



*Yorkshire and the Humber*

**Workforce and Education Directorate  
Non Medical Graduate Recruitment Final Report**

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September 2008

<b>Contents</b>	<b>Page No</b>
Introduction and Context	4
Recommendations	5 – 7
The NMGR Steering Group Action Plan	7 – 9
1. Proposals Funded by the SHA	9 – 24
2. Graduates Yorkshire	25
3. Skills for Care	25
4. Future Work for SHA regarding Non Medical Graduate Recruitment	25 – 26
Appendices	27
Appendix 1 - Mapping of workforce capacity and implementation plans across Yorkshire and the Humber, with regard to delivery of the 18 week target	28 – 29
Appendix 2 - Report on Graduate Employment – Managing the Employment issues 2007 Securing and Retaining Staff for Health and Social Care Gillian Gibbons 30/03/07	30 – 62
Appendix 2a – University Contacts	63 – 66
Appendix 2b - Organisational Contacts	66 - 73
Appendix 2c - Benefits Realisation	74 – 77
Appendix 2d – Graduate Focus Group - Questions to Consider	78 – 79
Appendix 3 – Case Study	80
Appendix 4 – Graduate Employment Costs	81
Appendix 5 - A Stakeholder Evaluation of a Non-medical Graduate Preceptorship Pilot Project in Six Mental Health Trusts	82 – 113
Appendix 5a – Project Management Group Members	114
Appendix 5b - Aide memoire for interviews with graduates	115

Appendix 5c – Topic Guide for Interviews with Trust Leads	116
Appendix 5d - Band 5 Preceptorship Placements	117 – 118
Appendix 6 - Bradford Teaching Hospitals NHS Foundation Trust. TNR/Preceptorship Scheme Evaluation Report	119 – 121
Appendix 6a Summary Analysis of the Evaluation of the TNR/Preceptorship Programme - nurses on the schemes perspective	122 – 124
Appendix 6b - Summary Analysis of the Evaluation of the TNR/Preceptorship Programme - manager's perspective	125 – 127

# **Workforce and Education Directorate Non Medical Graduate Recruitment Final Report**

## **Introduction**

This report outlines the issues around Non Medical Graduate Recruitment (NMGR) in Yorkshire and the Humber, and work that has been undertaken to support new healthcare graduates into employment.

## **Context**

From 2005 it had become increasingly clear that for the first time in a generation, the available job opportunities in the NHS was exceeded by the number of people seeking employment in the NHS. This led to competition for posts being much more challenging than in previous years and to many graduates finding it difficult to secure their first jobs post qualification.

It was recognised that every effort was required to protect the valuable skills of new graduates and to consider the long term supply of a skilled health and social care workforce, (taking into consideration retirement profiles) to avoid workforce shortages for the future.

Therefore in the autumn of 2006, Ministers asked the Social Partnership Forum to develop a set of recommendations that could be agreed between employers, trade unions and the education sector, that would put in place positive steps to maximise the employment opportunities for healthcare graduates.

A workforce summit took place in February 2007 and following on from that the Social Partnership Forum Action Plan ("Maximising employment opportunities for newly qualified healthcare professionals in a changing NHS") was published. It outlined the responsibilities of Strategic Health Authorities (SHA's), Employers and Higher Education Institutions.

## **Yorkshire and the Humber SHA**

Across the region it was anticipated that approximately 2,700 health professional students would graduate in 2007/ 08. Alongside these new graduates over the previous 12 – 20 months there had been an increase in the overall numbers of health care professionals graduating from Universities.

In November 2006 NHS Yorkshire and the Humber established a strategic level task group to take the work forward, which became the NMGR Steering Group. This group acted as a reference group for full time Trade Union Officers, and was a sound basis for partnership working. All workstreams that were discussed at the Steering Group were fed back to the Employers Organisation and the Department of Health.

## **Yorkshire and the Humber SHA Progress against the Social Partnership Forum Action Plan:**

**Recommendation 1:** *SHAs to develop talent pools of all new qualifiers seeking their first post, through the use of NHS Jobs, to identify and quantify newly qualified healthcare professionals seeking employment.*

The Yorkshire and the Humber Talent Pool was launched on 16 April 2007, Shirley Harrison is the SHA Lead for the Talent Pool. The Pool was promoted by Education Commissioning Managers to Higher Education Institutions (HEI's) and Employers, and by the Programme Manager for NMGR to the Yorkshire and the Humber Allied Health Professions (AHP) Forum, Independent Sector organisations, Social Care (Directors of Adult services and Directors of Children's services), and the Human Resource Directors network and again to HEI's and Trusts. The SHA also employed an Advisor on a short term basis to undertake sessions at HEI's on the employment situation and how to apply for jobs; the Talent Pool was promoted at these sessions. The Programme Manager also contacted HEI's last summer to discuss the use of the Talent Pool. Every HEI was promoting it, at cohort meetings, by letter or on notice boards.

In January 2008 the SHA Talent Pool Lead also undertook an e-mail audit of new graduates who registered on the Pool, in all 533 registrants were e-mailed. Unfortunately no one responded to this audit and so it was followed up by telephone calls to the registrants most of whom had not found the Talent Pool to be helpful in gaining employment.

An evaluation of a Non Medical Graduate preceptorship pilot project in six Mental Health Trusts also included the Talent Pool. Although lots of promotional work had been undertaken on the Talent Pool it was not actively used by these Trusts. Various reasons were given for this:

- Alternative arrangements had been made to recruit directly from cohorts identified with local universities.
- Despite all the promotion, there was a lack of awareness by Trusts of the Talent Pool and its parameters.
- Time constraints

**Recommendation 2:** *SHAs to work with each individual employer in their area, including Foundation Trusts, to try to determine the numbers of new qualifiers appointed in 2006 and to ascertain plans for employing new qualifiers in 2007.*

The SHA requested information from Trusts on the numbers of new non medical graduates that had been employed, Twenty two, out of thirty five Trusts, responded. Up to 30 September 2007, 653 new graduates had been employed which equated to 470.6 full time staff. However by 30 September 2007, 1770 health professional students had graduated across the region,

with a further 914 expected to graduate by March 2008, making a total of 2,684.

In March 2008 the SHA requested information again on the numbers of new graduates who had been employed in 2007 / 2008. Out of thirty five Trusts, twenty two returns were received (with those twenty two Trusts employing around two thirds of the Yorkshire and the Humber NHS workforce.) These returns indicated that 1,057 (855 Full Time Equivalent) newly qualified staff were employed during the year.

