs and mentors reported that NQPs could feel quite intimidated by other professionals, and highlighted the benefits of completing the programme in terms of enhanced confidence.

The impact of Flying Start NHS on recruitment and retention

- A large majority of NQPs, PEFs, managers, and mentors indicated that there was no evidence that Flying Start had had an impact on recruitment.
- Two-thirds of NQPs reported that their contracts were permanent, and most were grateful that they had secured employment. Several had had temporary contracts prior to securing a permanent contract.
- Despite the shortage of jobs, final year students and NQPs indicated that a positive student placement would be likely to influence their 'choice' of employment, both due to interest in a specific area, and because of the ease of transition if the environment was familiar.
- Final year students stressed the importance of feeling valued and indicated that their 'ideal' employer would have a reputation for supporting NQPs.
- The majority of NQPs who took part in the survey reported that they did not think that Flying Start had helped them to understand their future career options.
- Managers', PEFs' and mentors' perceptions of what attracts NQPs to a particular post corresponded with the above; they also drew attention to the potential impact of a negative student experience.
- Unfortunately, despite considerable effort to identify databases which would enable a statistical analysis of recruitment and retention patterns over the period since the introduction of Flying Start NHS, data of adequate quality were not available.

The impact of Flying Start NHS on recruitment directly into primary care

- Participants from one NHS Board, which had participated in the primary care pilot study, felt that it had been very successful, despite having been unable to provide permanent employment at the end of the year.
- PEFs, managers and mentors felt that there was still an expectation that NQPs would initially work in an acute setting, possibly due to a perception that staff needed to be more experienced prior to working in the community.

- Perception of the challenges faced by NQPs in acute and community settings varied, with some staff thinking that there was no difference, others suggesting that NQPs going straight into the community were at risk of isolation, and third group indicating that NQPs were well supported in the community and primary care settings.
- Six out of ten NQPs who completed the survey reported that they worked in an acute setting, a quarter worked in the community, and five percent worked in both acute and the community.
- A majority of students indicated that they expected to work in an acute setting in the first instance in order to consolidate their skills.
- In contrast to these perceptions, a higher proportion of NQPs who worked in the community reported that the support that they received from managers, PEFs, and mentors was good.
- A higher proportion of NQPs in the community reported being able to take protected time to complete tasks associated with Flying Start.

The interface between Flying Start NHS and other programmes

- One of the most significant changes during the course of the evaluation has been the roll out of the KSF.
- PEFs, managers, and mentors listed a range of training and induction processes for NQPs.
- NQPs drew attention to the tensions and burdens they felt in juggling Flying Start NHS, local orientation and induction programmes, and local CPD.
- There was a feeling that everything was duplicated, including learning undertaken at university.
- Those who recognised the links between programmes/tasks e.g. CPD, KSF, were able to appreciate the benefits of Flying Start; however, certainly in the early interviews this was unusual.
- A small number of NQPs, particularly those on the Clinical Fellowships, drew attention the materials on the Flying Start website and indicated that they thought it was a useful resource.

Recommendations

Our recommendations are based on a notion of 'best practice', our understating of what 'best practice' would comprise being derived from the findings of focus group, telephone, and face to face interviews with 228 individuals with a vested interest in the support provided to newly qualified health professionals entering employment in the NHS, as well as a survey involving 547 newly qualified practitioners.

Best practice: We recommend that key stakeholders at all levels, in each NHS Board, focus on the following statements, and use them as a benchmark for the future provision of support for NQPs undertaking Flying Start NHS:

- NMAHP students are aware that the Flying Start NHS programme has been designed to support their transition from student to newly qualified health professional.
- NMAHP students are provided with information about the Flying Start NHS throughout their undergraduate training and aware of what it will entail, and the support that will be provided.
- NMAHP student placements refer to Flying Start NHS and demonstrate its usefulness to NQPs.
- HEIs encourage NMAHP students to think of employment in the community post-registration.

- Students on community placements are provided with information relating to careers within the community.
- Student mentors, and others providing support to students on placement, are aware that a well supported placement is likely to result in students seeking employment in their area.
- All students on placement are treated with respect as potential candidates.
- All NHS staff are aware that they are role models for future health professionals.

- Newly qualified NMAHPs enrol on Flying Start immediately on entering employment
- NQPs are allocated a mentor to support their progress on Flying Start at enrolment, or if this is not possible within the first month of employment.
- Every effort is made to ensure that NQPs and their mentors are compatible in terms of location of employment/shifts etc. Should this not prove possible an alternative mentor is identified.
- NQPs whose first posts involve rotation are informed if they are to retain the same mentor when they move, or if they are to be allocated a new mentor, who this will be.
- NQPs who are unable to secure employment and join the Nursing or AHP Banks enrol on Flying Start within six months of registration.
- NQPs employed through the Nursing or AHP Banks are allocated a mentor in a suitable location.

- Flying Start has strategic support at all levels.
- NQPs are valued and encouraged to become a member of their team.
- The position of NQPs, as new members of staff who will not know everything is recognised.
- The aims and objectives of Flying Start NHS are understood and respected by NHS staff at all levels.
- Flying Start NHS is promoted for all NQPs, and information about the materials available on the website is available to all staff.

- Protected time is available for all NQPs and is incorporated into the work allocation model, and as such is sacrosanct.
- Tasks associated with Flying Start are completed in non-clinical areas, i.e. hospital libraries, offices, or home computers.
- All NQPs have access to the Internet in a non-clinical area on a weekly basis.
- A proportion of activities associated with Flying Start NHS are provided locally, allowing face to face interaction.
- Mentors fully understand the aims and objectives of Flying Start NHS and are provided with training to enable them to support NQPs.
- Time for mentoring NQPs is factored into workloads.
- NQPs meet their mentors at least monthly.

- Clear guidance is provided regarding the Flying Start NHS programme in terms of what is expected from NQPs at different levels, in different professions, and in different locations.
- Information is available relating to what a Flying Start portfolio should look like, as well as tips relating to progress, e.g. suggested milestones.
- NQPs are aware of the links to PDP and KSF which are clearly signposted.
- NQPs have a clear understanding of what completion looks like and who will assess and sign off their portfolio.

➢ Life-long learning and on-going CPD are understood to be an integral part of being a health professional.

➢ NQPs take personal responsibility for Life-long learning and on-going CPD.

➢ General induction programmes and discipline specific programmes provided in the first year of employment are revisited and their content compared to Flying Start NHS in order to identify and eliminate duplication.

➢ Support available to NQPs is modified to suit specific localities.

➢ There is equity of support between NHS Boards, and acute and community settings.

➢ Final year students and NQPs sit on an advisory group focusing on the future development of Flying Start NHS

➢ The Flying Start website is constantly updated in response to feedback from key stakeholders including students, NQPs, mentors, PEFs, and managers.

➢ NQP are aware that any communication between NQPs is confidential. Only requests of support and/or 'ask the expert' questions are viewed by NHS Education Scotland.

➢ Investment is targeted at the on-line peer community with a view to enhancing its usefulness to NQPs.

CHAPTER 1

INTRODUCTION

This report brings together the finding from a two-year evaluation of Flying Start NHS, a national web-based development programme for newly qualified nurses, midwives and allied health professionals (AHPs).

Background
In 2004, the Scottish Executive Health Department commissioned NHS Education Scotland to develop a web-based educational resource to support the transition from student to qualified practitioner for all newly qualified nurses, midwives and AHPs joining NHS Scotland. A seconded project team was brought together in April 2005 to work with stakeholders and external consultants to develop a web-based, blended learning programme. The drivers behind this initiative included, Health Policy, including Pay Modernisation and Modernising Medical Careers, the need to recruit and retain newly qualified staff, workforce development and workforce planning, as well as key policy documents which drew attention to a shortage of nurses, midwives and AHP, high staff turnover, coupled to an aging population.

In January 2006 "Flying Start NHS" was launched to NHS Scotland and Higher Education Institutions. The programme had been available to students who became registered practitioners from April 2005 onwards, with AHPs initially being rewarded financially for completing the programme; however, when nurses and midwives were also invited to complete it, financial incentives were no longer feasible. Flying Start was initially supported by a Lead contact in each NHS Board; newly qualified practitioners enrolled on the programme were in turn supported by their mentors, PEFs, and managers.

Aim
To evaluate the impact and effectiveness of Flying Start NHS in supporting the recruitment, confidence and skills development of newly qualified nurses, midwives and allied health professionals within NHS Scotland.

Specific research questions and objectives:

♦ **How does the model work?**
  o Build a knowledge base of the factors which support a successful outcome for newly qualified practitioners, including mentor support.
  o Evaluate the effectiveness of the on-line, multi-professional model selected for use in delivering Flying Start NHS.
  o Carry out an analysis of the on-line peer community and opportunities to build upon the virtual learning environment.

♦ **What is the impact on recruitment and retention?**
  o Evaluate the impact of Flying Start NHS on recruitment and retention of newly qualified staff within NHS Scotland.
  o Identify available baseline data from associated bodies concerning current recruitment and retention of newly qualified staff within the NHS.

♦ **What is the impact on recruitment directly into primary care?**

- Assess the impact of Flying Start for Newly Qualified Nurses in Primary Care in facilitating careers directly into primary care settings.
- Identify any change in the employment of newly qualified nurses directly into primary care settings.
- Elicit employers' views and experiences of the primary care initiative at strategic, line manager, and mentor level.
- Identify and examine factors which have been most influential in supporting the employment of newly qualified nurses in primary care, paying particular consideration to models of rotational experience and the effectiveness of support networks in primary care.

♦ **How does Flying Start NHS interface with other programmes**
- Evaluate how successfully Flying Start NHS interfaces with both national and local development activities.
- Review the compatibility of the NHS KSF and development review cycle, with particular reference to the NHS KSF Foundation Gateway.
- Report on the numbers and outcomes of learners who submit Flying Start NHS portfolios in order to gain Recognition of Prior Learning (RPL).

♦ Explore the potential for extending the learning programme to other groups of clinical staff. [1]

The Research Team

The initial research team comprised seven members:

♦	John Atkinson	University of the West of Scotland
♦	Pauline Banks	University of the West of Scotland
♦	Valerie Blair	University of the West of Scotland
♦	Helen Kane	University of the West of Scotland
♦	Billy Lauder	University of Dundee
♦	Michelle Roxburgh	University of the Dundee
♦	Martyn Jones	University of the Dundee
♦	European reference group	

Over the two years of the evaluation Valerie Blair left UWS and took up a new post at NES. She was replaced on the research team by Angela Kydd. Billy Lauder and Michelle Roxburgh both left the University of Dundee and took up new posts at the University of Stirling – both have remained actively involved in the project. The input of different members of the team has varied throughout the project depending on other work commitments and expertise.

Design and Methods

The evaluation employed a multi-method approach using a range of methods to gather relevant data from a variety of individuals and sources.

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[1] Due to Flying Start NHS being made available to other clinical staff during the evaluation, this aspect became superfluous.

Data collection

◆ Literature review
◆ Identification and collection of secondary data
◆ One to one face to face or telephone interviews
◆ Focus group interviews
◆ Critical Incident Technique
◆ Nominal Group Technique event
◆ Gricean analysis of on-line communication derived from Flying Start on-line communities
◆ On-line survey

Participants

◆ Flying Start NHS Lead Contacts
◆ Flying Start NHS Coordinators
◆ Newly Qualified Practitioners
◆ Managers
◆ Practice Education Facilitators
◆ Mentors
◆ Final semester nursing, midwifery, and AHP students

Ethics

An application for ethical approval was submitted to the University of the West of Scotland Ethics Committee and a favourable response received on 3rd March 2008, see appendix, page 135. Contact with NREC indicated that NHS ethical approval was not required. Applications for ethical approval for the focus groups involving final year students were subsequently made to individual ethics committees where requested.

Procedure

The evaluation began with a scoping element using telephone interviews to elicit information from Flying Start NHS leads in each NHS Board. The findings from these interviews were used to develop a Nominal Technique Event. Following the event telephone or face to face interviews were carried out with NHS Flying Start Coordinators who had come into post in some NHS Boards. This phase was following by further data collection using focus group interviews with final year students in all institutions providing nursing, midwifery, and/or AHP education, as well as NQPs in each NHS Board. Following the focus group interviews, telephone interviews were carried out with NQPs. Telephone interviews were also carried out with mentors, PEFs, and mangers in each NHS Board. A Gricean analysis of on line communication using the Flying Start website was carried out. In addition a literature review was conducted at the beginning of the project and updated near the end; secondary data were identified and interrogated, and a feedback event was hosted, which was attended by our European reference group. Finally an on-line survey was carried out in order to involve a larger number of newly qualified practitioners. The following diagram provides a pictorial representation of the procedure – not to scale.

Figure 1.1: Pictorial representation of the methods used throughout the evaluation
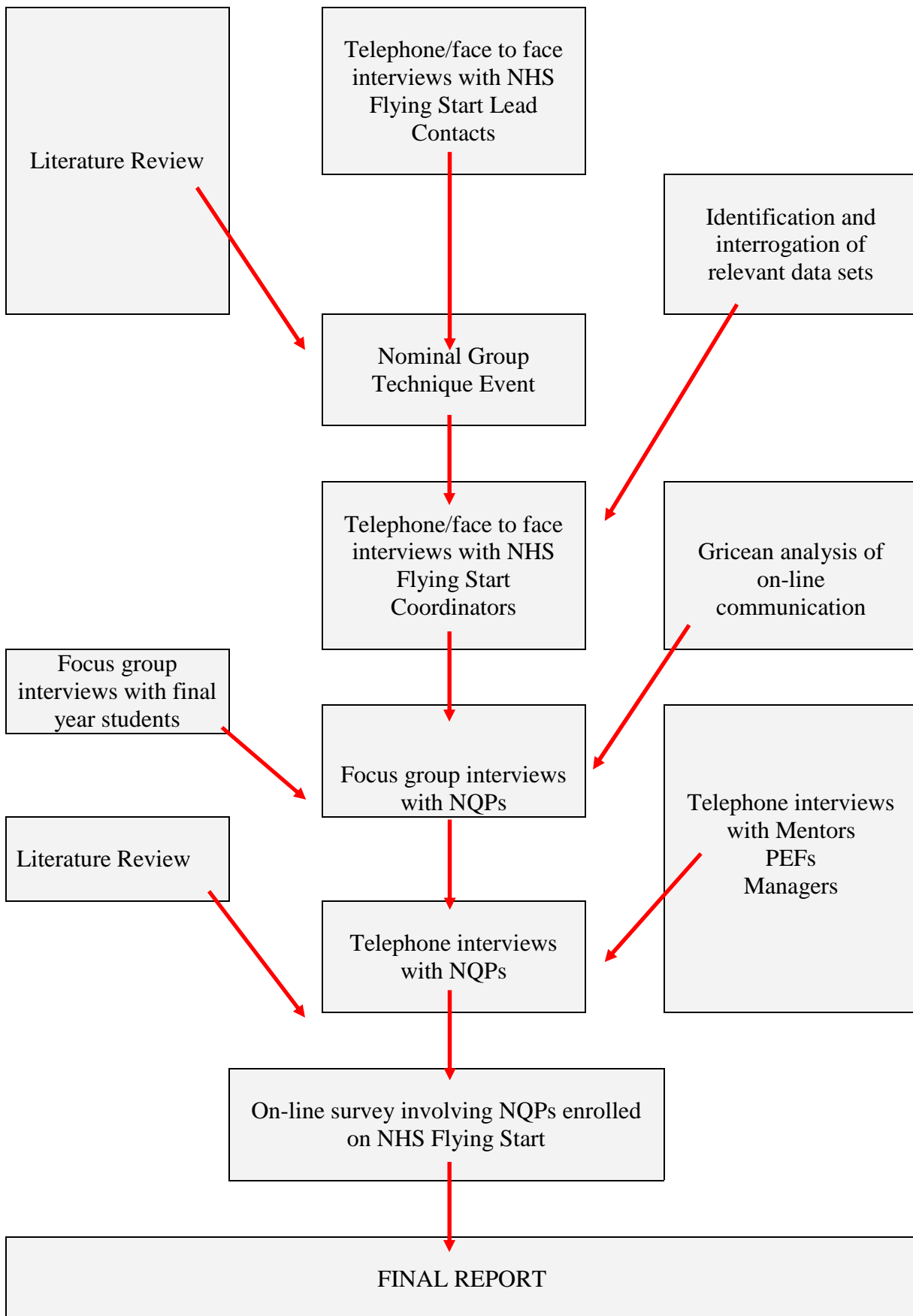
Timescale

Initially the evaluation was to be completed in 24 months. However, difficulty recruiting NQPs and other staff for telephone interviews resulted in a lower number of participants than anticipated. In order to address this shortfall a decision was taken to develop an on-line survey for completion by NQPs enrolled on Flying Start – this was not part of the original remit. The survey was made available to NQPs in December 2009 delaying completion of the project by two months.

Because the evaluation was undertaken over 24 months, with two months for final analysis and write-up, each part of the evaluation should be seen within the context of the time period in which it was carried out. The Flying Start NHS programme and its delivery have not been static over the time of the evaluation. The programme has been modified and evolved in response to the findings of the evaluation, feedback from key stakeholders, and the changing environment within the NHS. Significant changes have included short-term funding for each NHS Board to implement the programme, Masterclasses for PEFs and mentors, revision and development of the website, enhanced input to HEIs, awareness raising and an 'expectation' in all NHS Boards that all NQPs will complete the programme. In addition to the above, the impact of staff turnover within NHS Boards, economic and environmental factors, and recruitment from two to four new cohorts of NQPs should be borne in mind.

We make no apologies for any comments, critical or otherwise, derived from participants. Significance of, and response to criticisms will be covered in Chapter 11 in which we return to the research aims and objectives, drawing attention to changes within the programme and highlighting what works well and what could be improved, as well as presenting a range of recommendations. The findings from each stage of the evaluation are presented in chronological order based on a combination of the timing of data collection and, because data collection from different sources was carried out concurrently, completion of data collection and presentation of analysis:

Chapter 2:   Literature review
Chapter 3:   Interviews with NHS Flying Start Lead Contacts and Coordinators
Chapter 4:   Nominal Group Technique Event
Chapter 5:   Focus group interviews with final year students
Chapter 6:   Focus group and telephone interviews with NQPs
Chapter 7:   Gricean analysis of on-line communication
Chapter 8:   Secondary data analysis
Chapter 9:   Telephone interviews with mentors, PEFs, and managers
Chapter 10:   On-line survey: newly qualified practitioners
Chapter 11:   Revisiting the research aims and objectives, and recommendations

Finally we would like to thank all the NQPs, students, and NHS staff who gave up their time to participate in the evaluation. Particular thanks are due to the Lead contacts and Coordinators, who have provided support throughout the evaluation.

CHAPTER 2

LITERATURE REVIEW

Early experience in the workplace may be a vital predictor of future job satisfaction. Thus early career development and support for newly qualified health practitioners has been high on the Scottish agenda with a view to decreasing both student, and post-registration attrition rates (Scottish Executive, 2001a; 2001b; 2005a; 2006; 2007). Particular attention has focused on the transitional phase from being a student to becoming a qualified practitioner, and in January 2006 the Scottish Executive and NES provided funding to NHS Boards to support the implementation of Flying Start NHS, a web-based development for newly qualified nurses, midwives, and allied health professionals. In the autumn of 2006, 1,200 newly qualified practitioners were enrolled on Flying Start NHS; by autumn 2007 this figure had almost tripled to 3,653. However, there was evidence that the pattern of participation varied between areas with some NHS Boards making Flying Start NHS compulsory for newly qualified staff whilst others did not (Lauder et al 2008). There also appeared to be some diversity in delivery methods with reports of variation on the on-line mode. Furthermore, while Flying Start NHS had been implemented and continued to run in parallel with existing local development schemes, there was a lack of evidence relating to the way in which different provision interrelated, how these differences impacted on progress through, and completion rates of newly qualified practitioners, and in turn whether or not the programme achieved its stated aims. The project which will be detailed in this report sought to evaluate the impact and effectiveness of Flying Start NHS in supporting the recruitment, confidence and skills development of newly qualified nurses, midwives and allied health professionals within NHS Scotland.

Background

In the early 20th century the NHS in Scotland was facing major challenges and there was a recognition that the need for education and training for the workforce had never been greater (Scottish Executive Health Department 2002; 2005; 2006). The main drivers for this were the quickening pace of change for care delivery to NHS patients coupled with rapid and fundamental change. Policy initiatives emerging from these changes focused on the healthcare workforce and their need to provide flexible care (Jenkins-Clarke & Carr-Hill 2001).

These changes coincided with other initiatives including the Knowledge and Skills Framework, NHS24, Out-of-Hours Care, nurse prescribing, Agenda for Change, NMC task & finish group on strengthening standards in pre-registration education, the Scottish Executive Health Department review of mental health nursing, the one-year development programme for all newly qualified nurses, midwives and AHP and the pilot project to support new staff nurses into primary care. The 'Kerr Report' Building a Health Service Fit for the Future (Scottish Executive 2005) signified a period of potentially dramatic change in the delivery of health services in Scotland which required nursing, midwifery and AHP education to play its part by provide a practitioner whose portfolio of skills and attributes enabled them to be flexible and responsive in a changing environment (Scottish Executive 2005). More recently Delivering Care, Enabling Health (SEHD 2006) recognised and gave support to nursing, midwifery and AHP to embrace and take forward the healthcare agenda.

Increasing longevity, population growth, and technological advances were expected to result in a shortage of nurses, midwives and AHP worldwide (Stordeur et al 2006). At the same time reports of 'staff turnover' and the reasons for this were beginning to emerge in the literature. Stordeur et al (2007) reported that in the USA turnover varied between 10%-30% in 2000. In comparison Zurn et al (2005) reported turnover in the UK to be between 15%-20%. Factors associated of turnover have been researched extensively and include predictors relating to workload, work stress, job satisfaction, and supportive management (Champion 1996). However, attrition rates also vary with profession, e.g. Robinson et al (2005) reported that there was little evidence of attrition in mental health nursing in the first 6 months post-qualification.

The journey from student to newly qualified practitioner

The theoretical framework for the development of Flying Start NHS and its subsequent evaluation were based on the notion that the shift from studentship to qualified practitioner is a period of transition. Transition has become a key organising concept in the journey across the education spectrum from primary, secondary and tertiary sectors and is currently the focus of much activity in the HEI sectors including Australian, USA, England and Scotland under the 'experiences of 1st year students' banner.

The transition year from student to practitioner is seen as a:

> …*period of learning and adjustment when the graduate (diplomate) applies and increases knowledge and competence and is socialised into the workplace (Victoria Department of Human Services, 2002).*

The challenges experienced by newly qualified practitioners have been known for some time (e.g. Kramer, 1974; Mooney, 2007), and are widely reported worldwide, e.g. in Australia (Lauder 2003), Canada (Ellerton & Gregor 2003), Israel (Greenberger et al 2005), South Africa (Moeti et al 2004) and the UK (Holland 1999, Andrews et al 2005).

In order to find out what support was available to NQPs in other countries, and how unique the Flying Start NHS programme was, a member of the research team carried out a small scoping study (Roxburgh, 2008). Responses indicated that there was no national programme in China, Holland, or Spain, however, in Canada a new graduate mentorship program which had been regionally developed but was not national. In China hospitals usually offered the equivalent of an orientation program; in Spain, newly qualified practitioners were offered preceptorship on all shifts and given less complex patients to care for. Contacts in Holland expressed an interest in the Flying Start programme, and explained that their transition programmes focused on patients rather than staff.

Transition

In 1974 Kramar highlighted the 'reality shock' experienced by newly qualified graduate nurses in the USA when they found themselves in work situations which they felt inadequately prepared for. In the UK a number of later studies identified similar findings associated with the transition process (Humphries 1987, Lathlean 1987, Gerrish 2000). This was ascribed to the failure of pre-registration courses to equip students with the necessary knowledge and skills to assume the role of a qualified

practitioner and a lack of support during the initial post-qualification period. In Australia Adamson et al (1998) reported that graduates perceived gaps between their knowledge and skills required in the workplace, and Greenwood (2000) suggested that transition to practice continues to be problematic and stressful. An American study involving newly registered nurses indicated that they found being on the ward stressful, citing organisational, managerial, and clinical skill deficits. Goh & Watt (2003) highlighted the unrealistic expectation for graduates to be able to 'hit the ground running'. Stress has been less studied in AHPs but a recent study comparing physiotherapy students in UK and Australia concluded that to minimise stress academics needed to reduce the content and revision of the outcomes of physiotherapy curricula (Tucker et al 2006).

While studies reveal that new graduates are aware that they need a high level of support to successfully make the transition from graduate to competent and confident practitioner (Kerston & Johnson 1992, Fulbrook et 2000; Amos, 2001; Hamrin et al, 2006; Andrew et al, 2009), others report that the real world experience of the new graduate is often unsupportive and extremely traumatic (Kelly 1998, Clare et al 2002). For many, the transition experience is typified with fear of failure, fear of responsibility and fear of making mistakes (Claire et al 2003).

Confidence and competence

Problems during the transition phase have, on occasion, been reconceptualised as work readiness. However, a recent report (Lauder et al 2008) found that key stakeholders viewed NQPs as fit for practice at registration and that students/NQPs shared this view. Lauder et al point out that these views represent a shift from the findings of earlier studies.

The transition period is the time when practitioners learn to manage and control many aspects of their practice. This involves a balance between demands and control. Practitioners who report less job control report higher stress levels (Chang et al 2005). It is the adverse effect of participation without control, rather than participation per se, which affects job stress (Israel et al 1989). Lack of control over one's work has been identified both as source of stress and as a critical health risk for some workers. The *demand-control theory* of work is also linked to learning and professional development (Parker & Sprigg 1999, Taris et al 2003). Employees who are unable to exert control over their work are more likely to experience work stress, which in turn impairs learning amongst new staff (Taris & Feij 2004).

A number of studies highlight issues of competence amongst newly qualified practitioners (Runciman et al, 2000; Hickey, 2000; Amos, 2001). Based on a study involving in-depth interviews with 12 Irish nurses who were within one year of qualification, Mooney (2007) reported that newly qualified nurses have specific needs, many of which are unrealised. The vast and increased workload, which involves less patient-contact and more non-nursing duties, came as a surprise to participants as did the expectation of in-depth knowledge, coupled with feelings of increased responsibility, compounded by relatively little experience. A Swedish study investigating the transition from a three-year nursing programme to a professional role as registered nurse involved eight participants keeping diaries over a period of two months (Kapborg, Fischbei 1998). Again, participants reported that 'non-nursing' tasks including the management of paperwork, and administrative work, left them with less time to spend on patient-oriented activities. Participants felt uncertain about how best to

care of patients with complex presentations. All the nurses experienced a high workload and reported difficulties in feeling relaxed during their off-duty time.

O'Conner et al (2001) compared perceptions of the competence of newly qualified nurses as judged by 139 senior nurses and the actual observed competence of 36 newly qualified nurses. They found that newly qualified nurses consistently performed at a higher level than that expected by senior nurses. One of the least well known and certainly one of the least implemented Project 2000 recommendations was a period of mentored on-the-job preceptorship which was to last around three-four months. Perceptions of skill adequacy in newly qualified diplomates in their first staff nurse post, within a nursing home context, have been investigated by Runciman et al (2000). Perceptions of adequacy varied, but were on the whole favourable. All stakeholders agreed that perceived strengths were confidence, knowledge and a questioning approach (Runciman et al 2002). In contrast Fraser et al (2000) reported that the transition from student midwife to midwife was associated with a drop in confidence. This was improved if support was provided, and by the end of the first year midwives were described by managers as competent and confident. In a small scale cross-sectional survey comparing interview data of newly qualified nurses in 1985 and 1998 Gerrish (2000) reported that the latter cohort felt less stressed about transition than newly qualified nurses in 1985. Unfortunately, the relatively weak design prevents generalisation. However, based on a small scale evaluation of a course on community nursing involving mostly newly qualified nurses, Wright (2005) reported that participants felt the course had improved their key community nursing skills.

Lauder et al (2008) suggest that it is not lack of competence, nor lack of confidence which characterise newly qualified nurses, but a recognition of the considerable legal and professional accountability for care, combined with limited understanding of the disciplines of the workplace and the requirements of being an employee.

Transition programmes
Unlike Nursing, Midwifery and AHPs, Medicine has long recognised the need for a longer period of training with qualified medical staff undertaking training posts on qualifying. Whilst having been subject to less empirical research there are some data which suggest that during the transitional period, AHPs have similar experiences to nurses in terms of stress, feelings of inadequacy and being unsure about their professional identity (Rugg 1999, Mandy 2000).

Successful transition programmes, Heath et al (2002) suggest, encourage new practitioners to remain in the workforce and maximise the communities' investment in the education and training of practitioners. In Australia, transition programmes provide the initial sustained exposure to clinical contexts and an opportunity for the application of the theory learnt in the undergraduate degree. (Levett-Jones & FitzGerald 2005). Furthermore the first 3 -6 months is considered the crucial time for professional adjustment and for creating a commitment to a career in nursing, midwifery and AHP (Greenwood 2000).

Although a number of researchers during the 1990s suggested that formal transition programmes 'smoothed' the transition process (Crow, 1994; Currie, 1994; King and Cohen, 1997; Madjar et al 1997) there was minimal evidence to support efficacy, particularly in terms of improved retention. However, newly qualified practitioners have been found to value support post registration (Floyd, Kretschmann and Young, 2005). Evaluation of a residency programme for graduate nurses in

America (Altier and Kresk, 2006) found that satisfaction scores remained consistent throughout the first year and the authors suggest that graduate nurse programmes of this nature could prevent attrition in the first year post registration. Halfer (2007), based on an internship for graduate nurses in American, concluded that a well designed programme could reduce recruitment and retention costs through increased job satisfaction. It was suggested that introducing improved career development would improve morale at all levels. Another intervention involving peer-led support groups (Hamrin et al, 2006) found that they increased self confidence and leadership skills as participants gained experience in clinical practice and gained a better understanding of the nursing role. In Ireland, as in the UK, there has been a move to align certificate and diploma trained nurses with graduates. Finn and Fenson (2010) report on the development of post registration BSc (Hons) degree developed in response to the identification of limited impact of learning on practice. The new post registration-degree was introduced in 2005, and to date evaluation has been positive; however, it is not clear to what extent newly qualified practitioners are undertaking it. Barton (2008) drew attention to the importance of rites of passage and claimed that it was important that progress from student to newly qualified NMAHPs was acknowledged in order to clarify organisational boundaries, and reduce conflict. Barton claimed that completing education programmes signified social and professional status as well as the accumulation of clinical knowledge.

Many Australian healthcare agencies have developed a one year graduate programme for newly qualified practitioners as a consequence of limited exposure to clinical practice settings in pre-registration programmes and the perceived limit in competency of this group. The Australian review (Victoria Department of Human Services 2002) also reported that there was little empirical evidence to support the benefits of costly and complex graduate programmes. Once again the different needs and values of students, service providers, and academics were highlighted in this review in which students wished to have a programme which led them to be 'work ready' whereas academics wanted a programme replete with generic competencies to produce the 'educated person'.

The revised graduate programme in Victoria (Department of Human Services 2002) focused on clinical risk management, harm minimisation, management skills, clinical competencies and ethical dimensions of practice. They also suggested a framework for evaluation which measures recruitment and retention, anxiety reduction and integration, clinical competencies and growth and development of the professional. Earlier work in the USA described by Cooney (1992), described a three stage programme in Texas which started with an orientation and socialization period, followed by the development of advanced skills, and finally lead to assignments of complex cases after completing tailored educational courses. Cooney reported that the in-house evaluation indicated that nurses reported greater autonomy, increased job satisfaction and improved retention rates.

Mentorship and preceptorship
Both mentorship and preceptorship are believed to have the potential to reduce reality shock as the practitioner leaves the relatively safe and protected world of university and enter the health care environment with all of its complex challenges and pressures (Fitzgerald et al 20001, Pigott 2001, Smith & Camooso-Markus 2002). A study carried out in Australia (Croxon and Maginnis, 2009) focusing on the development of clinical competency drew attention to the opportunities for learning from more experienced staff. The authors stress the importance of facilitating this and highlight the importance of time and support being made available, claiming that the preceptorship model is more effective when the preceptor has time. However, time and resources can be limited; O'Malley et al

(2005) reporting on a study carried out in America found that preceptors wanted a reduction in workload and more support from clinical education – they suggested that there was a need for an education programme for NQPs, claiming that that recruitment and retention of new graduates was dependent on support from more experienced staff – they acknowledged that the request for additional resources was unlikely to be fulfilled. Lauder et al (2008) found that mentors in Scotland often had to fulfil their role with little practical support, in their own time, sometimes having to choose between patient care and supporting learning.

Recruitment and retention

There has been a wide ranging debate in both the professional and political spheres in Australia over the high attrition rates post qualifying with significant numbers leaving the profession. It was suggested that this may be a direct consequence of the lack of experience in clinical settings and the relatively wide gap between HEIs and health care providers in that country. However, changes in the economic environment during the period of the evaluation have impacted on both students and newly qualified practitioners. In the UK, lack of employment has lead to an increase in application to HEIs for all courses. Because the number of nursing and midwifery students admitted each year is decided at a national level, demand does not increase supply in terms of places, nor in reality is it likely to increase the 'quality' of applicants. Changing roles in the health service also require additional nurses (Dept of Health, 2006b). Nursing shortages are associated with higher mortality and morbidity rates (OECD, 2008). They are also associated with increased staff dissatisfaction and increasing attrition post-qualifying, thus compounding the overall problem (Healthcare Commission, 2009).

Having commenced training as a nurse, midwife, or AHP financial and family problems may well be exacerbated by the current recession putting students who may have family commitments under additional strain (Cameron, Roxburgh et al in press). On graduating, jobs are increasingly hard to find in an environment where people do not leave jobs voluntarily, and the public sector is looking to reduce costs. Thus the findings of previous research relating to recruitment and retention may lack validity in today's climate. That said, the NHS wishes to recruit the most suitable staff for every post, and having expended resources on education and induction to retain them.

The HEI/labour market interface is fundamental to successful transition for NQPs and Andrews et al (2009) claim that partnership working between clinical areas and HEIs is key to facilitating successful transition into the first year of employment and thereafter. As mentioned above, the student profile has changed with widening access policies attracting non-traditional students, and based on a study carried out in the USA, Raines (2008) drew attention to the responsibility for educators to accommodate the needs of these students in order to prepare them for the workforce.

Based on a study involving occupational therapists (Rugg, 1999) retention was found to be associated with good support, adequate resources, and opportunity for professional development; withdrawal was associated with lack of support, lack of autonomy, excessive responsibility, and unmet expectations of practice. More recent research has found that students often identify areas which they see as supportive and this encourages them to seek employment in these areas (Andrews et al 2005a), based on a study carried out in Canada found Andrews et al that job search is often based on a specific ward rather than a hospital. They also found poor mentorships and lack of support from ward staff on placements acted as a disincentive to seeking employment. Findings from a UK study

(Andrews, 2005b) suggested that recruitment strategies should take account of local factors that may influence newly qualified staff including familiarity and trust.

To date, measuring, quantifying and solving the problems faced by the new practitioner has proved more challenging than recognising that these problems exist. The following chapters will present the findings from the evaluation of Flying Start NHS, which are laid out in quasi-chronological order beginning with data collection involving Lead Contacts and Coordinators.

CHAPTER 3

INTERVIEWS WITH NHS FLYING START
LEAD CONTACTS & COORDINATORS

Data collection March-April 2008

In order to build a knowledge base of the factors which support a successful outcome for newly qualified practitioners, and identify factors which worked well or required further development, telephone interviews were carried out twenty-one Lead Contacts and/or Coordinators in the fourteen geographical NHS Boards, the Golden Jubilee Hospital and the National State Hospital.

Topics covered in the interviews included:
  ♦ Role of Lead Contact
  ♦ The way in which Flying Start NHS has been implemented in each NHS Board
  ♦ Support mechanisms for newly appointed practitioners undertaking Flying Start NHS
  ♦ Other initiatives available
  ♦ Support available for PEFs and mentors working with newly appointed practitioners
  ♦ Perceived impact on recruitment and selection of newly qualified practitioners
  ♦ Availability of information relating to uptake and completion of Flying Start

A copy of the interview schedule is included in the appendix, page 136.

All interviews were recorded and fully transcribed. Analysis, which involved the identification of themes, was undertaken using NVIVO. Quotations are included in this report in order to illustrate specific points rather than reflecting the views of more than one person.

Participants

Data collection involved three face-to-face interviews and 17 telephone interviews; one participant submitted written responses. Initially all named Lead Contacts were contacted and invited to take part in an interview. However, in some Boards the named Lead Contact had passed day to day management of Flying Start on to another member of staff, usually someone specifically employed as a Flying Start Coordinator, or a PEF with responsibility for supporting newly qualified practitioners. In each NHS Board the person deemed to be most appropriate took part in the interview. Particularly in NHS Boards where Flying Start Coordinators had been appointed it was apparent that there was a distinction between managing or enabling the programme, and implementation on the ground:

> *Although I've been the Lead Link in name, in actual fact over the last couple of years*
> *[other staff] have done the operational part... my understanding of it is that you are the*
> *person with the seniority in the organisation to make this happen.*

> *My manager, who is the Lead Contact … sort of oversees the more management*
> *perspective of Flying Start … as Co-ordinator, basically I suppose my role is more sort of*
> *on the ground really….*

While some participants had been involved with Flying Start since its inception, others were new to post or had only recently subsumed Flying Start into their remit. Lead Contacts reported that their

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roles included communication between the Scottish Government, the National Project, NHS Boards, and staff, as well as supporting mentors and newly qualified practitioners, and developing a system for monitoring registration, progress, and completion.