**Recommendation 3:** *Using this data, SHAs to develop appropriate mechanisms for bringing employers together across all sectors and the RDAs in processes to facilitate employment of newly qualified healthcare professionals, based on the principle of employers fairly sharing out the responsibility of ensuring that newly qualified health care professionals have access to their first job.*

The SHA formulated an Operational Action Team to take this work forward on a pragmatic basis. Membership included Trusts, HEI's , Human Resource Directors (HRD's) , AHP's, Social Care Directors and the private sector. The Operational Action Team met in June 2007. At the end of the meeting people wanted to be able to share good practice and to problem solve. It was decided that this could be done through existing networks and on a virtual basis, which is what happened following the June meeting.

**Recommendation 4:** *SHAs to lead on a partnership approach across the sectors to audit the staffing requirements to aid demand forecasting, ensuring that commissioners endorse these forecasts.*

This work is undertaken by the workforce planning team at the SHA. Future demand is being captured through the Learning Development Agreement. PCT's have also been asked to undertake a risk assessment with regard to workforce plans.

Workshops have taken place across the region on workforce planning, to support Employers.

**Recommendation 5:** *SHAs to work in partnership with the trade unions to ensure that the delivery of the recommendations in this action plan is discussed at the earliest opportunity within the new social partnership forums at a regional level.*

As mentioned previously the NMGR Steering Group was a reference group for Trade Unions. The Steering Group's role was to oversee the NMGR work and it provided an opportunity to share and problem solve.

**Recommendation 6:** *East of England SHA to undertake a feasibility study to maximise employment opportunities for newly qualified healthcare*

*professionals. One of the work streams of the study will include assessing the feasibility of an employment guarantee scheme for newly qualified healthcare professionals.*

Work from the East of England was shared at the NMGR Steering Group.

**Recommendation 7:** *SHAs to co-ordinate the mapping of workforce capacity and implementation plans in their area, to assess what may be needed for delivery of the 18 week target.*

A scoping exercise was undertaken across the region. Please refer to Appendix 1

### **The NMGR Steering Group Action Plan**

Prior to the Social Partnership Forum action plan (described above) the NMGR Steering Group had established an action plan, this included:

- 1. Mechanisms for capturing accurate data on vacancies and graduate output, making recommendations on how these could be improved.*

Work is ongoing at both national and regional level with regard to ascertaining accurate information on vacancies. The annual survey which monitors vacancies every three months is used. Also the Department of Health are looking at using NHS jobs and also the Electronic Staff Record with regard to vacancies.

Work is ongoing at regional level with regard to accuracy of graduate output.

- 2. Identifying good practice and disseminating this across the region.*

Two Non Medical Graduate Recruitment bulletins were produced and shared both regionally and nationally. These bulletins were sent to Deans, other HEI colleagues, Trusts, Social Care, AHP's, the Independent sector and to The Chief Nursing Officers group and to the SHA AHP Leads group.

Work from Yorkshire and the Humber also featured in the national AHP bulletin produced by the Department of Health, Frontline (a national Physiotherapy publication) and the Nursing Times.

The Programme Manager also shared examples of good practice with the Chief Executive of the NHS. Work across Yorkshire and the Humber was also discussed at the national Physiotherapy Managers meeting, at a Leadership celebration event in Calderdale and Huddersfield, at the Yorkshire and the Humber AHP Forum (which includes colleagues from

Social Care), at the Yorkshire and the Humber Directors of Nursing meeting, and at the Employers Organisation meetings.

3. *To oversee the implementation of the Talent Pool.*

Please refer to recommendation 1 of the Social Partnership Forum action plan above.

4. *To identify the levels of career advice, information and guidance healthcare students receive whilst at University.*

A stocktake of activity, including focus groups at HEI's with Students and interviews with Lecturers, was undertaken from Autumn 2006 to Spring 2007 ( Appendix 2) Information gathered showed that a better understanding was required with regard to employment outside the NHS, and also the NHS reform agenda.

The SHA therefore employed an Advisor to formulate and deliver a programme of help and advice for undergraduates and University staff on how to apply for posts in the NHS, and other health and social care sectors, and sessions also included the NHS reform agenda. The sessions were delivered to students and staff or a mixture of both in Summer 2007. The sessions received a mixed response. This varied from people being appreciative of the sessions, to severe frustration with the employment situation. However most people were pleased to have had the interaction with the SHA and to have their concerns acknowledged.

5. *To identify the extent to which healthcare students have access to information on the range of job opportunities in health and social care, including the independent and voluntary sectors.*

As previously mentioned the above sessions included advice on how to search and apply for jobs outside the NHS. The Programme Manager also contacted fifty two Independent Sector Providers to explore the possibility of employment for non medical graduates. These Providers ranged from small organisations to larger organisations, i.e. BUPA and Nuffield. Nine Independent Sector Providers expressed an interest in employing non medical graduates. Information on vacancies, including job descriptions and person specifications were shared with undergraduates through HEI colleagues and information was also shared through the Talent Pool.

A case study demonstrating work in different sectors can be found in Appendix 3.

6. *To explore the perceptions and experiences that new graduates are having in relation to securing employment.*

Again please refer to Appendix 2. The focus groups explored the undergraduates experiences and perceptions. The results of the focus groups revealed students and graduates to be extremely despondent, feeling cheated (promised jobs would be no problem), unvalued and ignored. There was anger that the situation had developed and at the lack of opportunity. The barriers that existed preventing them applying for many jobs exacerbated the anger.

Examples of these barriers were;-

- Ring fenced jobs for internal staff only
- Requiring experience
- NHS jobs require PIN number to process the applications

Students talked openly about the lack of information and dismissive comments of some of the employers.

*7. To secure a high level of stakeholder engagement in finding solutions.*

This has been achieved through the NMGR Steering Group and the various networks across the region.

## **Further progress to date**

### **1 Proposals Funded by the SHA**

The SHA made £600,000 available to support new healthcare graduates into employment. Initiatives that were approved were featured in the two Non Medical Graduate bulletins, along with other initiatives that Trusts funded themselves.

Of the £600,000, £391,229 has been spent (Appendix 4 ).

Trusts that received SHA funding were asked to do evaluations. The ones that have been received are listed below:

#### **Mental Health Services**

Mental Health and Learning Disability Trusts / Care Trusts worked collaboratively across Yorkshire and the Humber, with regard to the future employment of Mental Health and Learning Disability graduates. A model of preceptorship was agreed and was applied to Nurses and AHP's across the six Trusts.