Experience of implementing Flying Start

It was apparent that in some areas, despite having been introduced in 2006, the implementation of Flying Start is still in its infancy:

> *I think we're still very much in the early stages...*

> *I don't know that actually it's been there long enough to criticise it*

Taking a flexible approach
Participants spoke of raising awareness and providing information to key individuals at all levels:

> *A lot of it very much at the moment is about information, and getting the right information across to people in terms of what they have to do, what's expected of them, how they know that they've completed, and how Flying Start really links into KSF and professional development plans, and all that kind of thing.*

> *What we have done, quite recently actually, was to employ one whole time equivalent, two people 0.5 Flying Start PEFs to take forward the Flying Start agenda and what we have done is look at different ways of making sure that the population of qualified practitioners are aware of the programme prior to their training.*

Geographical variation: single or multi-site implementation
Given the number and diversity of tasks carried out by Lead Contacts and Coordinators it was not surprising that different systems had evolved, often associated with the size and geographical dispersal within NHS Boards. Participants drew attention to differences in practice between localities, between disciplines, and between acute and community:

> *There are different pockets of things happening across the whole [NHS Board] really, so no one place is actually the same. Some groups are more advanced I think, so that can obviously be divided into the professions, and also in terms of the location ...I guess the Acute Hospitals, they feel they're a little bit more pushed for time ...*

> *Most of our newly qualified practitioners are in the Infirmary ... we've got a few in outlying areas, but as PEFs we can see them on an individual basis.*

As might be expected the number of newly qualified practitioners employed, and the area covered varied between NHS Boards creating different challenges for staff:

> *Because of the size of our organisation we actually tried to appoint two PEFs to take it forward...*

> *Needless to say we have only got a handful of people doing the programme ... I think we started off with something like four people who were registered onto the programme.*

Single site NHS Boards also have different experiences in terms of organising support for newly qualified staff:

> *I think we're lucky we're a single site operation ... our two PEFs have got a high visibility profile and I think that has been a massive support and support for a) the ward managers, b) more importantly for the newly qualified staff themselves ...*

Supporting implementation
Participants emphasised the importance of support for the programme at all levels, with most NHS Boards involving Practice Development, PEFs, and Human Resources in the planning. Five Lead Contacts reported that their NHS Board had taken a 'top down' approach:

> *[Lead Contact] chairs that group ... people tend to be PEFs, and there is also a director of nursing, a chief nurse on it, there is also representation from HR.*

> *We decided early on to take a top down approach ... the chair was the nurse director and we were very fortunate.*

While others stressed the role played by ward managers:

> *If we could get our ward managers and our district nurses and health visitors on board with Flying Start and they see the benefits ... then it would be easier when they get the newly qualified staff.*

A majority of participants reported having received adequate support in their NHS Boards; where problems had occurred, in general, the situation appeared to be improving. However, it was apparent that in some areas, the provision of equitable support was quite challenging:

> *It's 100% implementation; we've done very well. We embraced it from the word go because we liked the concept and the principal of it.*

> *It has been very variable I would say depending on the local areas, whether they have had a champion ... if so it has moved forward quite well, and in other areas it has probably not been implemented as well.*

One participant felt that the implementation of Flying Start had not been well managed in their NHS Board:

> *It maybe wasn't launched in a way that [it] should have, maybe it was targeted at the wrong group, by that I mean when you launch anything you're always told, 'Go to the Director of Nursing, the Chief Nurses, and they will buy it...,' but down at the grass roots it's very different.*

Resistance to Flying Start
A small number of participants drew attention to negative attitudes amongst a proportion of new staff, including dislike of change in terms of feeling under pressure to complete a programme that had not been a requirement for newly qualified practitioners in the past, and a perception that they had completed their education at registration:

Whenever there's change there's always this resistance

People don't like new things they're very resistant to change … you are still getting people that are like 'Well if it's not statutory or mandatory, well then I'm not doing it

There is a lot of negativity, 'Why should I do it?' a lot of negativity from the, especially the nurses who have done their degree, 'I've done my degree I don't need to do it.

One participant reported that newly qualified practitioners in their NHS Board failed to recognise the potential benefits of Flying Start, and claimed that these perceptions were not revised after having undertaken the programme:

I think certainly within our organisation there are staff that don't see the benefit of doing it, and they don't seem to feel that they have gained an awful lot...

Optional or mandatory
There were mixed feelings about whether or not participation should be mandatory:

Perhaps if [Chief Nursing Officer] made it slightly more mandatory, I know we're kind of reluctant to say something like that, but I actually think saying something like that would just probably help us and the ones who are trying to facilitate the programme.

I think there needs to be some sort of more stronger steer…   it would help me implement it

There was a perception in most NHS Boards that Flying Start had been more readily accepted by nurses and midwives than AHPs. However, two participants felt that there had been a better uptake amongst AHPs in their area, possibly in part due to the initial funding:

The uptake is probably quite good on both sides but I feel that the AHPs, they've probably a wee bit more protected time.

Timing of enrolment
It was apparent that views relating to the best time to enrol varied, for example, one participant reported that in their NHS Board they had developed a workbook designed for newly qualified practitioners starting Flying Start *after* having time to settle in to their new posts. However they had since revised their opinion and believing that earlier was better.

We thought staff should start after three months … because we felt they needed time to settle in, and being newly qualified staff they obviously wanted to get a lot of clinical, they weren't interested in learning more at that point … we have changed our mind since.

I feel that anybody in a new job really should be allowed some settling in time you know, finding your feet and feeling comfortable in the work place before embarking on the programme.

One participant expressed concern that their newly qualified practitioners could not enrol straight away due to IT constraints. She explained that, after initial induction, it was difficult to keep track of new appointments:

> *They have to be in post before their number comes through ... so they can't actually register at induction unfortunately ... it means that we lose sight of them a bit because we haven't got them all together in one place again.*

Another participant supported this view, stressing the benefits of introducing Flying Start as soon as possible:

> *Although I don't think realistically we're going to get it as part of induction, we're going to try and make it so that people have to access [Flying Start information session] pretty much at the start.*

Some participants reported that they endeavoured to support newly qualified practitioners who had not secured employment immediately when qualified:

> *We have also incorporated [Flying Start] into our Bank aid care because we appreciate that not all newly qualified practitioners are getting permanent posts ... we will try and give them a placement that will facilitate them to do it.*

Support for newly qualified practitioners to complete Flying Start

When asked what they thought was the most effective aspect of implementation in their area, participants drew attention to the importance of support from senior management, involving representatives from all disciplines, face to face contact with PEFs, access to IT, support with IT literacy, protected time, and awareness raising in the HEIs so that newly qualified practitioners were aware of Flying Start before coming into post:

> *Through NES funding we were able to employ someone in an information/literary support role... We've developed that role to include basic IT skills for staff... it wasn't the newly qualified staff that had the problem with that, it was their mentors.*

> *We've got a local steering group ... so rather than it coming from the Practice Development or coming from NES, people actually see that they own it locally.*

> *Leadership and engagement with key stakeholders are probably the two things that have made it a valuable and effective process for us at this point in time.*

> *Protected time as well is causing a problem with implementation, people don't feel they have enough protected time... that's one of the issues that comes up again and again and also access to computers.*

Protected time
Six participants indicated that newly qualified practitioners in their NHS Board were given protected time to complete Flying Start. One NHS Board reported that money had been make available to provide backfill to enable newly qualified practitioners to have time to complete Flying Start. However, it was apparent that the time available varied considerably between areas:

It is not perfect, but we offer them two and a half hours a month, and they negotiate that time with their ward manager.

We took the stance when Flying Start first came on board that we would give them one hour per unit, just to do their fact finding on the Internet and things like that. Whether or not the charge nurses actually give them that length of time I really wouldn't like to comment… I doubt it.

What I said was that there was three/four hours per week, and it was up to them how they did it … whether they took a day a fortnight, or two days a month, I really didn't mind.

Where protected time was not available some areas were working towards addressing the issue:

There probably isn't protected time for them just now… we've reallocated all these funds to the clinical directorates in order that staff can be supported to have some protected time but we're still working through that with them.

Access to IT
Seven NHS Boards reported that access to IT in their Board was good, another three specifically bought laptops or computers to support newly qualified practitioners undertaking Flying Start. However, this did not always have the desired result:

With the Flying Start money that we were allocated we used that money to buy 13 laptops and many printers and computers.

As part of the allocation for Flying Start we've bought more computers …they've practically never been used, in fact I think if they've been used a handful of times if we're lucky.

It was apparent that location had an impact on access to PCs in work time:

We actually have good library facilities so I certainly know that some staff will go to the library for an hour or two hours …

I think we could do better; all areas do have [computers] at their sort of nurses' station, and in their Sister's office.

That again is very hit and miss … Within some of our busy clinical areas there may be one or two PC's in a clinical area, but they're used for admissions and transfers and discharges, blood results and everybody's competing for the one PC.

A number of participants reported that newly qualified practitioners were completing Flying Start in their own time on home computers:

I think most of them do it at home, any time I've ever had a call form someone about it it's always, 'Oh I'm at home, and I'm on the website just now…'

Much of Flying Start is done in their own time on home computers

Perceptions of whether completing Flying Start at home was a problem or not varied:

> *Most of our staff will probably do Flying Start from home, unfortunately.*

> *We try and support them at work time - again there is a responsibility on them to do it within their own personal time.*

Finally, a number of participants drew attention to the importance of face-to-face contact as well as on-line support:

> *We're actually not promoting it as an online programme ... yes the toolkit sits online, but actually you're doing it in your day to day work anyway.*

> *I think that's a really good idea to get [newly qualified practitioners] together so they can share thoughts. I know they can do it online... but other times you're really sort of wanting to talk things over with people.*

Mentors

Participants highlighted the lack of knowledge amongst some of the mentors who had not undertaken the Flying Start programme themselves, and had limited knowledge of the requirements:

> *We're finding quite a lot of the time that a lot of the mentors don't actually know anything about Flying Start.*

> *We still have big leaps and bounds to get mentors to understand fully their role.*

> *Because we haven't got mentors who have been through the programme... I think a lot of them are sitting back thinking, 'I don't want to make a fool of myself because I don't know what this is about...'*

Attention was drawn to the lack of experience in using on-line learning, and the need for support for both mentors and newly qualified practitioners:

> *Some of our mentor population, it would be fair to say, are not themselves aware of the concept of e-learning so there is a need for them to be developed in terms of supporting the participants.*

A majority of participants reported that support had been put in place for mentors so that they, in turn, could support newly qualified practitioners:

> *I'm putting mentor sessions on, which I think will be an ongoing thing because... there's always going to be new ones coming up.*

> *We have organised protected time for newly qualified practitioners [and] for the mentors, and I think word is now getting round about that.*

In some areas newsletters have been developed with a view to improving communication:

The other thing that we have now ... is a Practice Education Facilitators newsletter ... each one so far has had something about Flying Start in it. This goes out round all the mentors and we tell them a bit about protected time and whatever else.

However, a survey carried out in one NHS Board revealed that even if newly qualified practitioners had been allocated mentors, the mentors were not necessarily supporting them in any meaningful way. One participant drew attention to the potential for future mentors who have completed Flying Start themselves:

There was one [newly qualified practitioner] who has just about completed... she would be quite willing to come and talk to groups or even talk to the semester sixes ... So it's always another person who has been through, who knows what it's about ... I'm just wondering if we can have kind of a Flying Start mentor or maybe a different name - a Flying Start Buddy...

Other educational initiatives: complementary or duplication?

All but two NHS Boards had induction or other programmes already in place for new recruits, however provision varied between and within NHS Boards:

What we found when we scoped out through [NHS Board] was that it was very ad hoc - some placements did it very well, and others didn't do it at all - so the Flying Start was really welcomed ...

Perceptions of the way in which Flying Start fitted with existing programmes varied considerably between NHS Boards and between disciplines:

There is some duplication, but the Flying Start can also compliment ... I think just now they are seeing it as two entirely separate programmes and they are just appearing to refer to Flying Start at a later stage in the game ...

The orientation pack was mapped directly against Flying Start so it should compliment each other, but that said a number of staff do see it as two separate things...

A majority of participants reported that they were mapping previously existing programmes to Flying Start:

We had an interim programme for newly qualified practitioners. However, when Flying Start was launched we made the decision to no longer run with the interim programme...

We have tried to integrate [induction] with Flying Start so that the people didn't have two things to do.

Other training/development opportunities were retained as required:

We want the Flying Start to be the central component of a nurses' induction and the nursing induction programme that we devised locally will supplement that rather than the other way around.

Flying Start is our main thing yeah, and obviously we've got lots of in-house education and things but that's for everybody, that's not necessarily for newly qualified staff...

A number of participants emphasised the importance of linking all programmes together:

I think we have to do more work in linking it all in ... We have done a bit of that, linking in the competencies and Flying Start and KSF all as one programme rather than three individual programmes and there is still work to be done there.

Flying Start will dovetail into the competency framework and therefore is linked into their KSF framework... at the end of the year their manager will then pick up their portfolio as part of their performance review ... there's going to be enough evidence in there that will link them straight through to get their foundation gateway when they qualify.

One participant reported that their NHS Board was about to introduce a new initiative that would feed into Flying Start:

We have got a new initiative about to start... a new module called 'Newly Qualified Practitioners' Development Programme', which we are proposing for four core days so it would be for nurses and AHPs, four core days of normally 12 hour days in which they will have some information given in sessions that will be linked to skills for clinical practice, and quite a period of the day will be reflective processes ... what they would be doing would be the Flying Start portfolio, that would be the assessment criteria although we are not assessing it.

Attention was drawn to the benefits of face-to-face contact for some topics:

As clinical staff are concerned [with] the hands on stuff of moving and handling, violence and aggression stuff, you need face to face stuff, you need a workshop for these things ....

Monitoring uptake and completion of Flying Start

Participants indicated that having newly qualified practitioners enrol on Flying Start was not the main problem, although as mentioned above, there were issues about the best time for enrolment. However, monitoring and providing ongoing support was found to be more of a challenge.

It's easy to get them registered, that's not the difficult bit... I don't think there is a problem with registering. It's the rest of it.

We are aware of the uptake but we are not aware of the completion

Attention was drawn to the difficulty for newly qualified practitioners managing their time when coping with a new job and the difficulties associated with having no externally imposed deadlines or guidance:

> *I don't think many [newly qualified practitioners] had a focus - they had a year stretching ahead and it was, 'We've got a year, a year's plenty...'*

> *People don't necessarily get that the responsibility is on them because it's a self directed learning programme, there is no final assessment, it's according to their needs. I think that really confuses people.*

Monitoring progress

Having enrolled, there is no Scotland-wide accepted method of monitoring progress. Participants felt that the lack of structure did not motivate newly qualified practitioners:

> *I don't think [newly qualified practitioners] are very good at self-directed learning, no matter what they say, they're not actually very good at it.*

> *I think we're needing to make the programme more focussed*

> *What should my portfolio look like? How much are you expecting me to do? And one of the big questions is, 'Well what's the point in doing this if nobody's going to mark it?'*

A small number reported being able to track their newly qualified practitioners, but this tended to be in the smaller NHS Boards:

> *I am more likely to find out they have completed by a conversation with a mentor in the corridor ... because you can bump into people and you can ask how they are getting on, and get an answer, but you realise it is not a formal process.*

Larger Boards reported finding it more difficult:

> *This is where we want the local people to start taking a bit more responsibility, so that it will be policed a bit more down at local level, so that charge nurses will be doing reviews and making sure they're at least progressing if not completed it by the twelfth month.*

> *Just now we are just getting out lists of names with the Board, when you have a Board of this size it's difficult.*

A number of participants reported having developed, or being in the process of developing, their own systems with the joint aims of supporting newly qualified practitioners, and ensuring that benefits accrue from providing protected time. Regular meetings and updates are now required in many areas:

> *We're giving them deadlines now because every month they're going to get a progress form from me saying, 'What have you done? What are you working on?' ... because they are now given protected time.*

We were talking with NES about sign-posting people and giving them an idea at approximately two months, 'this is what you should be doing at the end of six months', 'this is what you'…I think this gives them more focus.

The PEFs follow up with the newly qualified practitioners every month, 'Where are you? What are you doing? How are you getting on? Do you need anything?'… That's by letter and they've got to respond...

In one NHS Board they have recently put a system in place for tracking progress:

I'm getting completion forms back and I've put on it, 'Have you completed?' and I've maybe had half a dozen so far, I just sent them out what, three weeks ago, I've had a few more back saying I've not completed, but I've asked for what date they envisage completion.

Other participants reported that they too were looking at systems for tracking progress, however, attention was drawn to the difficulties associated with monitoring a programme when there is no guidance as to what progress or completion look like:

It would probably have felt better from our perspective if [there was] some kind of bench mark to measure their work against.

That is extremely difficult because we/I think NES haven't even come up with an exit process - what I have done with my AHP colleague is that we have devised an exit process...

There was a perception that it was easier to monitor nurses than AHPs, possibly because a cohort of newly qualified nurses often starts at one time:

We can police and monitor the nursing but the other AHPs are very difficult … With the nurses we have like two cohorts come into an established programme twice a year, so it's really easy to police them and it's big numbers, but the other graduates, AHPs can be any time.

Monitoring completion
Almost all participants indicated that they had no way of tracking whether or not newly qualified practitioners completed Flying Start in their NHS Board:

We don't have any information on the completion rates.

I don't know is the easy answer, I don't know what [completion rates] are and I'm worried that they are actually very, very low.

It is difficult from my situation to see who we have got that has completed the programme, and who hasn't - you know we have got people who log on and literally don't do anything once they are on.

Accreditation

A number of participants mentioned work currently being undertaken which focuses on the potential for accreditation of Flying Start. It was apparent that there were mixed views, for example while some participants highlighted the disincentive for newly qualified practitioners at degree level or above, others felt it would increase uptake:

> *I think a lot of them think it unnecessary because they've got this graduate qualification, if there was some sort of accreditation then the uptake might improve.*

> *There are various different levels of work whether it was a graduate or a diplomat ... I felt it was a little bit too low for the people who have qualified as a graduate.*

However, one participant voiced concerns that accreditation might shift the emphasis from experiential learning to a more academic approach:

> *I've got some reservations about that because to accredit it is beneficial, but it could mean then that the newly qualified practitioner focuses on the academic content and not it's clinical application ...*

Recruitment and retention

When asked about their perceptions of the impact of Flying Start on recruitment and retention, a large majority of participants indicated that there was no evidence that the programme had had an impact on recruitment. In fact participants reported that there were generally more applicants than jobs available. One participant suggested that there might be more competition, both for jobs, and for good applicants in the central belt, but felt that in more isolated areas there was less choice for all health professionals including those who are newly qualified. Two participants believed that Flying Start *had* had an impact on recruitment in their NHS Board:

> *I think it does have a positive benefit on recruitment.*

> *I think it's always difficult to say that one particular issues has a clear correlation and identified influence over things like recruitment, but I think I can confidently say it has been part of our success in recruitment and retention ... we've got a good track record... I think Flying Start is playing its part in that.*

However, others were not convinced:

> *I don't think Flying Start will particularly make somebody stay in [NHS Board] because it's everywhere... I don't think that it would make that much difference.*

Interestingly a small number of participants indicated that they 'felt' that Flying Start *ought* to have some impact on recruitment. Two participants drew attention to the potential benefits:

> *If I was aware that somebody was actively participating in the Flying Start programme that would make them far more desirable to me .... certainly the students are made very much aware that this should be something that should be on their CV.*

> *I had a girl who qualified two years ago so she missed out on the complete programme because she went fairly quickly on maternity leave and this is her coming back to work*

… my advice to her was to re-register on Flying Start so therefore keep up her professional development.

One participant believed that AHPs might be more willing to move than their nursing colleagues and that AHPs from England might find Flying Start an attractive proposition. Others thought that increased confidence might have an impact on retention and future prospects:

Sometimes maybe the newly qualified just feel a wee bit out of place … to me that's quite a big issue where retention's concerned, if you feel welcomed in a team and you're made to feel welcome and enjoy what you're doing, chances are your going to stay a bit longer ….

I don't think there is any evidence ... I think what it does is it gives an opportunity of some equity of support for newly qualified practitioners ...

Life Long Learning and the Knowledge and Skills Framework

A number of participants felt that there was a need for a shift in ethos with health professionals recognising that learning is an ongoing process rather than a discrete event.

It's getting that culture into all staff... It's life long learning now... Even when you've qualified it doesn't mean to say that you don't need to do more learning... people need to change.

Flying Start Coordinators in particular reported that they were visiting students in their local HEIs in order to raise awareness of the Flying Start programme, promoting it as a source of support for newly qualified practitioners rather than another hurdle:

I think there could be a wee bit more education in the pre-reg stage about development, and life long learning.

Participants drew attention to the implementation of the KSF and the way in which Flying Start would fit with the Foundation Gateway.

KSF is a higher priority on their agenda whereas if they could recognise that [Flying Start] would compliment that, and give them the structure and evidence to support KSF.

although, one participant thought it was too early for the KSF to have an impact on the attitudes and behaviour of newly qualified practitioners:

I think the link to the KSF it isn't quite there yet, and it isn't quite evident and I think that the newly qualified practitioners aren't really seeing the value between the two, but I think that will change - I think that these two pieces of jigsaw will snap into place in October hopefully, or before that.

However, when asked about the anticipated timeframe for the KSF being implemented in their NHS Board, it was apparent that progress varied considerably:

I think it has been put back a year

I really haven't a clue

I'm tempted to say it's implemented to a certain degree

Primary Care Initiative

Although the majority of interviews focused on newly qualified practitioners in acute settings, a small number of participants mentioned newly qualified practitioners going straight into the community. In one NHS Board where newly qualified practitioners had been employed into the community they had failed to secure permanent employment at the end of their first year due to situations out with their control:

> *It was a real disappointment because I had a real angst for the primary care girls, had we set them up to fail because we didn't have permanent jobs for them?*

Despite this the above participant reported that the newly qualified practitioners who had been involved had valued the experience:

> *I mean all of them said that even if they didn't have a job at the end of it, they had learned such a lot and it was a really good programme and they would do it again.*

Attention was drawn to differences in the way in which newly qualified practitioners had settled into community settings and preconceived expectations:

> *Things we thought they might struggle ... clinical skills were not an issue ... they could learn them easily, it was things like team working that they struggled with...*

> *They could do the tasks but, they didn't appreciate how much more there was than the task... they just didn't have that bigger picture of the whole holistic nature of care.*

Another participant reported that in their NHS Board they had always recruited straight into the community:

> *We have always employed newly qualified staff in primary care here and while we had a sort of supervisee clinical supervision sort of mentor relationship for them we had no real programme as such.*

Thus Flying Start and the extra funds associated with the programme were greatly appreciated:

> *We were really innovative and we managed to have these three [newly qualified nurses] who rotated round that much wider community basis, and that was absolutely fabulous for us. It solved the recruitment problem it meant that it opened up you know exposure to students for the staff in those places, but it also meant that the students got that wider development of being a staff nurse in a remote and rural community.*

The future

When discussing potential improvements and the future development of Flying Start the vast majority of comments related to the issues raised above including protected time, lack of structure,

the ability of mentors to support newly qualified practitioners undertaking Flying Start, whether or not it should be compulsory, the integration of other programmes, and how Flying Start will fit into the KSF. However, there were also comments relating to the support currently available due to the additional funding, for example the Flying Start Coordinators posts. Particularly in the larger NHS Boards there was a perception that while considerable progress had been made over the past six to twelve months, further input was needed for Flying Start to be fully developed and embedded:

> *I mean I suppose from my point having the Flying Start co-ordinator in post, she won't have finished her job in the next six months ...Yes, and I think another year would really make a difference in getting us to a position where we have got all the systems in place.*

> *When I was given the post my lead made it very clear that I wasn't to start something that would need a person to support it long-term.*

Summary

As part of the evaluation of Flying Start NHS data were collected from twenty-one Lead Contacts and/or Coordinators covering all NHS Boards in Scotland. A thematic analysis of the data derived from the interviews highlighted the enthusiasm and excellent work being carried out across Scotland.

Despite having been introduced in 2006, the implementation of Flying Start appeared to still be in its infancy. It was apparent that a distinction had emerged between Flying Start Lead Links and/or Co-ordinators in terms of their roles, for example between managing or enabling the programme, and implementation on the ground. The number of newly qualified practitioners employed, and the area covered varied between NHS Boards creating different challenges for staff. Participants drew attention to differences between localities, between disciplines, and between acute and community settings, and emphasised the importance of support for the programme at all levels, including Directors, Practice Development, ward managers, PEFs, mentors and Human Resources.

Participants indicated that having newly qualified practitioners enrol on Flying Start was less of a problem than ensuring that they progressed and completed the programme. It was suggested that newly qualified practitioners found the self-directed approach to study difficult to manage. Some participants felt that it would be preferable if participation were mandatory, or if newly qualified staff were given a stronger strategic and professional steer that they should undertake Flying Start.

Participants drew attention to the importance of support from senior management, involving representatives from all disciplines, face to face contact with PEFs, access to IT, support with IT literacy, protected time, and awareness raising in the HEIs so that newly qualified practitioners were aware of Flying Start before coming into post. However, the provision of protected time and access to IT varied considerably between different NHS Boards/localities. Participants highlighted the lack of knowledge relating to Flying Start amongst some of the mentors who had not undertaken the programme themselves, and had limited knowledge of the requirements. A majority of participants reported that their NHS Board provided some face-to-face support for newly qualified practitioners, which was thought vital for a number of topics.

A small number of participants drew attention to negative attitudes amongst a proportion of new staff, including dislike of change in terms of feeling under pressure to complete a programme that

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had not been a requirement for newly qualified practitioners in the past, and a perception that they had completed their education at registration. It was suggested that there was a need for a shift in ethos with health professionals recognising that learning is an ongoing process rather than a discrete event. Concerns were raised about the best way to support newly qualified practitioners who did not secure employment immediately, e.g. those who join the Nurse or AHP Banks.

Perceptions of the way in which Flying Start fitted with previously existing education or induction programmes varied between NHS Boards and between disciplines. A majority of participants reported that they were mapping previously existing programmes to Flying Start. Participants drew attention to the implementation of the KSF and the way in which Flying Start would fit with the Foundation Gateway. However, it was suggested that perhaps it was too early for the KSF to have an impact on the attitudes and behaviour of newly qualified practitioners, particularly as the timing of full implementation is unclear in some areas.

A number of participants mentioned work currently being undertaken which focused on the potential for accreditation of Flying Start. It was apparent that views were mixed, for example while some participants highlighted the disincentive for newly qualified practitioners at degree level or above, others felt it would increase uptake. One participant voiced concerns that accreditation might shift the emphasis from experiential learning to a more academic approach.

Although the majority of interviews focused on newly qualified practitioners in acute settings, a small number of participants mentioned newly qualified practitioners employed in the community. One NHS Board, which had participated in the primary care pilot study, felt that it had been very successful, despite having been unable to provide permanent employment at the end of the year. Another participant reported that, due to the nature of their locality they had always employed directly into the community. However, the extra support associated with Flying Start had been beneficial. A large majority of participants indicated that there was no evidence that Flying Start had had an impact on recruitment.

Information gathered from the telephone interviews, presented above, was used to form the basis of a half-day Nominal Group Technique Event (NGT) to which all Lead Contacts and Coordinators for Flying Start NHS were invited. Further information relating to the NGT event is included in the next chapter, chapter 4.

CHAPTER 4

MODIFIED NOMINAL GROUP TECHNIQUE EVENT INVOLVING FLYING START NHS LEAD CONTACTS & COORDINATORS

Data collection June 2008

Initial work on the evaluation of Flying Start, which involved telephone or one-to-one interviews with twenty-one Lead Contacts and/or Coordinators covering all NHS Boards in Scotland, was presented in the previous chapter. The aim was to build a knowledge base of the factors which supported a successful outcome for newly qualified practitioners, and identify factors which worked well or required further development. A thematic analysis indicated that there were variations in the way in which Flying Start has been implemented in different NHS Boards, and that there were differences in the nature and quantity of support provided for newly qualified practitioners and the mentors who support them. In order to build on this early work and to provide an opportunity to share good practice between NHS Boards and disciplines, the findings derived from the interviews were used to underpin a modified Nominal Group Technique event held in Edinburgh in June 2008.

Procedure

Preparation for the NGT event began with circulation of the summary of the findings from the interviews and a list of a list of potential topics, identified from the analysis, to be ranked according to those deemed most important to discuss at the event:

- ◆ Role of Leak Link/Coordinator
- ◆ Whether Flying Start should be optional or mandatory
- ◆ Structure of Flying Start
- ◆ Support for newly qualified staff
- ◆ The role of mentors
- ◆ Monitoring
- ◆ Promotion of Flying Start and avoidance of duplication
- ◆ Primary care initiative

A full list of the topics is included in the appendix, page 137.

Based on the ranking of topics circulated to all Lead Contacts and Coordinators, two main topics were identified:

1. The role of staff, at all levels, supporting the implementation of Flying Start
   - ➢ Role of Lead Contact/Coordinator
   - ➢ The role of mentors

2. The organisation and structure of Flying Start
   - ➢ Should Flying Start be optional or mandatory?
   - ➢ Structure of Flying Start

The next stage of the process involved emailing all Lead Contacts and Co-ordinators the topics identified. They were also sent a *proforma* on which they were invited to independently and privately record their ideas and opinions relating to the questions and problems of interest, see appendix, page 4. Lead Contacts and/or Coordinators who were able to attend the NGT event were invited to bring their ideas with them. Those who were unable to attend were invited to email ideas and comments to the research team in advance of the event. A summary of the comments recorded on the *proformas* completed prior to the event are included in the appendix, page 139.

The Nominal Group Technique Event

Twelve NHS Flying Start Lead Contacts/Co-ordinators from nine NHS Boards attended the event. One Lead Contact, who was unable to attend, submitted comments. The two topics were managed in a similar fashion involving three stages:
1. A round-robin session to identify relevant themes or issues relating to each topic
2. Individual selection of themes/issues perceived to be of greatest importance
3. Group work in small groups to identify the main issues or difficulties, and potential solutions.

Findings

TOPIC 1: The role of staff, at all levels, supporting the implementation of Flying Start

Participants were asked to think about staff that currently, or in the future, could support the implementation of Flying Start, and indicate what they thought were the most important themes or issues. Themes were recorded on flip-charts (see appendix, page 9) and five main areas selected for further ranking, 1) Appropriate Lead Contact, 2) Sustainability after dedicated role, 3) Middle management support, 4) Expectations of newly qualified practitioners, and 5) Role of mentors

Participants were then asked to decide which three themes/issues from the above list they thought it most important to address, and write the reason they have chosen each theme or issue on a 'post-it'. The five topics were listed on a wall-chart, and participants were asked to put their three post-its beside the topics of their choice giving a visual picture of the topics deemed worthy of further investigation by the group as a whole. The topics selected as being the most important to address were:

♦ Sustainability after dedicated role: selected by 10 out of 14 participants
♦ Middle management support: selected by nine participants
♦ Role of mentors: selected by nine participants

Data are relating to the reasons participants chose each topic are included in the appendix, page 143.

Participants divided into three groups of four, with each group focusing on one topic for 30 minutes. Group interactions were recorded in order to enable clarification of any issues that were raised, and each group fed back their perception of the issues/difficulties associated with their topic and potential solutions.

a) Sustainability of Flying Start programme

Issues	*Potential solutions*

♦ Prolonged commitment to co-ordinators
   ♦ Maintain National/local consistency
   ♦ Liaising: NES, other NHS Boards
   ♦ Service development based on local need
   ♦ Capacity to trouble shoot local issues
   ♦ Relieves pressure on existing Practice Education priorities
 	
♦ Mandatory status
   ♦ Yes/no
   ♦ Requires extensive discussion
   ♦ Financial implications
	♦ Promote professional responsibility
	   ♦ CPD/PDP
	   ♦ KSF
	   ♦ Mentor – responsibility to new staff
	   ♦ Managers
	
	♦ Constant awareness raising
	   o Various methods
	      ▪ Leaflets
	      ▪ IT
	      ▪ Word of mouth
	      ▪ Forums – personnel required with sole focus
	   o Different groups
	
	♦ Protected time
	   o Mentor
	   o Newly qualified practitioner
	
	♦ Guaranteed IT access
	
	♦ What is completion?
	   o Would it give focus to Newly qualified practitioners
	   o Involves KSF

b) Middle management support

Issues	*Potential solutions*

♦ Capacity priority over development
♦ Not middle management early enough in process of Flying Start launch
♦ Lack of awareness and ownership of FS (valuing)
♦ KSF agenda delayed
 	
♦ Resources
   o Corporate objectives
   o Implementation of parental leave
 	
♦ Accountability – lack of!
♦ Leadership vision
♦ IT access – skills
	♦ Strategic support
	   ♦ Director down
	
	♦ Embedding CPD
	♦ PR Masterclasses for middle management level
	♦ Senior Charge Nurse Review
	   o SCN objectives
	♦ Resources – Workforce Planning
	   o National
	   o Local
	♦ Supporting CPD - ownership

c) The Role of mentors

Issues	*Potential solutions*

Support from Charge Nurses
o   Recognition of additional role
o   Understanding
o   Time
o   Resourced
o   High Expectations
o   Unrealistic
o   Selection of mentors

o   Clarity of roles
o   e.g. Pre and Post Registration
o   Preparation of role model
o   Programme

Quality assurance

o   Skills assumed
o   Enable newly qualified practitioners
o   Work blending
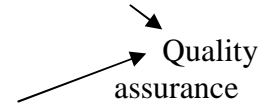
TOPIC 2: The organisation and structure of Flying Start

Discussion of the second topic began with a round-robin session in which participants were asked to think about the way Flying Start is currently implemented and indicate what they thought were the most important issues. Issues or themes were recorded on a flip-chart and four main areas selected for further ranking, 1) Completion/KSF, 2) Mandatory, 3) Signposting, 4) Start Point, see appendix, page 146.

Participants were then asked to decide which three themes/issues they thought it most important to address, and write the reason they have chosen each theme or issue on a 'post-it'– these data are included in the appendix, page 13. Again the themes were listed on a wall-chart, and participants were asked to put their three post-its beside the area of their choice giving a visual picture of the issues deemed worthy of further investigation by the group as a whole. The issues selected as being the most important to address by the most participants were:

♦   Completion/KSF: selected by 12 out of 14 participants
♦   Mandatory: selected by 12 participants
♦   Signposting: selected by 8 participants

Participants again divided into three groups of four, with each group focusing on one topic for 30 minutes the aim being to identify the main issues or difficulties and potential solutions.

a) Completion

Issues	*Potential solutions*
♦ There are more questions than answers!	No solutions were listed.

♦ What does it look like?
   o e.g. 10 concluding activities?
   o Evidence of reflection based on clinical experience not a collection of resources
   o Who marks it and gives guidance?	

♦ Will focusing on the KSF change the impact of the course for newly qualified practitioners?	
♦ Recognition of completion – where should it come from?	

b) Mandatory

If Yes:	**If No:**
♦ CNO and CAHP Officer endorsement ♦ All or nothing ♦ Lever for protected time ♦ Link to KSF : gateway ♦ Equity in Scotland ♦ Link to CPD and prep ♦ Prioritise learning ♦ ?Probational Year	♦ Framework for personal development – not an essential requisite ♦ Prescriptive - dimensionally ♦ Restrictive –dimensionally ♦ Becomes a paper exercise ♦ Limited to deep learning ♦ FS – RIP!

c) Signposting

Issues	*Potential solutions*:
♦ Where to start? How to progress? ♦ When to start? How to finish (should we call it finish?) ♦ Link to local programmes/training ♦ Link to KSF not evident for NQPs and mentors and managers	♦ Feedback from NES national writing workshop? ♦ Updating websites to address issues of user friendly ♦ Clarity for users and mentors ♦ Emails to participants at regular intervals ♦ National approach to "completion"- certificate? ♦ Local review of progression – guidance to underpin

Proposed actions

Two main topics, each encompassing three themes, were selected by Flying Start Lead Contacts and/or Co-ordinators and used as the basis for group discussions with a view to identifying areas of difficulty and potential solutions. The following table summarises some of the suggested actions:

TOPIC 1: The role of staff, at all levels, supporting the implementation of Flying Start

1.1 Sustainability of Flying Start programme
♦ Promote professional responsibility in terms of a) CPD/PDP, working towards the KSF Gateway, and b) the provision of support, managers supporting mentors and mentors supporting newly qualified practitioners
♦ Raise awareness of Flying Start programme through appropriate channels
♦ Provide protected time for NQPs and mentors
♦ Ensure NQPs have access to IT
♦ Clarify nature of completion

1.2 Middle management support
♦ Ensure strategic support at all levels
♦ Embed Flying Start programme in CPD and promote ownership
♦ Provide masterclasses at appropriate levels
♦ Focus on staffing levels

1.3 The Role of mentors
♦ Clarify staff roles pre and post registration
♦ Senior staff should provide/be seen as role models
♦ Mentors should support newly qualified practitioners
♦ Encourage work blending

TOPIC 2: The organisation and structure of Flying Start
2.1 Completion
♦ Clarify criteria for completion, who assesses it, and how it will be acknowledged

2.2 Signposting
♦ Provide guidance relating to timetable for beginning Flying Start
♦ Clarify what completion looks like for both users and mentors
♦ Establish a National approach to "completion"
♦ Update websites to provide information re completion
♦ Email participants at regular intervals
♦ Regular local review of progression

2.3 Mandatory

Potential actions

If Flying Start becomes mandatory:

♦ Provide strategic endorsement across Scotland
♦ Ring fence protected time
♦ Link to KSF gateway and CPD
♦ Prioritise learning

Potential actions

If enrolment on Flying Start is optional:

♦ Framework for personal development only, not an essential requisite
♦ Lacks teeth

Summary

The modified Nominal Group Technique Event brought together twelve NHS Flying Start Lead Contacts and/or Coordinators and allowed them time to discuss the implementation of NHS Flying Start in their own NHS Boards, comparing examples of good practice, positive experiences, and difficulties that they have encountered since its introduction in 2006. All participants approached the tasks with enthusiasm, expressing their belief in the Flying Start Programme and indicating their commitment to its future success.

Attention was drawn to differences between NHS Boards, highlighting the importance of allowing a degree of flexibility in the way in which the programme is supported. Despite this, participants indicated that there would be benefits associated with a tighter steer, possibly making the completion of Flying Start mandatory for newly qualified practitioners and if not mandatory, certainly stressing that they were *expected* to undertake the programme. Other areas of the programme where participants indicated that they would like a more structured approach included guidance on the best time to enrol on the programme, the extent to which participants' progress should be monitored, and what completion looks like. Issues of equity were also raised, e.g. differences in the time available for undertaking Flying Start and access to IT in different NHS Boards. Participants felt that greater emphasis should be placed on the opportunity to embed Flying Start into clinical practice and ongoing CPD as newly qualified practitioners work towards their first gateway; attention was drawn to the benefits of bringing together induction and other programmes where possible in order to reduce pressure on newly qualified practitioners and other staff. Participants also highlighted the importance of staff at all levels supporting the programme and creating role models for new staff and their mentors who may not have undertaken the programme themselves.

CHAPTER 5

FOCUS GROUP AND ONE TO ONE INTERVIEWS
WITH FINAL YEAR STUDENTS

Data collection April - December 2008

This chapter provides details of data collection involving final year (3rd/4th year, and Masters students) nursing, midwifery and allied health profession students which sought to assess students' attitudes as they approach registration.

Aim

The aim of this stage of the evaluation was to explore the views of final year students about to seek employment in the NHS. An interview schedule was developed covering a range of topics including:

- Knowledge relating to Flying Start NHS
- Perceived support needs following registration
- Positive and/or negative beliefs about Flying Start NHS
- Support required to complete Flying Start NHS
- Future employment

A copy of the interview schedule is included in the appendix, page 149.

Procedure

All HEIs providing education in Nursing, Midwifery, and the Allied Health Professions were contacted, provided with information about the evaluation of Flying Start, and asked if their final semester students could be involved in the evaluation. The aim was to carry out focus group interviews in eleven HEIs between April and July 2008. HEIs dealt with our request according to their own institutional procedures with some requiring a full application to their own Research Ethics Committees, and others accepting the approval granted by the University of the West of Scotland Research Ethics Committee. Perceptions of the relevance of involving final year students in the evaluation also varied, with staff in some institutions questioning whether or not it would be good use of their students' time. Thus while some institutions organised recruitment of students and provided a venue very quickly following our request, the involvement of students in other institutions was more difficult. Student participation also varied; on a number of occasions members of the research team arrived at an arranged venue and no students attended, on other occasions one to one interviews were carried out rather than focus group interviews.

Participants

Overall 70 final year nursing and AHP students attending Glasgow Caledonian University, Queen Margaret University, University of Abertay, University of Dundee, University of Edinburgh, University of Glasgow, Napier University, University of Stirling, University of Stirling Highland Campus, University of Strathclyde, and the University of the West of Scotland were involved. Unfortunately we failed to involve students at one University because no students attended a scheduled focus group interview. Further attempts to involve students were unsuccessful despite considerable effort on the part of members of the research team and staff in the institution. However, we felt that it was necessary to put a time limit on the period over which data were collected.

A small number of participants had in fact completed their courses prior to participating in the focus group interviews, but none had started working as a qualified practitioner. Fifty-six participants were female, 14 male. Age ranged from 20 to 52 years with a mean of 31 years; however the age distribution was skewed towards the younger ages - half of all students (50.0%) were aged less than 30, with a second peak (27.1%) in early to mid 30s (see figure 1 below). There was no difference in the distribution of age associated with gender or profession.

Figure 5.1: Final year Nursing, Midwifery, and AHP students: age
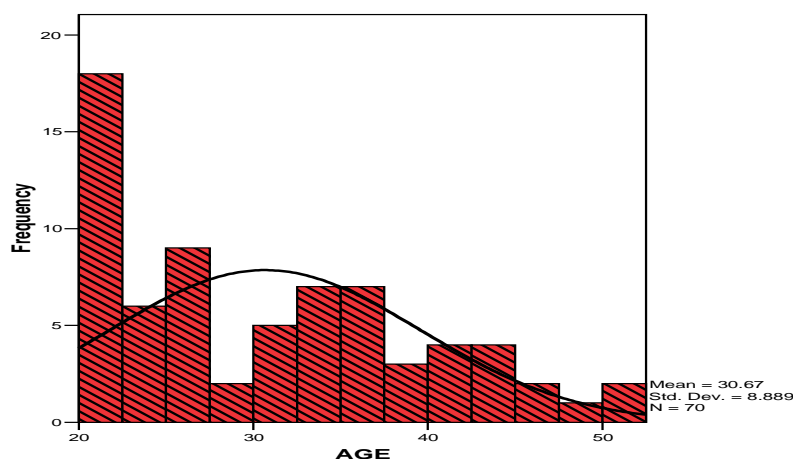
Forty-six participants were nursing students, of whom 41 were working at degree level and five were completing a diploma. Twenty-eight nursing students reported that they were working towards registration as general nurses, 12 were specialising in adult nursing, and 10 in mental health nursing. Six students were working towards registration as midwives, and four reported that they were studying nursing and midwifery. Amongst the students working towards registration as AHPs, disciplines included speech and language therapy (1), Diagnostic Imaging Science (1), and Occupational Therapy (8); two students were working towards undergraduate degrees and eight were completing an MSc. The following table provides information relating to the location and discipline of participants.

Table 5.1: *Final year students involved in focus group interviews, location and discipline.*

HEI	Nursing	Midwifery	Nursing & Midwifery	AHP	Total
Glasgow Caledonian University	3	-	2	2	2
Napier University	3	-	-	-	3
Queen Margaret University	-	-	-	7	7
Robert Gordon University	-	-	-	-	0
University of Abertay	1	-	-	-	1
University of Dundee	4	-	2	-	6
University of Edinburgh	4	-	-	-	4
University of Glasgow	8	-	-	-	8
University of Stirling	4	-		-	4
University of Stirling Highland Campus	8	-	-	-	8
University of Strathclyde	-	-	-	1	1
University of the West of Scotland	15	6	-	-	21
Total	**50**	**6**	**4**	**10**	**70**

The choice of focus group interviews, which involve a relatively small number of participants rather than other methods, e.g. a survey, which could potentially reach a larger number of students was based on a desire to gather in-depth information from students, and typically low response rates achieved in many surveys. However, it is important to acknowledge that it is not possible to gauge how representative of final year NMAHP students our participants were. Asking students to give up their time to participate in a focus group interview at a busy time in their studies would undoubtedly have had a negative impact on recruitment – certainly one student questioned her own suitability:

> You know we were selected by [lecturer] - sat in front of a room and said, *Who is prepared to take part?* So we'll see … I don't know how representative my views are…

We were also aware of a tendency for friends to agree to participate together, i.e. groups with generally shared attitudes towards a number of issues. Despite this, discussion in all focus groups covered a range of opinions, thus while the attitudes of students in some institutions did appear to be more positive than those expressed by students in other institutions we do not feel that it would be appropriate to take the next step and attribute these differences to the ethos within the host institution.

Findings

Knowledge relating to Flying Start NHS

Students were asked what they knew about Flying Start. Responses varied, with students from four HEIs demonstrating a good knowledge of the programme:

> *It is making the transition from student to staff nurse with the support of a mentor to progress and gain more confidence.*

> *It is almost kind of linked to your initial pay increments and things, and you can use it to demonstration certain competencies or whatever...*

However, students from six institutions had limited knowledge:

> *I am not entirely sure how Flying Start is implemented, if it is online, or if it is face to face meetings...*

> *We hadn't heard about Flying Start until this[week] ….*

In one institution, where data collection involved a number of focus groups and one to one interviews, it was apparent that knowledge varied between students, possibly indicating that some students had sought information independently rather than having received information within their course. When asked about the ways in which they had heard about Flying Start, some students reported that they had attended talks:

> *We've had a few talks from PEFs and things like that.*

I went to one of the Flying Start lectures at the beginning of the year ... 3rd year students were asked because there were spaces... I found it really interesting actually ... it instilled a lot of sort of confidence.

Others indicated that their institution had done little to inform them:

We haven't been told anything about it, and it is mentioned in passing like, You will undertake this programme... but we don't really know what it is.

There is something written into it that every university has to tell their pupils about it, but I just got, There's the web address.

Other students reported having heard about the programme through word of mouth:

Funnily enough it was mentioned to me in passing by a relative

A majority of students who had been provided with information about Flying Start revealed that it was something that was raised towards the end of their education/training.

First impressions of Flying Start NHS website
Students in a number of focus group interviews reported that they had looked at the Flying Start website prior to attending the interview. Initial perceptions varied, with some students being very positive, drawing attention to the resources available through the programme, and the fact that it can be accessed at any time of day or night, from anywhere:

There are tons of examples we can look at in each section, and loads of references and reading. It is pretty good.

I looked at the website and it is some kind of 'ask the expert' kind of thing.... I think for [newly qualified practitioners] in rural areas or one of the islands up there, I think they would be completely lost on their own, and it is a great way for them to get some support.

I think that is quite a good way of accessing support even of an evening ...

While others reported feeling overwhelmed:

I think looking at the website last night I was just a bit overwhelmed by the amount... I was thinking God, you know, never work through all this in the next year ...

Having looked at the website I suppose my initial reaction to it is to say it's a little bit, I feel a little bit down ... you're confronted with a sort of one size fits all programme ...

Attention was drawn to the potential for duplication of effort:

It just gets a bit over whelming sometimes ... you've got your Knowledge and Skills Framework, you've got your Flying Start, and you've got all your learning outcomes from your university, and portfolios...

Contact with newly qualified practitioners

One potential source of information relating to Flying Start is contact with newly qualified practitioners when on placement. The students acknowledged that speaking to others who had completed or were currently undertaking Flying Start would be valuable:

> *If I had got some positive feedback from somebody…. some kind of feedback about whether it's valuable to sink your effort and energy into [Flying Start].*

However, several participants reported that newly qualified practitioners that they had met while on placement had not enrolled on Flying Start or if they had, had not mentioned the programme:

> *I have spoken to people in the wards who are newly qualified and I have not come across anyone that has registered for it yet.*

Others reported that their contact with newly qualified practitioners undertaking the course failed to convince them of it value:

> *At my last placement there was nurses there that said that they weren't doing it because they felt that they didn't have the time and they didn't feel it was going to benefit them.*

> *There was a nurse who was undertaking the programme up in [rural area] and she was working with district nurses and she was having to travel into [town] to do the course …*

> *One [newly qualified practitioner] was towards the end of her first post qualified year and she hadn't even looked at Flying Start.*

Participants drew attention to the difficulties of coping with a new job:

> *They seemed quite harassed a lot of the time but I think that is just a general settling in period….*

> *At the moment there are quite a lot of newly qualified [staff] on the ward … they have been thrown in at the deep end, and they are kind of feeling out of their depth.*

A perception that managers did not value the programme was not unusual:

> I've seen some newly qualified nurses not bothering with it. It's not because they don't feel it's important, but it's because like they're not getting… they're not being told that it's important by their employer

Participants reported that newly qualified practitioners spoke of difficulty accessing support from managers and mentors particularly in terms of providing time within working hours:

> *I worked with a girl that had been qualified for a year and a half and she was saying that she didn't get time to do it at all, she had no protected time because the ward was so busy and she was trying to get to grips with what was happening on the ward and her mentor for Flying Start wasn't on the same shift as her…*

Other participants reported that newly qualified practitioners they had worked with spoke positively about Flying Start:

> *[Newly qualified practitioner] found it very useful and I think it was partly because she was given the time from her supervisor to go away and work on it ... I wouldn't quite say 'raved about it', but [she] definitely said it was a positive experience to the extent where I would think about doing it myself.*

However, it was apparent that support from managers, particularly in terms of time, was vital if newly qualified staff were going to progress:

> [My ward manager] was saying that she has got no problem with newly qualified staff if they have got time then to go away into the computer room and get on with it ...

> One [newly qualified practitioner] had just got the job, and one had got the job just about Christmas time, just after she qualified, and both of them were saying about Flying Start, but they hadn't actually started it … understaffed, overworked, busy ward and no time …

A few students reported having spoken to AHPs who had benefited from funding[1] to complete Flying Start:

> *It was at the point where they were getting paid for it, so they felt they had to do it to get their money, but it did feel a necessity rather than they wanted to do it ... they were doing it for the money ...*

Support needs following registration

When asked what they thought their support needs would be when taking up their first appointment post-registration, students acknowledged the significance of the move from student to qualified professional:

> *It's really daunting the whole prospect of going from student and kind of being held by the hand, and then all of a sudden you've got to do everything all by yourself ...*

> *You are getting totally cut off and the whole responsibility of having a job and, you know, being a new recruit, it is dreadful ...*

they drew attention to the differences between working in a ward in which they had recently completed a placement and entering a less familiar environment/speciality:

> Just to let you get your feet on the ground and then getting to know the ward …

> New job, you'd need support into the regular day to day running of the ward as a staff nurse, as well as say it's a speciality you'd want support into learning about that speciality…

Others stressed more generic skills:

> *Em, confidence, basic clinical skills, and to be able to confer with staff if you need them, and continuing personal development.*

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[1] Initially AHPs received funding for undertaking Flying Start; this is no longer available.

Differences in support needs in acute and community settings
Students were asked whether they thought support needs would vary between acute and community settings. The vast majority of students thought that there would be significant differences between acute and community settings for newly qualified practitioners, and drew attention to the potential for feeling isolated in the community, different ways in which health professionals interact with patients and their families, and the different skills that might be required:

> *You are kind of more on your own. You have more support in the wards, I think.*

> *You are seeing patients in their home so it is a different atmosphere compared to being on the wards.*

> *Due to different client groups, there will be different developmental needs*

Some students felt that they might be more vulnerable working in the community:

> It's a safety thing as well … going in as a newly qualified staff nurse you don't know what you're going into.

However, not all students were convinced of the drawback of newly qualified practitioners going straight into the community:

> I don't think it's as isolated as people conceive it to be, if you're in community.

Some students thought that working in the community would have advantages in terms of pace of work:

> *My experience of placement in the mental health setting was quite a slow pace, and you get time to think and time to reflect, and time to plan your interventions*

> *I think it is more relaxed in the community, isn't it, I think they do tend to have more time*

This topic is covered further later in the chapter.

Attitudes towards lifelong learning
In light of their perceived support needs following registration and their knowledge of Flying Start, students were asked how they felt about continuing to study when they had just completed their courses. A majority of students were philosophical about it, indicating the lifelong learning was something that they had always understood would be a part of their working lives:

> We knew that when we started that it's an ongoing learning thing …

> I think I was always aware that, even when I started the course, that my nursing is a constantly evolving profession.

However, students drew attention to the importance of Flying Start being relevant to their new roles:

If it is relevant to your job and it is going to help you then, yeah, but if it is something that is not relevant, then I don't want to be doing it for the sake of doing it.

It's evidenced based learning …

Some students expressed reservations about beginning Flying Start straight away, for example questioning the time allowed to undertake it:

If you had protected time at work to do it then you might have a wee bit more incentive to do it and that is if it was rolled out over a longer period of time rather than 1 year …

[Flying Start] wouldn't be an issue for the majority of us, providing it is done in our work time - as soon as it spills over into our personal time then people will resent it ….

The focus group interviews corresponded with a very busy time for some students who were approaching the end of their courses, and one student at least reported feeling overwhelmed by his current work without beginning to think about the next set of tasks:

I kind of feel a little bit out of control at the moment and I think that's maybe what's bothering me…

Many students were tired, reporting that a combination of work and study over a number of years had taken its toll:

I think that we have done so much work across the years and then to start another thing …

It is the assignments that put me off I hate writing essays and I am thinking, Yes, we are finished! And then we have got to do more reflective accounts.

I think it could add to the stress from the transition from student nurse to staff nurse …

Some students believed that Flying Start would be different from the study that they had carried out over the past few years:

Compared with what we are doing just now and what we have just done I don't think. It doesn't seem like a lot to me …

A number of students reported that they had really enjoyed studying and did not want to stop:

[Flying Start] wouldn't bother me at all and that is why I joined the profession to improve myself.

I can't imagine not studying; I want to keep going…

Some reported that they intended to continue studying immediately on completing their courses:

I'd quite like to do the MPhil so … if everything goes well I'll can start on that after the honours finish….

Other participants who had initially thought they might continue studying following registration indicated that they needed a break for a variety of reasons:

> *After doing the 3 years and with all the paper work …I just want to get on the wards now rather than doing more work.*

> *It is financial I can't afford to stay on anymore I have to get out to work now*

Should Flying Start be compulsory?

When asked if they thought Flying Start should be compulsory or voluntary, responses varied. A number of students indicated that they did not, or had not, known whether the programme was compulsory.

> *It was never actually explained that this was something we had to do.*

One student recounted the rather incongruous content of a lecture they had attended just prior to the focus group interview:

> *We've just had a lecture on change this morning and one of the things that came up was you know, being really clear with people whether or not they have a choice about the change that's being imposed, to opt in or opt out, and obviously you know we don't have a choice …*

Some students indicated that their attitudes towards the programme would vary depending on whether or not it was compulsory.

Advocates of compulsory registration on Flying Start NHS
Students who thought that the Flying Start should be compulsory felt that if the programme was compulsory there would be more pressure on employers to provide adequate resources to enable them to do it as part of their work:

> *It if is compulsory they have to support you to do it, the managers.*

A number of students extended the concept of 'compulsory' beyond newly qualified practitioners registering on the programme, pointing out that responsibility was a two-way thing:

> *Personally I do [think it should be compulsory] and I think it should also be made compulsory for the work places to incorporate and promote it as well, I think it has to be both ways.*

> *I think it should be compulsory for ward managers to support you through it rather than compulsory to do it…*

However, others had their doubts relating to voluntary participation:

> *I don't think there would be a very good uptake if it was voluntary.*

Advocates of voluntary registration on Flying Start NHS

Advocates for voluntary uptake divided into three main groups, those who wanted to have a choice about what they did:

> *I think you should have some sort of choice over whether you want to take part in it or not because some people are just not interested.*

> *I would be annoyed if someone told me I had to use it.*

Those who felt that they should not be asked to work outwith their working hours unless given remuneration:

> *I wouldn't be happy doing it outwith my working hours I think your working hours are enough ...*

And those who could see personal and/or professional advantages of completing Flying Start, particularly if their peers decided against it:

> *If you go for a job you can say, I did the Flying Start on the Internet for the first year and kept my studies up to date ... which will look better than saying, Yeah not done anything for a year*

> *You are still in the learning process anyway so nearer the end of your year you'll be a lot more competent having been on the Flying Start ...*

Attention was drawn to the flexibility of Flying Start as it is currently organised:

> *It sounds as if it is meant to be very flexible and you use it in the way you need to.*

Taking a pragmatic approach, some students thought that making Flying Start compulsory might be counterproductive:

> *I think people that are made to do things don't do them well.*

The optimum time to enrol on Flying Start

Given that new recruits to the NHS are likely to be *expected* to complete Flying Start, students were asked about their views on the optimum time to enrol. As mentioned earlier students felt that their needs when starting work would be influenced by how long it had taken them to secure a job, and whether or not they were familiar with the physical environment/speciality:

> *Depending how long it takes now for us to get a job, I mean how long that's going to be, how deskilled are we at that point.*

> *If you have been there during your placement you probably would want to [enrol on Flying Start] straight away... but if you come in really new you may want to get used to the ward and the environment...*

The majority of students indicated that they thought that a settling in period would be beneficial:

I think the first couple of months in the job you will just want to get familiar with the job and settle into the place

One student indicated that despite misgivings she thought that she would enrol on Flying Start:

I probably will make time to do it because I think on the whole it is good, it is good for you...

A small number of students reported having met qualified health professionals who had enrolled on Flying start some time after registration:

I spoke to a newly qualified nurse last week ... she had been qualified for 10 or 11 months or something. She feels that it is pointless now because she has already been qualified for a year, but now she has got a post she has to go and start to do her Flying Start.

Students at three institutions suggested that it might be useful to have access to Flying Start prior to registration:

I think maybe an idea might be to, you know, introduce it within third year at some stage and people start it ... because then you've had a flavour of it and you kind of say well I would like to keep this support going for my first job ...

If you could actually access it ... there's a lot of things on it like delegation, team working - it could have been like used in your class work because it gave you some good references and things like that...

Mode of delivery: online-learning

Because Flying Start is an on-line programme, students were asked about their experiences of on-line learning. Students reported that a number of institutions are putting coursework on-line for their students:

Our whole course is based around the web support, and we have a lot of interactive learning, study and stuff like that.

All your resources are all online based ...

Many students reported having completed online modules as part of their course. However, there were mixed feelings regarding this mode of learning:

Not a problem at all, I would rather do it online because you are free to stop and start or whatever whenever you like and it is always there for you.

It's easy to assume that because something's done online, done away from the work place and in your on time... somehow it takes less time and it doesn't...

Some students found it easy to let things slip if expected to complete them online:

I think not having to submit anything or hand anything in you could just kind of click through it and not really focus.

One student explained that, despite being competent in working online, their cohort tended to avoid online activities:

> *We are all very competent in using the internet and finding information but ... for some reason... none of us use it.*

Several students expressed a preference for face-to-face communication:

> *I just don't think that online learning is for me I need somebody like almost face to face ...I have to have some sort of interaction with people*

One student who had attended a Flying Start session locally drew attention to the advantages of people meeting face to face:

> *There was a lot of newly qualified nurses there who could all talk to each other about how they felt as well and I think that's extremely valuable ...*

Advantages for newly qualified practitioners undertaking Flying Start

Students were asked about the advantages and disadvantages of undertaking Flying Start. There were marked differences both within, and between groups. While some students were very positive:

> *I was going to do it.*

> *It's really a good idea.*

Others expressed feelings of resentment:

> *I understand it is just more work*

Supervision

Students in all focus groups discussed the potential for receiving support to undertake Flying Start, including supervision from mentors, managers, or the on-line programme:

> *A wee bit of guidance and knowing that you are not just being flung in there and a wee bit of help for you...*

Some students appeared to lack confidence in their own commitment to complete a programme that was self-directed and indicated that they would appreciate managers taking an interest in their progress and monitoring what they were doing:

> *Because [I] don't think I'd be so self disciplined in doing that ...*

> *Asking how you're getting on with it.*

More positive comments grouped around the recognition that they were *newly qualified* practitioners, *confidence,* and *having a structure for CPD.*

The transition from student to qualified practitioners

Attention was drawn to the importance of recognising that they were new recruits and not expected to know everything

> *I think it's a reassurance as well that they don't expect us to be out there all knowing or doing at first ... you're not really thrown in at the hard end without any support at all.*

> *Makes you feel like it's alright to still be learning things as well ... you're consciously aware that you should be learning and you're not supposed be finished.*

Confidence.

As mentioned above, students recognised that the transition from student to qualified practitioners could present a considerable hurdle. In a number of focus groups students suggested that completing Flying Start would enable them to become more confident:

> *I think it seems like its going to give you a wee bit more confidence that you have got something there to help you when you need it.*

One student suggested that the reflection required for Flying Start could alert them to the potential of developing poor practice:

> *If you find yourself in a setting where a lot of the team are doing things the way they have always done for years and years because that is the way they have always done it, it [is] just making sure that you don't get sucked too much into that ...*

Having a structure for CPD

Students drew attention to the benefits of developing good practice early their careers:

> *Knowing that you're working within the evidence base, being able to reflect on things ... if you didn't get into that kind of habit in your first year post qualifying then it would be harder to pick that up...*

> *The advantages are there, they are there to prompt you and keep and put all your details in and a good way of keeping all your records together.*

Some students believed that it would be very easy to lose their way due to the demands of a new post:
> *I think it will be very easy to get lost and just doing things but not really thinking about what you are doing.*

Thus they felt that Flying Start would help to develop organisational skills without imposing an overly rigid structure on their individual needs:

> Good way to introduce to CPD - content optional

> It still keeps you in that frame of mind like building up knowledge rather than just going out on the job …

Students recognised that they were on a continuing journey and that they required to document their learning for themselves, their supervisors, and managers if they wished to progress:

> *You are showing some evidence that … in say a year and a half, two years time, that actually I am going to for a senior post, because look how I have progressed in different areas.*

> *I was under the impression that it would help to identify practitioners with promise as well.*

Interdisciplinary interaction

In one focus group interview attention was drawn to the benefits of being able to meet with and share learning resources with other disciplines, particular reference was made to the on-line communication:

> *Personally I would quite like to speak to OTs, Physios, dieticians, because you work so closely with them anyway in all of the wards so it would be nice to get their point of view…*

Support required to complete Flying Start NHS: identifying and overcoming perceived disadvantages

Despite students acknowledging that they would undertake education and training throughout their careers, and a self-reported acceptance of the mode of delivery of Flying Start, i.e. an on-line programme, students appeared to have little confidence that they would be given the support they perceived necessary to complete the programme:

> *Is the mentorship going to be there for you, and the backup, the time, the support, and resources?*

> *I don't think the people at the moment get the right support*

Other concerns related to *access to IT*, *lack of time*.

Access to IT

The vast majority of participants reported that, based on their experience on placement, access to computers created problems. Students reported problems with passwords, outdated and slow computers, lack of time, and lack of privacy.

> *Usually where we are you're lucky to have a one computer on the ward - it's usually getting used to get blood results, and technical things...*

> *Normally the computers are right at the nurse's station so you've got everybody coming back and interrupting you, and relatives and everybody.*

A number of students thought that there would be advantages in using their home computers to complete Flying Start:

> *It would give you more privacy*

It's more confidential

Time

As mentioned above, students' perceptions of the support that was likely to be available was often based on interactions with newly qualified practitioners met while on placement and failed to instil students with confidence:

> *We had a lecture yesterday by last year's students who had just qualified, and they said they were meant to get protected time, but in practice it doesn't happen.*

Given the age profile of the students who took part in the focus group interviews, it is unsurprising that a substantial number reported having school age children to care for when not working. Attention was drawn to the potential impact on families of having to complete work-related tasks in their own time:

> *If your area/department did not support you well enough to do it and you did end up having to do it in outside areas and it could affect your home life.*

Students indicated that they believed that there should be time available for training and development:

> *I think newly qualified staff nurses should be allocated x amount of hours through the year for these study type day things, and I think that would be a good idea.*

Some students drew attention to the difference between different wards and disciplines:

> *Night shift or something … the ward is quiet anyway, you could take half an hour and get to it.*

> *It depends on the ward doesn't it? Because the first ward I was in [newly qualified practitioner] was enjoying it, but the other ones felt that it was such a busy ward that they weren't getting the support and time to do it.*

Ethos on the wards

Students raised concerns about the general ethos in relation to newly qualified practitioners undertaking Flying Start suggesting that there needed to be an acknowledgement of the importance of undertaking the programme at all levels:

> *I think it definitely has [to] come from the top of management*

Knowledge and commitment amongst managers

Some students felt that there was little knowledge about Flying Start within the NHS, and that managers did not understand what was entailed:

> I think that's a big problem as well, the awareness - how staff or nursing managers are actually aware of what it entails and what sort of support newly qualified staff are needing.

> Some are kind of aware it exists, but no very sure what it is.

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One student expressed surprise that ward managers were not better informed about Flying Start:

> *It is quite amazing how things like this don't percolate down to ward management level.*

Mentors

Students highlighted the importance of mentors for newly qualified staff taking up their first posts:

> *Your mentor is key, almost everything .... if your mentor is creative and adaptive and able to support you in a way that is suitable for you as an individual then you know you're going to win every time, if you've got a mentor that's not bought into the process then you'll really struggle ...*

Reports of their experiences with mentors while on placement were mixed:

> *Some of us have had extremely positive placements with fantastic mentors ... on the other hand we've had some bad placements ... as a result of bad mentorship*
>
> *Mentors don't seem to get the time to spend with you to teach you ...*

Reports gleaned from newly qualified practitioners students had had contact with included a few positive examples of successful mentoring:

> *Where I was on placement ... there was a very, very good mentoring system so I did see them getting support...*

However, a proportion of the messages that students had taken from newly qualified practitioners they had had contact with were negative:

> *[Newly qualified practitioner] was trying to get to grips with what was happening on the ward and her mentor for Flying Start wasn't on the same shift as her ...*
>
> *It wasn't very well structured for them and what was promised them at the start with regard to mentorship wasn't fulfilled ...*

Students expressed some sympathy for the mentors

> *The mentors should have protected time as well.*
>
> *I think mentors need support as well, as much as the students do.*

And suggested that support for Flying Start should improve as more people complete the programme:

> *The more people that do it the easier it will get for people coming up doing it because you'll have more of a knowledge of how to do it ...*

The future: seeking and securing employment

The final part of the focus group interviews focused on students' attitudes towards their chosen profession as they approached registration, their progress in securing employment including the advice that they had received, the strategies that they were planning to adopt, and the nature of the posts that they were seeking.

Careers advice
When asked to rate the careers advice that they had received from 1, *poor,* to 10, *excellent*, ratings ranged from 1 to 10, with a mean of 5.76. However, not all students were in a position to rate careers advice because they had not, as yet, received any, and scores in each focus group interview tended to be similar, giving a bimodal distribution indicating that students had received either *very good* or *very poor* advice.

In a number of HEIs students reported that they were expecting to be given advice prior to completing their courses or that careers talks were scheduled for later in the semester. Some students who had received careers advice reported that it had benefited them:

> *I would say we really have only had stuff to do with that in the last two week, but it has been really beneficial ...*

Those who had not received advice reported feeling disadvantaged:

> *I think the advice should have come a lot earlier....*

> *A lot of people are saying to me, like on placement and things, to apply in April time because that is when the financial year comes to an end so people know what their budgets are ...*

One student explained that lack of advice had had implications for her plans:

> *I was also considering leaving this area and going to another [NHS Board] but I can't because all the jobs have been done for that [Board] ... we didn't have any guidance to help us.*

Students from some institutions reported that much of the advice received by the time of the focus group interviews had been informal, with students actively seeking advice either from a lecturer or staff they met on placement. However, this did not always provide the desired result and one student drew attention to the importance of being careful whose advice was sought. Students in one focus group interview reported that they were providing their own guidance:

> *Yeah, we have actually been supporting each other; the first girl to get a job sent us a list and loads of question of what she got asked.*

> *I think there are certain things that are such a big thing at the moment, and we are all trying to get our heads around [them] and that is how we put our portfolios together.*

The perceived impact of Flying Start on recruitment and retention
Students were asked if the support available to undertake Flying Start would influence their choice of employer. Despite the fact that many students reported they were unlikely to have a

'choice' of employer, a number of students indicated that they would use Flying Start as a way of gauging potential employers' commitment to supporting their future career development.

> *With newly qualified practitioners the emphasis is always on retaining staff and so on, well [Flying Start] is a key thing ... if they recognise this then [newly qualified practitioners] might hang about longer.*

> *If there was [a post] available that promoted Flying Start and one that didn't, I would take the one that promoted the Flying Start. Yeah it would have an impact.*

Interestingly, students in one group reported that they had based some of the documents prepared in anticipation of job applications around Flying Start:

> *[One student in our cohort] set her portfolio and did a summary, and everyone is trying to do it, and it was nine sections of Flying Start ...*

Attitudes towards chosen profession

The vast majority of students reported that they were, or would be seeking employment in their chosen profession. However, for a number of students this was their second or even third career, reflecting the fact that a 'career for life' appears to be a thing of the past:

> *Stay in nursing*

> *Yeah, for the foreseeable future.*

> *Yeah, for a few years.*

Only one student was adamant that his chosen profession was not the right choice:

> *It's nursing, I really don't want to do nursing...*

Attention was drawn to the physical demands of the workplace and it was suggested that the decision to stay in a chosen profession might depend on a variety of factors including age and specific role:

> *There is an age limit at which I will have to give up through the sheer physical health... if I am in a ward situation and not being able to keep up with other people, but again if I am a health visitor then hopefully that will be longer.*

Other students also highlighted the range of choices available following registration:

> *I think there are a lot of avenues that you can go down like health visitor or community nurse ...*

A small number of students who were perhaps unsure about their future drew attention to the transferable skills developed during their course:

> *Even if nursing is not for you ... it allows you to look at everything, whether you like the theory side of it or the practical side of it or whether you like anatomy or just the basic care of the patient and things like that ... I suppose it opens up so many different opportunities for people and gives you different ideas.*

I did the degree along with my diploma so I could go and do a year's teacher training to be any kind of teacher so it even opens up that.

Nature of desired employment
Students were asked where they were hoping to work following registration. A few students had already secured their first posts; however, for the majority job search was in the future. Students indicated that, in an ideal world, their interests would be varied:

I'd love to work in rehab; accident and emergency; adults with learning disabilities; cancer nurse in oncology; cardiology; community or ITU; ENT; elderly; gyni; theatres; medical or surgical; mental health; orthopaedics; paediatrics; palliative care; surgery; not sure.

For many there was a perception that the best outcome would be to secure a post where they had had an enjoyable placement. However, in the real world, students recognised that their choices were likely to be limited:

Ah well, I'm trying not to be sort of, very particular, because there's not much choice at the moment …

If I had an option of where to work and wasn't just sort of taking the first job that was available…

A majority of students indicated that they expected to work in an acute setting in the first instance in order to consolidate their skills.

I'd like to start off in acute because I don't think I'd like to go straight into community - I wouldn't have the confidence …

I'd want to get a bit of experience before I went into the community

Students highlighted the differences in roles between acute and community setting, and suggested that they would need different skills in different settings. A mental health nursing student drew attention to different learning environments in the community:

I think it would help you to hone your counselling skills if you've got a group of people …that you're seeing on every shift, you're seeing them basically five days a week, you're sort of building up a relationship with them. That helps you hone skills you're really going to need in the community when you're only seeing people for a little window for an hour once a fortnight

While some students indicated that an acute setting would be their first choice:

A hospital I prefer the environment for some unknown reason I like the fast pace of the sort of clinical nature of it.

Others felt that the time they would spend in an acute setting was almost an extension of their training prior to beginning what they really wanted to do:

I'm not allowed [to go straight into community] they don't want to employ newly qualified staff in [NHS Board] so it'll be acute for me.

If a community job came up I would take it but I think there's the security within the wards - that back up's right there right now.

I feel much more comfortable in community and actually I'm the opposite with wards it's a bit scary for me ...

There was a perception that having worked in the community it would be difficult to move to an acute setting:

You can't go back into mainstream ward life... I think once you've specialised you are sort of streamlined to continue on that road aren't you?

A little bit like kind of serving an apprenticeship, but you're learning from experienced people ...

A midwives felt that it was important for them to have acute experience following registration:

Acute to start with and then maybe do a bit of both.

You've got totally different stuff happening out in community you've got your anti-natal care, you've got your post-natal care, you've got the occasional rare home birth happening. In hospital probably about 90% of what you're doing is deliveries ...

However a minority of student felt that spending time in an acute setting would be unnecessary and demoralising for anyone whose real ambition was to work in the community:

Could you imagine doing a year in the wards if [community] is really where you don't want to be?

A small number of participants reported that they did not want to stay in one area for too long, and indicated that they would prefer to move around:

I don't want to work in one area... I would like to move and see different parts, different perspectives on the problems and maybe different solutions ...

One student who had had placements in different geographical locations thought that it had been a valuable experience:

[They] gave us the choice of while we were training to go anywhere else ...I'd say to anybody to go and do it because it worth it ... I'm used to all different things and different guidelines, different ways of working, different layouts ....

Failing to secure employment
Some students expressed concern about securing employment and the delay before a post became available:

You can't even get on the Bank just now because there's so many.

We've just got to sit back and wait and it's the same with the Flying Start thing we can't do anything about it until we're employed, so until we become employed ….

By that time you've not used any skills for eight months.

There appeared to be some confusion relating to the one-year guaranteed posts and a number of participants reported feeling quite disillusioned:

Although it's called a one year guaranteed post offer it really isn't...

I'm a newly qualified unemployed midwife

NHS or private
Students were asked whether they intended to work in the NHS or if they would consider another employer. With the exception of a small number of students who indicated they planned to work overseas, the vast majority of students reported that they hoped to work in the NHS:

I think the NHS, but some day I would maybe like to go abroad and work.

A small number of students reported that they had considered applying to the private sector for a variety of reasons including the need to secure employment as soon as possible:

I had never considered private nursing before, and I've been to visit two [private] places since that careers fair, and I think it's fantastic. I like their ethos and I've applied for jobs there.

Wherever a job came up … I really need to work … I'm the only one person who works in my house …

One student who wanted to work in the field of Learning Disability thought that she would find it difficult to secure employment within the NHS:

I'd like to work in NHS, but learning disability, there isn't the jobs there so you have to step outside the NHS...

Another student wanted to work in palliative care, an option that she thought would have implications for remaining in the NHS:

I would like to go into palliative care and hospice care, and obviously they're predominantly charitable organisations... although they get NHS funding, I don't think you're strictly employed by the NHS …

Career progression
Students were asked where they saw themselves in five or ten year's time. For some students, at a busy time approaching registration, the whole concept of the future appeared to be overwhelming, and elicited a significant amount of 'nervous' laughter. Looking to the future can

be difficult, and clearly individual perceptions and ambitions will change over time in a shifting environment:

> *A lot of it depends on how your professional development grows over the next few years, and areas that you work, and opportunities, so it is difficult to say.*

The 70 students who took part in the interviews varied on a number of dimensions; some had been school-leavers at the start of their course, some had left school with no qualifications and gained entry by completing an access course, others had started other degree courses and changed discipline, some had young families, and others were achieving their second or third career change. People's priorities shift as they move through the lifecourse, and students taking part in the focus group interviews demonstrated very different attitudes towards their future careers.

Students divided into a number of 'types' including those who indicated that they just wanted to secure a job in their chosen profession and see what happened, for example a number of students reported that they would be happy to remain at Band 5 for the foreseeable future:

> *Mainly because of family commitments, its not that I don't want to work my way up, but eventually, but not in 5 years time, maybe 15 years time.*

> *I'll just wait and see; I'm not greatly ambitious*

> *I don't want to progress up. I just want to go in and do nursing for the patients, so I have got no aspirations; I just hope I stay a band 5 after 10 years.*

Some students appeared to have set themselves a 'ceiling':

> *Yeah, I would go up to band 6, but I'm going no further.*

Students were concerned that the nature of the job would change if they sought promotion and indicated that they did not want additional responsibility:

> *I would like to keep up patient contact I don't really want to go into management so if going up the bands involves going up the management I don't really want to do it.*

> *I mean difficult decisions have to be made, I mean it just becomes stressful, and basically not worth it.*

Other students expressed more ambitious goals and spoke of moving through the Bands:

> *I want to be on Band 6, and then Band 8 in ten years*

> *I would hope that after a 5 year period I would be pretty close to the 'expert' nurse...*

Or choosing different routes:

> *You know charge nurse, ward manager ... I don't know they all look good to me.*

> *I have no qualms about taking on extra responsibility...*

I quite fancy getting into research ... I've always thought research would be really good to go into

However, even the more 'career-minded' students indicated that there might be 'trade-offs' along the way:

There's good responsibility and bad responsibility and I'm not sure how good the responsibility is….

There is something really nice about that kind of direct patient relationship you have as a staff nurse, or as a community nurse or as a specialist … Having said that I can see that management could be extremely rewarding if you see it as an opportunity to care for your nurses in the same way as you care for people

Summary

This paper has presented the findings of an analysis of data derived from 70 final year (3rd/4th year) nursing, midwifery and allied health profession students attending nine universities in Scotland. Findings indicated that.

♦ Students' knowledge and attitudes towards Flying Start varied both within, and between groups.
♦ A majority of students who had been provided with information about Flying Start revealed that it was something that had been raised towards the end of their education/training.
♦ Some students who had looked at the Flying Start website prior to attending the interview responded positively, others reported feeling overwhelmed.
♦ While some students were very positive about the programme, others expressed feelings of resentment.
♦ Perceived advantages included the potential for receiving supervision from mentors, managers, or the on-line programme, recognition that they were *newly qualified* practitioners, *confidence,* and *having a structure for CPD*.
♦ Students were philosophical about continuing to study following registration indicating that lifelong learning was something that they had always understood would be a part of their working lives. However, they drew attention to the importance of Flying Start being relevant to their new roles.
♦ Opinions relating to whether Flying Start should be compulsory or voluntary varied with some students believing that they might be better supported if the programme were compulsory.
♦ A majority of students thought that a settling in period prior to enrolling on Flying Start would be beneficial. However, students at three institutions suggested that it might be useful to have access to Flying Start prior to registration.
♦ Concerns relating to Flying Start included to access to IT, lack of time, fears about the support that would be available from managers and mentors, and lack confidence in their own commitment to complete a programme that was self-directed.
♦ Students reported having mixed feelings about on-line learning, with several students expressing a preference for face-to-face communication.
♦ A substantial number of students reported having school age children to care for and drew attention to the potential impact on families of having to complete work-related tasks in their own time.

- Some students felt that there was little knowledge about Flying Start within the NHS, and that managers did not understand what was entailed.
- Contact with newly qualified practitioners while on placements did not always convince students of the benefits of the programme.
- Students believed that their support needs following registration would depend on whether they secured employment in an area in which they had recently completed a placement compared to entering a less familiar environment/speciality.
- A majority of students thought that there would be significant differences between acute and community settings for newly qualified practitioners, and drew attention to the potential for feeling isolated in the community, different ways in which health professionals interact with patients and their families, and the different skills that might be required.
- A majority of students indicated that they expected to work in an acute setting in the first instance in order to consolidate their skills. There was a perception that the best outcome would be to secure a post where they had had an enjoyable placement.
- All but one student reported that they were, or would be seeking employment in their chosen profession.
- Although students reported they were unlikely to have a 'choice' of employer, a number of students indicated that they would use Flying Start as a way of gauging potential employers' commitment to supporting their future career development.
- Some students expressed concern about securing employment and the delay before a post became available.
- There appeared to be some confusion relating to the one-year guaranteed posts and a number of participants reported feeling quite disillusioned.

CHAPTER 6

FOCUS GROUPS AND INTERVIEWS
WITH NEWLY QUALIFIED PRACTITIONERS

Data collection April 2008 - August 2009

Chapter 6 provides details of data collection involving focus group interviews with newly qualified practitioners including nurses, midwives and allied health professionals. Data derived from a small number of telephone interviews have also been included in the analysis. Prior to the focus group interviews participants were asked to prepare two critical incidents, one in which undertaking Flying Start NHS had contributed to their ability to deal with a situation, and one in which they had not felt adequately equipped to deal with a situation. Few participant completed this task; however, those who did provided some useful insights to the benefits of the programme and the challenges of being a NQP – examples are included in this and future chapters for illustrative purposes.