## **The Preceptorship Model**

Each Trust / Care Trust agreed to recruit an amount of graduates from the total pool and provide them with a Learning Contract. The Learning Contract was to ensure that these graduates fulfilled the preceptorship requirements of professional bodies and therefore maximised their opportunities to secure employment.

The preceptorship model was about ensuring that all graduates received the following from the designated Trust:

- 2 day induction / mandatory training course
- A preceptorship workbook
- An identified supervisor within the Trust
- A number of shifts in practice (depending on availability) paid at Agenda for Change band 5.
- Pre employment checks e.g. Occupational health screening, CBR etc
- Exposure to a range of settings to support the shift from student to staff nurse / basic grade AHP.
- Access to continuous professional development opportunities / modules from local Universities

The preceptorship model was designed to work in tandem with the Yorkshire and Humber Practice Learner Facilitator strategy in order to maximise and support learning opportunities.

## **Summary of the evaluation**

The full final evaluation is in Appendix 5.

The following Trusts participated in the pilot scheme:

- Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust (RDaSH).
- Leeds Partnerships Foundation Trust (LPFT).
- South West Yorkshire Mental Health Trust (SWYMHT).
- Bradford District Care Trust (BDCT).
- Sheffield Care Trust (SCT).
- Humber Mental Health Trust (HMHT).

The pilot was evaluated by Professor Gordon Grant and Helen Oldknow. Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust (RDaSH) co-coordinated the evaluation.

The objectives of the evaluation were to assess:

- How the preceptorship model was implemented in each Trust

- What variations to the model would be necessary, taking into account local conditions
- How the preceptorship model was experienced by stakeholders within and between participating Trusts
- Connectivity and workforce issues.

The evaluation was originally due to take place over a six month period, but due to some difficulties with recruitment and the phased implementation of preceptorship arrangements the evaluation was extended beyond March 2008.

The preceptorship model was approved by the SHA as a way of helping new Non Medical Graduates into employment. However RDASH, Bradford, Leeds and SWYMHT all encountered high levels of attrition from initial expressions of interest to people remaining in post. In Bradford 7 of those who accepted preceptee posts managed to secure employment internally or externally. In RDASH the level of acceptances was low, apparently only 3 out of 10. In Leeds and SWYMHT there were only a handful of people who presented themselves for interview.

It is difficult to explain these outcomes. It could be that a part-time, fixed-term post is not as attractive as a full-time post, and that this prompts individuals to look further afield outside the region, or that they consider other career options.

The table below demonstrates preceptorship recruitment and retention figures.

### Preceptorship recruitment and retention figures

Non Medical Graduate Preceptorship Pilot Trust Recruitment Figures						
Nurses	RDASH	Bradford	Sheffield	Humber	Leeds	SWYMHT
Expressed Interest	29	18-20	24	16		5
Interviewed	10	10	15	16	3	2
Accepted Post	3	8	11	16	3	1
Start date	Dec 07	Oct 07	Oct 07			Jan 08
Still in post	1	1	10	16	2	1
Gained employment	1 internal 1 external	5 internal 2 external				1 internal (pt)
<b>AHPs</b>						
Expressed Interest	54					
Interviewed	6					
Accepted Post	3 Physios 1 O/T					
Still in post	3 Physios					
Gained employment	1 OT					
Variations to contracts	6 Month fixed term 18.5 hrs	6 Month fixed term 18.5 hrs	6 Month fixed term	Full time substantive posts	Considering 3mth F/T Fixed term contract	One scheme on 10 hr contract, secured 27.5

	(1 nursing post from Salford)			(4 posts from Manchester)		hr substantive post in Trust
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### Conclusions from the evaluation

The findings based on interviews with providers suggest support for the view that preceptorship as implemented in this pilot is:

- A necessary response to a challenging workforce problem where the available evidence suggested an over supply of graduates
- Useful in helping to retain a qualified, fit for practice and accountable workforce, even if the numbers are few
- More likely to work if variations in the practice model can be accommodated to take account of local workforce needs
- Likely to work even without use of the talent pool
- Almost impossible to evaluate in quantitative terms because of difficulties associated with tracking graduates.

As a result of a combination of circumstances associated with timing, organisation and workforce planning itself, implementation challenges were not easy to resolve, especially:

- Predicting take-up at almost every stage of the process from gauging expressions of interest, interview attendances, post acceptances and starting – this was demonstrated graphically with AHPs at one Trust:
- Communications between graduates and NHS employers
- Making a part-time commitment to preceptorship viable for everyone
- Implementing the pilot under pressure not to lose graduates from the cohort whilst still having to educate or convince NHS colleagues about how the pilot would work
- Getting people to buy into the talent pool
- The idea that the scheme was subsidising the private sector.

Based on interviews with the graduates the following findings were most in evidence:

- The main reason graduates became involved in the scheme was to gain employment.
- Direct and indirect evidence showed that the pilot was serving its primary purpose of enabling graduates to secure employment;
- Additionally the pilot enabled graduates to (i) confirm their vocational interests, (ii) maintain hope about securing a permanent post, (iii) build confidence in their practice skills, and (iv) experience being part of a team;
- The experience of university study days did not evaluate well, apparently for reasons to do with the failure of communication between the university and Trusts involved;
- However all had access to CPD and this was received well;

- Whilst helpful to a minority, the part-time nature of the scheme did not suit most;
- Graduates were unaware of the talent pool;
- The pilot preceptorship scheme was viewed in a positive light, and almost everyone would have recommended it to their peers.
- Roles and responsibilities of preceptors were not always as clear as they could be;
- There was variability in the availability, form and effectiveness of preceptorship packs.

On two levels – securing of substantive posts and subjective appraisal of the initiative - the pilot can be judged as a success. Of the 38 nursing graduates involved, 28 secured substantive posts. Given the prevailing concerns about job shortages nationally and regionally this is very encouraging, and suggests that preceptorship has a key enabling role to play in helping newly qualified graduates to secure employment. Of course there is no way of knowing whether individuals would have enjoyed the same level of success in securing employment without the experience of preceptorship. The second main criterion for judging the success of the pilot was how the experience was evaluated. Encouragingly, all stakeholder groups – graduates, mentors and Trust leads – assessed the pilot in very positive terms. Given the short timeframe for planning the pilot in response to a reading of the rapidly changing (deteriorating) employment opportunities for nurses and AHPs in the latter part of 2007, this can only be judged as a pleasing outcome.

Overall the findings lend support to what Gibbons (2007) reported, notably that preceptorship supported consolidated learning, enabling graduates to practise their skills, whilst at the same time enhancing knowledge of local policies and procedures, and more generally helping individuals to feel more confident about being fit for professional practice.