Aim

To build a knowledge base of the factors which support a successful outcome for newly qualified practitioners, and identify factors which work well or require further development.

Specific objectives:
♦ To investigate participants' perceptions of how and where Flying Start NHS supports the transition from student to newly qualified practitioner, and if the programme needs to change to meet changing demands
♦ To evaluate the effectiveness of the on-line, multi-professional model selected for use in delivering Flying Start NHS NHS.
♦ To provide a picture of newly qualified practitioners' experiences of entering their first NHS post after registration.
♦ To identify the challenges and rewards which newly qualified practitioners may experience in practice.

Procedure
Focus groups and telephone interviews were carried out with Newly Qualified Practitioners during between May 2008 and August 2009. Topics covered in the interviews included:

- Factors considered when seeking employment
- Awareness of the Flying Start programme
- Timing of enrolment on Flying Start
- Identification of main development needs as newly qualified practitioners during first year post qualifying
- Experience of the Flying Start programme:
- Organisational support to undertake the programme
- Experience of on-line learning environment

A copy of the interview schedule is included in the appendix, page 150.

Participants

Focus group interviews were carried out in all NHS Boards except NHS Orkney because they did not have any NQPs at the time. Overall that 94 NQPs took part, 85 in focus group interviews, five one to one or telephone interviews targeting areas where input was low. A further four telephone interviews were carried out with NQPs employed under the community initiative.

Table 6.1: Newly qualified practitioners involved in data collection, discipline, and NHS Board

NHS Board	Nursing	Midwifery	AHP	Total Freq	Total %
Ayrshire & Arran	4	0	8	12	13.8
Borders	2	0	0	2	2.1
Dumfries And Galloway	4	1	0	5	5.3
Fife	3	1	5	9	9.6
Forth Valley	1	2	3	6	6.4
Grampian	7	0	2	9	9.6
Greater Glasgow & Clyde	6	0	0	6	6.4
Highland	2	0	2	4	4.3
Lanarkshire	3	0	5	8	8.5
Lothian	10	0	3	13	13.8
Shetland	3	0	0	3	3.2
Tayside	5	0	3	8	8.5
Golden Jubilee	3	0	0	3	3.2
State Hospital	5	0	0	5	5.3
Joint Lothian/Borders	1	0	0	1	1.1
Total	59	4	31	94	100%
	62.8	4.3	32.0	100%	

Of the NQPs who took part in a focus group or telephone interview, 83 were female and 8 male, the gender of three was unknown. Age ranged from 21 to 59 with a mean of 30 years, thus the range and distribution was similar to that amongst the students.

Figure 6.1: Newly qualified practitioners by age group (n=91)
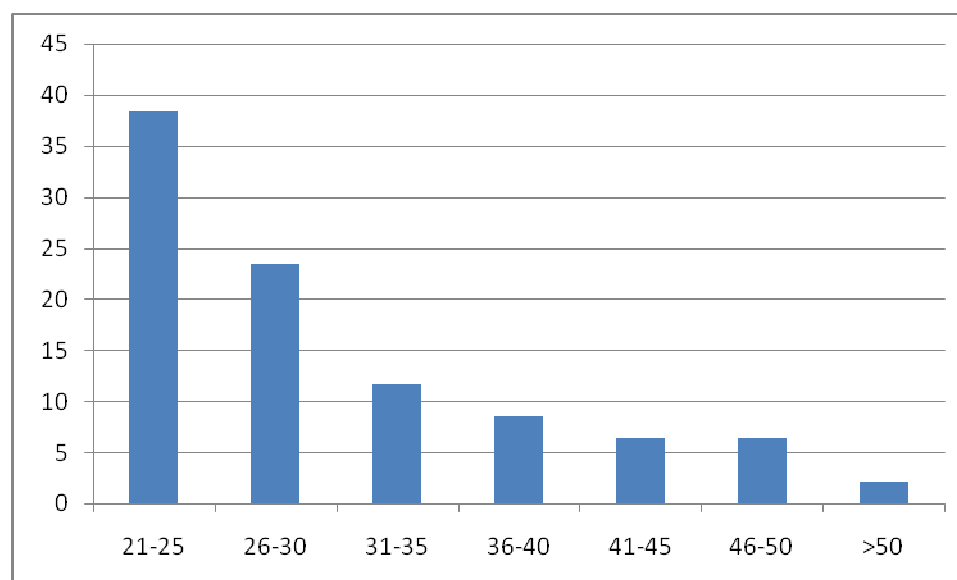
Fifty-nine of the NQPs were nurses, four were midwives and 31 were AHPs. Courses undertaken included Nursing (adult, children's, mental health), midwifery, dietetics, occupational therapy, physiotherapy, podiatry, radiography, and speech and language therapy, see table 2 below. Reported level of study ranged from Diploma to Masters:

Table 6.2: Reported course and level of study (n=91)

Course	Diploma	Degree	Honours Degree	PG Diploma	Masters
Nursing	25	16	15	-	-
Midwifery	-	4	-	-	-
Human nutrition & dietetics	-	2	-	-	-
Occupational Therapy	-	1	7	-	2
Physiotherapy	-	3	5	-	2
Podiatry	-	-	2	-	
Radiography	-	-	1	1	
SALT	-	-	5		
Total	25	26	35	1	4

Seventy-eight participants reported that they had secured a permanent job, eleven, seven nurses and four AHPs had not managed to secure permanent employment, six did not respond to this question. Time in post ranged from two weeks to four years, with a mean of one year one month. A majority of NQPs reported that they worked in an acute setting (n=57, 60.6%), 18 (19.1%) reported that they worked in the community, and five, four AHPs and one midwife reported that they worked in both acute and community settings.

Analysis of interview data

All interviews were recorded and fully transcribed. Analysis involved reading through transcripts to gain an overall understanding of the data, followed by a more detailed thematic analysis. Four key themes emerged, each of which had sub-themes:

- ♦ **Role transition**
  - o Gaining employment
  - o Timing of enrolment on Flying Start
  - o Learning the job
  - o Burden
  - o CPD
  - o Benefits & challenges
- ♦ **Support**
  - o Mentors
  - o Organisational commitment
- ♦ **Expectations**
  - o Organisational
  - o Career progression
- ♦ **Improvement**
  - o Units
  - o Support
  - o Clarity
  - o IT access

Role transition

Not surprisingly across all focus groups with NQP the notion of Role Transition arose. Within this theme a number of sub-categories have been identified.

Gaining employment: Early experience in the workplace may be a vital predictor of future job satisfaction. Thus early career development and support for newly qualified health practitioners has been high on the Scottish agenda with a view to decreasing both student, and post-registration attrition rates (Scottish Executive, 2002; 2005; 2006a,b). A majority of participants reported difficulties when seeking their first posts.

> *It was really just what job was going at the time. There were no surgical posts going when I qualified, so I just had to take what was there.*

> *There were not many jobs either and just anything in any area, but again I was looking for rotational posts rather than be stuck in one area.*

For some NQPs a job within their chosen profession was not possible at the time of registration:

> *When I first qualified there were not a lot of OT jobs. I went straight into a summer play school and just started working outwith OT for nine to ten months. I just wanted to get a job within OT and continue with my skills, and ended up with this job after four interviews.*

In exploring what participants' ideal posts would be, NQPs described how placement experience as a student shaped their views. However the issue of *choice* came through strongly, with very few indicating that they had secured their first ideal post - those that had, attributed it to 'luck' or 'right place at right time'.

> *It was my options placement at the finish of my training and [I was] lucky enough to choose what placement I wanted to go to. I was lucky enough to get to go there, and was lucky that a post became available when I was there – so I think I was fortunate ...*

> *I work for the Acute Adult Mental Health Team. Mental Health was the area I always wanted to go into again just from being at uni on placements and things.*

> *I've been in post for seven months now and team midwifery was the post I wanted, so I work on the post I wanted, lucky me.*

Timing of enrolment on Flying Start: A key aim of Flying Start NHS is to support the recruitment, confidence and skills development of newly qualified nurses, midwives and allied health professionals within NHS Scotland during this period of transition. In exploring with NQP when they enrolled on Flying Start NHS there were significant variations both within and across organisations identified:

> *I worked about four months before starting it*

> *Just straight away*

> *I had been in my job a year before I was confirmed on Flying Start. I felt that the Flying Start programme wasn't very helpful to me at that time, perhaps if I'd known about it at the start of the year, it may have been more useful*

Exploring the optimum time to enrol and undertake Flying Start NHS there was a general consensus from the NQP that there was a need for a settling in period before commencing Flying Start NHS.

> *It was quite daunting starting a new job and then getting told I had to do this Flying Start thing…. I think you need time to adapt to that…I feel that I've been qualified 6/7 months, now I'm ready to do Flying Start*

> *I just think that it's a lot to ask somebody that's newly qualified. You've just got a job and you're needing to settle in and consolidate everything …*

From the exerts above, our findings support earlier work by Greenwood (2000) who identified the first 3 -6 months as the crucial time for professional adjustment and for creating a commitment to a career in nursing, midwifery and AHP. Information derived from the interviews with Flying Start NHS Lead Contacts and Coordinators also supported the notion of a settling in period for the NQP before undertaking Flying Start NHS

> *I feel that anybody in a new job really should be allowed some settling in time you know, finding your feet and feeling comfortable in the work place before embarking on the programme.*

However, not all Lead contacts were convinced:

> *We thought staff should start after three months … because we felt they needed time to settle in … we have changed our mind since.*

Although Flying Start Lead Contacts recognised that a period of settling could be beneficial, the majority of NQP participants in this study were guided to commence Flying Start NHS immediately.

Further support for a 'settling in' period is evident when reviewing the theme of self-efficacy, from the Gricean Analysis, whereby within 1 year of post qualifying practitioners feel better able to manage their time, cope with different situations and feel less anxious in their role

Throughout the focus groups, NQP detailed the tensions and burdens they felt in juggling Flying Start NHS, local orientation and induction programmes, and local CPD. There was a feeling that everything was duplicated. However, a number of participants had recognised that there were links:

> *I've been working my way through it now, the rotation lady told us it's quite tied into our rotation documentation that we already have so there's not as much to get duplicated*

> *I have been issued with PDP as well from my mentor, and a lot of that I find relates to Flying Start and some of the information I collect for one I can use for the other …*

> *I can see that it's very much linked. I am over the year now and when I flick through Flying Start and I look back I think oh yeah I've done that and oh I might like to pick up on this again...*

Exploration with Flying Start NHS Lead Contacts and Coordinators drew attention to the efforts the NHS were making to bring many of the initiatives expected of newly qualified practitioners together:

> *I think we have to do more work in linking it all in ... We have done a bit of that, linking in the competencies and Flying Start and KSF all as one programme rather than three individual programmes and there is still work to be done there.*

> *Flying Start will dovetail into the competency framework and therefore is linked into their KSF framework ... there's going to be enough evidence in there that will link them straight through to get their foundation gateway when they qualify.*

Critical incident 1: newly qualified practitioner

Where were you?	*Interview*
Who else was present?	*Interview Panel*
What happened?	*Used flying start folder as evidence towards participation in CPD.*
In what way did Flying Start help you?	*Provided evidence to move through **KSF pathway**.*

An area of particular tension identified by NQP was their perception of the duplication of learning undertaken at University.

> *I personally thought a lot of the tasks we have done at university. From the minute we got into a lecture at university it was reflection, reflection. I have left that section until last cause I personally don't feel I need to do it...*

> *Well I just felt that when I looked at Flying Start at first this is a repetition of what I've proved I can do to get my diploma, so why do we have to do it all over again?*

> *It's like going back to scratch again. You open the first page communication its something you covered in Semester 1*

Throughout the focus groups some NQP demonstrated negative attitudes towards Flying Start NHS:

> *I only did it because of the authorities. I honestly don't see any advantages, but as I said all along I just think it's a lot to ask you to do when you're newly qualified*

> *I actually got to the stage, 'No I'm going to stop this, this isn't meaningful for me, this is a complete waste of time'*

However, not all NQPs felt this way, for example participants on the Early Clinical Career Fellowship Scheme who undertake Flying Start NHS as part of this programme spoke positively of their experiences:

> *I've finished mine, I had a really good experience because I finished Flying Start and it got me into the fellowship, the early clinical career fellowship and I'm now doing my masters so I've had a positive experience of the programme.*

Critical incident 2: newly qualified practitioner

Where were you?	*Stroke team meeting*
Who else was present?	*2 senior staff and OT assistant*
What happened?	*I fed back information as part of sharing evidence of best practice, which stimulated discussion. From this myself and OTA began to explore potential group work and held a meeting with patients to identify where they felt gaps were. This led to provision of increased activity on ward and prompted me to commence literature review looking as self-management in stroke.*
In what way did Flying Start help you?	*It was through the undertaking of this module that I began to think about service provision/development. It encouraged me to **broaden my thinking** and review my practice.*

The transition period is the time when practitioners learn to manage and control many aspects of their practice. This involves a balance between demands and control. Practitioners who report less job control have been found to report higher stress levels (Chang et al 2005). In a study of 876 Dutch teachers Taris et al found that the transition to high demand/low control posts (such as we see in the newly qualified practitioner) is associated with a strong deterioration in learning and self-efficacy.

A majority identified their main development needs early into qualification as developing confidence in their practice and learning the clinical skills of their new posts

> *Just to learn about the speciality really, I mean there's so much, cardiac is a huge area, and especially in intensive care, we don't do that much in your pre-registration...*

> *Developing your clinical skills and your documentation skills and anything like that that's ward based.... I'm more a hands on sort of person that's how I learn more when I do actually, than sort of sitting in front of a sort of document like Flying Start*

Throughout the interviews NQPs discussed the benefits and challenges in undertaking Flying Start NHS. These included detailing the programme as being a framework to support them evaluating their own work, to assist in structuring their work and in supporting them to gain access to the first gateway in KSF.

> *It does take a lot of time but I think it is useful it makes you sit down and think about it and reflect on what you have done in practice*

> *Really the advantage is to know that you've got like, a kind of start on your portfolio, because... can that not count towards your personal development portfolio thing like?*

> *It builds confidence*

> *I thought it was so easy to go through Flying Start ... you know your learning priorities, it is so easy to pick things from that and put it in your KFS it cut the process down.*

> *I suppose it kind of formalises your first year PDP and KSF I suppose and that's useful and I think it's especially if you decide to move on from your post so future employers that I've done my first year Flying Start and to show that you have that under your belt it's a useful thing to have*

Conversely they detail the volume of work Flying Start entails, the associated stresses and their lack of understanding of how to utilise the units for maximum benefit.

> *If you pick out the activities relevant to your area... you don't have to go through each section, but nobody tells you that, you just think you have to work through it all*

Support

While studies reveal that new graduates are aware that they need a high level of support to successfully make the transition from graduate to competent and confident practitioner (Kerston & Johnson 1992, Fulbrook et 2000), others report that the real world experience of the new graduate is often unsupportive and extremely traumatic (Kelly 1998, Clare et al 2002). AHPs have similar experiences to nurses in terms of stress, feelings of inadequacy and being unsure about their professional identity (Rugg 1999, Mandy 2000).

As part of this evaluation NQP were asked to describe their experiences of undertaking Flying Start NHS. A key and crucial theme identified across all data sets was that of support. Within this theme a number of sub-categories have been identified.

Mentor support:

In all focus groups and interviews was apparent that the allocation of mentors to the NQP was 'patchy' with many NQP detailing the length of time it took to get a mentor

> *Yea, but it was quite late on - 6/9 months after qualifying*

> *I just got one like last month or something and that had been sort of a year I didn't know you were supposed to go and find your own mentor*

> *I haven't no. I know they've just started allocating people they were saying for doing the Flying Start mentorship*

A majority of NQP described the lack of understanding that mentors had of the programme.

> *I've been allocated a mentor that hasn't even done a university course so she just goes, 'Oh that looks good,' but she's not got any idea about what Flying Start is at all you know*

> *Well as far as Flying Start is concerned I don't think any staff know what it's about. I don't think they, any of them, realise how to be a mentor to you or what they're supposed to be doing*

> *Yeah but they're just kind of you know, Get in there, learn from you peers and muck in, and like it's not really recognised as an important thing to do.*

NQP also detailed the competing demands mentors have, and how this can influence their commitment to supporting them through the programme:

> *Some of the mentors have been in the job for ten years plus, they don't like change. They see this as a hindrance to be honest...*

[Senior staff] do not want to be bothered with a new programme, you know to make the newly qualified staff nurses feel like they're progressing, because it's not a priority. There priority is their budget, sickness, annual leave...

I think there's problems in Physio because we rotate so we only have four months in one area and I'm normally in different hospitals from my mentor for a few months as well

Organisational Commitment

NQP were asked to describe how much protected time they were allocated for Flying Start, how this was managed and how accessible computers were within the workplace. A majority of NQP reported having no protected time to complete Flying Start NHS as part of their workload. Most undertook the activities associated with Flying Start NHS at home, in their own time:

I think that if you're going to have set deadlines you need to also have ring fenced time. I don't think it's fair to expect us to do it out with in our own time

I don't get protected time. No don't get time.

I did the majority of it at home. It was completed at home. That is how I found it particularly challenging because there were other things I wanted to do as well...

In some cases protected time was available but often not taken for a number of reasons

Sorry, even if you do get two hours yourself, what good's two hours yourself. To me the two hours needs to be spent with somebody else. It's alright reflecting on your own practice but you need somebody to reflect off of, or reflect with ...

It's just not feasible to, you know, to sit down and be, 'Oh I'm taking time out', and you've got five patients that still need their tablets, or speak to a relative, that kind of comes first, so doing [it] at home is your only option

Gricean Analysis supports these excerpts as many of the postings by NQP analysed discuss the challenges of managing their time to complete the programme in the one year suggested.

However, lack of time was not universal, focus groups with NQP highlighted the variation within and between NHS Divisions:

I have to admit our ward is pretty good, but that all falls down to the senior staff nurses who allocate all the newly qualified. We get about six hours. You're allocated to do whatever you want, your Flying Start, that could even involve your PDP or your ward orientation. You can use a computer either in the office or go down to the ones in the library its really, really good.

It would be good if that was like across the board. I don't know how it can be like that how someone can get six and we can't get one...

Importantly NQP identified the need for mentors to have 'protected' time to provide crucial support for the NQP undertaking Flying Start NHS

I think mentors need time allocated. To give us time as well. I don't think it's just us that need the time off. I think the mentors definitely time beside because you can't speak to them in the ward ...

I think a major disadvantage that I keep coming up against is that the seniors in our department do not have a clue, they don't have a clue, nothing has filtered down to them as to what their role is, and how important it is for us to be doing this.

Accessing Flying Start NHS

Asynchronous communication has now become the dominant mode of on-line instruction (Laffey et al 2006). It is suggested that this form of communication creates a greater sense of reflection in student communications (Garrison 2003). Much educational theory, including on-line educational theory, places much emphasis on the virtual community and virtual shared engagement in promoting effective learning. Grice (1975) suggested that for on-line communication to be successful and meaningful some form of social goal had to be explicit. The social goal of Flying Start NHS is to develop confident, capable practitioners through structured support in the transition phase from student to practitioner ensuring work readiness. On-line programmes have a number of objectives including the delivery of educational materials to individuals through to the development of on-line communities.

NQP were asked to describe their experiences of navigating the Flying Start NHS website, how they utilised the materials and their understanding of what the requirements are for completion.
A majority of NQP had had previous extensive experience of using on-line sites in their undergraduate curriculums

I used Blackboard on one of my last courses

We did Cleanliness Champions at university so it's similar

A majority detailed their confusion at how to utilise the learning units with a number believing that they had to complete all units and activities

I think it's very vague I don't think there's a good description I couldn't work out from the website what a) was expected of me, where do I start and where do I finish it and what goes in between

It seems an awful lot with the drop down menus and to work out what fits

A majority of NQP detailed how trying to access a computer in working time was challenging and that when they did have the opportunity they tended to download and print of information from the site.

In my work it's a wee bit more difficult. There are only two computers in our department and I'm in a department with all the adult team and all the elderly team and then the Head OT's as well... so I've got to kind of jump on at work print things off

I printed it off. It was easier

In the hospital you need to have internet access, basic ward staff like us wouldn't get that unless we could justify it ...

Challenges of accessing IT at work were highlighted by Flying Start NHS Lead Contacts and Coordinators with location having an impact on accessibility

> *I think we could do better; all areas do have [computers] at their sort of nurses' station, and in their Sister's office*

> *That again is very hit and miss ... Within some of our busy clinical areas there may be one or two PC's in a clinical area, but they're used for admissions and transfers and discharges, blood results and everybody's competing for the one PC*

A majority of NQP also detailed how they have gone into the discussion forum but not engaged with it for a number of reasons

> *I have only logged on to have a look. Haven't really done anything else...*

> *'Ask the expert' thing doesn't seem to have any function to me. I looked at it but the last time the ask the expert thing it was last year like mid last year and nothing coming up at all. And the forum I think doesn't seem to have much purpose... It doesn't seem to generate proper discussion or stimulate ideas*

> *I've looked at the forum.....I've not sort of used it for myself but I've seen people saying Not sure what to put in my portfolio, do you know all this kind of thing and other people saying I feel the same or so. That's quite nice to know that you're not the only one ...*

> *I don't go on the website anymore it was so annoying you go find something and it just crashed.*

Gricean Analysis identified little evidence of long discussion strings which suggested that very few NQP engaged in the type of interactive engagement which is essential for creating on-line learning communities. The above excerpts support this finding.

Expectations

Gricean Analysis identified that Flying Start NHS is seen by NQP as assisting them to plan their future career pathways, with many having the next step in their career journey already identified i.e MSc programme commencements, ECCF Programme commencements lined up. In the focus groups NQP discussed their expectation of how the programme will assist their career progression through the KSF gateways

> *When we started they said you wouldn't get your gateways unless you did your Flying Start because they told us at (university) that if you didn't do the Flying Start you wouldn't get your first increment either*

Others detail their career aspirations

> *Well I've been there for a year now in the post I'm in so I know I'm actually looking to soon change my position. Maybe just different skills and also just variety to see what area I would like to specialise in towards progressing.*

> *Because there are no Band 5 jobs in [NHS Board] you are paid as a band 5 for 2 years ,and if you complete your Flying Start, you do your essay and you do your Speech and language therapy competencies you can progress to a band 6*

Across all focus groups with NQP it was evident there were confusions about completion:

> *I don't understand what completion is because what do you need to have*

> *Well I suppose it's supposed to be self directed, but it's a bit em free, and you can just pick and choose whatever you want, the activities that you want to do*

> *I mean it's knowing where to start you know if there was something on the online package that was saying if this is your first time coming here try doing this part .... but being faced with these ten units with all these different subsections it's too vast, you don't know what's appropriate for you, which to tackle first*
> *No one has actually explained and said to me that's you finished, completed the programme - I am just doing it until the tasks are finished ...*

These confusions were also identified by Flying Start NHS Lead Contacts and Coordinators who noted, there is no Scotland-wide accepted method of monitoring progress:

> *I think we're needing to make the programme more focussed*

A number of NQP identified the Flying Start programme as being a useful resource to dip in and out of

> *It's a useful resource for information although I know it's very generic it's helpful with the large knowledge gap from student to practitioner particularly in community*

Many NHS Divisions have made Flying Start NHS compulsory for NQP, however there were mixed reactions across focus groups to this idea

> *I feel that if it's mandatory then it should be mandatory. We didn't have a choice on it and if managers are told you need to let your staff away to do this then they should be made to do that*

> *I think that should be compulsory, I don't think you should... Because I think you work hard, you've graduated this is your job and this is a requirement of your job*

> *Again at these two meetings that I did go to, the question was asked, 'Is this mandatory?' - 'No it's not mandatory' - but in the same breath the facilitator says that, defy you to try and find another job without having done it*

Improvement

In exploring with NQP how Flying Start NHS could better support their development needs a number of areas were identified: support, clarity, IT access

In relation to support the key areas identified were around 'protected time' and mentors being more knowledgeable about the programme.

> *Disadvantage is time, time from home because you've no time on the wards to do it we keep going back to that*

My mentor went to one of the workshops and we found out a lot I had been doing and what I should be actually doing ……. you need some guidance and seniors definitely need to be aware of how to go about mentoring or it's a complete waste of time

The first time I told my clinical supervisor how much time Flying Start people are expecting us to take out our clinical time to do Flying Start she laughed at me

Clarity and guidance was also requested in relation to how to utilise the learning units and more clarity around knowing when they had completed Flying Start and who decided this.

You could have just been sitting there and saying, Oh, I've done it, and you know fine that you haven't ….

The ideal system would be like if you had books that you could sit down at first [with] your PEF and say, 'Right, Flying Start, eh this module would be suitable for me, this module would be suitable for you and this one. Three or four modules to do that you work on...'

For some NQP the issue around accessing IT whilst at work was raised but when IT accessibility was not optimum the requirement for the materials to be provided in a folder for eas of use and completion was a suggestion:

I think even if there is time it's very difficult well our computers in the middle of the ward and I had hand written stuff and I thought right I'll sit and type this in at work but it's so difficult because there's things going on and patients buzzing and I just find it impossible to sit and type its just not right

Probably it would have been easier if it was all sent, do you know, already printed off for me, but it's a hell of a lot of paper

Although the number of NQPs taking part on the focus group interviews fell within the lower boundary of our target numbers, analysis of the data suggests that we had reached saturation with this method, getting the same messages from different groups.

Summary

This chapter has provided details of data collection involving focus group and telephone interviews with newly qualified practitioners including nurses, midwives and allied health professionals. Overall 94 NQPs, 59 nurses, four midwives and 31 AHPs, took part.

- Although NQPs indicated that placement experience as a student shaped their choice of future employment, in fact few had a 'choice', with almost all participants reporting that they were grateful to secure employment.
- There were significant variations both within and across organisations in the time lag prior to enrolling on Flying Start.
- NQP indicated that they thought that there was a need for a settling in period before commencing Flying Start NHS.
- A majority identified their main development needs early into qualification as developing confidence in their practice and learning the clinical skills of their new posts.

- NQP drew attention to the tensions and burdens they felt in juggling Flying Start NHS, local orientation and induction programmes, and local CPD. There was a feeling that everything was duplicated.
- NQP also felt that they there was duplication of learning undertaken at University.
- NQPs who recognised the links between programmes/tasks e.g. CPD, KSF, were able to appreciate the benefits of Flying Start; however, certainly in the early interviews this was unusual.
- Although many NQPs held negative views of Flying Start, NQPs on the Early Clinical Career Fellowship Scheme spoke positively of their experiences.

- A proportion of NQPs reported having to wait a considerable time prior to being allocated a mentor.
- NQP raised concerns about the lack of understanding that mentors had of the programme.
- NQP also drew attention to the competing demands mentors have, and how this can influence their commitment to supporting them through the programme.
- A majority of NQP reported having no protected time to complete Flying Start NHS as part of their workload, most undertook the activities associated with Flying Start NHS at home, in their own time.
- In some cases protected time was 'technically' available, but often not taken for a number of reasons including wards being too busy.

- Despite NQPs having had previous experience of using on-line sites, a majority reported that they found the Flying Start site confusing, a number believing that they had to complete all units and activities.

- Across all focus groups it was evident there were confusions about completion, and lack of monitoring.
- Access to a computer in working time was challenging and NQPs reported that when they did have the opportunity they tended to download and print of information from the site.
- A high proportion of NQP reported that they had gone into the discussion forum but not engaged with it for a number of reasons.
- However, in contrast, a number of NQP indicated that the Flying Start programme was a useful resource to dip in and out of.
- In exploring with NQP how Flying Start NHS could better support their development needs a number of areas were identified including: support, clarity, and IT access

CHAPTER 7

GRICEAN ANALYSIS OF ON-LINE COMMUNICATION

Data collection March 2009

Introduction

Asynchronous communication has now become the dominant mode of on-line instruction (Laffey et al, 2006). It is suggested that this form of communication creates a greater sense of reflection in student communications (Garrison, 2003). Much educational theory, including on-line educational theory, places much emphasis on the virtual community and virtual shared engagement in promoting effective learning. Earlier models on on-line learning emphasised the individual's engagement with the learning materials. Communities of practice theory views learning as emerging from what is essentially a social process (Lave and Wenger, 1991).

Grice (1975) suggested that for on-line communication to be successful and meaningful some form of social goal had to be explicit. The social goal of Flying Start NHS is to develop confident, capable practitioners through structured support in the transition phase from student to practitioner ensuring work readiness. On-line programmes have a number of objectives including the delivery of educational materials to individuals through to the development of on-line communities. These objectives may be shared within programmes and any evaluation of on-line programmes should explore the extent to which all objectives are realised.

Aims

To provide a direct and objective understanding of the quality of the online community and give an indication of areas of strength and weakness with a view to future developments.

Method

This element of the project involved a Gricean analysis of students' on-line postings in both the general, and the 10 learning unit columns in Flying Start NHS. Grice (1975) proposed four maxims which underpin communication and these were quantity, quality, relevance and manner. These four maxims were adapted by Ho & Swan (2007) and formed the conceptual framework for this study:

Gricean Dimensions

1. **Quantity:** The posting provides as much information/material as is necessary and no more

2. **Quality**: The posting is a new contribution, reflective of the student's belief and/or opinions, and is supported by sufficient evidence where necessary

3. **Relevance:** The posting is on the same topic, and follows a natural conversation from either the conference topic or previous posting, whichever is applicable

4. **Manner:** The posting is logically organised and clearly presented

The Gricean rating rubric developed by Ho & Swan (2007) was employed in this study. Independent analysis was undertaken by Roxburgh and Lauder followed by discussions and agreement on qualitative analysis. Ratings were given after a content analysis of each posting. Postings in both the general forum, and the learning units forum, were scored on each of the four dimensions. Each dimension was scored on a four-point scale with 0 being low and 3 being high. An overall rating for each posting was also calculated by summing all four dimension scores. A total of 98 student postings were rated. These were posted on the Flying Start NHS website with date ending 23rd March 2009.

Qualitative analysis of the postings was undertaken by employing an adapted narrative analysis approach. This required the researcher to complete an initial impression reading of all data and memo record of emergent ideas. This was followed by conducting a thematic content analysis and finally a detailed analysis with illustrative verbatim quotes.

Findings
Student Postings
In the general forum there were 67 postings in 20 topics with a range of 0-20 postings for each topic.

In the 10 learning units a total of 221 posting were made and a range of 1-72 for each learning unit with a mean student posting of 22.1 for each learning unit. In each learning unit a different number of topics were covered ranging from 2 – 25 topics. A number of postings were administrator postings and these were excluded from the analysis. There was little evidence of long discussion strings which suggest that very few students engaged in the type of interactive engagement which is essential for creating on-line learning communities.

Gricean descriptive analysis for student postings
Scores for manner, relevance, quantity and quality were rated on a 4 point scale with 0 being low and 3 being highest. The highest mean score for students' postings was for the dimensions in descending order were manner (1.77), relevance (1.73), quantity (1.63) with the lowest being the quality dimension (1.23). Quality also had the lowest mode score (1.00) amongst the four dimensions.
The majority of scores in all dimensions apart from quality were in the higher end of the scale, see table 1.

Table 7.1: Frequency and percentages for Gricean dimensions

Dimension	Quantity	Quality	Relevance	Manner
0	19 (19.4%)	18 (18.4%)	7 (7.1%)	12 (12.2%)
1	19 (19.4%)	42 (42.9%)	30 (30.6%)	17 (17.3%)
2	39 (39.8%)	31 (31.6%)	43 (43.9%)	51 (52%)
3	21 (21.4%)	7 (7.1%)	18 (18.4%)	18 (18.4%)

Correlations Between Dimensions

Correlations between scores in each of the four dimensions were explored using Spearman's Test. There were high positive correlations between all dimensions with the highest being between manner and quantity ($r = .716$, $p = .001$), see table 2.

Table 7.2: Correlations between Gricean Dimensions

	Quantity	Quality	Relevance	Manner
Quantity	1			
Quality	.679*	1		
Relevance	.695*	.559*	1	
Manner	.716*	.666*	.675*	1

*p = .001

Qualitative Analysis

The data from the various learning unit postings can be reclassified to provide an overview of core themes which cut across learning units:

Cross cutting themes
♦ Time Management/Protected Time
♦ Career Aspirations
♦ Tensions
♦ Self-efficacy Growth

Time Management/Protected Time

Many of the postings by students discuss the challenges of managing their time to complete the programme in the one year suggested. A number of NHS Boards are considering providing ring-fenced time for practitioners during their working hours to undertake Flying Start NHS (Lauder et al 2008). However from the postings sampled participants detail a lack of supported, protected time as illustrated below

> *I have not had any time allocated for study for Flying Start and am finding it difficult to make the time.*

> *I would be flabbergasted if I was offered time for this.*

Some participants did detail their ability to independently manage their time in order to undertake Flying Start programme:

> *I don't get protected time for Flying Start, however I am quite fortunate at the moment that one of my clinics is quite quiet and I have a bit of time to spare.*

> *I work in a range of settings both community and acute adult services, and so we have periods when we have few patients and others when we have too many! I just try to capitalise on the quiet times and make the most of the time I have.*

Linked to the issue of time management was the feeling of stress whilst undertaking the programme:

> *It's not helping – actually its making newly qualified life more stressful!*

This programme can make being newly qualified more stressful especially when problems such as understaffing and heavy caseloads make your shifts very stressful.

Career Aspirations

Planning and mapping of a future career pathway is central to many of NHS Scotland's policies (Scottish Executive 2006a, b). Of note is how participants viewed undertaking Flying Start NHS as assisting with their future career development and choices.

It may be difficult to get into the perfect job immediately, but at least Flying Start gets you thinking about it early in your career, so if your ideal job does come up, then you will be in a good position to go for it.

I am starting a post-grad course next year, cannot wait to do this....I may branch out as I really want to be an Educator in nursing! Too ambitious you may think? I guess so in a way.. but I relish the challenge.

I too am starting Early Clinical Career Fellowship*! Getting excited about starting! Excellent opportunity to meet with others who are going through similar issues and to debate situations.*

Tensions

Across the sampled postings participants identified a number of tensions they faced in both undertaking the programme and in trying to learn and develop in their new role. Many of the postings indicated that participants were on rotational programmes, moving clinical area approximately every six month to gain broad experience. However, many reported that this was unsettling, fearful and posed difficulties in them trying to 'fit in'

I am due to move to a different ward and I am not sure I will enjoy it. I know senior staff say it's for the experience but I am nervous, or rather, anxious about my next ward move.

Although each and every one of us knew what our role when qualifying would entail, why didn't we see how stressful this would be as students.

I will be moving to acute adult at some point. I am both nervous and excited about this.

I was the newest staff nurse there in about six or seven years, so the MDT were aware that I was new. They seemed reluctant to put any great faith in me.

Further tensions were identified in relation to completing the Flying Start programme whilst being expected to also complete local orientation/induction programmes and CPD activities.

I am not convinced that Flying Start is the best way to facilitate my development. For one thing the prohibitive amount to work through.

I, like most, could do without the extra work Flying Start causes.

I'm a newly qualified midwife in (name of region). I have ended up with piles of duplication.... There's not enough time in the day to keep going over all this self education malarkey – let me do my job!

Where in earth do we find the time, but really a lot of the Flying Start stuff (as much as I find it annoying to do) is CPD. I did a CPD diary now and then before I started Flying Start, and I find a lot of the stuff is similar.

Self-efficacy Growth

Many of the postings detail the growth and development of self-efficacy and competency during the transition period, aided by organisational support, experiencing situations and through personal reflection on situations:

About making the transition from student to newly qualified. I have been qualified for a year now and looking back, I feel from my first day I have changed so much. When I first started I used to be running about like a headless chicken. But I have learnt so much. Delegation, better time management, and basically working in a team. You are more exposed to risk and I have done a rotation post and I found that I have learnt a better understanding and knowledge and different ways of working........this allowed me to adopt different situations to allow me to develop and this allowed my confidence to grow.

I've been working for almost a year now and I have found that there are more up days and fewer down days. I think it's a confidence thing, as you work longer there are more areas that become your safe zone. I've been lucky with brilliant supervisors.

There ought to be a balance between asking and trusting your own judgement, its very easy to form a dependence on seniors and as a result your self confidence as a practitioner will struggle to grow.

Other staff members are supportive of me and that helps a lot. I do a lot of self-reflective learning to improve my skills and my ability to work in these situations and I find it very helpful.

Discussion

There were relatively few postings in the general forum with only 20 topics being posted and a small number of postings in each thread suggesting that conversations were relatively brief and engaged a small proportion of potential participants. The evolution of on-line communities develop most effectively when they exist outwith the control of individual organisation or controls (Schlager and Schank 2002). The extent to which Flying Start NHS exists in the same way as social network sites such as Facebook is open to debate. It is interesting that organisations such as the IHI Open School use the Facebook website to build their community of learning.

The large majority of postings in both the general and learning units were relevant to the students' progression through Flying Start, but few were directly related to the learning materials in the programme. This may be expected in the general forum but was unexpected in the learning unit forum. The sharp distinction between both types of forum may, in practice, be less defined.

The use of the on-line element of Flying Start NHS had a functional purpose in that students used it as almost a form of `frequently answered questions` facility. Those communications which began to engage with the learning materials were limited and there was little evidence of the development of critical debate or building of an on-line learning communities. It may be that this national programme was essentially a series of more local and spatially defined groups whose learning took place outwith the on-line dimension and in a more traditional face-to-face method in specific locations. In that respect Flying Start NHS may be seen as a vehicle for the delivery and access of materials which were then experienced by individuals or as small groups working in the same location.

As far back as 1975 Kramar highlighted the 'reality shock' experienced by newly qualified graduate nurses in the USA when they found themselves in work situations which they felt inadequately prepared for. In the UK a number of later studies identified similar findings associated with the transition process (Lathlean 1987, Gerrish 2000). Through exploring the qualitative data one can identify that the period of transition remains fraught with challenges for today's newly qualified practitioner. The high demands of undertaking Flying Start NHS alongside local CPD are seen by many as a duplication of effort. Much of this can be attributed alongside the practitioner learning to manage their time but also from an organisational perspective whereby no official protected time has been offered to participants to undertake Flying Start. The result of these deficits is a feeling of stress and over-burden on newly qualified practitioners. Findings from this study support earlier studies whereby lack of control over one's work has been identified both as source of stress and as a critical health risk for some workers (Chang 2005, Israel et al 1989). The transition period is the time when practitioners learn to manage and control many aspects of their practice. This involves a balance between demands and control. Practitioners who report less job control report higher stress levels (Chang et al 2005). It is the adverse effect of participation without control, rather than participation per se, which affects job stress (Israel et al 1989). However as can be seen when reviewing the theme of self-efficacy, within 1 year of post qualifying practitioners feel better able to manage their time, cope with different situations and feel less anxious in their role. Crucial to this journey has been the support of supervisors. Our findings support those of previous studies which identified high stress levels during the transitional stage (Hartshorn, 1992; Chang et al, 2005), and that supervisor support to newly qualified nurses is crucial during this period (Smith & Chalker, 2005, Lauder et al, 2008),

Flying Start NHS is seen by students as assisting them to plan their future career pathways, with many having the next step in their career journey already identified i.e MSc programme commencements, Early Clinical Career Fellowship Programme commencements lined up.

Summary

This chapter has presented an analysis of on-line communication derived from the Flying Start NHS website.
The analysis was based on a conceptual framework focusing on four dimensions, 1) quantity, 2) quality, 3) relevance, and 4) manner. Overall 98 students postings were rated using the above framework, as well as a thematic content analysis.

♦ Analysis revealed that there was considerable variation in the number of posting associated with different learning units.
♦ Postings in the general forum related to a range of topics.
♦ There was a lack of postings directing related to the learning materials.

- There was little evidence of long discussion strings suggesting that very few students engaged in the type of interactive engagement necessary for on-line learning communities.

- Scores derived from the Gricean descriptive analysis were found to be mainly positive although the scores relating to 'quality' of postings were low.

- Qualitative Analysis identified four themes which cut across the learning units:
  - Time Management/Protected Time
  - Career Aspirations
  - Tensions
  - Self-efficacy Growth

CHAPTER 8

IDENTIFICATION OF SECONDARY DATA AND ANALYSIS

Data collection: May 2008 - June 2009

As part of the evaluation of Flying Start NHS the research team undertook to carry out a scoping exercise to identify available baseline data from associated bodies concerning current recruitment and retention of newly qualified staff within the NHS.

The aim of this element of the Flying Start evaluation was to:
♦ Examine the impact of Flying Start NHS by tracking changes in recruitment and retention by year following implementation of Flying Start in April 2005
♦ Evaluate the effect of Flying Start NHS on recruitment and retention patterns in hard-to-recruit geographical, discipline, and specialty areas.

The original bid drew attention to the potential for difficulty in accessing such information, given that initial information from ISD suggested that in 2006 they did not identify newly qualified staff in their datasets.

Our plans were to gather data relating to recent graduates and career destinations from relevant HEIs via the HESA database. Additional potential sources of information relating to newly qualified staff and appointments in Scotland were to be sought from other sources including the SWISS data base.

Procedure

Phase 1: Following early discussion with a member of the project steering group 'relevant' data were purchased from HESA, and a request submitted to ISD for information relating to other data identified. The data received from HESA were of poor quality and unable to fulfill our requirements. Contact with ISD failed to identify the required data.

Phase 2: In early 2009 HESA data for 2006-2007, which covered the academic year after the commencement of Flying Start in April 2005, were obtained from ISD. The aim was to examine the number of leavers from all institutions in Scotland in full time paid work only, part time paid work only and in work and further study. However, this interrogation would not provide the kind of the data we needed on recruitment or retention by year, nor would it shed light on geography and speciality. We had doubts regarding the quality of data and were unclear whether it was possible to obtain data from previous years. Ultimately this did not prove possible. There was also some a lack of clarity in some of the coding which limited the potential usefulness of the data set.

A more promising option was provided by the SWISS data base. In April 2009, a list of variables that were on the SWISS data base relating to recruitment, retention by year was requested. It was hoped that the variables would allow the identification of those NMAPHs entering employment from HEIs, in Scotland, and allow us to determine how long they stayed (or turnover in a particular period). It might then have been possible to examine such relationships for Nursing, Midwifery and the AHP group and to examine this by Health Board area.

ISD was asked to provide the following data for the last available year in order to ascertain whether it would be possible to perform the required analyses.   If it had been found to be possible, we would have requested these data for preceding years to allow a comparison before and after April 2005.

1.9 Gender
1.11 DOB
1.38 Employing Organisation - Key item
1.40 Main location
1.43 Payscale Code (includes Health Board area - Key item
1.44 Post description, grade- Key item
1.48 Date appointed to grade
1.51 Occupational code (speciality) - Key item
1.52 Date started in NHS
1.53 Employment start date - Key item
1.54 Employment end date - Key item
1.55 Contract type
1.57 Planned end of contract
1.58 Contracted hours
1.61 Entry source (includes J- HEI) - Key item
1.62 Country from which employee recruited, inc Scotland) - Key item
1.64 Leaving destination- Key item
1.65 Reason for leaving
1.66 Employment duration

2.7 Registration body- Key item
2.10 Registration part- Key item

Unfortunately ISD were unable to release a data base that would allow for the tracking of individuals over time due to concerns regarding confidentiality. It was suggested that there might be a possibility that ISD could extract the data and perform our required analysis. However, this would have had cost implications, which had not been quantified, and there was no guarantee of success.

A request was subsequently submitted for anonymous average yearly statistics from the SWISS database from present year back to 2005 (start of Flying start) and to 2000 if possible, identifying the following:

1. The numbers of entrants to NHS, who enter from HEI's in Scotland
   - by Health Board Area
   - by Nursing, Midwifery and AHP professions
2. The numbers of these entrants who subsequently leave during that year.
   - by Health Board Area
   - by Nursing, Midwifery and AHP professions
3. Overall joining rates to NHS by NMAHPS
4. Overall turnover rates by NMAHPS

Again, there were concerns regarding the quality of some key variables in SWISS, in particular 1.61, entry source (includes HEI) and 1.62 (country), with 92% of data missing from these headings. ISD suggested that the data quality for such headings was poor. Without data from these headings it was not possible to look at those people entering the NHS from HEIs in Scotland.

Ultimately ISD advised us that our proposed analysis was not possible. However, we were informed that the Scottish Government and ISD were already undertaking work in this area. It is important that interested parties are aware of work of this nature and given an opportunity to inform its development with a view to ensuring that future data bases are fit for purpose.

Summary

This chapter has presented information relating to the identification and proposed analysis of secondary data with a view to examining the impact of Flying Start NHS on recruitment and retention of newly qualified NMAHPs, particularly in hard-to-recruit geographical, discipline, and specialty areas. Despite considerable efforts available data bases proved to be of poor quality with a high proportion of unpopulated variables, and we were unable to fulfil our aims.

CHAPTER 9

TELEPHONE INTERVIEWS

with

MENTORS, PRACTICE EDUCATION FACILITATORS, & MANAGERS

Data collection: January- November 2009

In order to investigate the perceptions and experiences of staff in a position to support NQPs undertaking Flying Start telephone interviews were carried out with managers, practice education facilitators, & mentors. This chapter presents the finding from these interviews.

The original intention was to involve one manager, one PEF, and three mentors in each NHS Board. The rationale for including these staff being that incumbents in each role support NQPs in different ways, for example managers may influence the environment and general ethos, while mentors work directly with NQPs. Unfortunately, it proved difficult to recruit the required number of staff. On a several occasions, although interviews were arranged to suit the interviewee, their circumstances changed prior to the appointed time and they were unable to take part. In some cases interviews were re-scheduled; however, in other instances busy work schedules and limited time resulted in interview arrangements breaking down more than once, or contact numbers being unobtainable. In these circumstances we did not feel that it was appropriate to keep contacting individuals. Eventually, 43 interviews were carried out involving 22 mentors, 12 PEFs, and nine managers, see table 1.

Table 9.1: Newly qualified practitioners involved in data collection, discipline, and NHS Board

NHS Board	Mentors	PEFs	Managers	Freq
Ayrshire & Arran	1	1	-	3
Borders	-	1	-	1
Dumfries And Galloway	2	1	1	5
Fife	-	1	1	2
Forth Valley	2	1	1	4
Grampian	3	1	-	4
Greater Glasgow & Clyde	2	1	1	4
Lanarkshire	2	1	1	4
Lothian	3	1	-	4
Shetland	2	1	1	4
Tayside	1	1	1	3
Golden Jubilee	2	1	1	4
State Hospital	1	1	1	3
Total	22	12	9	43

It can be seen from the above table that we were able to involve a number of staff who were in a position to support NQPs undertaking Flying Start in thirteen out of the sixteen NHS Boards. However, as mentioned previously there were no NQPs undertaking Flying Start in NHS Orkney, and although there are no staff from two other NHS Boards listed above, they did input to the project

at other times. Sixteen mentors who took part in the telephone interviews were nurses, two were midwives, and four were AHPs. Ten PEFs were nurses; four managers were nurses, one was a midwife, and three were AHPs. Although a majority of mentors (77.3%) were employed in an acute setting, five mentors, three nurses, and two AHPs, worked in a community setting. PEFs were located in both acute and community settings, as were managers (see table 2).

Table 9.2: Mentors, PEFs, and Managers by profession and setting of employment (frequency)

	Nursing			Midwifery			AHP		
	Acute	Community	Acute & com.	Acute	Community	Acute & com.	Acute	Community	Acute & com.
Mentors	13	3	-	2	-	-	2	2	-
PEFs	5	3	2	-	-	-	-	-	-
Managers	4	-	-	0	1	-	1	1	1
Total	22	6	2	2	1	-	3	3	1
Data relating to two PEFs and one manager are missing.									

Mentors, PEFs, and managers were all asked about:
♦ Factors that facilitate or hinder the employment of newly qualified practitioners into or community acute settings
♦ Whether newly qualified practitioners employed in community setting experience different challenges from those employed in acute settings
♦ Whether newly qualified practitioners experience challenges from other professionals due to their status
♦ Support available to newly qualified practitioners
♦ Their own knowledge of the Flying Start programme
♦ The impact of Flying Start NHS
♦ Perceived limitations in the Flying Start programme
♦ Future provision of Flying Start

A copy of the interview schedule is included in the appendix, page 152.

In each of the following sections the views of managers are presented first, followed by PEFs, and finally mentors.

Factors that impact on the employment of newly qualified practitioners

Participants were asked what factors facilitate or hinder the employment of NQPs into their area. Managers, PEFs, and mentors all drew attention to the tendency for NQPs to seek employment in an area in which they had a positive student placement:

The majority of recently employed have benefited from previous experience in the ward during pre-registration course. (Manager)

"I think a lot of them have come here on student placements and they really enjoy the type of work … (PEF)

We have had a few students that have been with us that have come back … they feel it's from the experiences they got from their student placements. (Mentor)

Participants also felt that reputation for supporting newly qualified staff, providing training, and rotational posts were attractive:

> *We're a very friendly staff presently we support CDP and we have a good programme of in service training and we can offer a good range of rotations. (Manager)*

> *We've got a good reputation so lots of people want to come and work for us, which is great... (Manager)*

> *I would say it's the fact it's a rotational post so they're getting experience of different areas... (Mentor)*

Variety was perceived to be important:

> *Probably I think the fact it can be quite diverse, there is quite a bit of choice, and there's a lot of activity you know, there's a wide range of activity that they can manage, and they can obviously hone in on the clinical skills very quickly. (Manager)*

> *Where I'm working at the moment, it's a day surgery unit I'm in, so we have a huge amount to be learned ... there's a whole range of skills and you know different types of nursing I mean we can be doing a bit of everything in the one day never mind in the one week. (Mentor)*

Attention was also drawn to more pragmatic considerations including location:

> *We're quite centrally located, that definitely facilitates new graduates wanting to come ... (Manager)*

> *I think sometimes people want to work quite near where they live as well so we do have a tendency to gather people who work or live locally. (Manager)*

> *I think we are quite unique in that it is the only hospital in the whole of the area you know it is the only main hospital in the whole of the area so there isn't a huge amount of choice for a lot of our newly qualified. (PEF)*

And hours of work:

> *Where I work its day surgery, its Monday to Friday, so a lot of people are attracted by that, the hours... (Mentor)*

However, there was an acknowledgement that finding employment was not easy for NQPs:

> *Well it's really governed by vacancies, so if we've got a vacancy then we will go out to the market place to recruit... (Manager)*

> *I would say availability is probably the biggest, it's where the jobs are... (PEF)*

Lack of suitable jobs was the main reason cited for not employing NQPs:

> *We've not got enough jobs for the amount of people that are there (Manager)*

Probably the lack of posts, particularly these days when we're all trying to cut back and be a bit leaner. (PEF)

There is a huge shortage of posts for NQP and junior physiotherapists (Mentor)

The hours that they're offered you know, and the part time nature, the temporary hours; they're having to go onto the Bank first. (Mentor)

Participants suggested that more experienced staff would be employed before NQPs, and that staff were not 'moving up' in the way they might in the past:

There is such a large number of trained staff that they will remain quite junior, and not get an awful lot of management experience … (Mentor)

Negative experiences during student placements were deemed to be a factor that might prevent NQPs choosing a particular area:

If they have had a bad experience with a particular ward area [or] a member of staff, they tend to avoid that area, and I think patient quality is a big factor. (Manager)

If they didn't have good placements and just through that they felt unsupported as a student, then they may well think twice about coming because they may look at it and think, 'I'm going to be unsupported as a new staff nurse'. (PEF)

One mentor suggested that established staff were not always as supportive as they might be:

I don't think that we, as professionals, trained nurses, actually help a great deal. I think you know, we kind of hark back to when it was our day, and this and that and the next thing, and I think that kind of, I think it puts them off. (Mentor)

Acute versus community setting?

Participants drew attention to the shift into the community, both in the provision of care, and as a place for newly qualified practitioners to begin their career:

Basically it's quite a new concept taking newly qualified into the community however; I've seen an increase especially with the Flying Start. (PEF)

There's been a big drive from hospital care to community care [in mental health] I don't think there's the same opportunities for ward based newly qualified staff so I think it's becoming, although it is still quite new for the communities to be employing newly qualified staff, I think we're going to be seeing more of it in the future… (Mentor)

I would say for community that's always been quite something that people would like to do, but it's not always something that's been open to newly qualified practitioners (Mentor)

However, others felt that the tradition of spending time in an acute setting following registration would continue to be attractive:

For NQP there is an attraction to acute hospitals due to the rotational element – a chance to learn core skills in a supported environment that offers organised training (Mentor)

To gain experience, most newly qualified midwives feel 'safe' in the ante/postnatal ward. (Mentor)

And that there was a lingering perception that staff needed to be more experienced to work in the community.

A perceived requirement for experience by existing staff who believe that they need a wee bit more life experience, of caring for patients because[it's] mostly autonomous working in primary care settings."(PEF)

The kind of historical mind set of people in that, you know, they feel that people have to be within an acute sector or else they don't get a baseline of skills and that's a historical thing that comes from both the education side as well as those in practice. (Mentor)

Challenges faced by newly qualified practitioners employed in acute and community settings

Participants' perceptions of the different challenges faced by NQPs in acute and community settings varied with some staff thinking that there was no difference:

I don't think the actual issues are any different I think it's just that they probably manifest themselves slightly differently. (Mentor)

While others thought that NQPs going straight into the community were more isolated than those taking up a post in an acute setting and would require additional support:

A newly qualified person needs to consolidate their knowledge and therefore they do need to follow a core set of rotations, and lone working can be very intimidating for a new practitioner. (Manager)

I suppose the remoteness of some of the community settings as opposed to the sort of team infrastructure there is within acute mentoring and clinical supervision. (Manager)

I don't think their experiences in community throughout their training have been very extensive… (PEF)

When you first qualify I mean you need to rely on ones that have been qualified for years you don't know everything… when you're in the ward you've got all that support round about you. (Mentor)

However, a third group of participants felt that there was adequate support in the community:

Mentorship for newly qualified staff is 'ongoing' by mentors who have previously had a staff nurse as a student. (Manager)

I think they're better supported within the community health care teams because of the experience of the existing staff because of, you know, the team working and the available support. (PEF)

and primary care settings:

> *If anything they experience less problems because of the supportive environment. (Mentor)*

> *Because it was a new situation for us here, the support, well I think was not too bad, because initially all kind of new visits were all joint and worked together in the day hospital we tried to make kind of allowances for that, but at the same time try to give opportunities to develop you know confidence and autonomy. (Mentor)*

One PEF indicated that supporting NQPs who were experiencing difficulty was part of their role:

> *You know that's where my role would come in, to work quite closely with them you know, we may be asked to go in by their mentor or their manager they may approach us themselves to say that they're struggling. (PEF)*

Critical incident 3: newly qualified practitioner

Where were you?	*N/A*
Who else was present?	*N/A*
What happened?	*Had new client on caseload. I had no experience of clients with similar difficulties*
In what way did Flying Start help you?	*Did not know what strategies to use with the client. Needed to make a home visit - was unsure how to carry out the session.*

The challenge of being a newly qualified practitioners working with established professionals

Managers, PEFs and mentors were asked if they thought that newly qualified practitioners experience challenges from other professionals. Responses were again mixed with some participants reporting that NQPs could feel quite intimidated by other professionals, particularly medics:

> *Yes, they're often intimidated by district nurses and they're frightened to ask them to do like dressings and things. (Manager)*

> *I think there is an expectation that once they're qualified that's them they're ready just to run. (PEF)*

> *When they first come to the ward, just because they're newly qualified, I would say probably from the doctors… they don't know everything and they maybe do get a bit challenged by that sometimes. (Mentor)*

Participants referred to the challenges and benefits of working in a multidisciplinary team:

> *Within this unit there's a multi-disciplinary, we do a team approach… we have a meeting every morning inclusive of the physiotherapists, you know, the AHPs because they see that, and they're involved in that… I don't really think there is a huge issue with it certainly within this area. (Manager)*

I think they probably do[face challenges] in terms of just you know settling into their role and learning the job and even just from speaking to some newly qualified people they might have issues around assertiveness within the multi-disciplinary team. (PEF)

However, some participants felt that any conflict was due to lack of confidence on the part of NQPs

I would hope not, I would hope that all professionals would understand that they're newly qualified, but it really depends on their confidence…(Manager)

I don't know that they are necessarily challenged by other professionals; I think they challenge themselves in feeling that they possibly don't have the knowledge, or the skills to share with these other professionals, just because of their own confidence … (Mentor)

Critical incident 4: newly qualified practitioner

Where were you?	*Ward C (was moved from my own ward to another ward to help out)*
Who else was present?	*Ward staff (other newly qualified staff that I trained with)*
What happened?	*The nurse in charge had slept in leaving just newly qualified staff on the ward.*
In what way did Flying Start help you?	*Felt ill equipped to be moved to ward with a very diverse patient group where IV administration was required when I had none and to be left with fell newly qualified staff just 2 months out of our training. I felt very isolated and distressed over the situation.*

One mentor suggested that, in some circumstances, what might be taken to be a lack of confidence in a NQP was a realistic appraisal of their own ability:

I think they're quite intimidated. I would hope they are intimidated - I have to say that as well, I hope they're intimidated because if they don't recognise their short falls... but a confidence thing, no, I think it's an educational thing. (Mentor)

It was also suggested that this would apply to anyone taking up a new role, not just health professionals:

This would happen in any job, until they have knowledge and experience within their job (Mentor)

A small number of participants felt that there was a lingering 'traditional' mentality:

There still is this age old kind of expectation that they don't now need any support, and even with the increase in mentorship and the training that's in place now, even with that, you still get that impression. It's not as bad as it used to be but I think it's still there. (PEF)

However, others were more optimistic:

I think gone are the days of intimidation and bullying, I certainly hope so... (Manager)

Attention was drawn to the benefits of Flying Start for NQPs fitting into their new role:

> *Occasionally a NQP may have to deal with another team member of seniority challenging their interventions, but this should not arise if adequate supervision is in place, and through Flying Start communication and conflict resolution training. (Mentor)*

Critical incident 5: newly qualified practitioner

Where were you?	*Discharge planning meeting*
Who else was present?	*Nurse, OT, PT, SW*
What happened?	*There was a patient being discussed who is hoping to be discharged imminently. The other team members were keen for discharge and felt the patient would cope at home. I was able to raise my concerns about this patient and how he would actually cope at home.*
In what way did Flying Start help you?	*Identifying good communication skills and developing confidence in my role helped me to.*

Support available to newly qualified practitioners

Participants were asked about the support provided for NQPs in their NHS Board/area. Although some participants mentioned Flying Start in response to these questions, this section predominantly excludes Flying Start which is covered in detail later in the chapter.

Managers listed a range of training and induction processes for NQPs, e.g.:

- *Hospital induction process*
- *Hospital orientation programme*
- *Corporate induction and mandatory training*
- *Clinical supervision process in the hospital*
- *In service training*
- *Specific training for 'on-call'*
- *Six months preceptorship*
- *Flying Start*
- *Condition-specific training*
- *Clinical educator on the ward to identify individual needs*
- *PDP*

Managers also drew attention to the support available from PEFs and mentors, and highlighted the challenges in different areas:

> *For the emergency admitting wards, because of the acuity and the busyness of the area, it can be very difficult to spend the quality time with the newly qualified nurse (Manager)*

It was apparent that different areas had developed their own methods depending on their own specific challenges:

We've got the Development Grade Programme for them, they each have a mentor a designated mentor, and a buddy, and they have a minimum of one session per week and ideally two sessions per week to develop into their role during that first year. (Manager)

Initially they would have a month supernumery, and then they would still be working with a mentor you know, to the best of our ability we would have them with the mentor the second month, and they would initially be supernumery, and the two of them would have the same caseload for that month. (Manager)

They would be supported, they would never be left to be in charge of a ward, they would be given support, they would be able to do clinical skills that they were competent to do and start to learn (Manager)

Yeah well, what they tend to do is they come in and there kind of shadowing at the outset, very sort of tentatively, that you're going to allow people to engage the caseloads. (Manager)

If they're up on the wards they've always got a senior nearby, and the senior would prioritise work and give them their caseload. (Manager)

They're also expected, but not immediately, but within about the first six months, to start doing some house visits you know initially we get them to build up their confidence in a clinic …(Manager)

PEFs also drew attention to induction programmes and preceptorship:

Robust and structured induction programme. (PEF)

They're given preceptorship, so they're given one allocated individual who has been qualified for at least a year, and has undertaken preceptorship training in house and they're given their supervised practice. (PEF)

Each newly qualified member of staff is allocated a mentor. (PEF)

Mentors referred to the role of PEFs and clinical supervision as well as their own role in providing support:

When they come in we've got a practice education facilitator, so she supports them a lot at the start with finding out what training they want to do, and she trains them with some of the stuff she does personally... (Mentor)

The input clearly varied between areas:

Each newly qualified nurse receives two mentors. (Mentor)

Mentors reported that there was significant informal support from staff other than their mentor:

Weekly supervision (formal), daily informal supervision and work shadowing within each Rotation. (Mentor)

> *We do try and have it so that the new start's always working with their mentor. (Mentor)*

While some mentors felt that NQPs in their area were well supported:

> *Within the hospital they're quite well mentored, they wouldn't be left in charge of a ward or anything, and they are well supported. (Mentor)*

However, others were less confident of the support in practice:

> *A mentor, me, that sounds a bit basic. (Mentor)*

> *[NQPs] are assigned a mentor as soon as they come to the ward as well, but to be honest it doesn't always quite work. (Mentor)*

Knowledge of Flying Start NHS

When asked if they were familiar with the Flying Start Programme, managers and PEFs, indicated that in general they were:

> *Yes I've been through it with some of the students but I mean I've never looked at it in depth but you know I can see how they have their learning sets to move through. (Manager)*

> *The ten things, I couldn't tell you each individual one, but there's ten. (Manager)*

> *Oh yes, been there many times, yes I know all about the units and the bits in between and the concluding activities and what people should be doing. (PEF)*

> *Yes, and there's ten units and I can name some of them, but I struggle to remember them all off the top of my head. (PEF)*

However, there was some variation in the level of knowledge amongst mentors:

> *I know a little bit about it yes, I know that they have various, it's like competencies that they do over the year with the mentor… You know I've not seen it being used. I've spoken to a couple of the girl's sort of first year development and I don't think they've really done very much with it. (Mentor)*

> *I do not know the number of units on the Flying Start programme, but have had an overview of the programme on a recent in-house study day. (Mentor)*

> *I am fully aware of all units and themes incorporated in Flying Start. I use these to undertake KSF. Knowledge and skills appraisals with foundation level Band 5 nurses within my line of work. (Mentor)*

In fact one manager drew attention to the lack of knowledge they had found amongst mentors:

> *The mentors felt, although they could mentor, they hadn't a clue about Flying Start - they didn't know the computer system, you know, so we had a lot of training to do there. (Manager)*

The impact of Flying Start NHS

Participants were asked about their perceptions of the potential impact of the Flying Start programme. Mentors drew attention to the flexibility of the programme:

I think it makes it easier for [NQPs] knowing what they need to do, like developing their skills it's something, it's good they can work through at their own pace in their own time ...

However, it was felt that some guidance was necessary:

There's so much material there, and because a lot of it is just in a very open way, it can form into whatever area and kind of ... I think that's maybe where the mentor comes in, they need to have the depth of knowledge and the depth of understanding to be able to enhance the candidate within the Flying Start.

Attention was drawn to the benefits of completing the programme in terms of enhancing confidence:

It will help improve their confidence and it gets them into a habit straight away of having a CPD portfolio which they will then go on and build on and the modules are really very relevant and very good within the programme. (Manager)

My perception is of Flying Start is to ground people, make them confident, you know, capable practitioners. (PEF)

I think it helps the newly qualified build confidence within the themes and allows them to link theory to practice. (Mentor)

However, some managers felt that the programme was repetitive for some NQPs and overly academic when they really wanted to gain practical experience:

I think it is purely academic you know, and I think they need a lot of practical input ... (Manager)

I seriously think that the majority of staff they've done so much theory throughout that its putting it into practice...(Manager)

PEFs were more positive indicating that they thought it would ease transition for NQPs

It should make things easier for the newly qualified person to actually adjust from being a student. (PEF)

I think Flying Start, from the people that I've spoken to who are doing the programme, find it very helpful with, in particular communication skills and team working. (PEF)

However, they also acknowledged NQPs' desire to focus on their practical experience:

I think certainly my experience of newly qualified nurses is they want to come in and they want to learn how to do the clinical part of their job. (PEF)

And drew attention to the need for support for NQPs undertaking the programme:

> *I think its raised awareness that practitioners need some form of immediate support within their first year. (PEF)*

Strengths

Participants drew attention to some of the strengths of the Flying Start:

> *I think they're finding the Flying Start is helping them because it's allowing the NQP to actually think for themselves, you know they're trying to find things out for themselves and trying to actually improve their practice. (PEF)*

> *I think it's a very useful tool for newly qualified staff I think it lets you think a wee bit and it's good for getting into all the policies and that. (Mentor)*

> *I mean it's been a fantastic learning tool for you know my colleague and myself who have both been around for you know quite a long time although we've both been very experienced with students you know coming through as well but we've found it brought a completely new dimension to ourselves and it's been a really good learning experience for us. (Mentor)*

And suggested that it would be useful for more experienced staff as well:

> *I don't think it should be looked as just for new starts, I think any grade of staff if they're going to do a project on a particular topic I would encourage them to look at the Flying Start programme, because all the different modules has so much information there it's a good basis to start a very good learning resource for any level. (Manager)*

> *Flying Start is superb for all grades of staff you know, it doesn't have to be a new graduate ... (Manager)*

Perceived limitations in the Flying Start programme

A number of reservations mentioned by managers, PEFs, and mentors have already been higlighted, including knowledge of mentors, perceived emphasis on desk based work rather than practical skills, and repetition of work undertaken prior to registration. However, when asked about perceived limitations three main areas were mentioned, the structure of the programme, time, and support.

Structure: Managers, PEFs, and mentors all questioned the generic nature of the programme:

> *I think to be honest because it's quite a generic programme some of the issues, all be it I think it's really useful for helping people consolidate their training in a theoretical sense, I think applicability to practice might be something that they maybe struggle a little bit more with. (Manager)*

> *Well I think what they ask them to do is very, very broad and it does give them good tasters of everything, but it's difficult for them to be able to see that in their actual practice whilst they're actually developing their skills. (Manager)*

Flying Start is very generic you know so it's about being a bit flexible you have to be sort of open minded and I think you know use your imagination to some extent with some of the activities ... (PEF)

If I had a criticism it would be that sometimes within your own profession it's maybe not particularly targeted at you. (Mentor)

In addition to the generic content of Flying Start being perceived to a disadvantage by some participants, attention was drawn to the need to mould the programme, or the provision of the programme to suit different areas:

I think it's like any sort of these centralised things you know it's more a sort of general approach rather than you know looking at it on a sort of local basis... it's up to the people locally to try and sort of make sure that its adapted and suitable for use at a local level sort of using that as the overall template (Manager)

While some participants welcomed the self-directed flexible nature of the programme, others felt that the lack of structure and guidance created difficulties:

I don't know whether the staff have completed [or] not completed, are they struggling to complete? The senior charge nurses don't know that all the time either, and if they haven't got that information they can't chivvy staff on... (Manager)

From where I've been standing it never seems to be checked by anyone other than their mentor... They need the official, you know they've just finished university, and they need that kind of approval that they've definitely done it. (Mentor)

In order to address this, some NHS Boards had introduced a structure of their own:

We have created a certificate for completion, as I say it's this ambiguity about how much information should be included in that, Have we done enough? (Manager)

Attention was drawn to the potential for NQPs feeling isolated because of the way in which the programme is provided:

I think limitations to me would that it's virtual that they have to work through it on their own. (PEF)

Time: Managers, PEFs, and mentors all drew attention to the amount of work involved in undertaking Flying Start and the lack of time available to NQPs to do so:

I just think that there's quite a lot of work involved and I don't know if that's appreciated across the board ... (Manager)

Although, one manager reported that even when time had been made available completion rates were not impressive:

"We offered time, we offered support not lots of time having said that but were trying to push it to try and get people to complete it and there's very few people have actually ended up completing it which is disappointing" (Manager)

However, mentors suggested that it was not only the NQPs who needed time: they also felt that they did not have sufficient time to provide the required support:

> *I think more dedicated time to Flying Start because I think eventually it will pay dividends. (Mentor)*

> *If I had more time set aside to, not only get a better understanding as a mentor what I'm hoping to provide, and also to spend time with the people that I'm mentoring ... (Mentor)*

> *Getting time with their mentor, for the newly qualified to work together with them. (PEF)*

Support for Flying Start NHS

Attention was drawn to the need for ongoing support for NQPs and their mentors:

> *We have meetings just for the Flying Starts and their mentors; we have meetings every three months, four months.... It started because it was a new thing but I think we've found that it's still required and that's really to keep them going, keep the momentum going...(Manager)*

> *I think the PEF's need to be more involved than they are, I think you need somebody to drive it and to believe in it. (Manager)*

> *Engagement and completion is the biggest thing. Getting them started isn't a problem because there's a high level of support there, it's the continuing support and we don't have that capacity to be badgering people to finish it so it's getting that momentum and I think that truly has to come from the mentors and the managers. (PEF)*

Attention was drawn again to the need for understanding amongst the wider staff, and support for NQPs completing the tasks:

> *More guidance required with regard to the role of the mentor and sort of the expectations of the candidate. (Mentor)*

> *I think there is a lack of knowledge I think amongst the senior charge nurses about Flying Start they just switch off. (Mentor)*

The future

While participants felt that there had been some progress, they expressed regret that the programme had not been more widely welcomed:

> *I do see a change in the last two years but I still feel disappointed that it's not embraced by everybody, and you know, I don't know what the answer is. (PEF)*

Participants felt that there was some resistance to completing the programme:

> *I have had thirty people going through it and I still have only a handful or less of people who have completed it. (Mentor)*

and that NQPs were not motivated:

> *What is interesting is people are finding time to do the new [speciality] they're not finding time to do the Flying Start, which in itself speaks volumes ...*

> *It sometimes feels like it's been something they've been told they have to do or they've got an obligation to do but there not actually making it useful for their development they're just doing it to get it out of their hair. (PEF)*

> *I just find they are sort of reluctant really to do their Flying Start it is quite difficult to get staff motivated to do it. (Mentor)*

Participants recognised the challenges that NQPs faced in the transition from student:

> *They've got that much else to focus on in their first year as a newly qualified ... (Manager)*

> *Changing roles from being a student and being directed and then just the transition into being the staff nurse so that would be difficult. (PEF)*

> *There seems to be this big transition from final placement student to staff nurse. (Mentor)*

Interestingly three managers suggested that it would be useful to introduce Flying Start prior to registration, the idea being that final year students would have a clear understanding of their own strengths and weaknesses and would have Flying Start available to support them *through* the transition from students to registered practitioner rather than being perceived as an additional challenge immediately following transition:

> *I definitely think to focus on it in their final year what they need to gain out of the Flying Start and they can start, you know doing that without the additional pressures. (Manager)*

> *I think in their third year, if they focus on what they feel they need to get out of Flying Start and then they've got that - so when they do get their post, they can take that brief with them, and they can sit down with an allocated mentor and say, This is what I need...*

Summary

This chapter presented the finding from telephone interviews with managers (n=9), practice education facilitators (n=12), and mentors (n=22) from a variety of professions, working in both acute and community settings.

Topics covered in the interviews included factors that facilitate or hinder the employment of newly qualified practitioners into or community acute settings, challenges faced by newly qualified practitioners and support available to them, knowledge of the Flying Start programme, the potential impact of Flying Start NHS, perceived limitations in the programme, and future provision of Flying Start.

Recruitment: Factors that were thought to facilitate the recruitment of NQPs included having had a positive student placement, having a reputation for supporting newly qualified staff, providing training, and rotational posts, posts that provided variety of experience, location, and hours of work.

- Attention was drawn to the economic situation and the lack of available posts.
- Negative experiences during student placements were deemed to be a factor that might prevent NQPs choosing a particular area.

Acute versus community setting: Attention was drawn to the shift into the community, both in the provision of care, and as a place for newly qualified practitioners to begin their career.
- Participants felt that there was still an expectation that NQPs would initially work in an acute setting, possibly due to a perception that staff needed to be more experienced to work in the community.
- Perception of the different challenges faced by NQPs in acute and community settings varied with some staff thinking that there was no difference, others suggesting that NQPs going straight into the community were at risk of isolation, and third group indicating that NQPs were well supported in the community and primary care settings.

Challenges: Managers, PEFs and mentors reported that NQPs could feel quite intimidated by other professionals, particularly medics.
- Some participants felt that any conflict was due to lack of confidence on the part of NQPs, or a realistic appraisal of their own ability.
- Attention was drawn to the benefits of Flying Start for NQPs fitting into their new role.

Support available to newly qualified practitioners: Participants listed a range of training and induction processes for NQPs, and drew attention to the support available from PEFs and mentors.
- It was apparent that different areas had developed their own methods depending on their own specific challenges.
- Input varied between areas, and while some mentors felt that NQPs in their area were well supported, others reported being less confident.

Flying Start NHS: Managers and PEFs, indicated that they were familiar with the Flying Start Programme.
- There was some variation in the level of knowledge amongst mentors:
- Mentors drew attention to the flexibility of the programme, and it was felt that some guidance was necessary.
- Attention was drawn to the need for support for NQPs undertaking the programme.
- Some managers felt that the programme was repetitive for some NQPs and overly academic.
- PEFs were more positive indicating that they thought it would ease transition for NQPs, although they acknowledged NQPs' desire to focus on their practical experience:
- Attention was drawn to the benefits of completing the programme in terms of enhancing confidence.
- Participants drew attention to some of the strengths of the Flying Start, and suggested that it would be useful for more experienced staff as well.
- They also highlighted a number of reservations, including knowledge of mentors, perceived emphasis on desk based work rather than practical skills, and repetition of work undertaken prior to registration, the structure of the programme, lack of time for NQPs and mentors.
- Participants questioned the generic nature of the programme:
- Attention was drawn to the need for ongoing support for NQPs and their mentors, as well as a wider understanding amongst the staff in general.
- While participants felt that there had been some progress, they expressed regret that the programme had not been more widely welcomed.

- Participants felt that there was some resistance to completing the programme and that NQPs were not always motivated.
- Participants recognised the challenges that NQPs faced in the transition from student.
- Three managers suggested that it would be useful to introduce Flying Start prior to registration to support NQPs *through* the transition from students to registered practitioner rather than being perceived as an additional challenge immediately following transition.

CHAPTER 10

FINDINGS OF ON-LINE SURVEY

Data collection December 2009.

As part of the evaluation newly qualified nurses, midwives and allied health professionals in each NHS Board have taken part in focus group interviews. However, focus groups can only involve a limited number of participants, and in order to ensure that members of the research team engaged with a comprehensive range of professions and locations, an online survey was developed for completion by newly qualified health practitioners (NQPs) currently undertaking Flying Start (n=9,500).

The questionnaire was laid out in four sections:
>   1: The new job
>   2: Experience of undertaking Flying Start
>   3: Support to undertake Flying Start
>   4: Future career
>   A copy of the survey is included in appendix 2, page 162.

A push email was sent to NQPs inviting them to complete the survey in the third week of November; a thank you to those who had completed the survey and final reminder indicating when the survey would be closed was sent three weeks later. Over a period of four weeks 547 NQPs took part. Unfortunately, a large proportion of respondents did not complete all sections of the survey – the number of missing responses are reported throughout the following chapter; however it is important to be aware that when analysis involves more than one variable, e.g. profession and level of education, the number of respondents included in tables may differ as data will not be available for respondents who failed to provide information relating to either variable or both. We have not included tables or analysis that could lead to identification of participants, e.g. profession by NHS Board.

The following chapter is divided into three sections. The first section introduces the NQPs who took part in the survey including their profession, where they were working in terms of NHS Board and whether in an acute of community setting, the nature of their contract, time in post, and perceptions of their development needs on entering employment. The second section focuses on the Flying Start Programme including the ten learning units, NQPs' perception of its impact on their clinical skills development and confidence, and future careers development. Section three presents information relating to the support provided to NQPs to undertake Flying Start. Critical incidents are included for illustrative purposes.

Participants

Profession

Of the 547 NQPs who took part in the survey nurses accounted for 61.1%; 237 adult nurses, 70 mental health nurses, 19 children's nurses, and eight learning disability nurses, 20 were midwives, and 287 AHPs, see figure 10.1, and table A1, page 153.

Figure 10.1: Profession of respondents: percentage (n=544)
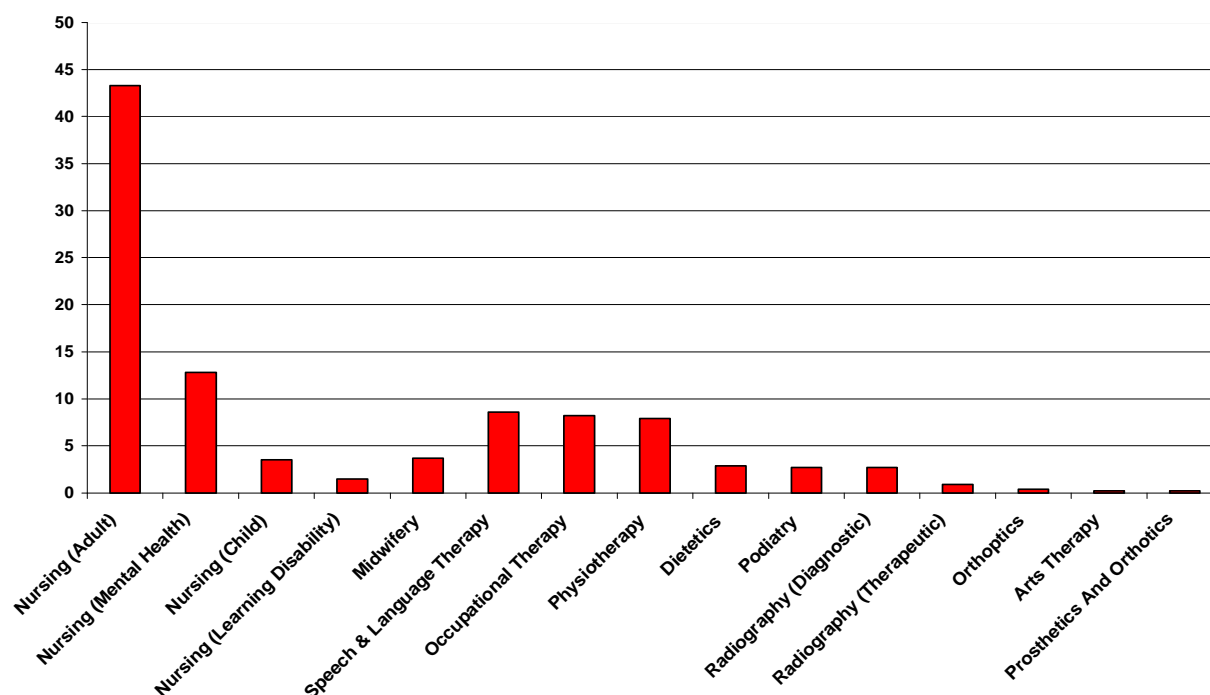
Level of education

Two-hundred and ten participants (38.4%) were educated to degree level, 132 (24.1%) had completed an honours degree, 68 (12.4%) had completed a diploma, and 25 (4.6%) had undertaken a Masters degree. A higher proportion of AHPs (87.4%) compared to nurses (9.1%), or midwives (5.9%), had an honours or masters degree. The proportion of NQPs educated to different levels varied between professions, for example a higher proportion of children's nurses had a diploma (38.9%), than any of the programmes/professions; however, the majority of nurses in all branches were educated to degree level (68%). All AHPs are educated at degree level or above, the professions with the highest proportion of practitioners with an honours degree were podiatry (100.0%), dietetics (84.6), and speech and language therapy (82.4%); a higher proportion of arts therapists (100%), physiotherapists (28.2%), and occupational therapists (22.9%) had a Masters degree, see figure 10.2, table A2, page 154. However, it is important to bear in mind that there were a higher number of respondents from some professions than others – in the chart below data relating to nurses and midwives are presented on the left; data relating to AHPs are then presented from left to right with those on the left having the highest number of respondents.