Inevitably there were implementation challenges – short timescales led to a certain amount of guesswork about take-up and Trusts had to work out local recruitment strategies as things moved along; building a business case was not straightforward so the securing of matched funding from Trusts was not unproblematic; and ‘reading the local labour market’ proved to be as much an art as a science. Indeed there was some early revising of assumptions about whether or not there was a crisis in helping new graduates to find and retain substantive posts.

There were mixed views about the value of the pilot as a part-time undertaking for the graduates. It suited some more than others, due largely to personal circumstances.

Overall the findings underline the value of preceptorship, and arguably suggest a case for it to be a permanent part of standard practice rather than something that is optional. Funding Trusts to pay for preceptorship is believed to be under discussion as part of the NHS Next Stage Review.

The SHA approved £51,669 for the scheme:

Rotherham, Doncaster and South Humber £21,000  
Humber Mental Health £30,000  
South West Yorkshire £669,00.

## **North East Yorkshire and Northern Lincolnshire evaluations**

### **Harrogate NHS Foundation Trust**

Harrogate NHS Foundation Trust ran a series of evening skills workshops for physiotherapy graduates to enable them to keep their skills up to date. The sessions lasted approximately two hours and were well attended. A couple of graduates contacted the Trust to say thank you as they had secured physiotherapy posts and felt that they would not have been offered employment if they had not been able to demonstrate that they had been able to keep their skills up to date.

Also over the last year some physiotherapy graduates worked in the Trust in non physiotherapy roles, e.g. as healthcare assistants and also doing clerical work. This meant that these staff became known to the physiotherapy service and were able to apply for physiotherapy posts when they were advertised to internal staff only (one person was employed to a physiotherapy post in this way). Some of these staff also attended physiotherapy in service training.

Harrogate NHS Foundation Trust also employed graduates into Assistant posts or Assistant Practitioner posts.

### **Evaluation**

Between 6 – 18 graduates were booked on each session, with 8 – 14 attending. However since the SHA made the sessions free for the new graduates the non-attendance rates increased significantly so the Trust had to reintroduce a deposit for each session which was refundable if they turned up or cancelled.

Three physiotherapists who attended the sessions gained employment at the Trust, one permanent, full time and two on a temporary basis, one being full time and the other part time. The Physiotherapy Manager is investigating if the others have gained employment elsewhere.

The Trust wanted to establish a clinical attachment scheme, but have not had capacity to do so. However they feel that the Clinical Professional Development evening sessions were a useful recruitment tool.

The SHA approved £2,250 for the scheme.

## **Scarborough and North East Yorkshire Trust.**

The Trust accepted nine Nurses onto the Nurse Bank and offered preceptorship. Three Midwives were also accepted onto the Nurse Bank and offered preceptorship.

### **Evaluation**

All the nurses were successful in gaining substantive employment with the Trust. The Assistant Chief Nurse felt that the scheme helped them to employ newly qualified nurses that they would otherwise not have been able to take. She felt that whilst the finance they received from the SHA for each nurse was relatively small, it made a difference and it meant that these professionals have not been lost to the healthcare workforce.

The SHA approved £22,000 for the scheme.

## **East Riding of Yorkshire PCT**

The Trust ran two schemes for physiotherapy graduates; evening training sessions with experienced clinicians and direct employment onto the physiotherapy bank.

### **Evening training sessions.**

The Trust ran nine sessions, led by experienced physiotherapists. Each session lasted two hours. The average attendance was eight. There was positive feedback from both clinicians and delegates. The delegates were very thankful that an interest had been taken in the employment situation of newly qualified physiotherapy graduates.

### **Direct employment of Band 5 Physiotherapists onto the bank.**

Five graduate physiotherapists were taken onto the bank. Three gained employment with the Trust, another gained employment at the acute Trust in Hull and the final physiotherapist is still on the bank (due to personal reasons that person was not seeking permanent employment at that time).

Prior to the scheme the Trust had a small band 5 physiotherapy rotation, however being able to employ band 5 physiotherapists onto the bank was an opportunity to demonstrate to physiotherapy managers and senior physiotherapists that new graduates could be supported and developed in community settings. Also through skill mix and new funding the Trust was able to expand the band 5 rotations.

The Trust continues to offer band 5 posts and currently have another two within the Trust.

The Trust feels that the scheme has been good for the new graduates. However from the Trusts perspective it was time consuming, for little reward, as initially ten graduates were interviewed but by the time Human Resource procedures had been adhered to five out of the ten had gained permanent employment elsewhere.

The SHA approved £15,000 for the scheme.

## **South Yorkshire Evaluations**

### **The University of Sheffield School of Nursing and Midwifery**

The University of Sheffield School of Nursing and Midwifery formulated a programme for new nurse graduates to help them with the transition from secondary to primary care.

The programme was developed by the Centre for Health and Social Care Studies and Service Development to facilitate health care workers to make a successful transition between the secondary and primary care sectors. The purpose of the programme was to support participants to adapt their existing knowledge, skills and professional behaviours in order to engage effectively and competently within and across the organisational and professional boundaries of the two sectors.

The programme is about offering a flexible, supported framework within which participants can undertake supervised engagement within care provider organisations. Through this participants gain experience and insights relevant to maintaining the currency of their prior learning and competence and their capacity for future employment.

#### **Evaluation**

The scheme is due to be launched in Rotherham in May, after some delays with Trusts, so the evaluation has not yet taken place. The top up support is being evaluated.

The SHA approved £40,000 for the scheme.

## **West Yorkshire Evaluations**

### **Mid Yorkshire Hospitals NHS Trust**

As part of the Locality Plan the Mid Yorkshire Hospitals NHS Trust undertook an options appraisal to decide on an appropriate model to help new Nurses into employment.

The Trust decided to use finance from the SHA to fund some Continuing Professional Development (CPD) for new nurse graduates who had qualified

in the last 12 months. As part of their CPD the Trust are training them on a one day workshop to become 'Student Buddies'. This role is one of support not mentorship and is aimed at supporting students with day to day practical issues, e.g. local induction; introduction to the Multi Disciplinary Team etc. This day is informed by the feedback themes we have from some students on our online evaluation e.g. lack of local induction, lack of support on placements.

The Trust is using a training company to deliver the training. The outcomes of the day will be:

- To produce a role profile for the 'Student Buddy'
- To produce a 'Student Charter'
- To understand the importance of being a team member and it's impact upon patient care
- To identify further CPD developments for the graduate Buddies

### Evaluation

Evaluation will take place on the day and then in six months time by involving both Student Buddies and students working in the areas that have a Student Buddy and also students who work in areas which do not have the system in place. The Trust will also evaluate the scheme on an ongoing basis using the online evaluation tool.

The SHA has approved £20,000 for the scheme.

## **Airedale NHS Trust**

Airedale NHS Trust has employed a range of strategies in order to maximise employment opportunities for newly qualified healthcare professionals.

### Midwifery Graduate Employees

The proposal put forward by Maternity Services was in two parts. Firstly there was a commitment to employ four graduate midwives on 0.5 WTE contracts. This meant that hours could be worked flexibly when needed, and meant that the Trust could offer double the number of posts which were actually available with the possibility of additional bank shifts for these midwives.

The second part of the proposal was for the Trust to appoint a Clinical Educator on a 0.2 WTE, on a twelve months secondment, who commenced on 4 February. Prior to this newly qualified midwives were each given

- A 3 months rotational programme of induction within each area of Antenatal, Postnatal and Delivery suite
- A Trust Preceptor pack
- An Airedale NHS Trust Induction Package
- A preceptor within their own clinical area

It was felt that the majority of the Knowledge and Skills Framework (KSF) competencies in relation to progression to Band 6 could be achieved by these midwives in the time given and in order to support this, a dedicated Clinical Midwife Educator has been employed to work with the new graduates and other new staff on the Unit.

Since the appointment of the Clinical Educator each newly qualified midwife has been interviewed to identify any problems or requirements with teaching/training needs. The rotational programme of induction continues with added support from both Preceptors and the Clinical Educator. However, as a result of the scheme it has been identified that a four month rotation to each area would be more beneficial to allow continuity within each area and with each preceptor. A clinical induction day is being developed specifically for new graduate midwives. Further adjustments need to be made to the preceptor package to incorporate teaching of medical devices and this is currently being worked on.

The Trust feels that productivity has improved as a result of the scheme. Also identifying and acting upon the learning and teaching needs of newly qualified midwives, has led to more clinically competent and efficient practitioners.

Newly qualified midwives.

As stated four 0.5 WTE newly qualified midwives equivalent were initially employed on temporary contracts in August 2007. Since the initial appointments, two have gained full time permanent contracts, one has a WTE temporary contract and the fourth has a 0.56 WTE temporary contract. It is intended that permanent hours will be given when available.

Funding from the SHA scheme acted as a springboard for further investment within the Trust with, a further two newly qualified Midwives (who previously had not been in employment) being appointed in April 2008. Also a temporary 0.8 WTE contract has been used to cover maternity leave.

The SHA approved £8,000 for the scheme.

Child Branch Nursing

Three newly qualified child branch nurses were recruited onto the Children's Ward within the Trust. Two of the nurses were guaranteed 3 month full-time contracts, whilst the other nurse was employed on the TNR Bank with a guarantee of 12.5 hours per week (with a possibility of 37.5 hours depending upon staffing levels). These nurses had all their mandatory checks and processes completed and attended the Trust's mandatory training sessions as well as a clinical induction and the Trust's rolling programme of clinical skills and professional practice workshops. The nurses were supernumerary for a two week period upon taking up appointment and have received preceptorship from experienced qualified nurses. All three nurses continue to be employed by the Trust.

The SHA approved £3,000 for the scheme.

### Physiotherapy

The physiotherapy department were able to support one newly qualified physiotherapist within the Acute Care of the Elderly Unit, working on a full time basis and employed on a 3-6 month contract. Six newly qualified physiotherapists were recruited onto a newly formed physiotherapy pool, on bank contracts. All these newly qualified physiotherapists had their mandatory checks and processes completed and attended the Trust's mandatory training sessions. All the newly qualified graduates were given a period of one weeks orientation and induction to the physiotherapy department and were invited to take part in regular in-service training sessions. From these original newly qualified graduates, one was recruited on a six month fixed term contract, four on three month fixed term contracts, all within the Trust, with the remaining two having been successful in gaining employment elsewhere. It is felt that the fact that they had gained a period of employment and experience within the Trust significantly enhanced their employability.

It was felt that this strategy has been so successful that a further cohort of newly qualified physiotherapists are being recruited under the same initial terms.

The SHA approved £8,000.

### Adult Branch Nursing

It was the Trust's original intention to employ as many newly qualified nurses as they could support, initially on 3-6 month contracts, in order to provide these nurses with preceptorship and a stable and supportive workplace experience. To date the Trust has employed a significant number of newly qualified nurses onto permanent contracts, from a range of higher education institutions and into a variety of workplace settings. These nurses had all their mandatory checks and processes completed and attended the Trust's mandatory training sessions as well as a clinical induction and the Trust's rolling programme of clinical skills and professional practice workshops.

The Trust continues to recruit newly qualified nurses and is looking forward to supporting many more from cohorts leaving HEIs in March 2008.

The SHA approved £9,000 for the scheme.

### **Bradford Teaching Hospitals NHS Foundation Trust.**

Bradford Teaching Hospitals NHS Foundation Trust in partnership with Bradford University implemented a Temporary Nurse Register (TNR) to provide employment for nurses. The first scheme commenced in March 2005

and has subsequently been repeated. The evaluation of the scheme is in Appendix 6.

#### Midwifery Initiatives.

Funding from the SHA initially allowed the Trust to appoint a part time Practise Educator/Support Midwife to assist with the recruitment and retention of new graduate midwives into maternity services in Bradford.

The Practise Educator/Support Midwife commenced in the role on 4 February 2008. Meetings were arranged with all the newly appointed graduate midwives (who commenced work in the Trust in November 2007) to discover what strategies and processes would help them during their first year and what would have been helpful during their recruitment. Findings from the meetings are described below.

#### Newly qualified Midwives

Fourteen new graduates were interviewed and out of these, twelve were employable. Initially the Trust was able to offer eight part time posts, and at the start of 2008 another four were offered some hours, and began working in maternity services.

From these twelve new appointments, one midwife subsequently left (she also had a nursing qualification and felt she would be happier in a nursing post). The remaining eleven are all still in post.

The group felt that the following was needed during recruitment, and the lead up to graduation:

- The need for improved communication/liaison with the University about forthcoming vacancies
- The need for communication/contact with a Supervisor of Midwives
- Help with interview preparation to look particularly at the employer/Trust perspective, to complement advice provided by the University
- To have the opportunity to meet with midwives to discuss range of practise issues
- To attend regular meetings held within the maternity services, e.g. Clinical Governance and Perinatal Mortality meetings
- To attend the multidisciplinary skills training sessions in the maternity unit.