Figure 10.2: Level of education by profession: proportion of respondents in each profession*
(percent, n=434)
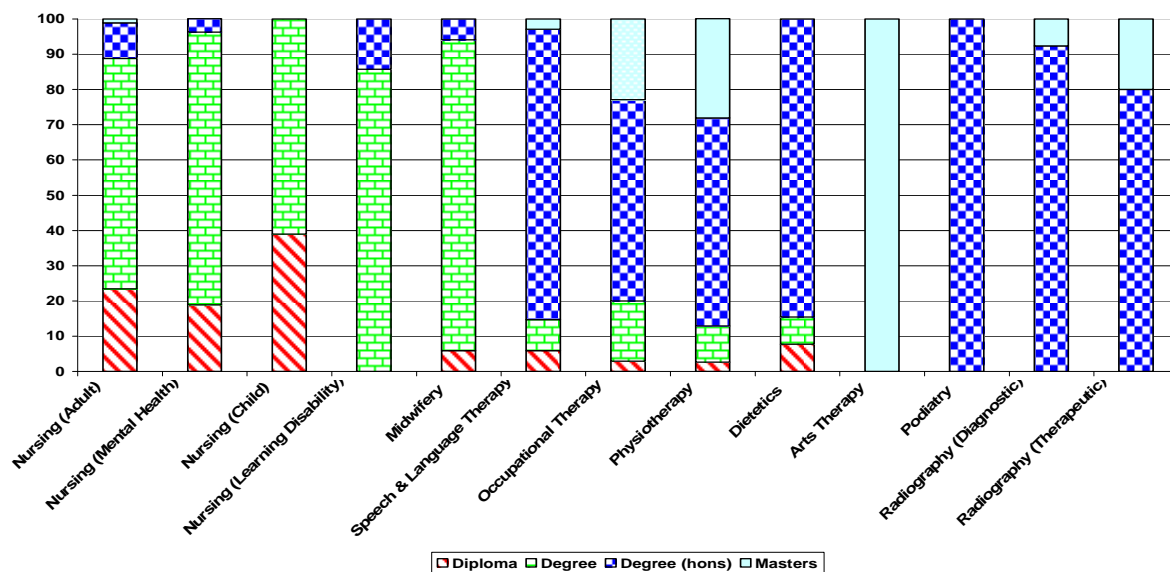
It should be noted that, although a small number of AHPs reported that they were educated to Diploma level, all AHP education is at degree level or above, thus responses may have been entered in error.

Employer

Responses were received from all NHS Boards with the exception of NHS Western Isles, see figure 10.3, and table A3, page 154. However, 110 respondents (20.1%), did not indicate which NHS Board employed them, possibly indicating anxiety relating to confidentiality.

Figure 10.3: Employer (NHS Board): percentage (n=437)
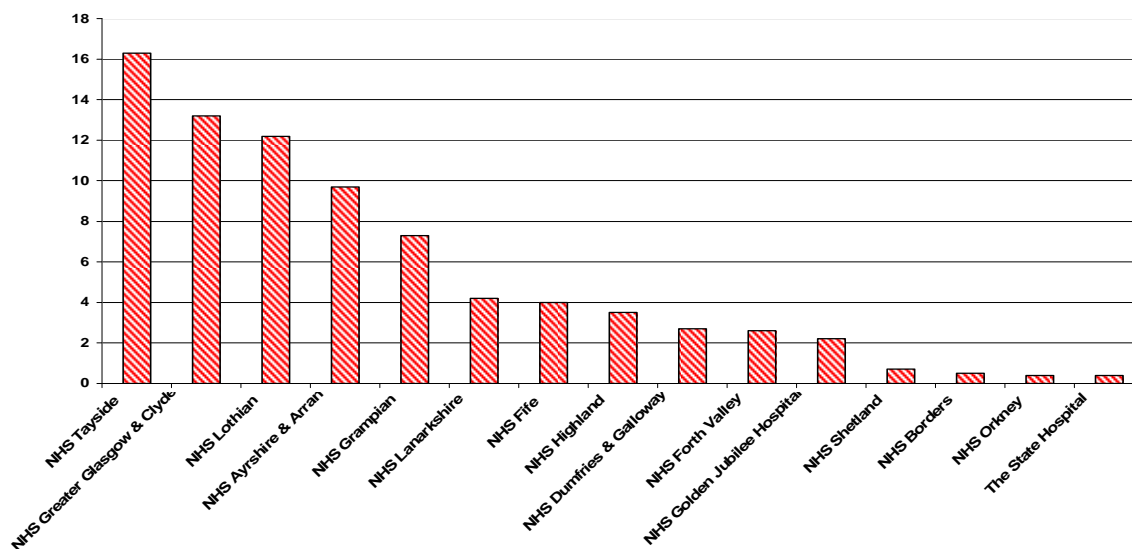
Nature of contract

Two-thirds of respondents (n=368, 67.3%) reported that their contracts were permanent, 59 (10.8%) that theirs were temporary; six nurses were employed on the Nurse Bank, and two AHPs on the AHP Bank. One hundred and twelve respondents did not answer this question. Five respondents indicated that they were employed under the staff nurse development programme; one was employed through the Scottish Executive one-year Job Guarantee as well as working on the Nurse Bank. One nurse reported being unemployed; a midwife reported having voluntarily left her post. Two AHPs reported that they worked in two jobs, one permanent, and one temporary. Another AHP reported having had six temporary contracts prior to gaining a permanent contract. A lower proportion of midwives (40.0%) reported securing a permanent contract compared to nurses and AHPs.

Setting

Two hundred and fifty-eight NQPs (47.3%) reported that they worked in an acute setting (, 101 worked in the community (18.5%), and 22 worked in both acute and the community (4.0%). Fifty-four respondents reported that their posts were rotational (9.9%); 107 respondents (19.6%) did not answer this question, see table 10.1.

Table 10.1: Employment setting by profession: frequency and percentage of profession (n=435)

Profession	Acute		Community		Both Acute & Community		Rotation		Total
	Freq	**%**	**Freq**	**%**	**Freq**	**%**	**Freq**	**%**	
Nursing	206	77.4	34	12.8	7	2.6	19	7.1	266
Midwifery	8	53.3	3	20.0	1	6.7	3	20.0	15
AHP	44	28.6	64	41.6	14	9.1	32	20.8	154
Total	258	59.3	101	23.2	22	5.1	54	12.4	435

Time in post

Twenty-five respondents indicated that they had been in post for more than three years*, thus were not newly qualified practitioners. It would be unusual for NQPs to be over 30 months in employment; it may be that these respondents were HNC students who would have been employed for 24 months prior to starting Flying Start. Amongst the 404 respondents who indicated that they had been in post less than thirty-six months the mean length of time in post was just over one year, see figure 10.4, table A4, page 155. It can be seen that, of those who responded to this question, more than four out of five (83.2%) had been in post for 18 months or less.

Figure 10.4: Time in post (months): percentage (n=405)
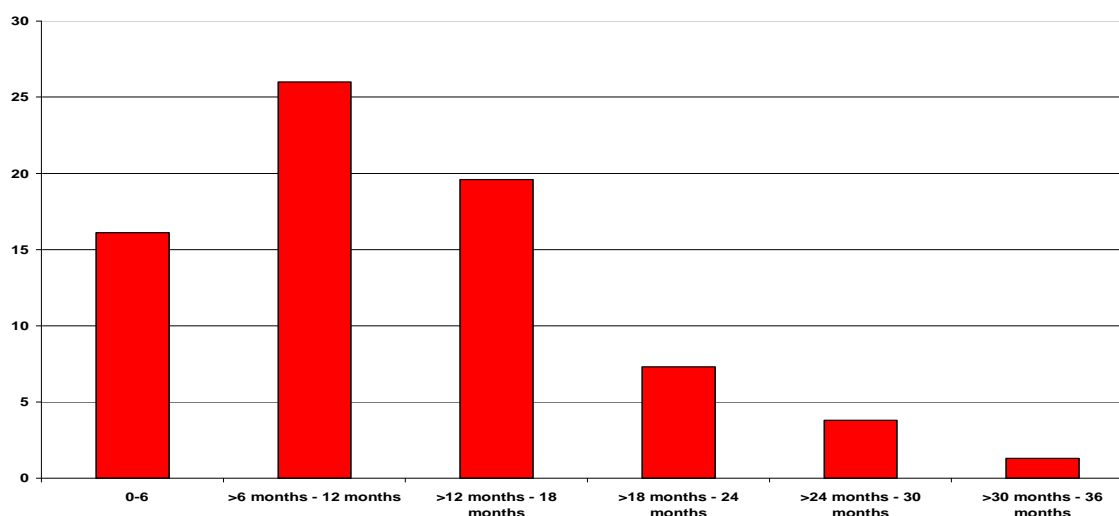
* Respondents who indicated that they had been in post for over three years are excluded from further analysis based on 'time in post'; however they were not excluded from other analysis as it was thought that their responses relating to time in post could have been an error on entry.

Newly Qualified Practitioners' perception of their development needs

In order to find out what newly NQPs thought their main development needs were on entering employment, respondents were asked to rank four aspects of their new job on the basis of how important each was to them when entering employment:

1) Learning the job
2) Becoming a member of the team
3) Orientation/induction to the clinical area
4) Organisation commitment/career progression

Three hundred and one participants, 71.33% of the 422 who answered this question, rated *learning the job* as their most important development need. *Becoming a member of the team* and/or *Orientation/induction to the clinical area* were perceived to be the next most important, leaving *Organisation commitment/career progression* rated as least important by 75.12% of respondents who answered this question, see table 10.2.

Table 10.2: Perceived importance of development needs: frequency (n=422)

Development need	Most important	2nd most important	3rd most important	Least important
Learning the job	**301**	89	24	8
Becoming a member of the team	37	**186**	174	25
Orientation/induction to the clinical area	76	125	**164**	60
Organisation commitment/ career progression	18	28	58	**317**

The questionnaire invited respondents to identify any other development needs they were aware of when they first entered employment. A small number of participants identified additional developmental needs including:

♦ Role transition
♦ Knowledge and skills development
♦ Confidence building
♦ Caseload management
♦ Gaining a permanent contract

THE FLYING START NHS PROGRAMME

Enrolling on Flying Start

The length of time that respondents had been enrolled on Flying Start ranged from 'newly enrolled', to 35 months with a mean of 10.11 months. Respondents who reported having entered employment within the past year reported having enrolled on Flying Start significantly more quickly than those who had entered employment more than two years ago, mean time to enrolment =1.77 & 3.35 months respectively {$F_{(2)}$ = 9.799, p <.001}. The time lag between enrolling and undertaking activities associated with Flying Start ranged from 'straight away' to eleven months with a mean of 1.44 months. No difference associated with time in employment was found in the time lag between enrolling on Flying Start and becoming actively involved.

Flying Start Learning Units

The Flying Start Programme includes ten learning units, and in order to find out more about the way in which NQPs approached the programme respondents were asked to indicate whether they had completed some activities for each learning unit as well as whether or not they had completed the concluding activity. The following table (table 10.3) lists the number of NQPs that reported that they were currently working on each learning unit, i.e. reported that they had completed some activities associated with a unit, but did not indicate that they had completed the concluding activities, and the number that reported having completed the concluding activities. A further 84 respondents reported that they had completed the concluding activities for all ten learning units indicating that they had completed Flying Start. Thus it can be seen that a proportion of NQPs were currently working their way through a number of learning units, and some had completed some learning units.

Table 10.3: Flying Start Activity: number of NQPs who had completed activities at time of survey

Learning Unit	Completed some activities	Completed concluding activities*
Communication	75	110
Clinical Skills	78	84
Teamwork	72	76
Safe practice	75	55
Research for practice	52	39
Equality and Diversity	62	44
Policy	61	27
Reflective practice	74	50
Professional development	67	33
Career pathways	47	13
* Note that a further 84 NQPs who completed the survey indicated that they had completed the concluding activities for each learning unit.		

In order to focus on progress, data relating to individual learning units were summed allowing a measure of the number of learning units on which NQPs were currently working as well as the number of NQPs who had completed learning units. The following chart indicates that 43 NQPs, 48.9% of those who had been in employment for less than six months had completed some activities associated with at least one learning unit; of these 29 had not completed any concluding activities, ten had completed some but not all concluding activities, and four reported having completed all concluding activities (see figure 10.5). This was followed by a peak of activity reported by those who had been in employment for 6-12 months and 12-18 months.

It is of interest to note the shift with time, with the number who are actively involved initially increasing and then decreasing again, while the number of NQPs who reported having completed Flying Start increased to a maximum at 18 months; from 6-18 months the number who had completed the concluding activities associated with some but not all of the learning units remained constant. By 24 months the number of NQPs who had completed all the concluding activities was almost equal to the number who still had activities outstanding. However, it should be noted that this may have more to do with the self-selection of participants - after 18 months of employment 37 NQPs reported that they had *not* completed the concluding activities for *all* the learning units, after 24 months 16 respondents had not completed.

Figure 10.5: Flying Start by time in post: NQPs who are actively undertaking activities associated with Flying Start, NQPs who have completed some, but not all concluding activities, and NQPs who have completed all concluding activities (frequency)
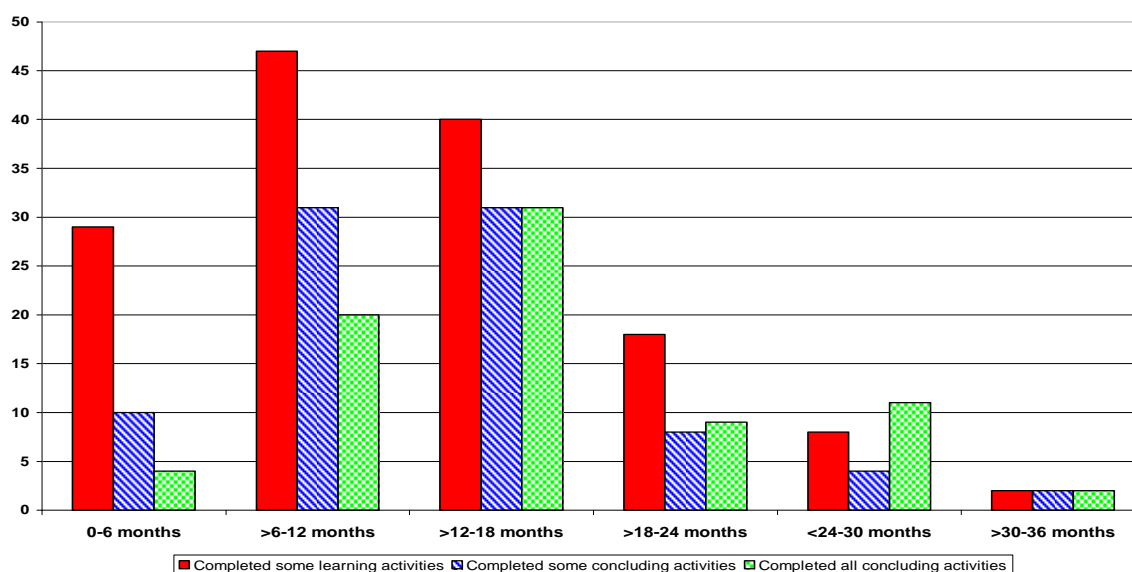
* *NQPs were taken to be actively working on a learning unit if they had completed some activities, but not the concluding activities; completion indicates that the concluding activities had been undertaken.*

Impact of learning units on clinical skills development and confidence of NQPs
We were interested in whether NQPs undertaking Flying Start thought that the programme had had an impact on their confidence and clinical skills development. In order to investigate this further scores derived from 1) NQPs who were currently working on each learning unit, i.e. they had completed some of the activities, and 2) NQPs who had completed the concluding activities on each of the learning units were analysed. Because a different number of NQPs were included

in each analysis the following section presents frequencies rather than proportions/percentages. Further information is included in tables A5 in the appendix, page 155, which present data relating to the responses from NQPs who were currently undertaking, or had completed each learning unit and their perception of how useful they had been in their clinical skills development and increasing their confidence.

Because we do not know how many activities participants who were undertaking each learning unit had completed at the time of the survey, data relating to NQPs who were still completing each learning unit may be of limited value. However, it is of interest to look at any changes between NQPs who were currently working on activities associated with each learning unit when they completed the survey and those who had completed the concluding activities. Looking at the following four charts (figures 6-9, and table A5 and A6) it can be seen that the learning units with the highest number of NQPs either currently undertaking activities or having completed the concluding activities were Communication, Clinical Skills, Teamwork, Safe Practice, and Reflective Practice reflecting the main development needs identified in the previous section, i.e. *learning the job*, *becoming a member of the team* and *orientation/induction to the clinical area.*

Impact of learning units on clinical skills development
Looking first at Figure 10.6, which presents data relating to NQPs who were currently completing activities associated the learning units but had not completed the concluding activities, it can be seen that approximately six out of ten NQPs who were currently undertaking activities relating to Clinical Skills, and Safe practice, and half of those working on Reflective practice and Professional Development reported that they thought that the learning units/activities were useful in terms of Clinical Skills Development. Half of those undertaking activities relating to Communication, Teamwork, Research for practice, Equality and Diversity reported that the activities were not useful for Clinical Development. However, it can be seen from Figure 10.7 that a higher proportion of NQPs who reported having completed the concluding activities associated with all of these learning units reported that it had been useful for their Clinical Skills development. A small but relatively consistent proportion of NQPs who were currently undertaking or had completed each learning unit were unsure whether or not the tasks had had an impact on their clinical skills development, or felt that this was not applicable.

Figure 10.6: Impact of learning units on clinical skills development: participants <u>currently undertaking</u> each learning units' perception of usefulness (frequency).
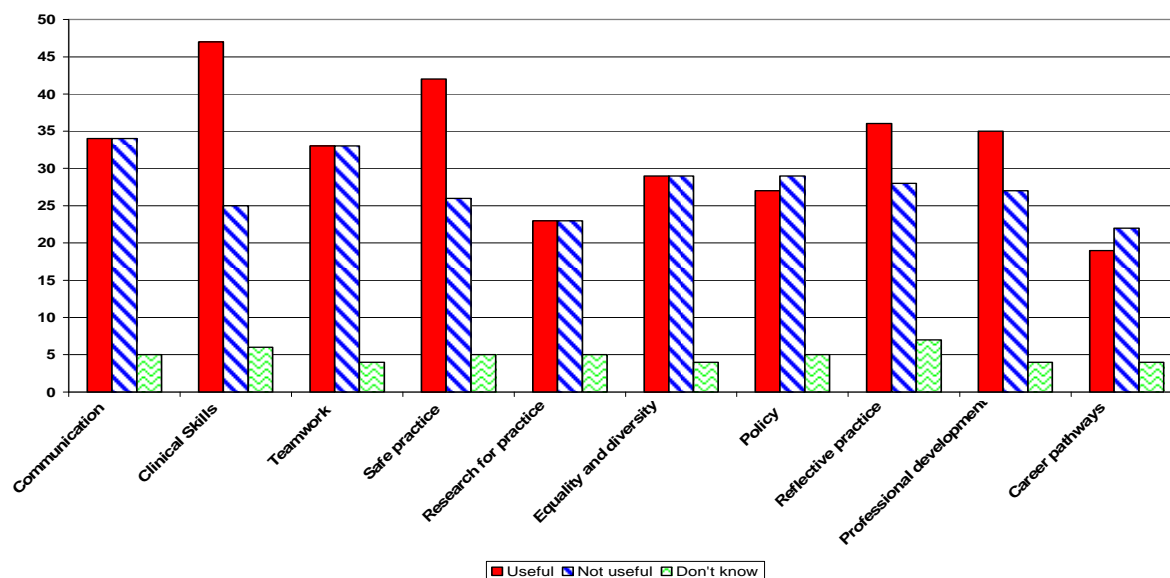
Figure 10.7: Impact of learning units on clinical skills development: participants who have <u>completed</u> concluding activities on each learning unit perception of usefulness (frequency).
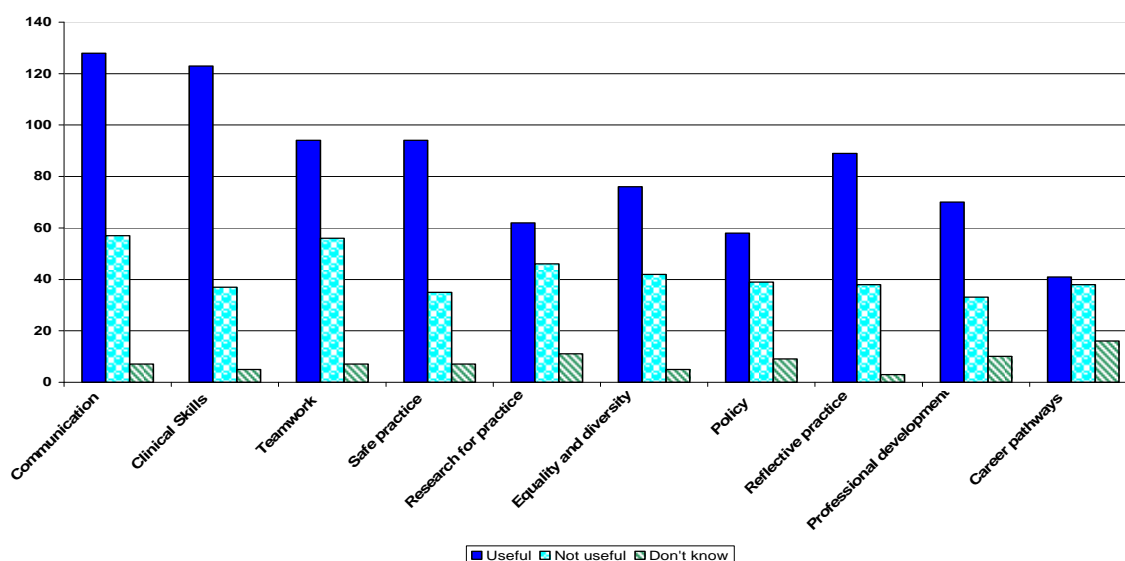
Critical incident 6: newly qualified practitioner

Where were you?	*In a pulmonary rehab education talk*
Who else was present?	*Eight patients and Technical Instructor*
What happened?	*I was taking my first education talk for the pulmonary rehab class. This involved me educating eight patients on an element of their disease and how they could change things to help their health.*
In what way did Flying Start help you?	*Using the **clinical skills** section and the enabling ones and improving health tasks I was prepared on what I needed to know to be able to teach others.*

Impact of learning units on confidence of NQPs

Focusing Figure 10.8 it can be seen that approximately half of all NQPs who were currently undertaking tasks associated with each learning unit reported that they had not found it useful in terms of increasing their confidence. However, again a higher proportion of respondents who had completed the concluding tasks indicated that they felt that the learning units had been useful compared to those who were still working on them, see figure 10.9. The learning units rated as useful in engendering confidence by the highest proportion of NQPs who had completed them were, Communication, Clinical Skills, Teamwork, Safe practice, and Reflective practice (see table A6, appendix, page 156). Again a small proportion of NQPs who were currently undertaking or had completed each learning unit were unsure whether or not the tasks had had an impact on their confidence, or felt that this was not applicable.

Figure 10.8: Impact of learning units on the confidence of NQPs: participants <u>currently</u> <u>undertaking</u> each learning units' perception of usefulness (frequency).
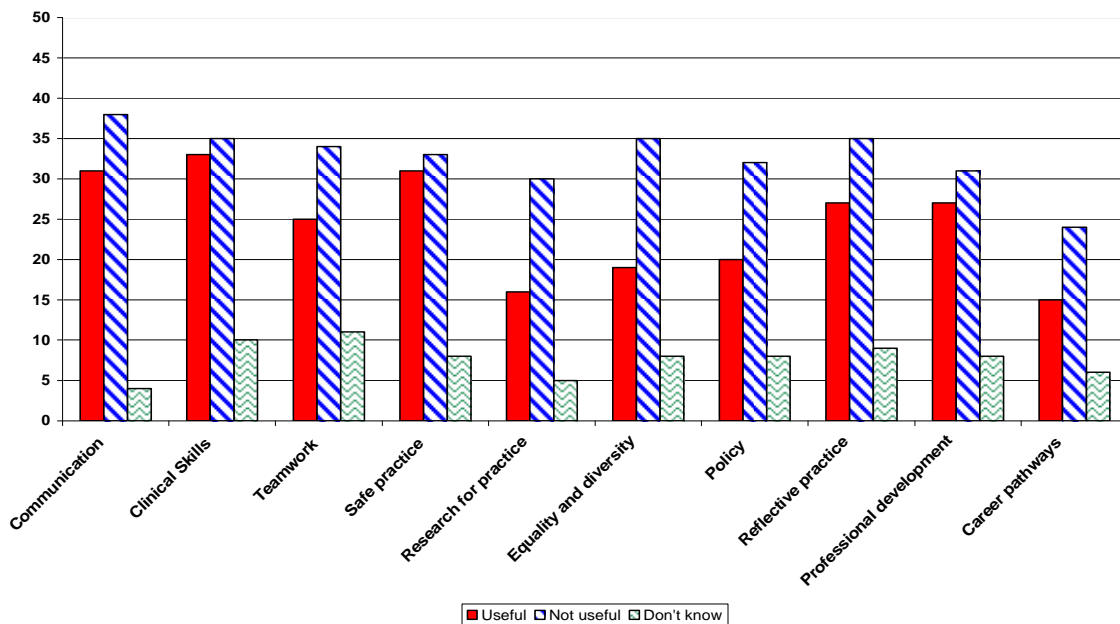
Figure 10.9: Impact of learning units on the confidence of NQPs: participants who have <u>completed</u> concluding activities on each learning unit perception of usefulness (frequency).
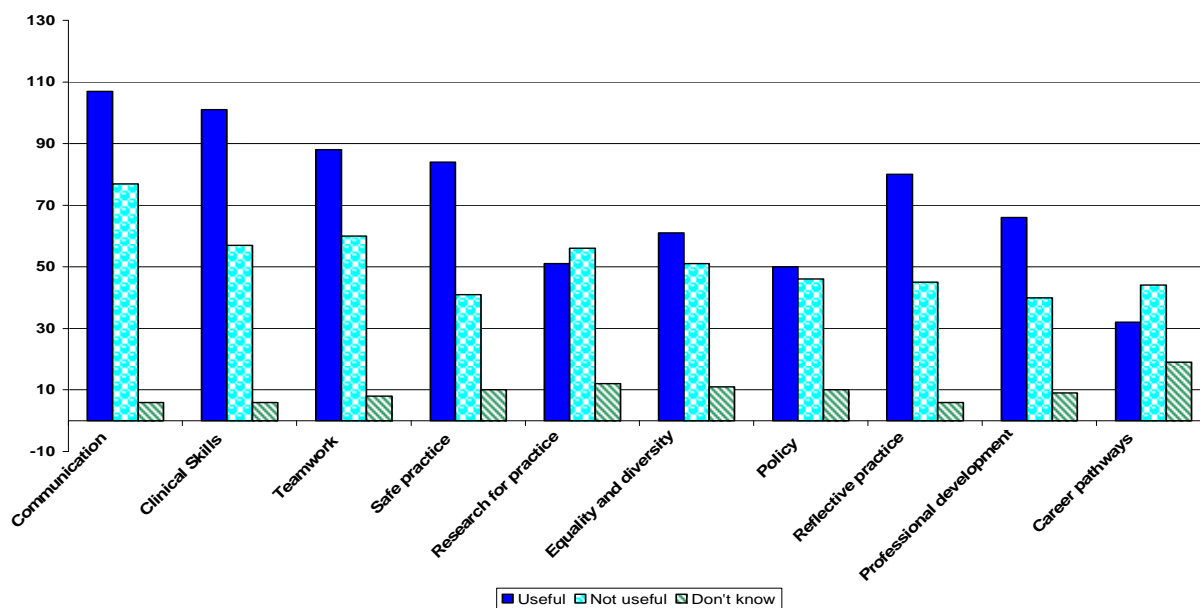
It should be noted, however, that although the shift in reported perceptions from feeling that the learning activities undertaken were not useful in terms of clinical skills development, or engendering confidence, to a higher proportion reported that they had found them useful was welcome, a sizeable minority of NQPs who had completed the concluding tasks associated with each unit reported that they had not been useful in terms of Clinical Skills Development (25%-40%) or Confidence (30%-47%).

Critical incident 7: newly qualified practitioner

Where were you?	*In the ward*
Who else was present?	*Care Assistant*
What happened?	*Care Assistant took drugs out of the locked cupboard for her personal use when |I was putting tablets away. (I thought it was a staff nurse at the time as she reached over form behind me)*
In what way did Flying Start help you?	*It gave me the **confidence** to report the incident to the ward sister. Flying start definitely helped me handle the situation in a professional manner. It is still helping me now as there is a certain degree of harassment happening to me now which I am comfortable dealing with myself – although sister is aware, we are keeping documentation.*

Future Career

The Flying Start programme is designed to support NQPs in their transition from student to qualified health professional. Respondents were asked if they intended to continue in their chosen career as a registered nurse/midwife/allied health professional on completion of the programme. Two-hundred and ninety-one respondents (53.2%) indicated that they intended to continue in their chosen career, one nurse indicated that they did not intend to continue, and 14 (2.6%), 13 nurses and one AHP, reported that they did not know. Two hundred and forty-one respondents (44.1%) did not answer this question.

Respondents were asked to indicate the level they would like to be at in five and ten years time – a list of the Bands with examples of the nature of posts associated with each band was provided for guidance:

- ♦ Band 5: e.g. Staff Nurse, AHP
- ♦ Band 6: e.g. Health Visitor, Nurse Specialist, AHP specialist, Midwife community/hospital, Practice Education Facilitator
- ♦ Band 7: e.g. Manager, Health Visitor Specialist, Nurse Advanced, AHP advanced, Midwife higher level
- ♦ Band 8/9: e.g. Manager, Consultant, Education, Voluntary Sector, Independent Sector, Research, Working overseas

Desired grade after five years

It can be seen from the following chart that only nurses (45.9%) aspired to be employed at Band 5 after five years. A similar proportion of nurses (46.5%), just over two-thirds of midwives (66.7%), and four out of five AHPs (83.3%) aspired to be employed at Band 6 within five years. One third of midwives reported that they would like to be employed at Band 7; however, the number of midwives who answered this question was small.

Figure10.10: Desired grade after five years by profession: percentage (n=296)
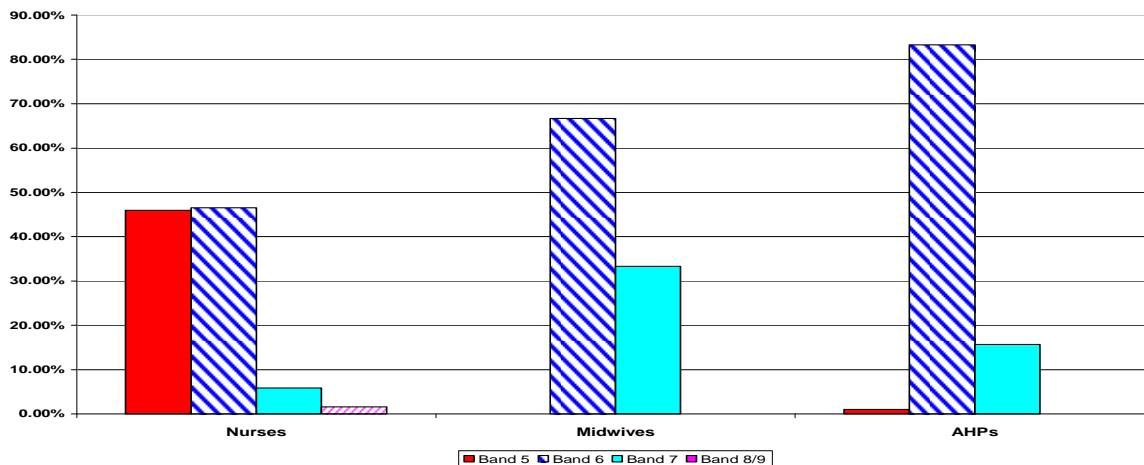
Desired grade after ten years

Inspection of the following chart which presents information relating to NQPs aspirations relating to ten years in the future indicate that more than half the nurses (53.0%) reported that they would be happy to be a Band 5 or 6 in ten years. However, three out of ten nurses indicated that they would like to have progressed to Band 7 e.g. Health Visitor Specialist, Nurse Advanced, and 29 (16.0%) reported that they would like to see themselves as a Band 8/9 e.g. Manager, Nurse Consultant. Almost three-quarters of the AHPs (72.4%) reported that they would like to achieve Band 7, and 17 (17.3%) reported that they aspired to reach Band 8/9. Midwives aspirations saw them more evenly distributed across the Bands; however, again it is important to bear in mind that the number of midwives was low.

Figure 10.11: Desired grade after ten years by profession: percentage (n=288)
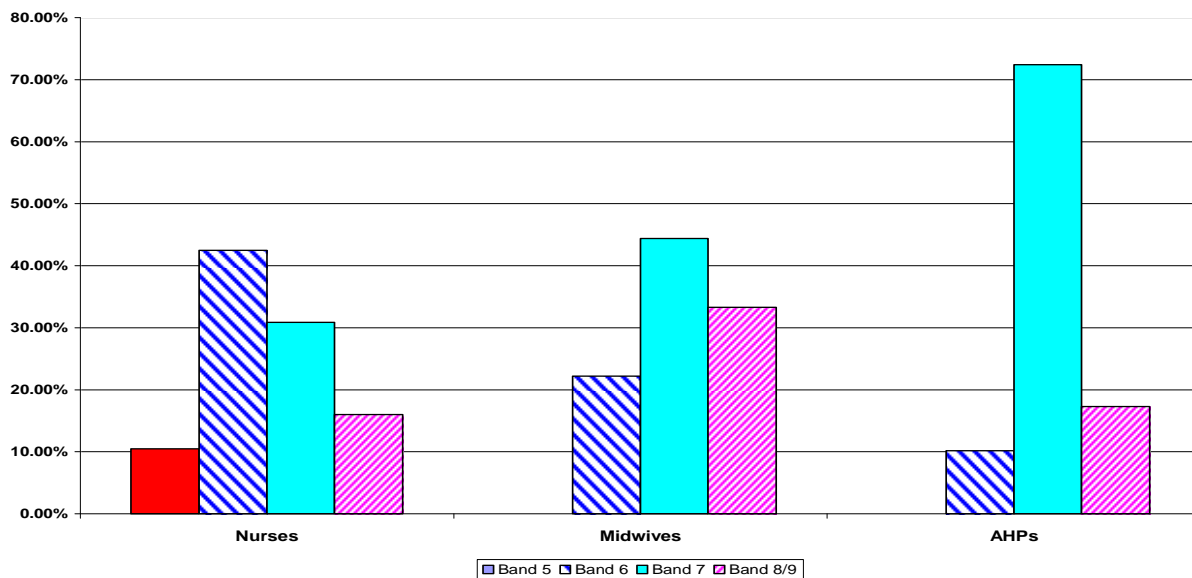
A final question asked NQPs if Flying Start NHS had helped them to understand their future career options. Responses indicated that 65 NQPs (11.9%) reported that Flying Start had helped

them to understand their career options, 48 (8.8%) reported that they did not know whether it had helped or not, and 173 (31.6%) reported that it had not helped them. Two hundred and sixty-one respondents (47.7%) did not answer this question. There was no difference in perception of whether or not Flying Start had helped NQPs understand their future career options associated with profession.

Because Career Pathways and Professional Development are two of the learning units that NQPs are expected to complete as part of Flying Start, further analysis focused on whether a higher proportion of respondents who had completed these units (n=81 & n=99 respectively) might have felt that Flying Start had helped them to understand their career options compared to those who reported that they had not completed them (n=124 & n=114). Overall one third (33.3%) of those who had completed the concluding activities associated with the learning unit Career Pathways reported that Flying Start had helped them to understand their future career options compared to one in five (19.4%) of those who had not completed it. However, more than half the NQPs who had completed the concluding activities (n=56.8%) reported that it had not helped them to understand their future career options. One third (32.3%) of those who had completed the concluding activities associated with the learning unit Professional Development reported that Flying Start had helped them to understand their future career options compared to 18.4% of those who had not completed it. More than half the NQPs who had completed the concluding activities (n=54.5%) reported that it had not helped them to understand their future career options. There was no difference associated with time in post.

Support To Undertake Flying Start NHS

In order to investigate the experience of undertaking Flying Start, and identify potential barriers, NQPs were asked about the support they received and how satisfied they were with it.

Protected time

NQPs were asked if they had protected time to work on tasks associated with Flying Start, and if they had protected time how it was spent. Three hundred and ten respondents (56.67%) reported that they did have protected time for Flying Start, however, just over a third of these (n=110) reported that *occasionally* they were unable to take this time due to pressure of work, and almost half (n=146) reported that they *usually* were unable to take protected time due to pressure of work. Sixty-three respondents, one in five (20.32%) of those who reported having protected time for Flying Start reported that their time was within their work setting with their mentor, 128, four out of five (41.28%) reported that their protected time was not used within their work setting.

The proportion of respondents who reported that they had protected time for Flying Start was almost identical for nurses (57.19%), midwives (55.0%), and AHPs (56.84%). The number of hours of protected time available to NQPs ranged from one to six hours per month with a mean of 3.39 hours (standard deviation = 1.80); there was no difference in the number of protected hours between the professions. However, a higher proportion of nurses and midwives than AHPs reported that they were unable to take the time they were allocated $\{\chi^2_{(4)} = 19.11, p=.001\}$.

Activities carried out in protected time

One hundred and seventy-six respondents reported that they normally completed the learning activities related to Flying Start on a home computer, 77 used a computer in a ward or office at their workplace, 28 were able to use a library or training suite, and 54 reported that they printed

off relevant materials and completed tasks wherever and whenever there was an opportunity. A higher proportion of nurses (60.7%) and midwives (72.7%) reported using a home computer than AHPs (35.9%) who were more likely than their colleagues to have access to a computer at work $\{\chi^2_{(6)} = 20.94, p=.002\}$.