During the first year in employment:

- To have dedicated time to complete the Trust Induction

- To meet on a regular basis with Supervisor of Midwives
- To receive more information about progressing from Band 5 to Band 6
- To attend a skills session for only newly qualified midwives
- To receive a consistent approach to preceptorship across the maternity services
- to get together for reflection/discussion on the transition to qualified practitioner

The Trust is now about to commence recruitment of this year's new graduates, and are implementing some of these approaches, as described below:

- A dedicated contact person within the Division of Midwifery, to advertise vacancies for midwives on Blackboard
- Students in year 3 of the programme are allocated a Supervisor of Midwives and the supervisory team are invited to have input on the degree where relevant
- Seminars to prepare for interviews are planned (first one to be held on 14 April)
- Three seminars per month for student midwives are now being held. These are facilitated by the Practise Educator Midwife with the support and input of clinical specialist midwives. The seminars are advertised throughout the unit and on Blackboard.
- Details of the regular meetings within the unit are now being forwarded to the University and promoted on Blackboard. A small number of students have been attending.
- The dates for multiprofessional skills sessions and other mandatory days have been advertised on Blackboard and students have been booking places and attending.
- One of the Supervisors of Midwives has begun running a newly qualified midwives forum once every quarter. The purpose of the sessions is to discuss practise issues, reflect on experiences, and to support each other.

Further initiatives are now planned:-

- Following recruitment from the next group of newly qualified midwives, a dedicated skills session will be organised as part of the induction process, to be facilitated by the Practise Educator Midwife and the Professional Development Midwife.
- The preceptor package will be redeveloped to ensure consistency across the service, with local information for specific areas. This will incorporate information on moving from Band 5 to Band 6, and what a

newly qualified midwife needs to achieve in relation to the KSF. This work is ongoing across the Trust, and the Practise Educator Midwife is involved in this development work.

- A new system for supervisory support is being developed by the Supervisors of Midwives.
- The Practise Educator Midwife will have the opportunity to meet with the newly qualified midwives in the clinical area, and will work alongside them in order to offer clinical support, to help to develop personal development plans which can then be incorporated into the appraisal process. This should also aid progression across the Bands for all newly qualified midwives regardless of where they are working.

#### Current situation

The Trust has 5 Whole Time Equivalent (WTE) posts to recruit to in order to maintain the establishment and be able to offer a number of part time posts. By September the Trust expects to have more posts. The graduate group from 2007 have all been offered extra hours to bring them up to, or closer to, full time if they should wish.

The SHA approved £18,000 for the scheme.

#### **Leeds Teaching Hospitals Trust**

A Clinical Educator to support new graduates midwives has been in post since July 2007. The post holder has been actively engaged in the recruitment, and retention of the newly appointed staff. This has led to new graduates feeling empowered and confident, and able to progress through the knowledge and skills frame-work to competent Band 6 midwives.

Newly qualified midwives.

Twenty one new graduates were appointed in May 2007; currently sixteen are still in post. The majority of these midwives are full time. Of the appointed staff three left for geographical reasons and two for a change of career.

Thirteen new graduates were appointed January and February 2008. Out of these eleven are full time and two are part time.

There is currently a recruitment scheduled for an additional fifteen full time midwives due to the uplift in the midwifery establishment.

Overall thirty four new graduate midwives have been appointed in full or part time posts.

## Productivity

Productivity has increased as all the new midwives are focused and have competencies that they need to achieve. This has enabled the recruits to obtain the relevant experience in various areas in order to have all round midwifery experience. The first intakes of midwives have nearly completed a year and have grown in confidence and experience which can be clearly seen in the clinical areas. If there has been any issue within the areas the clinical educator has worked closely with the midwife and the staff to rectify and move forward through support, facilitation and reflection.

## Future Plans

The Trust intends to once again recruit from the local talent pool, to support recruitment for the midwifery students from the March 2008 programme. The Clinical Educator led the recruitment for the last intake of graduates, ensuring that they were supported from the beginning. This has meant that the Trust has a dynamic skill mix and this supports workforce planning in ensuring that the progression to Band 6 is achieved successfully. Because the Clinical Educator is in post the Trust can maximise the potential of new graduates as there is a support framework in place.

The Trust feel that the scheme has been successful, due to:

- The development of competencies. Each midwife has a preceptorship package which is carried through all areas of midwifery care over a period of eighteen months. Competencies have to be achieved and signed off before moving on to next area. This involves work with the preceptor with regular documented meetings so problems can be identified early if competencies are not going to be achieved. The Clinical Educator is able to work clinically with the midwife if need arises. The competencies definitely keep midwives and preceptors focused which enables skills to be developed.
- Action learning sets. These have proved successful. The midwives find these beneficial to their learning and to the adjustments that have to be made to being a newly qualified midwife. There is also the opportunity to focus on the individual needs of the new midwives.
- The midwives state it is beneficial to be able to liaise with the Clinical Educator prior to and when commencing employment with any queries they may have. They were also able to contact the Clinical Educator direct via mobile phone or e. mail. The Clinical Educator would respond quickly to any queries and could also ensure that the induction programme was robust ensuring all relevant mandatory study days were arranged and attended in accordance with Clinical Negligence Scheme for Trusts requirements.

- A recent LSA audit undertaken in January 2008 highlighted the importance and value of the Clinical Educator. In the good practice points it stated that ‘ The newly appointed practice development midwife is key in the newly appointed midwives feeling supported during their rotation around the unit gaining experience in all aspects of hospital based midwifery following qualification’(Leeds Teaching Hospital Trust Interim Audit Report January 2008). This was further supported by a student supervisor taking the ideas from the preceptorship programme back to her unit.
- The Clinical Educator has been able to organise specific study days to compliment the clinical areas, for example a recent initiative would be facilitating antenatal education sessions to help promote active birth involving an experienced delivery suite co-ordinator and active birth teacher. This study day helped the new starters to address styles of teaching and how to deliver the antenatal programme to work alongside the practical aspect in order to achieve the antenatal clinic competency relating to antenatal education.
- The Clinical Educator has linked with the midwifery education group to feed back on issues around training and themes on expectations of the new graduates.
- The Clinical Educator closely links with the Head of Midwifery, supervisors and service matrons to support effectiveness of the preceptorship programme.

Things that could have been done differently.

The Trust feels that it would have been useful to appoint the newly qualified midwives to full time posts at the beginning of the scheme, in order to consolidate practice. However there is also recognition that it is good to be able to offer the opportunity for part time working if that is desired. In the next recruitment campaign, vacancies will be offered as full and part time positions.