When NQPs who had protected time for Flying Start were asked to rank a range of activities according to what they found the time most useful for, ninety-four respondents indicated that they found protected time most useful for *completing their portfolio*, see table 10.4. This was followed by *reflection*, *working with a mentor*, and *work shadowing colleagues*. *Peer support groups* were rated as *least* beneficial.

Table 10.4: Perceived benefits of protected time to undertake Flying Start (n=422)

Activity	Most beneficial	2nd most beneficial	3rd most beneficial	4th most beneficial	Least beneficial
Completing portfolio	**94**	17	17	8	14
Reflection	18	**60**	32	27	12
Work with mentor	16	38	**40**	33	18
Work shadow colleagues	21	14	33	**39**	33
Peer support groups	10	20	20	33	**57**

Respondents were invited to comment on the best way of utilising protected time. Comments divided into three areas, *support from mentors* which is covered in the following section 3.3 below, *lack of time*, and *other potential activities*

Lack of time
It should be borne in mind that although 310 NQPs who answered this question reported that they had protected time to undertake tasks associated with Flying Start, one third (35.5%) also reported that they did not always get it, and almost half (47.1%) reported that they were usually unable to take the time. Furthermore there were significant differences in the amount of time that was allocated. It was apparent that some participants were dissatisfied with the time available for Flying Start:

> *No protected time allocated. Really not helpful as it is time consuming.*

> *Do not get any time*

> *Didn't have protected time*

> *It was not made clear to me in any of the clinical areas that I was entitled to this allocated time.*

> *Activities not completed*

However, other participants indicated that they had completed the programme in their own time:

> *I did all activities on Flying Start in my own time. No time was allocated during Flying Start as the programme was not up and running when I did it.*

> *Never used or asked for the time*

Other activities

Two respondents reported that they found their protected time useful for other activities:

> *Discussing cases with colleagues*

> *Spending time with PEF (practice education facilitator) and doing our portfolios and any other work needed to complete*

Mentors

NQPs were asked how soon after starting employment they were allocated a mentor, how much time they spent with their mentor, and the nature of meetings.

Identifying a mentor

Twenty five respondents (4.57%) reported that they were allocated a mentor straight away, 170 (31.1%) were allocated a mentor within four weeks, and further 49 (9.0%) by the time they had been in post for twelve weeks. By six months in post another 18 NQPs (3.3%) had been allocated a mentor, however, after this period a small number of respondents (3.1%) reported that they waited between six months and a year before being allocated a mentor, see figure 10.12, and table A7, appendix page 156. Two hundred and sixty-seven respondents (48.8%) did not answer this question.

Figure 10.12: Time from beginning employment until allocated a mentor (percent, n=279)
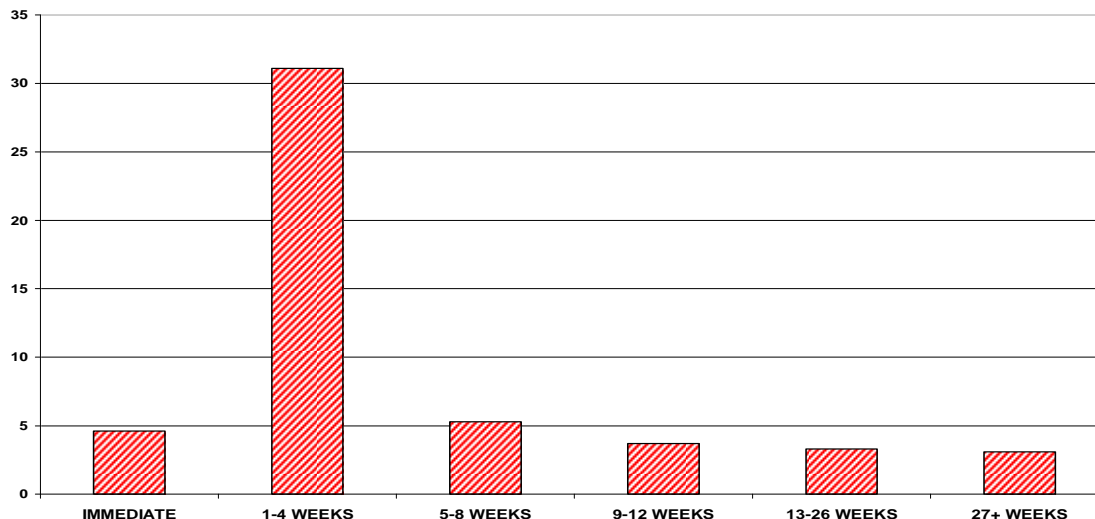
It should be noted that 54 respondents, 19 nurses, three midwives, and 32 AHPs reported that their posts were rotational. Of the 13 participants who indicated that their posts were rotational, eight nurses, two midwives, and three AHPs reported that their mentor would change when they moved to another position, 14, two nurses, one midwife, and 11 AHPs reported that their mentors would not change; nine indicated that they did not know. However, there was no difference between NQPs whose posts were rotational and other NQPs in terms of time to being allocated a mentor.

Further analysis indicated that AHPs who answered this question waited longer (mean=9.06 weeks) than nurses (mean=4.84 weeks) and midwives (mean=4.25 weeks) before being allocated a mentor {$F_{(2)}$ = 6.262, p=.002}.

Time available with mentor

As mentioned above, it is not only the NQP who requires time for tasks associated with Flying Start, mentors also require time if they are to fulfil their mentoring role. The amount of time spent with mentors ranged from one to six hours per month with a mean of 2.17 hours (standard deviation 1.69 hours). There was no difference in the amount of time spent with mentors associated with profession. Respondents were invited to comment on the time that they spent with their mentors. One hundred comments were received, many of which mirror the comments relating to the frequency of meetings. While some NQPs indicated they were able to spend adequate time with their mentors:

> *More [time] if and when required*

> *I have regular contact with my mentor as she is ward manager - support is on a daily basis if required.*

Other responders reported that time with mentors could be in short supply:

> *Approximately one hour every 2-3 months*

> *One hour every three months at most*

> *Hardly any time to devote to Flying Start with my mentor*

> *Twenty minutes in last five months*

Attention was drawn to the difficulties of making time on a busy ward:

> *Dependent on how busy it is in the unit*

> *The ward very rarely allows time due to the activity during the shift. We have spent no time discussing the Flying Start*

> First rotation, I spent an hour a month with my mentor, second rotation I did not meet with my mentor due to both mine and her very busy caseloads

Working with mentors

Eighty-nine respondents reported that they met with their mentor on request, 85 met occasionally if on the same shift, 30 reported meeting monthly and 12 met weekly. Three hundred and thirty-one respondents did not answer this question. Nurses (54.4%) and midwives* (57.1%) reported that they were more likely to meet with their mentors if on the same shift, whereas AHPs tended to request meetings (54.8%), see table A9. Respondents were invited to include additional comments relating to the frequency of meetings with their mentors; 84 comments were received. Eight themes were identified, 1) time since beginning employment/enrolling on Flying Start, 2) examples of good practice, 3) incorporating support into supervision, 4) difficulties of rotation

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and/or bank working, 5) lack of mentor, 6) examples of inadequate support, 7) ad hoc meeting, and 8) taking personal responsibility.

* Percentages relate to the proportion of each profession that answered these questions.

Time since beginning employment/enrolling on Flying Start
NQPs who had just entered employment and were still finding their feet were not in a position to comment on support received:

> *Have not yet met with mentor, due to start*

> *I have not done much with Flying Start at the moment but will be attending a forum on 7th December and hope to get a better idea of what is expected then and will arrange regular meetings with my mentor*

One respondent reported that the support available had varied as the year progressed:

> *Initially twice a month, then phased down to approx every six weeks towards the end of the year*

As mentioned above a number of respondents had completed Flying Start:

> *Finished flying so don't meet with mentor now*

Examples of good practice
A number of respondents indicated that the support that they had received or were currently receiving worked well:

> *I shadowed mentor for 1st six weeks of job and often worked on same shift in 1st year.*

> *I work with her every day as we work in a small team of three people, she is the sister and I am one of the staff nurses.*

One NQP reported that monthly peer group meetings were available although support from a mentor was not.

Incorporating support into supervision
Some respondents indicated that support for Flying Start was incorporated into regular supervision or appraisals:

> *We discussed Flying Start during supervision once a fortnight*

> *Mentor was supervisor, so Flying Start was part of monthly clinical supervision*

> *Tried to incorporate it in supervision although there was not always time*

Rotation and Nursing/AHP Banks
NQPs whose posts rotated, or who had not secured a permanent post faced particular challenges:

We have not been given a specific mentor, merely get our senior of whatever rotation we are currently undertaking.

First rotation - monthly meetings... this rotation no meetings in four months.

Don't really have a mentor as such, as on the Bank working in acute and community, so no continuity, or rights as a permanent employee.

Lack of mentor

Thirty-seven NQPs reported not having received any support from a mentor:

I have not been allocated a mentor
Was not allocated mentor as both my mentors left! Was given a new [one] six months later

Did all activities on my own

No meeting with mentor until completion then she left area before checking folder

My ward offered no support in undertaking it at all. I wasn't ever allocated anybody

Attention was drawn to the fact that allocating time *per se* was not necessarily enough if mentors or other key individuals were not available:

To be honest there was no time provided to work with a mentor, peer group or shadow because even if you are given time to study it doesn't mean other staff have time to work with you.

Reported limitations in support

A number of respondents cited examples of poor support from their mentors, which for one NQP resulted in a withdrawal from the programme:

Very occasionally work the same shift. We have never sat down and discussed or worked through any of the Flying Start.

Mentor and colleagues not interested in Flying Start. Mentor says it is 'nothing to do with her'

Whenever mentor can be bothered

It took three months to have a mentor, but so far, in over 6 month, my mentor has never had time to mentor me on the programme, therefore I stopped working on it after a while.

Ad hoc meetings

Several respondents reported that they discussed Flying Start with their mentors if on the same shift; however, this was something outwith their control:

If on shift together we can discuss any matters needed

Often on same shift, disscussed Flying Start as need arisen.

Randomly throughout year

Taking personal responsibility

A small number of respondents indicated that they had sought support for themselves:

> *I appointed myself a mentor recently after asking about Flying Start and not getting anywhere.*

> *When I asked my mentor she didn't know anything about Flying Start but was happy to take me on.*

> *Once I telephoned them and arranged to meet with them on the ward to find out what I was entitled to and how to use the resources available.*

> *Once a unit is finished I arrange a meeting with mentor.*

Access to the Internet and the Flying Start website

Respondents were asked if they had used the Flying Start website to identify and/or contact other newly qualified practitioners, and if so how useful they had found it. Overall 55 respondents (10.01%), 34 nurses, 2 midwives, and 19 AHPs, reported that they had used the Flying Start website to either identify (n=43) or contact (n=36) other NQPs. Forty-three respondents reported that they had used the website to identify other newly qualified practitioners. Of these, 20 had communicated with other NQPs from the same profession, 11 from a different profession, and seven with others from their own profession as well as another profession. Six respondents who had used the Flying Start website to identify and/or contact other newly qualified practitioners reported that they had found it *very useful*, 24 that they had found it *useful*, ten reported that their communication had *not been very useful* and three that it had *not been at all useful*.

Respondents were also asked if they had posted threads on the Flying Start website, if they had read threads posted by other people, and if they had read thread posted by others, if they had found it useful. One hundred and twenty-four respondents (22.67%), 72 nurses, 7 midwives, and 45 AHPs, reported that they had posted threads (n=32), or read threads posted by other NQPs (n=122). Of these seven reported having found it *very useful*, 44 found it *useful*, 33 reported that they had *not found it very useful*, and 6 that it had *not been useful at all*. When asked about other activity on the website, three responses were received:

> *I did it all on a pen drive not the actual site. (No Internet at home and not enough CPD time to complete in the work place)*

> *I have tried to [communicate] but was unable*

> *Communicated with other newly qualified staff in my area*

Satisfaction with support

In order to gauge how well the support available to NQPs undertaking Flying Start, respondents were asked to indicate, on a scale from *very poor*, through *poor*, *neither poor or good*, *good*, to

very good, how satisfied they were with the support that they had received from their mentors, their line managers, and their peers. As with previous questions a significant proportion of NQPs had not responded to this question. However, 292 respondents had rated the support that they had received from their mentors, and 302 respondents rated the support that they had received from their line managers and their peers. As can be seen from the following chart and table A8, page 156, few respondents felt strongly, either positively or negatively, about the support that they had received to undertake Flying Start.

Figure 10.13: Satisfaction with support received to undertake Flying Start NHS (Percent, n=302)
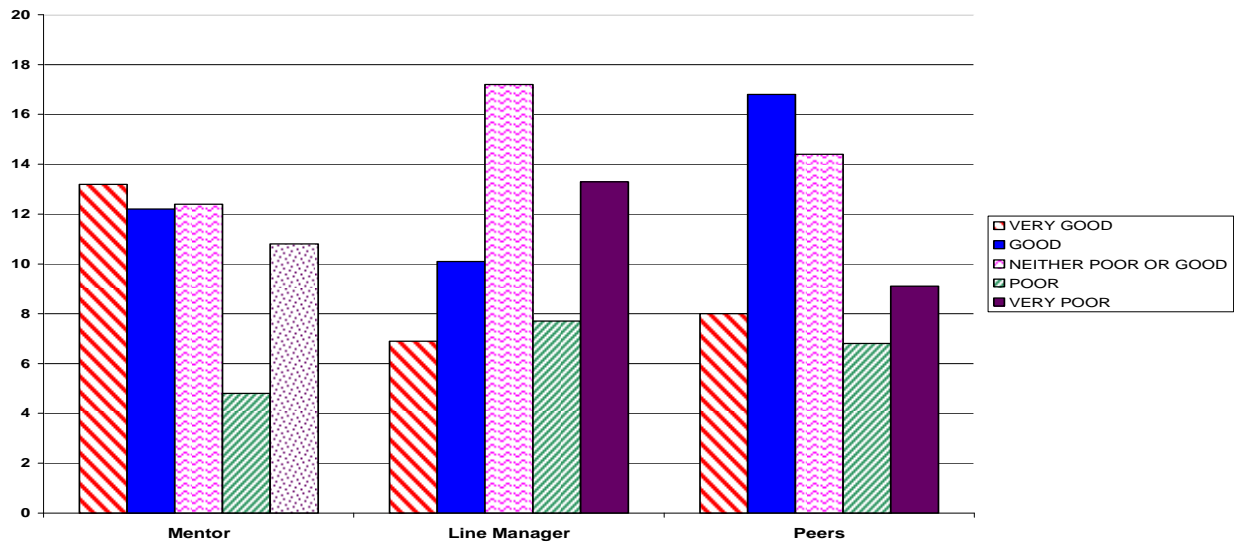
In order to carry out further analysis on the scores relating to reported satisfaction with support received to undertake Flying Start, categories were collapsed such that responses fell into one of three levels, *Good*, *Neither Good or Poor*, and *Poor;* participants who were employed by the Nurse or AHP Banks were excluded as the number were too small to be meaningful. Analyses focusing on differences associated with setting and/or profession are reported separately as the number of respondents prohibits analysis involving multiple independent variables.

Setting
NQPs working in community settings who answered questions relating to satisfaction with support to undertake Flying Start expressed greater satisfaction with all sources of support than those working in acute settings, both acute and community settings, or posts that involved rotation. A higher proportion of NQPs working in the community reported that the support that they received from the mentors was *good* (66.2%) compared to those employed in acute settings (40.0%) $\{\chi^2_{(6)} = 13.59, p=.035\}$. The proportion of NQPs employed in posts that involved working in both acute and community settings (54.5%) and rotation posts (50.0%) who reported receiving *good* support from mentors was lower than amongst those employed in the community and above the proportion employed in acute settings, see figure 10.14.

Figure 10.14: Satisfaction with support received from mentors to undertake Flying Start NHS by setting (percent, n=287)
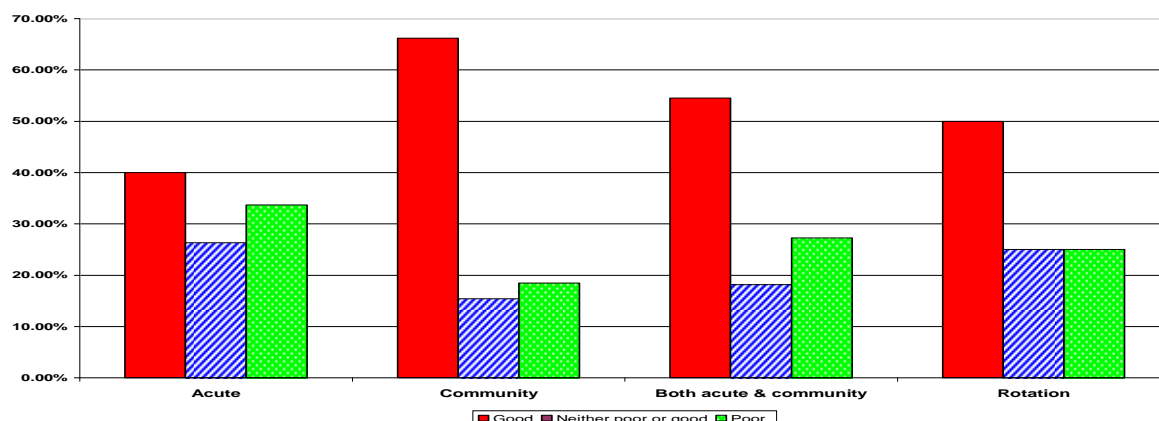
Just over half the NQPs working in the community and four out of ten of those in rotation posts (43.2%) reported that the support they received from managers was *good* (53%). Only one in five NQPs working in acute settings (21.0%) and a quarter of those working in both acute and community settings (25.0%) reported that the support they received from their line managers was *good*. The differences between settings was found to be statistically significant {$\chi^2_{(6)}$ = 28.04, p<.001}. A similar pattern was seen in reported satisfaction with support received from peers with a higher proportion of NQPs working in community settings reporting that the support they received from their peers was *good* (68.2%) compared to those in acute settings (35.6%) {$\chi^2_{(6)}$ = 22.55, p=.001}.

Profession
The small number of midwives that answered this question prohibits further analysis; however, a high proportion (85.7%) of those midwives that did respond, compared to nurses (42.5%), or AHPs (54.5%) reported that the support they received from their mentors had been *good* (see figure 10.15 below). The difference between the scores relating to mentors derived from nurses and AHPs was not found to be statistically significant (p=0.147). Less than three out of ten nurses (28.3%) reported that support received from their line managers was *good* (see table 10.6). A higher proportion (60.8%) of AHPs reported receiving *good* support from their peers compared to nurses (38.0%) {$\chi^2_{(6)}$ = 18.597, p<.001}.

Figure 10.15: Satisfaction with support received from mentors to undertake Flying Start NHS by profession (percent, n=292)
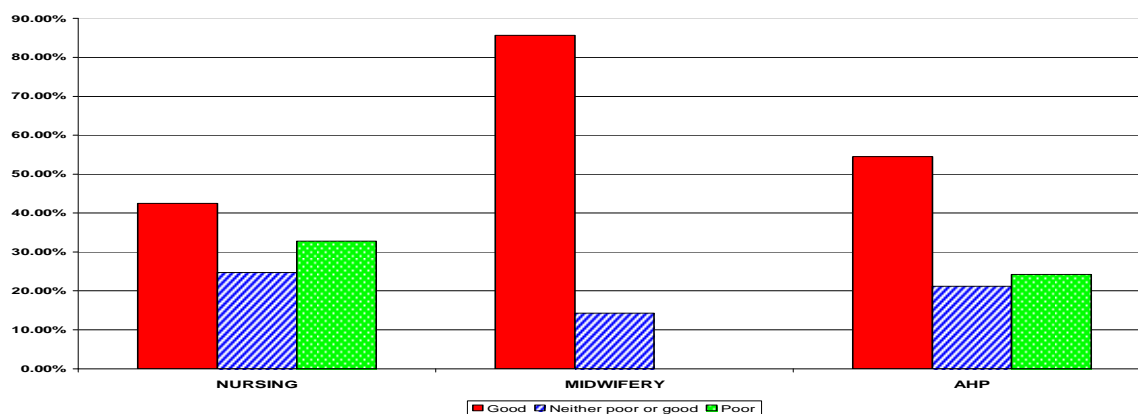
Figure 10.16: Satisfaction with support received from line managers to undertake Flying Start NHS by profession (percent, n=302)
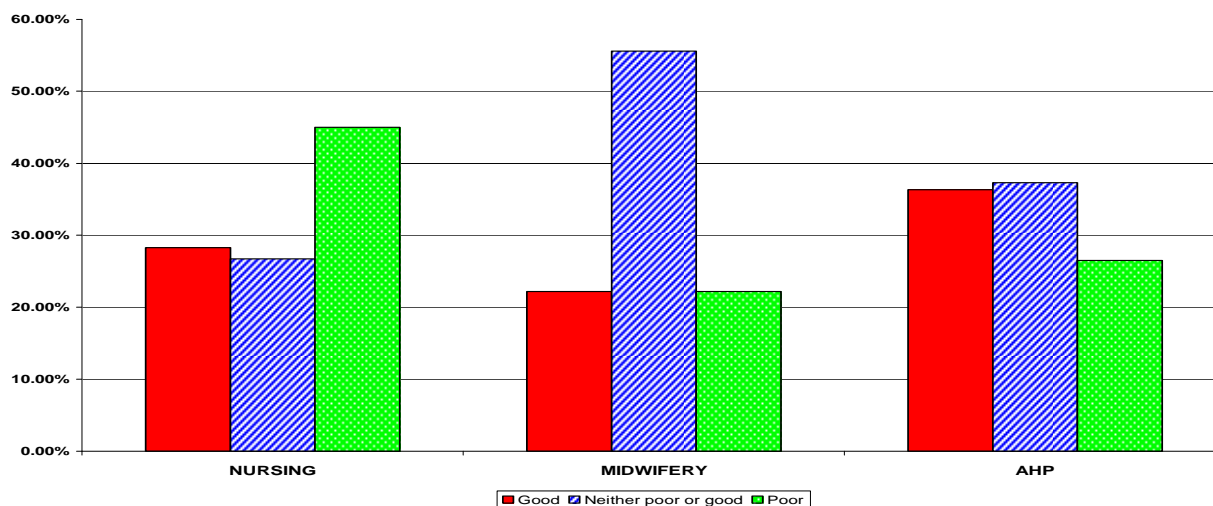
Protected time

Three quarters of NQPs (74.1%) who reported that they had protected time to undertake tasks associated with Flying Start rated the support received from mentors as very good (46.3%) or good (27.8%) compared to one third (32.3%) of those who reported that they were usually unable to take the time $\{\chi^2_{(8)} = 37.348, p<.001\}$, see table 10.5.

Table 10.5: Satisfaction with support received from mentors by protected time (frequency and percent, n=289)

Satisfaction with support from mentor	Protected time available and able to take it		Protected time available, but occasionally don't manage to take it due to pressures at work		Protected time available, but usually I don't manage to take it due to pressures at work	
	Frequency	%	Frequency	%	Frequency	%
Very good	25	46.3	26	24.8	20	15.4
Good	15	27.8	28	26.7	22	16.9
Neither poor or good	8	14.8	28	26.7	32	24.6
Poor	3	5.6	6	5.7	17	13.1
Very poor	3	5.6	17	16.2	39	30.0
Total	54	100.0%	105	100.0%	130	100.0%

A similar pattern was evident with perceptions of support received from line managers with two thirds of NQPs (64.8%) who reported that they had protected time to undertake tasks associated with Flying Start rated the support received from line managers as *very good* (27.8%) or *good* (27.8%) compared to one third (15.9%) of those who reported that they were usually unable to take the time $\{\chi^2_{(8)} = 58.382, p<.001\}$., see table 10.6.

Table 10.6: Satisfaction with support received from line managers by protected time (frequency and percent, n=299)

Satisfaction with support from mentor	Protected time available and able to take it		Protected time available, but occasionally don't manage to take it due to pressures at work		Protected time available, but usually I don't manage to take it due to pressures at work	
	Frequency	%	Frequency	%	Frequency	%
Very good	15	27,8	15	14.2	8	5.8
Good	20	37.0	19	17.9	14	10.1
Neither poor or good	11	20.4	39	36.8	44	31.7
Poor	5	9.3	13	12.3	24	17.3
Very poor	3	5.6	20	18.9	49	35.3
Total	54	100.0%	106	100.0%	139	100.0%

Early reports indicating that mentors were experiencing difficulty providing support to NQPs because they had not completed the programme themselves were addressed by delivering a series of workshops and information sessions for mentors. However, no differences associated with time in post or since enrolling on Flying Start were identified in reported satisfaction with support provided by mentors or line managers.

Summary

An Evaluation of Flying Start NHS an online survey was developed for completion by newly qualified health practitioners (NQPs) currently undertaking Flying Start. Five hundred and forty-seven NQPs took part. Unfortunately, a large proportion of respondents did not complete all sections of the survey.

Participants

♦ Of the 547 NQPs who took part in the survey nurses accounted for 61.1%; 237 adult nurses, 70 mental health nurses, 19 children's nurses, and eight learning disability nurses, plus 20 midwives, 190 AHPs.

♦ Level of education included diploma (12.4%), degree (38.4%), honours degree (24.1%), and Masters degree (4.6%). The proportion of NQPs educated to different levels varied between professions

♦ Responses were received from all NHS Boards with the exception of NHS Western Isles. However, 110 respondents (20.1%), did not indicate which NHS Board employed them, possibly indicating anxiety relating to confidentiality.

♦ Two-thirds of respondents (67.3%) reported that their contracts were permanent, 10.8% that theirs were temporary; six nurses were employed on the Nurse Bank, and two AHPs on the AHP Bank.

♦ Two hundred and fifty-eight respondents (59.3%) reported that they worked in an acute setting, 101 (23.2%) worked in the community, and 22 (5.1%) worked in both acute and the community. Fifty-four respondents (12.4%) reported that their posts were rotational.

♦ Twenty-five respondents indicated that they had been in post for more than three years, thus were not newly qualified practitioners. Amongst the 404 respondents who indicated that they had been in post less than thirty-six months 83.2% had been in post for 18 months or less.

- 71.33% rated *learning the job* as their most important development need followed by *becoming a member of the team* and *orientation/induction to the clinical area*.

The Flying Start NHS Programme
- The mean length of time that respondents had been enrolled on Flying Start was 10.11 months with a range from 'newly enrolled', to 35 months.
- Respondents who reported having entered employment within the past year reported having enrolled on Flying Start significantly more quickly than those who had entered employment more than two years ago.
- 21.0% of respondents who had been in employment for less than six months had completed some activities associated with at least one of the ten learning units; a proportion had completed some concluding activities
- Activity in terms of undertaking learning activities and completing concluding activities increased amongst NQPs who had been in employment for 6-12 months and 12-18 months
- The learning units with the highest number of NQPs either currently undertaking activities or having completed the concluding activities were Communication, Clinical Skills, and Teamwork.
- Between half and three-quarters of the NQPs who were either currently working on the learning activities associated with each learning unit, or had completed the concluding activities, indicated that they had found it useful in terms of their clinical skills development.
- A slightly higher proportion of respondents who had completed the concluding tasks indicated that they felt that the learning units had been useful in terms of their clinical skills development compared to those who were still working on them.
- The learning units rated as useful in the development of Clinical Skills by the highest proportion of NQPs who had completed them were Clinical Skills (74.5%), Safe Practice (69.1%), Reflective Practice (68.5%), and Communication (66.7%).
- Between four out of ten, and half the NQPs who were either currently working on the learning activities associated with each learning unit indicated that they had found it useful in terms of increasing their confidence.
- A higher proportion of respondents who had completed the concluding tasks for each learning unit indicated that they felt that the activities had been useful compared to those who were still working on them. The learning units rated as useful in engendering confidence by the highest proportion of NQPs who had completed them were, Safe Practice (62.2%), Clinical Skills (61.6%), and Reflective Practice (61.1%).
- Only one nurse indicated that they did not intend to continue, and 14 NQPs, 13 nurses and one AHP, reported that they did not know whether they would continue.
- A higher proportion of nurses compared to Midwives or AHPs reported that they would happy to be employed at Band 5 in five years or Bands 6/7 in ten years.
- The majority of NQPs who took part in the survey reported that they did not think that Flying Start had helped them to understand their future career options.

Support to undertake Flying Start
- All NQPs who answered the question relating to protected time (n=310) reported that they had protected time for Flying Start, however, 82.6% reported that they were not always able to take it due to pressure of work.
- 20.32% of those who reported having protected time for Flying Start reported that they took their time was within their work setting
- 41.28% reported that their protected time was not used within their work setting
- There was no difference in the number of protected hours between the professions.

- A higher proportion of nurses and midwives than AHPs reported that they were unable to take the time they were allocated.
- A majority of respondents reported that they normally completed the learning activities related to Flying Start on a home computer
- A higher proportion of nurses and midwives reported using a home computer compared to AHPs who were more likely than their colleagues to have access to a computer at work

- A majority of NQPs reported that they were allocated a mentor within the first couple of months of employment.
- Nurses and midwives reported that they often met with their mentors if on the same shift, whereas AHPs tended to request meetings.

The main barriers to completing tasks associated with Flying start were
- No mentor or mentor not being available
- Lack of time
- Difficulty of making time on a busy ward
- Rotational posts or not having secured a permanent post faced particular challenges
- Attention was drawn to the fact that allocating time *per se* was not necessarily enough if mentors or other key individuals were not available:

Examples of good practice:
- High level of support initially then phased down as NQP settled in
- Shadowing mentor when come into post
- Being on same shift as mentor in 1st year.
- Working in a small team

Flying Start website
- Fifty-five respondents (10.01%) reported that they had used the Flying Start website to either identify or contact other NQPs. Of these, 20 had communicated with other NQPs from the same profession, 11 from a different profession, and seven with others from their own profession as well as another profession.
- Thirty respondents who had used the Flying Start website to identify and/or contact other newly qualified practitioners reported that they had found it *useful*, thirteen reported that their communication had *not been useful*.
- One hundred and twenty-four respondents (22.67%) reported that they had posted threads (n=32), or read threads posted by other NQPs (n=122). Of these 51found it *useful*, 39 reported that they had *not found it useful.*
- A small number of NQPs reported having difficulty accessing the Internet and/or communicating via the Flying Start web site.

Satisfaction with support
- A higher proportion of NQPs working in the community (66.2%) reported that the support that they received from the **mentors** was *good* compared to those employed in acute settings (40.0%).
- Just over half the NQPs working in the community and four out of ten of those in rotation posts (43.2%) reported that the support they received from **managers** was *good* (53%). Only one in five NQPs working in acute settings (21.0%) and a quarter of those working in both acute and community settings (25.0%) reported that the support they received from their line managers was *good*.

- A higher proportion of NQPs working in community settings reported that the support they received from their peers was *good* (68.2%) compared to those in acute settings (35.6%).
- A higher proportion of midwives, compared to nurses (42.5%), or AHPs (54.5%) reported that the support they received from their mentors had been *good* .
- Less than three out of ten nurses (28.3%) reported that support received from their line managers was *good*.
- A higher proportion of AHPs reported receiving *good* support from their peers compared to nurses.
- A higher proportion of NQPs who reported that they had protected time and were able to use the time for Flying Start reported that the support they received from mentors and managers was good or very good.
- Despite a series of workshops and information sessions being delivered to support mentors in their role, no differences associated with time in post or since enrolling on Flying Start were identified in reported satisfaction with support provided by mentors or line managers.

CHAPTER 11

REVISITING THE RESEARCH AIMS AND OBJECTIVES

As stated in the introduction, this chapter will revisit the original aims and objectives of the evaluation, presenting the findings from each stage. It is important to bear in mind that the evaluation has been carried out over a period of twenty-six months, with the original bid being submitted two months prior to this. Both the Flying Start programme and the economic and social environment have changed during this period, and the data that have been collected and analysed have been managed at a particular period of time. The report has been laid out in a quasi-chronological order, and we make no apology for including data that refer to perceived limitations in the Flying Start programme that have subsequently been addressed. In this chapter, we present a summary of the findings under four main headings:

- ♦ The Flying Start model
- ♦ The impact of Flying Start NHS on recruitment and retention
- ♦ The impact of Flying Start NHS on recruitment directly into primary care
- ♦ The interface between Flying Start NHS and other programmes

These sections will be followed by our recommendations, which will focus primarily on what has been found to be beneficial, to work well in supporting NQPs as they take up their first posts, rather than dwelling on any reported limitations.

The model

When conducting the first stage of the evaluation, interviews with Lead contacts and coordinators, it was apparent that, although Flying Start had originally been introduced in 2005, the roll-out of the programme was still in its infancy. Since then significant changes have been made to the Flying Start programme including the content of the website, the structure and guidance, and the way in which it is promoted and supported.

When Flying Start was first introduced for AHPs they were offered a financial incentive. The withdrawal of financial incentives for AHPs, which had not been offered to nurses and midwives, may have resulted in a degree of dissatisfaction, which will undoubtedly dissipate with time. However, the initial lack of guidance, or requirement for NQPs to enrol on the programme gave a mixed message. In our early data collection we were aware that different NHS Boards, or sub-divisions, were adopting a variety of approaches which sometime resulted in NQPs enrolling on the programme, but failing to progress thereafter. A significant proportion of Lead contacts, final year students, and NQPs indicated that they thought that Flying Start should be compulsory.

Flying Start is designed to be a generic programme suitable for all professions, from diploma to Masters degree, and in all NHS Boards. However, there are considerable differences between areas in terms of the number and proximity of NQPs, the nature of work, and contact with experienced staff. These differences mean that support requires to be tailored to individual circumstances. It was apparent that different areas had developed their own methods depending on their specific challenges. There was evidence that Flying Start was most successful if there was an ethos of

support at all levels from senior management to mentors, and an understanding of the purpose of the programme, and what NQPs were required to do to complete it successfully.

NQP indicated that they thought that there was a need for a settling in period before commencing Flying Start NHS. Initially Lead contacts tended to support the notion of a settling in period, although subsequent steer indicated that NQPs should enrol as soon as possible. Analysis of the data from the on-line survey indicated that there was significant variation both within and across organisations in the time lag prior to enrolling on Flying Start. However, NQPs who had come into post more recently tended to enrol on Flying Start within a shorter period of time, and become actively involved more quickly. More recently employed NQPs also reported being allocated a mentor within a shorter period of time than those employed earlier.

Managers, PEFs and mentors recognised the difficulties faced by some NQPs on entering employment, and final year students in one focus group interview and three managers suggested that it would be useful to introduce Flying Start prior to registration to support NQPs *through* the transition from students to registered practitioner rather than being perceived as an additional challenge immediately following transition.

NQPs reported that they found self-directed study difficult and required support, both to manage their time and through the provision of feedback on their progress. Across all focus groups it was evident there were confusions relating to completion, and dissatisfaction with the lack of monitoring. Where some recognition of completion had been put in place NQPs reported that they felt that the programme itself, and their efforts, were recognised.

A proportion of NQPs reported having to wait a considerable time prior to being allocated a mentor. They raised concerns about the lack of understanding that some mentors had of Flying Start NHS, and drew attention to the competing demands mentors have, and how this can influence their commitment to supporting NQPs through the programme. NQPs who worked closely with their mentors, either on the same shift, or had regular meetings, reported feeling supported and in turn more motivated. However, although NQPs reported that protected time was 'technically' available, it was often not taken for a number of reasons including wards being too busy. A majority of NQP reported that they undertook the activities associated with Flying Start NHS at home, in their own time. NQPs who reported that they had protected time for Flying Start, and were able to take the time, reported greater satisfaction with the support provided by their mentors and managers.

Managers PEFs and mentors drew attention to the need for support for NQPs undertaking the programme, and highlighted the benefits of completing the programme in terms of enhanced confidence. Although some managers felt that the programme was repetitive and overly academic, others drew attention to some of the strengths of the Flying Start, and suggested that it would be useful for more experienced staff as well, particularly learning activities such as equality and diversity. PEFs' perceptions of the programme tended to be more positive, in that they thought it would ease transition for NQPs, although they acknowledged NQPs' desire to focus on their practical experience.

The on-line peer community

Final year nursing, midwifery, and AHP students and NQPs who took part in the focus groups and telephone interviews reported having mixed feelings about on-line learning with a significant proportion expressing a preference for face-to-face communication. Despite having had previous experience of using on-line sites, a majority of the students who had viewed the Flying Start website, and NQPs enrolled on the programme, reported that they found the website confusing. NQPs reported that they found accessing a computer at work difficult, and at time inappropriate if patients and carers required attention. Many reported that they tended to download and print information from the website. A majority NQP who had explored the discussion forum reported that they had not engaged with it any further for a number of reasons.

The Gricean analysis of postings revealed that there was considerable variation in the number of postings associated with different learning units. Postings in the general forum related to a range of topics; however, there was little reference to the learning materials, and a lack of evidence to suggest that students were engaged in the type of activities necessary for an on-line learning community to flourish.

During the time that the evaluation has been carried out the website has been modified considerably with increased guidance and structure being added. The message to NQPs has also been modified in that the programme is now described as being 'hosted on-line' rather than being an on-line programme. Thus some of the comments from the earlier data collection refer to a very different model.

The Gricean analysis was based on postings on 23rd March 2009, now over 10 months ago. However, analysis of the on-line survey data, collected in December 2009, revealed that only 125 NQPs, 22.67% of respondents, reported that they had posted threads, or read threads posted by other NQPs, four out of ten reported finding it useful. Fifty-five NQPs, 10.01% of respondents, reported that they had used the Flying Start website to either identify or contact other NQPs. Of these, just over half reported that they had found it useful.

The impact of Flying Start NHS on recruitment and retention

A large majority of participants indicated that there was no evidence that Flying Start had had an impact on recruitment. Labour market conditions have changed considerably over the past two years. The most severe recession since the 1930s has resulted increased levels of unemployment and underemployment. Both were evident in our data, with the majority of NQPs indicating that they were grateful to secure a job; one in ten was employed on a temporary contract, eight were on the nursing or AHP Banks, and others were only working part-time.   Thus the fact that only four of the 95 NQPs who took part in focus group or telephone interviews reported that they did not intend to pursue their chosen career was unsurprising, alternatives are not enticing.

Despite the shortage of jobs, final year students and NQPs indicated that a positive student placement would be likely to influence their 'choice' of employment, both due to interest in a specific area, and because of the ease of transition if the environment was familiar. Final year students stressed the importance of feeling valued and indicated that their 'ideal' employer would have a reputation for

supporting NQPs and that the provision of support to undertake Flying Start would be one way of gauging potential employers' commitment to supporting their future career development. Managers', PEFs' and mentors' perceptions of what attracts NQPs to a particular post corresponded with the above; they also drew attention to the potential impact of a negative student experience.

Unfortunately, despite considerable effort to identify data bases which would enable a statistical analysis of recruitment and retention patterns over the period since the introduction of Flying Start NHS, data of adequate quality were not available.

The impact of Flying Start NHS on recruitment directly into primary care

Although the majority of interviews with Lead contacts focused on newly qualified practitioners in acute settings, a small number of participants mentioned newly qualified practitioners employed in the community. Participants from one NHS Board, which had participated in the primary care pilot study, felt that it had been very successful, despite having been unable to provide permanent employment at the end of the year. Another participant reported that, due to the nature of their locality they had always employed directly into the community. However, the extra support associated with Flying Start had been beneficial.