It would have been helpful for existing staff to have more preparation in supporting new graduates.

It would be better to have more of a focus on community and integrated team working.

It would be helpful to have more of a focus on the ongoing audit of practice placements, however this is being developed.

The SHA approved £39,812 for the scheme.

## **2 Graduates Yorkshire**

The SHA has commissioned Graduates Yorkshire, an online recruitment career service, and also a Social Enterprise to help with recruitment across the region.

Graduates Yorkshire aim to deliver a definitive recruitment service to graduates and employers in Yorkshire in order to contribute to the success of the area. Retaining graduates is seen as a key part of the regional economic strategy.

The key feature of Graduates Yorkshire is that it is the only dedicated job site for Yorkshire and the Humber. Over 13,000 graduates are registered on the site with around 1400 – 1500 being healthcare graduates. Students find out about Graduates Yorkshire from HEI careers services, and tend to register in their final year.

The SHA have commissioned Graduates Yorkshire to undertake recruitment work until December 2009. It is envisaged that the recruitment microsite that Graduate Yorkshire are developing will compliment the role of the Talent Pool and therefore give new healthcare graduates further opportunity to find out about jobs in the region.

## **3 Skills for Care**

The Allied Health Professions Lead is a member of the Skills for Care New Type of Worker Advisory Group. The group is focussing on innovative work redesign in Social Care. The purpose of the group is to establish effective partnerships with Social Care and Health employers, who are involved in workforce development and planning, and the commissioning of new roles across the region. A national report is due out soon to draw together key themes and learning from the twenty eight national pilot sites.

It is likely that one of the priorities for the Advisory Group in 2008 / 09 will be further integration of the health and social care workforce. This may present further opportunities for new graduates who are still seeking employment.

## **4 Future work for the SHA regarding Non Medical Graduate Recruitment**

From local intelligence and information received from Trusts it appears that the graduate employment situation is getting better for most professions. However physiotherapy still remains a “hot spot”. The Chartered Society of Physiotherapists state that as of May 2008, 62% of graduates from 2006 / 2007 have permanent jobs, a further 17% have short term contracts or are doing bank work. However this still leaves 372 physiotherapists looking for work, with a further 2250 due to graduate in 2008 / 2009. Across Yorkshire

and the Humber it is anticipated that 179 physiotherapists will graduate in 2008 / 2009.

The SHA AHP Lead for Yorkshire and the Humber will lead on NMGR issues for AHP's and has set up a regional steering group to look at preceptorship models. The rationale behind this scheme is to enable more newly qualified band 5 AHP's (with an emphasis on physiotherapists) to work in the community. This should not only improve the employment situation for these newly qualified staff but should also fulfil the requirement of the Next Stage Review.

As previously stated the SHA will continue to work with Graduates Yorkshire on recruitment for newly qualified healthcare professionals.

Work will be launched by the AHP Lead on Modernising AHP Careers, and as part of this work stream NMGR will be taken into account, where applicable.

The Associate Director of Human Resources will continue to attend the regional Social Partnership Forum meetings and will therefore feedback on NMGR issues.

**Elizabeth Foley**

**Non Medical Graduate Recruitment Programme Manager and Allied Health Professions Lead.**

## Appendices

Appendix 1 - Mapping of workforce capacity and implementation plans across Yorkshire and the Humber, with regard to delivery of the 18 week target	28 – 29
Appendix 2 - Report on Graduate Employment – Managing the Employment issues 2007 Securing and Retaining Staff for Health and Social Care Gillian Gibbons 30/03/07	30 – 62
Appendix 1a – University Contacts	63 – 66
Appendix 2a - Organisational Contacts	66 - 73
Appendix 3 - Benefits Realisation	74 – 77
Appendix 4 – Graduate Focus Group - Questions to Consider	78 – 79
Appendix 3a – Case Study	80
Appendix 4a – Graduate Employment Costs	81
Appendix 5 - A Stakeholder Evaluation of a Non-medical Graduate Preceptorship Pilot Project in Six Mental Health Trusts	82 – 113
Appendix 1b – Project Management Group Members	114
Appendix 2b - Aide memoire for interviews with graduates	115
Appendix 3b – Topic Guide for Interviews with Trust Leads	116
Appendix 4b - Band 5 Preceptorship Placements	117 – 118
Appendix 6 - Bradford Teaching Hospitals NHS Foundation Trust. TNR/Preceptorship Scheme Evaluation Report	119 – 121
Appendix 1c - Summary Analysis of the Evaluation of the TNR/Preceptorship Programme - nurses on the schemes perspective	122 – 124
Appendix 2c - Summary Analysis of the Evaluation of the TNR/Preceptorship Programme - manager’s perspective	125 – 127

## **Appendix 1**

### **Mapping of workforce capacity and implementation plans across Yorkshire and the Humber, with regard to delivery of the 18 week target.**

A scoping exercise was undertaken across the region, and based on evidence collected from a questionnaire, and health community visits, four common issues around workforce capacity and capability for achieving and sustaining the 18 week patient pathway identified, three of which related to Allied Health Professionals, as follows.

#### **Radiography (MRI and Ultrasound) Workforce**

There is an inability to recruit radiographers due to a perceived shortage of qualified radiographers.

Some Trusts reported they have not been able to offer training placements to students as they do not have staff capacity to provide supervision and mentor support. This is and will continue to impact on recruitment of qualified radiographers/succession planning. The Yorkshire and the Humber SHA Radiography Forum is looking at how Trusts and education providers could support placements and increase succession planning across the region and, develop new roles to support new ways of working.

Regional plans for the Independent Sector to provide imaging provision was cancelled. However, NHS Trusts' had not planned for the change in service provision and consequently they had insufficient capacity to meet the increased demand.

There are areas of good practice where new and extended roles as part of the 4-tier framework have been developed and these appear to have had a positive impact on the 18 week waits.

New roles in ultrasound are only just being developed and considered at national level by the Department of Health and Royal College.

Radiography is a diagnostic tool and plays a key role in numerous clinical pathways such as cancer, cardiology, diabetes and obstetrics. Consequently, it forms part of the 18 Week pathway. Further development of the 4-tier model locally could have a significant impact on the 18 weeks by increasing capacity, supporting service redesign and pathway development if other research across radiography specialties is to be believed.

#### **Neurophysiology (Peripheral) Workforce**

In stark contrast to other health professions where there is considerable evidence of work done to develop new and extended roles and implement new ways of working across organisational boundaries, there was very little evidence available for this particular group of professions.