Managers, PEFs and mentors drew attention to the shift into the community, both in the provision of care, and as a place for newly qualified practitioners to begin their career. Despite this, participants felt that there was still an expectation that NQPs would initially work in an acute setting, possibly due to a perception that staff needed to be more experienced to work in the community. Perception of the challenges faced by NQPs in acute and community settings varied, with some staff thinking that there was no difference, others suggesting that NQPs going straight into the community were at risk of isolation, and third group indicating that NQPs were well supported in the community and primary care settings.

A majority of students thought that there would be significant differences between acute and community settings for newly qualified practitioners, and drew attention to the potential for feeling isolated in the community, different ways in which health professionals interact with patients and their families, and the different skills that might be required. Thus it was not surprising that a majority of students indicated that they expected to work in an acute setting in the first instance in order to consolidate their skills, and in fact six out of ten NQPs who completed the on-line survey reported that they worked exclusively in an acute setting. In contrast to these perceptions, a higher proportion of NQPs who worked in the community reported that the support that they received from mangers, PEFs, and mentors was good. They were also more likely to be able to take protected time to complete tasks associated with Flying Start.

The interface between Flying Start NHS and other programmes

One of the most significant changes during the course of the evaluation has been the roll out of the KSF. Early data collection indicated that perceptions of the way in which Flying Start fitted with previously existing education or induction programmes varied between NHS Boards and between disciplines. Lead contacts and coordinators drew attention to the forthcoming implementation of the KSF and the way in which Flying Start would fit with the Foundation Gateway. However, the roll

out happened at different times in different NHS Board; thus NQPs inability to see links between Flying Start and other training/induction opportunities was understandable.

NQPs drew attention to the tensions and burdens they felt in juggling Flying Start NHS, local orientation and induction programmes, and local CPD. There was a feeling that everything was duplicated, including learning undertaken at University. Those who recognised the links between programmes/tasks e.g. CPD, KSF, were able to appreciate the benefits of Flying Start; however, certainly in the early interviews this was unusual. A small number of NQPs, particularly those on the Clinical Fellowships, drew attention the materials on the Flying Start website and indicated that they thought it was a useful resource. However, a majority of NQPs who took part in the early focus groups, and the later online survey, identified their main development needs as developing confidence in their practice and learning the clinical skills of their new posts.

Managers, PEFs and mentors who took part in the telephone interviews, which were carried out well into the evaluation, listed a range of training and induction processes for NQPs, despite a majority of Lead contacts and coordinators having reported at the beginning of the evaluation that they were mapping previously existing programmes onto Flying Start in order to reduce duplication. A number of Lead contacts mentioned work currently being undertaken which focused on the potential for accreditation of Flying Start. It was apparent that views were mixed, for example while some participants highlighted the disincentive for newly qualified practitioners at degree level or above, others felt it would increase uptake. One participant voiced concerns that accreditation might shift the emphasis from experiential learning to a more academic approach.

Recommendations

Over the course of the evaluation we have worked closely with the project Steering Group and communicated our findings as the work progressed. Thus some of our recommendations have already been addressed, in addition to the introduction of a number of other modifications and improvements, associated with the on-going development of the programme:

> *Flying Start NHS is a national development programme for all newly qualified nurses, midwives and allied health professionals in NHS Scotland. It has been designed to support their transition from student to newly qualified health professional by supporting their learning in everyday practice through a range of learning activities and additional support from work based mentors. (Flying Start NHS website)*

Building on good practice creates an energy, whereas criticism can be draining, whether intended constructively or not. Thus our recommendations are based on a notion of 'best practice', our understating of what 'best practice' would comprise being derived from the findings of focus group, telephone, and face to face interviews with 228 individuals with a vested interest in the support provided to newly qualified health professionals entering employment in the NHS, as well as a survey involving 547 newly qualified practitioners.

We recommend that key stakeholders at all levels, in each NHS Board, focus on the following statements, and use them as a benchmark for the future provision of support for NQPs undertaking Flying Start NHS:

Best practice

♦ NMAHP students are aware that the Flying Start NHS programme has been designed to support their transition from student to newly qualified health professional.
♦ NMAHP students are provided with information about the Flying Start NHS throughout their undergraduate training and aware of what it will entail, and the support that will be provided.
♦ NMAHP student placements refer to Flying Start NHS and demonstrate its usefulness to NQPs.
♦ HEIs encourage NMAHP students to think of employment in the community post-registration.
♦ Students on community placements are provided with information relating to careers within the community.
♦ Student mentors, and others providing support to students on placement, are aware that a well supported placement is likely to result in students seeking employment in their area.
♦ All students on placement are treated with respect as potential candidates.
♦ All NHS staff are aware that they are role models for future health professionals.

♦ Newly qualified NMAHPs enrol on Flying Start immediately on entering employment
♦ NQPs are allocated a mentor to support their progress on Flying Start at enrolment, or if this is not possible within the first month of employment.
♦ Every effort is made to ensure that NQPs and their mentors are compatible in terms of location of employment/shifts etc. Should this not prove possible an alternative mentor is identified.
♦ NQPs whose first posts involve rotation are informed if they are to retain the same mentor when they move. If they are to be allocated a new mentor, they will be informed who this will be in advance.
♦ NQPs who are unable to secure employment and join the Nursing or AHP Banks enrol on Flying Start within six months of registration.
♦ NQPs employed through the Nursing or AHP Banks are allocated a mentor in a suitable location.

♦ Flying Start has strategic support at all levels.
♦ NQPs are valued and encouraged to become a member of their team.
♦ The position of NQPs, as new members of staff who will not know everything, is recognised.
♦ The aims and objectives of Flying Start NHS are understood and respected by NHS staff at all levels.
♦ Flying Start NHS is promoted for all NQPs, and information about the materials available on the website is available to all staff.

♦ Protected time is available for all NQPs and is incorporated into the work allocation model, and as such is sacrosanct.
♦ Tasks associated with Flying Start are completed in non-clinical areas, i.e. hospital libraries, offices, or home computers.
♦ All NQPs have access to the Internet in a non-clinical area on a weekly basis.

- A proportion of activities associated with Flying Start NHS are provided locally, allowing face to face interaction.
- Mentors fully understand the aims and objectives of Flying Start NHS and are provided with training to enable them to support NQPs.
- Time for mentoring NQPs is factored into workloads.
- NQPs meet their mentors at least monthly.

- Clear guidance is provided regarding the Flying Start NHS programme in terms of what is expected from NQPs at different levels, in different professions, and in different locations.
- Information is available relating to what a Flying Start portfolio should look like, as well as tips relating to progress, e.g. suggested milestones.
- NQPs are aware of the links to PDP and KSF, which are clearly signposted.
- NQPs have a clear understanding of what completion looks like and who will assess and sign off their portfolio.
- Life-long learning and on-going CPD are understood to be an integral part of being a health professional.
- NQPs take personal responsibility for life-long learning and on-going CPD.

- General induction programmes and discipline specific programmes provided in the first year of employment are revisited and their content compared to Flying Start NHS in order to identify and eliminate duplication.
- Support available to NQPs is modified to suit specific localities.
- There is equity of support between NHS Boards, and acute and community settings.

- Final year students and NQPs sit on an advisory group focusing on the future development of Flying Start NHS
- The Flying Start website is constantly updated in response to feedback from key stakeholders including students, NQPs, mentors, PEFs, and managers.
- NQP are aware that any communication between NQPs using the Flying Start website is confidential. Only requests of support and/or 'ask the expert' questions are viewed by NHS Education Scotland.
- Investment is targeted at the on-line peer community with a view to enhancing its usefulness to NQPs.

APPENDIX I

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WEST *of* SCOTLAND

3 March 2008

Dr Pauline Banks,

STUDY TITLE: An Evaluation of Flying Start NHS

Reference: REAG/050208/BANKS/28

I would like to notify you that University of the West of Scotland Research Ethics Advisory Group have considered your application and ethical approval has been granted.

Kind Regards,

Aleona Blinova
Secretary to the Research Ethics Advisory Group
Innovation and Research Office
University of the West of Scotland
0141 848 3576

Flying Start NHS

Telephone Interview Schedule: Lead Links

♦ Could you explain about your role as a Lead Link?

    o How long have you been in post?

♦ How has Flying Start been implemented in your organization?

    o prompts how has it been facilitated? How has it been delivered?

♦ What do you think have been the most effective aspects of the way in which Flying Start has been implemented into your organization, and why?

♦ What support mechanisms are in place to assist newly qualified practitioners through flying start program – prompts allocating time, allocation of a mentor, availability of computers/internet access

♦ Do you have a Flying Start coordinator in your area? i.e. someone funded at a level below lead link – not everywhere has them, and not all called the same thing. If so what does their role involve? What will happen when this funding runs out?

♦ Has there been a Masterclass for PEFs/Lead Contacts in your area? If so this been useful?

♦ How have PEC/practice educators in your NHS Board linked in with FS?

♦ What other initiatives are/were in place in your organization to support newly qualified practitioners – for example orientation program, period of supernumery status etc?

♦ Do you think these compliment Flying Start or duplicate provision?

♦ Are you aware of the uptake and completion rates of flying start by staff locally?
    o Explore yes/no answer further – numbers registered, professional groups undertaking. E.g. Do you have an understanding of the number of staff have registered, completed, or at what stage they are at? Do you have a system to monitor this?

♦ When will KSF be fully implemented in your NHS Board?

♦ Do you think that flying start has had an impact on recruitment and retention of newly qualified staff in your area? If so in what ways?

♦ What, if anything could be improved?

♦ Is there anything else you would like to add

Potential Questions for the NGT event

In the table below is a list of eight potential topics for discussion at the NGT event on 19th June. Based on **your experience** of implementing Flying Start in your NHS Board, please rank the topics from 1 - 8 according to how important you feel it is for the future development of Flying Start that these issues are addressed – '1' being <u>most</u> important and '8' <u>least</u> important. The second column contains some points that you might like to consider when making your rankings. Please return completed forms – no identification required, to <u>helen.kane@uws.ac.uk</u> by **Thursday 12th June.**

Topic	
Role of Leak Link/Coordinator	What are the main tasks/responsibilities for an individual taking the lead on Flying Start in each NHS Board? Who should undertake this role in terms of qualifications? How should the time allocation be calculated?
Should Flying Start be optional or mandatory	Should Flying Start be mandatory? If not what should the position be? Should it be standardised in all NHS Boards or at their own discretion? What role do HEIs have in raising awareness and building links with pre-registration training?
Structure of Flying Start	When should newly qualified practitioners enrol on Flying Start (e.g. immediately/time to settle in to new job)? Should there be a structure for newly qualified practitioners undertaking Flying Start? e.g. this is where you should be at three months, six months, nine months etc? If so what would it look like?
Support for newly qualified staff	Protected time: Should newly qualified practitioners have protected time to complete Flying Start? If so, how much and when? Access to IT: Should there be an expectation that newly qualified practitioners undertaking Flying Start use their own computers? If so, how quickly can they be linked to nhs.net? If not, how can realistic access to the Internet be provided in work settings?
	What level of face-to-face support should be provided for newly qualified practitioners undertaking Flying Start, and by whom? How should newly qualified practitioners who do not secure employment be supported? How to ensure equity?
The role of mentors	Should input from mentors be standardised? If so what should it comprise? How can mentors be supported to adequately provide this support?
Monitoring	Should a Scotland-wide method of capturing data relating to progression and completion be developed? If so by whom and what should it look like?
Promoting Flying Start and avoiding duplication	How should Flying Start sit with other programmes? Should Flying Start replace previously existing induction programmes? If so should this be voluntary or compulsory? How best to raise awareness of the link with KSF. What are the roles of HEIs and senior NHS staff in promoting life-long learning? How can they be supported to do so?
Primary care initiative	Should newly qualified practitioners be supported straight into employment in primary care settings? If so what is the best way to support them? Is this different from the support required by newly qualified practitioners in acute settings?

TOPICS FOR INCLUSION IN NOMINAL GROUP TECHNIQUE EVENT

NHS Flying Start Lead contacts and Coordinators were asked to independently and privately record their ideas and opinions relating to the following questions on a *proforma*. If they were able to attend the NGT event they were asked to bring their listed thoughts and ideas with them, if unable to attend they were asked to email their ideas and comments to the research team in advance of the event.

THE ROLE OF STAFF, AT ALL LEVELS, SUPPORTING THE IMPLEMENTATION OF FLYING START
➢ What are the main tasks/responsibilities for an individual taking the lead on Flying Start in each NHS Board?
➢ Who should undertake this role in terms of qualifications?
➢ How should the time allocation be calculated?   ➢
➢ Should input from mentors be standardised?
➢ If so what should it comprise?
➢ How can mentors be supported to adequately provide this support?
➢ Other issues relating to leads/staffing

THE ORGANISATION AND STRUCTURE OF FLYING START
➢ Should Flying Start be mandatory? If not what should the position be?
➢ Should it be standardised in all NHS Boards or at their own discretion?
➢ When should newly qualified practitioners enrol on Flying Start (e.g. immediately/time to settle in to new job)?
➢ Should there be a structure for newly qualified practitioners undertaking Flying Start? e.g. this is where you should be at three months, six months, nine months etc? If so what would it look like?
➢ What role do HEIs have in raising awareness and building links with pre-registration training?
➢ Other issues relating to implementation/structure:

Summary of comments relating to both topics recorded on proformas prior to NGT event

1. THE ROLE OF STAFF, AT ALL LEVELS, SUPPORTING THE IMPLEMENTATION OF FLYING START

➢ **What are the main tasks/responsibilities for an individual taking the lead on Flying Start in each NHS Board?**

♦ Support e.g. to mentors and newly qualified practitioners, and elsewhere as required
♦ Awareness raising e.g. within organisations and with clinical staff
♦ Create an overall programme of learning including benchmarking and aligning with KSF
♦ Promoting good practice
♦ Link to NHS Education Scotland
♦ Contributing to national coordination as well as national and local consistency
♦ Adapt to suit local environment
♦ Ambassador for Flying Start
♦ Monitoring: identification of newly qualified practitioners, audit, targets
♦ Funding
♦ Liaise with HEIs

➢ Who should undertake this role in terms of qualifications?

o   Someone with interest in education/learning
o   Clinical and management experience.
o   Nursing or AHP
o   Experienced mentor/equivalent
o   SCQF 9
o   Excellent communication skills
o   Ability to motivate and negotiate
o   Change manager

➢ How should the time allocation be calculated?

This prompt was interpreted differently by different participants with a majority referring to time allocation for newly qualified practitioners. However, one participant suggested that the Flying Start could become a full-time post working with Occupational Health and taking responsibility for graduate return or return to practice students, and developing Flying Start packages for individuals.

➢ Should input from mentors be standardised?

Mixed views, yes, no, and possibly:

♦ Those who thought that the role *should be* standardised felt that there was a need more explicit guidelines.

- Those who felt that the role should *not* be standardised suggested that Flying Start is a Self directed course, that mentoring is a facilitative role, and that needs vary too much to standardise.

➢ If input from mentors were standardised what should it comprise?

- Support
- Clinical supervision
- Regular contact/monitoring of progress
- Guidance on completion
- Input should be negotiated between mentor and newly qualified practitioner
- Role model
- Time allocation

➢ How can mentors be supported to adequately provide this support?

- Training sessions/workshops
- Online activities
- Support forum - multidisciplinary
- Guidelines
- Skills incorporated into PDP
- Increased knowledge of Flying Start programme
- Support from managers, PEFs, Flying Start Coordinators

➢ Other issues relating to leads/staffing

- Promotion of ownership in clinical areas
- Dedicated individuals to promote uptake
- Dealing with change fatigue
- Newly qualified practitioners taking professional responsibility
- Funding
- Status of programme

➢ How should the time allocation be calculated?

- Protected time
- Agreed balance between clinical practice and CPD

2. THE ORGANISATION AND STRUCTURE OF FLYING START

➢ Should Flying Start be mandatory? If not what should the position be?

Mixed views with a majority thinking that Flying Start should be mandatory, some participants felt that an *expectation* was sufficient.

- If required for KSF foundation Flying Start should be mandatory
- Easier to promote if mandatory

- ♦ Promotes equity
- ♦ Clarify role of HEIs and managers

- ♦ Lack of guidance

- ♦ How to police
- ♦ Difficulty of contractual ties

➢ Should it be standardised in all NHS Boards or at their own discretion?

The majority of participants felt that Flying start should be standardised as it is a National programme:

- ♦ Encourage participation
- ♦ Ensure equity and consistency
- ♦ Standard core with flexibility for local differences

However, there was some support for guidelines, leaving promotion to the discretion of individual NHS Boards.

➢ When should newly qualified practitioners enrol on Flying Start?

- ♦ As soon as possible
- ♦ Immediately
- ♦ Need time to familiarise themselves with the programme
- ♦ Opportunity to reflect on early experiences

➢ Should there be a structure for newly qualified practitioners undertaking Flying Start? E.g. this is where you should be at three months, six months, nine months etc? If so what would it look like?

A majority believed that a structure would be beneficial, e.g. in line with KSF and job description, however, a minority favoured guidance rather than structure:

- ♦ Helpful but not essential
- ♦ Signposts and targets
- ♦ One structure would not fit all

➢ What role do HEIs have in raising awareness and building links with pre-registration training?

Participants believed that HEIs had a role in promoting Flying Start:

Raising awareness /responsibility for CPD/life long learning
as part of professional responsibility

Attention was drawn to the difficulties of accessing AHP students who do not tend to train in their own NHS Boards in the ways nurses do. Participants also acknowledged that some HEI staff misunderstand Flying Start in that they view it as a criticism of their students.

- ♦ Raise profile
- ♦ Yearly presentations
- ♦ Promote portfolio guidance

➢ Other issues relating to implementation/structure:
- ♦ Raise awareness of links to PDP and KSF
- ♦ Accreditation
- ♦ Lack of funding
- ♦ Competing priorities
- ♦ Support
- ♦ Leadership
- ♦ Protected time
- ♦ IT access
- ♦ Lack of knowledge of Flying Start programme amongst managers and PEFs
- ♦ Reward for newly qualified practitioners

Topic 1: Round-robin feedback

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┌──────────────┐      ┌──────────┐    ┌──────────┐              ┌──────────┐
│ No capacity to│      │ Role of  │    │ Buying in│              │ Could be │
│ pick up      │      │ Charge   │    │ middle   │              │ pulled   │
│ workload     │      │ Nurse/   │    │ level    │              │          │
└──────────────┘      └──────────┘    └──────────┘              └──────────┘
                                      ┌──────────────┐
                                      │ Time limit   │       ┌──────────────┐
            ┌────────┐                │ 6-12 mths    │       │ Secondment   │
            │ PEFS   │                └──────────────┘       └──────────────┘
            └────────┘

┌──────────────┐                  ┌──────────┐                ┌──────────────┐
│ What can PEF │                  │  ROLES   │                │ Time limited │
│ support when │                  └──────────┘                └──────────────┘
│ designated   │
│ role ends    │      ┌──────────────┐         ┌──────────┐        ┌──────────────┐
└──────────────┘      │ Mentor       │         │Fixed term│        │Consolidation │
                      │ acceptance of│         │ contract │        └──────────────┘
                      │role/expectation/│      └──────────┘
                      │ approach     │
                      └──────────────┘       ┌──────────────┐
          ┌──────────────┐                   │ Time limited by│
          │ Some have no │                   │ finance      │
          │ coordinators │                   └──────────────┘
          └──────────────┘
                        ┌──────────────────────────┐
                        │ Dedicate resources       │    ┌──────────────┐
                        │  ♦ Brings profile        │    │ Mixed        │
                        │  ♦ Priorities are different│  │ expectation of│
                        │  ♦ Develop more sustainable│  │ what lead role│
                        │    resouces              │    │ was          │
                        └──────────────────────────┘    └──────────────┘
┌──────────────────────────────────┐
│ Appropriate people in roles      │
│ Strategic                        │
│ Ground level                     │
│ If people more senior – impact   │
│ No consistency in who is lead    │
└──────────────────────────────────┘
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Role of middle level, i.e. Charge Nurse – tend to be lead for everything – priority
- ♦ Need to see how this links to PDP etc
- ♦ Using it as structured approach
- ♦ Getting them to see big picture
- ♦ Lack of awareness
- ♦ Maybe should have given support earlier
- ♦ Giving back to units to support

Newly qualified role

- ♦ Light touch mentoring
- ♦ Message from HEI
- ♦ Students/newly qualified see as separate
- ♦ Introduce earlier in programme

Reported importance of issues associated with <u>Topic 1</u> - The role of staff, at all levels, supporting the implementation of Flying Start

The five main topics selected for further ranking and the reasons that participants selected them for further discussion

1. Appropriate Lead Contact
2. Sustainability after dedicated role
3. Middle management support
4. Expectations of newly qualified practitioners
5. Role of mentors

Sustainability of flying start programme (10)
- How will the programme continue to be promoted and advocated following co-ordinator role finished
- Who will promote?
- Who will push/police?
- Role of co-ordinator possible length does not demonstrate belief and value
- Need for support already in place is continued
- It will fall by the wayside without a plan
- Ensuring success continues without co-ordinator input
- Resources
- Developing exit strategy to support ongoing programme uptake and completion
- Flying start participants are often overwhelmed by the programme at first look.
- Support and direction are crucial at this stage of embarking with support guidance and encouragement required throughout the programme.
- Because need to decide on what has to happen once the implementation money runs out.
- Big fragmented board. Dedicated role needed to consolidate implementation. Also to 'troubleshoot' non-implementors.
- To provide consistency in implementation across board.
- Danger of FS NHS being 'lost' amongst competing clinical agenda.
- Priorities differ
- Exit/no exit strategy dictates work that can be done
- Profile given to course will differ depending on staff and dedicated time given to it.

Role of mentor (9)
- They are pivotal to the support of the NQP
- Lack of clarity of the mentor role and what is needed to support mentors
- Nurturing support and encouraging NQPs
- Key to it all
- Mentors apprehensive about e-learning
- Role and function unclear
- Not to make FS feel different from any other staff/mentor relationship
- Supporting ongoing progress of programme – maximising benefit for both mentor/NQP
- Expectations of?
- Preparation of?
- Support of?
- Availability of?

Middle management (9)
- Need to be on board so staff (NQP) is supported and valued
- Raise greater awareness od NQP role/development and benefits of FSP (tool for all)
- They need to encourage ownership of CPD at a local level
- They have authority to regulate time out progression etc
- If you get this lot right it will bring mentors on board
- 'leaders' – they are responsible for development of their staff in addition to their responsibility for standard in their dress.
- Support at this level underpins mentor NQP participation
- Programme importance needs to be better recognised by middle management. It needs to be rioritised alongside clinical and organisational need: - not considered an optional extra or add-on
- The role continues to be the least supportive
- They can provide resources needed to support NQP: time to undertake it, support, learning environment
- Tem leads in clinical areas pivotal to success of NQPs under their management engaging in FS.
- No buy-in from manager locally – no support for NQP
- Can support implementation issues contributing to success in FS – monitoring, completion/protected time locally

Expectations of newly qualified practitioners (6)
- Sometimes NQP are starting with unrealistic ideas about programmes
- If they know about it in advance then it comes as no surprise when they qualify.
- Need to not look at flying start as a 'course'
- HEI need to create culture of life long learning
- Clinical not academic work
- When fs introduced
- Hands off 'light touch' mentoring
- They do not see it as important to them.
- How do you get NQP to see the benefit of FS
- To be recognised as a continuum from prereg with life long learning
- Develop good profiling CPD/development skills

Appropriateness of lead/coordinator (2)
- Needs to be senior enough to drive and support – others will follow
- Direct the implementation
- Management level dictates the progress that can be achieved
- Co-ordinator needs focus and to be motivates

Topic 2: **The organisation and structure of Flying Start.**

Feedback from Round Robin: What do you think are the most important issues that should be addressed around the organisation and structure of Flying Start?

- What does mandatory mean?
- What would be the consequences of it being mandatory? (For example staff being given designated time and support to complete FS activities. Will there be backfill for newly qualified practitioners and for mentors?
- All staff have to do KSF – it is mandatory – should FS be the same?
- There needs to be a consistent message given across all Board areas – in terms of FS being mandatory or not, in terms of being given designated time and support.
- There should be better and more consistent links to the KSF
- Is FS the only evidence that newly qualified practitioners will need and that will be accepted to get through the first gateway?
- What do we mean by completion?
- Do newly qualified practitioners need more signposts to facilitate completion rates i.e. targets set at 3 months, 6 months, 9 months etc
- When should newly qualified practitioners start FS?

Reported importance of issues associated with <u>Topic 2</u>, the organisation and structure of Flying Start

MANDATORY (12 respondents)
- There are mixed messaged about what is meant by mandatory.
- How could this be policed?
- If it is mandatory staff (newly qualified practitioners and mentors) need protected time.
- If it is mandatory – uptake, completion and the consequences of doing and not doing it are implicit
- KSF is non negotiable – therefore FS should be the same – it should be identified as the overarching vehicle to take newly qualified practitioners to 12 months but other learning opportunities should also be incorporated.
- If mandatory it would give a clearer message to all of the importance of the FS programme and the development of newly qualified practitioners
- Need to have the choice removed – KSF is not a choice
- It is exceptionally difficult to promote and encourage completion if it is not mandatory , also it would ensure equity amongst the NHS Boards
- Need to identify structure and then make it mandatory – structure is terms of completion and the consequences of completion
- There needs to be consistency and support
- Presently the programme can "drift" with no consequences of not doing it and no reward for doing it
- If mandatory – what are the consequences?
- Cannot be done on a whim – has to have major implications – if it essential for the 1st gateway there needs to be limits and directions required by the manager, the mentors and the newly qualified practitioners. We all need to be saying the same i.e. FS is mandatory and the reasons why – otherwise no one will do it!

SIGNPOSTING (8 respondents)
- Need progress structure – maximising learning within the 1st year as FS designs
- My experience so far is that newly qualified practitioners need to be encouraged and reminded regularly about completing the programme> Mentors also need regular reminding of its importance. The programme could easily be "lost" ad loose its importance to clinical activity and other pressures.
- There is a lack of clarity to progression throughout the year
- Need for guide and bite size chunks of learning and development
- There is a lack of clarity of what to do when
- Signposting would help
- What happened to the work that NES did at the writing day?
- Could be a dangerous routs to follow – too prescriptive – could mean we are leading and not enabling newly qualified practitioners
- Start point is part of this
- Make a guide , create a pathway
- Makes the programme seem more manageable and gives people an idea of where they should be, when are they ahead, behind etc for completion in 12 months.

START POINT (5 respondents)

♦ Should have a designated time period to commence, short enough to not prolong but long enough to cover all staff
♦ Who starts – first 12 months – what is no job for 18months or mat leave or break etc
♦ When do they start – right away – will it blend with other existing area programmes
♦ Needs to be started sooner then later to get maximum benefit otherwise newly qualified practitioners will have their own support mechanisms
♦ Start point is immediate
♦ Programme and learning activities are designed with a 12 month journey in mind
♦ Advocate on settling into new role/job and identifying key development areas and use as signpost

COMPLETION/KSF (12 respondents)

♦ Goal to work to and to get through gateway
♦ Real lack of clarity about how this is acknowledged – no consistency
♦ Should not focus on finishing – just another KSF review
♦ KSF foundation gateway evidence this should be the "carrot"
♦ There is no set end at the moment – newly qualified practitioners feel "is that it!"
♦ No celebration or well done!
♦ The question everyone asks is – how and when will I know I have finished FS?
♦ We need to give a focus to work towards
♦ What does completion look like and who decides?
♦ No consistency about "answers£ or outcomes
♦ No visible/tangible completed profile to compare against
♦ No target to aim for
♦ Consistency, vision, end point and recognition at ending programme
♦ Lack of clarity of completion - individual's interpretation
♦ Underpins links with KSF
♦ Who takes ownership?
♦ Relates to KSF fulfilment
♦ Quality assurance – who? When? How?
♦ Measured against KSF foundation outline?

Flying Start NHS

Focus Group Schedule

STUDENTS

♦ Introduction and collation of demographic information e.g. gender, age, previous experience
♦ Can you tell me what you know about the Flying Start programme

NB: If students not aware of Flying Start programme then an explanation and info abut it will be required before continuing

♦ Where did you find out this information?
♦ What do you think your development needs will be as a newly qualified practitioner during your first year post qualifying?
   Prompts: education, professional development, role transition, support
♦ What support from your employer do you think you would require to undertake Flying Start NHS?
♦ What are the advantages and disadvantages of undertaking Flying Start for newly qualified staff?
♦ How do you feel about keeping studying once you have qualified?
♦ Have you had any previous experience of on-line learning?
♦ Do you think Flying Start should be compulsory for all newly qualified practitioners? Would compulsory registration and/or level of support available have an impact on where you chose to work for your first post?
♦ Where are you hoping to work once you register? Explore acute vs community
♦ Do you think that the needs of newly qualified practitioners vary between acute and community settings?

♦ When you have been out on placement have you worked with newly qualified staff? If so did they mention Flying Start? If so how were they getting on?

   ♦ How would you rate the quality of career advice you have received to date. On a scale of 1 to 10 ... 1 being poor - 10 being excellent.
   ♦ In 5yrs time which Band of Agenda for Change do you see yourself being on?
   ♦ In 10 yrs which band of Agenda for change do you see yourself being on?
   ♦ Do you intend to take up employment in the NHS or private sector?
   ♦ Do you intend to stay in Nursing (Midwifery) (AHP) over the foreseeable future.

♦ When you are looking for a job, what factors did you or will you take into account, e.g. what would prompt you choose a particular area? *Prompts: a student placement you enjoyed, support for Flying Start etc.*
♦ Anything else?

Flying Start NHS

Focus Group Schedule

NEWLY QUALIFIED PRACTITIONERS

♦ Introduction and collation of demographic information e.g. where are they working? Acute/community? Was this where they had wanted to work? How long have they been in post?

♦ Can you tell me whether or not you are enrolled on Flying Start?
*For those that **are enrolled**:*

♦ Were you aware of the Flying Start programme before registration? If aware where did you access information?

♦ Was the support available to undertake Flying Start a factor in your choice of job?
*Those that are **not enrolled**:*

♦ Were you aware of the Flying Start programme before registration? If aware where did you access information?

♦ Can you tell me why you have chosen *not* to enrol on the programme? Do you think that this is something that might change?
*For those that **are enrolled**:*

♦ How soon after starting employment did you enrol on Flying Start? Do you think, in hindsight, that this was a good time to enrol

♦ When you were looking for a job, what factors did you take into account, e.g. what made you choose a particular area? *Prompts: a student placement you enjoyed, support for Flying Start etc.*

♦ What do you think are/were your main development needs as newly qualified practitioners during your first year post qualifying?
Prompts: education, professional development, role transition, support

♦ Can you tell me about your experience of the Flying Start programme:

♦ In what ways does your employer support you to undertake the programme e.g. IT, time, where do they do the work?

♦ How have you found the on-line learning environment? Had you had previous experience of on-line learning?

♦ What support do you receive from mentors- what does it entail? Any problems? Examples of good practice?

♦ Have you accessed any face to face sessions e.g. sessions organised locally?

♦ What are the advantages and disadvantages of undertaking Flying Start for newly qualified staff? Has it fulfilled your needs?

♦ What do newly qualified practitioners who have not enrolled think the advantages and disadvantages are?

- How did you feel about continuing to study once you had qualified?
- Do you think that the needs of newly qualified practitioners vary between acute and community settings?
- You were asked to think of an example from your work when having access to Flying Start enabled you to feel more competent – did you manage to think of any examples?
- You were also asked to think of an example from your work when you felt ill-equipped to cope with a situation? Did you manage to think of any examples?
- Could Flying Start have helped?
- Anything else?

Flying Start NHS

Telephone Interviews

NHS Strategic Mangers, Line Mangers, PEFs, Mentors

- Welcome, introductions and demographic information including details of role.
- What factors facilitate the employment of newly qualified practitioners into an acute setting?
- Conversely what factors hinder the employment of newly qualified practitioners into an acute setting?
- In your experience do newly qualified practitioners who are employed directly into a acute setting experience additional problems to newly qualified staff employed in a community setting?
- Do newly qualified practitioners experience challenges from other professional groups as a result of their being newly qualified?
- Can you tell us what forms of support have been put in place to assist newly qualified practitioners in their first post in an acute setting?
- Are you aware of the content of the Flying Start programme?
  Prompts – number of units, themes of the units
- Do you think that flying start will overcome any of the issues previously discussed?
- Are there limitations in what fly start can offer – if so what additionally needs to be put into this programme to overcome these limitations?
- Can you describe what newly qualified nurses will do, case load how operate/work?
- Describe in what ways this role is different to the more traditional appointment to the acute?
- Can you describe the types of experiences the newly qualified practitioner will experience e.g. Rotation, support network?

Table A1: Profession of respondents: frequency and percentage

Profession	Frequency	Percent
Nursing (Adult)	237	43.3
Nursing (Mental Health)	70	12.8
Nursing (Child)	19	3.5
Nursing (Learning Disability)	8	1.5
Midwifery	20	3.7
Speech & Language Therapy	47	8.6
Occupational Therapy	45	8.2
Physiotherapy	43	7.9
Dietetics	16	2.9
Podiatry	15	2.7
Radiography (Diagnostic)	15	2.7
Radiography (Therapeutic)	5	.9
Orthoptics	2	.4
Arts Therapy	1	.2
Prosthetics and Orthotics	1	.2
Total	**544**	**99.5**
Missing	*3*	*.5*

Table A2: Employer (NHS Board): frequency and percentage (n=437)

Employer	Frequency	Percent
NHS Tayside	89	16.3
NHS Greater Glasgow & Clyde	72	13.2
NHS Lothian	67	12.2
NHS Ayrshire & Arran	53	9.7
NHS Grampian	40	7.3
NHS Lanarkshire	23	4.2
NHS Fife	22	4.0
NHS Highland	19	3.5
NHS Dumfries & Galloway	15	2.7
NHS Forth Valley	14	2.6
NHS Golden Jubilee Hospital	12	2.2
NHS Shetland	4	.7
NHS Borders	3	.5
NHS Orkney	2	.4
The State Hospital	2	.4
Total	**437**	**79.9**
Missing	110	20.1

Table A3: Level of education by profession: proportion of respondents in each profession (n=434)

Profession	Diploma	Degree	Degree (hons)	Masters
Nursing (Adult)	23.4	65.4	10.1	1.1
Nursing (Mental Health)	18.9	77.4	3.8	0
Nursing (Child)	38.9	61.1	0	0
Nursing (Learning Disability)	0	85.7	14.3	0
Midwifery	5.9	88.2	5.9	0
Speech & Language Therapy	5.9	8.8	82.4	2.9
Occupational Therapy	2.9	17.1	57.1	22.9
Physiotherapy	2.6	10.3	59	28.2
Dietetics	7.7	7.7	84.6	0
Arts Therapy	0	0	0	100
Podiatry	0	0	100	0
Radiography (Diagnostic)	0	0	92.3	7.7
Radiography (Therapeutic)	0	0	80.0	20.0
Total	15.4	48.4	30.4	5.8

It should be noted that, although a small number of AHPs reported that they were educated to Diploma level, all AHP education is at degree level or above, thus responses may have been entered in error.

Table A4: *Time in post: months (n=405)*

Time	Frequency	Percent
0-6 months	88	16.1
>6 months -12 months	142	26.0
>12 months -18 months	107	19.6
>18 months -24 months	40	7.3
>24 months -30 months	21	3.8
>30 months -36 months	7	1.3
Total	**405**	**74.0**
Missing	117	21.4
> 36 months	25	4.6

Table A5: Impact of learning units on **clinical skills development**: participants currently undertaking, or having completed each learning units' perception of usefulness (frequency and percentage of NQPs for each unit.).

Learning Unit	Currently undertaking						Completed					
	Useful		Not useful		Don't know		Useful		Not useful		Don't know	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Communication	149	58.2	94	36.7	13	6.6	128	66.7	57	29.7	7	3.6
Clinical Skills	159	67.4	63	26.7	14	5.9	123	74.5	37	22.4	5	3.0
Teamwork	121	55.0	85	38.6	14	6.3	94	59.9	56	35.7	7	4.5
Safe practice	122	62.5	57	29.2	16	8.2	94	69.1	35	25.7	7	5.1
Research for practice	85	52.1	63	38.7	15	9.2	62	52.1	46	38.7	11	9.2
Equality and diversity	94	54.0	68	39.0	12	6.9	76	61.8	42	34.1	5	4.1
Policy	81	52.3	61	39.4	13	8.3	58	54.7	39	36.8	9	8.5
Reflective practice	129	65.2	59	29.8	10	5.0	89	68.5	38	29.2	3	2.3
Professional development	102	59.0	57	32.9	14	8.1	70	61.9	33	29.2	10	8.8
Career pathways	62	48.4	50	39.1	16	12.5	41	43.2	38	40.0	16	16.8

Table A6: Impact of learning units on the **confidence** of NQPs: participants currently undertaking, or having completed each learning units' perception of usefulness (frequency and percentage of NQPs for each unit.).

Learning Unit	Currently undertaking						Completed					
	Useful		Not useful		Don't know		Useful		Not useful		Don't know	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Communication	123	46.9	126	48.1	13	5.0	107	56.3	77	40.5	6	3.2
Clinical Skills	125	53.6	89	38.2	19	8.2	101	61.6	57	34.8	6	3.7
Teamwork	105	46.5	99	43.8	22	9.7	88	56.4	60	38.5	8	5.1
Safe practice	102	53.1	69	35.9	21	10.9	84	62.2	41	30.4	10	7.4
Research for practice	66	40.5	80	49.1	17	10.4	51	42.9	56	47.1	12	10.1
Equality and diversity	73	44.5	81	49.4	10	6.1	61	49.6	51	41.5	11	8.9
Policy	65	42.2	72	46.8	17	11.0	50	47.2	46	43.4	10	9.4
Reflective practice	104	52.8	77	39.1	16	8.1	80	61.1	45	34.4	6	4.6
Professional development	85	49.4	70	40.7	17	9.9	66	57.4	40	34.8	9	7.8
Career pathways	47	36.7	57	44.5	24	18.8	32	33.7	44	46.3	19	20.0

Table A7: Time from beginning employment until allocated a mentor (n=279)

Time	Frequency	Percent
Immediate	25	4.6
1-4 weeks	170	31.1
5-8 weeks	29	5.3
9-12 weeks	20	3.7
13-26 weeks	18	3.3
27+ weeks	17	3.1
Total	279	51.0
Missing	*268*	*49.0*

Table A8: Satisfaction with support received to undertake Flying Start NHS

Source of support	Very poor		Poor		Neither poor or good		Good		Very good		Total
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.
Mentor	59	10.8	26	4.8	68	12.4	67	12.2	72	13.2	292
Line Manager	73	13.3	42	7.7	94	17.2	55	10.1	38	6.9	302
Peers	50	9.1	37	6.8	79	14.4	92	16.8	44	8.0	302

Table A 9: Frequency of contact with mentor (frequency and percentage)

Contact	Nursing		Midwifery		AHP		Total	
	Frequency	%	Frequency	%	Frequency	%	Frequency	%
Weekly	6	4.4	0	0	6	8.2	12	5.6
Monthly	10	7.4	0	0	20	27.4	30	13.9
On request	48	33.8	3	42.9	40	54.8	89	41.2
Occasionally if on same shift	74	54.4	4	57.1	7	9.6	85	39.4
Total	136	-	7	-	73	-	216	100.0
331 respondents did not answer this question								

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APPENDIX II