The evidence from around the country provides a picture that is reflected within the Y&H region in that there is some evidence of workforce modernisation and pathway redesign taking place for this profession/service. However, there remains a great deal of work to do both at a national and Y&H regional level in order to meet the 18 weeks patient pathway and other national policies such as Care Closer to Home, National Service Frameworks.

Further development of the multi-professional team is required, in particular, the advanced Clinical Physiologist role, to increase capacity both nationally and within the Yorkshire and the Humber region. Trusts should identify their training requirements through their workforce plans in order that the SHA can commission the appropriate type and number of training places.

The Yorkshire and the Humber SHA Education Commissioning Team are working with stakeholders to establish a Neurophysiology Education Commissioning Network to address the above workforce development and planning issues.

Jayne Andrew  
Programme Support Manager  
Yorkshire and the Humber SHA Workforce Directorate

**Appendix 2**

**Report on**

**Graduate Employment –  
Managing the Employment issues 2007**

**Securing and Retaining Staff for Health and Social Care**

**Gillian Gibbons 30/03/07**

## **Contents**

**Constraints**  
**Terms of reference**  
**Introduction and background**  
**Terms of reference duplicated**  
**Constraints**  
**Methodology**  
**Risks**  
**Benefits realisation**  
**Information gathering/Fact finding Visits**  
**Higher Educational Institutions**  
**Graduates and Students**  
**Cohort Numbers**  
**The findings**

**Employers**  
**Part Time Graduates**  
**Tracking of Graduates post graduation**  
**First Destinations**  
**Information on future employment**  
**Job applications and job Bulletins**  
**Jobs**  
**Support and Direction from the Top.**  
**Band 5 posts**  
**Support worker roles.**  
**Benefits of the Support preceptorship period**  
**Bank staff**  
**Geographical relocation**  
**University Staff**  
**Preceptorship**  
**NHS Jobs**  
**Other issues**  
**Sabbaticals**  
**Backfill for Staff released for training**  
**Competition**  
**New areas of work**  
**Social Care**  
**Conclusion**  
**Recommendations**  
    **Key proposals/solutions**  
    **Short Term**  
    **Short to medium term**  
    **National Initiatives**

## **Executive summary**

This report has examined the issues facing the graduates completing nursing, midwifery and physiotherapy programmes and finding employment in 2007. Consultation has taken place with a wide number of stake holders. The responses of these groups to the situation, to some of the proposals that have been suggested both locally and nationally, and areas of innovative work to overcome the problems, have been recorded.

Key recommendations are to retain the graduates in some supported employment with the view that over a period of a few months they will find and be offered, substantive posts at appropriate remuneration and hours.

There are recommendations that can be executed at regional level and others such as Sabbatical leave for staff with a few years experience to work overseas either in countries with a shortage of these disciplines or third world requires a National programme.

This document should be read by SHA, Chief Executives and the DH leads as well as employing managers to make them aware of the possible impending crisis and shortfall in future staffing if systems are not in place to enable current and future graduates find work.

## **Introduction and background**

Over the past 2/3 years there has been increased anecdotal evidence that significant numbers of nursing, midwifery and physiotherapy graduates are failing to secure paid employment in the healthcare labour market on completion of studies.

Nursing was removed from the priority Jobs Risk Register in 2006 with the removal of physiotherapy earlier this year (2007). The issue remains however that graduates from these professions are finding it increasingly difficult to find work of suitable hours (sufficient to allow them to gain the required preceptorship or supervisory practice) and at an appropriate remuneration (Band 5 Agenda for Change).

Graduate unemployment figures vary between Universities and disciplines and it has been difficult to gauge the exact scale of the problem. The transferable skills of these graduates make them very attractive to other industrial sectors and there is a real danger that these graduates will gain employment in an alternative sector and will be lost to the Health care sector permanently.

The lack of employment opportunities for graduates has major implications on long-term workforce plans and financial loss in training time and cost to train, (approximately £37,911 for bursary student to £63,000 for the seconded route).

The media attention in the past few months has identified a need for a more robust means of capturing and monitoring the first the work destinations of graduates. The development of a comprehensive to approach to monitor and anticipate similar problems in nursing, physiotherapy or any other discipline is required. Early intervention may avert a repetition of the current issue. This is a national problem and the Department of Health together with NHS Employers have drawn together key stakeholders to collectively develop means by which the immediate problem can be addressed and future issues anticipated and averted.

SHAs were charged with taking a lead at regional level. NHS Yorkshire and the Humber formed a strategic level task group under the lead of Kath Hinchliff, Head of Education and Commissioning, and it was agreed that a regional audit should be carried out. A project worker was identified and Terms of reference set out for a short piece of work.

For the purpose of this document, undergraduates will be referred to as students.

## **Terms of reference**

1. Outline mechanisms for capturing accurate data on vacancies and Graduate output including recommendations on improvements.
2. Identify areas of good practice and make recommendations for dissemination.
3. Explore the potential for using NHS Employers 'talent pool' for signposting posts and tracking of new graduates.
4. Identify levels of career advice/support for healthcare students whilst in our HEIs including their personal experiences and aspirations.
5. Identify the extent to which healthcare students have access to information on the range of job opportunities in health and social care.
6. Explore new graduates' perceptions on the barriers to securing employment in different geographical locations.
7. Make recommendations for establishment of systems and processes to maintain and manage graduate employment in Yorkshire and the Humber.

## **Constraints**

The time scale for this piece of work has been extremely short starting in January 2007 and completion by mid March 2007. This has resulted in:-

- An opportunist approach to gathering information and Data.
- Benefits from the university perspective had to be gathered on an individual basis (Table 2).
- Disciplines reviewed restricted to nursing, midwifery and physiotherapy
- The author has been able to meet and discuss issues with a limited number of employers.

## **Methodology**

Whenever possible, interviews with University and other key stakeholders has been to a predetermined questionnaire, and a standard time framework, however there were occasions when this was not possible. Opportunity to explore and expand on areas of divergence or special note was taken within the limitations of time available.

- A desk top review of Yorkshire and the Humber information on current nursing midwifery and physiotherapy cohort numbers. Establish the means by which graduates are tracked following graduation.(nursing, midwifery and physiotherapy students only).

- Limited Desk top and internet search of job sites, information available, ease when accessing sites and application methods.
- Consult Universities and gather information on all student numbers for the discipline of physiotherapy and nursing, and midwifery. Discuss current arrangements for supporting graduates to find work. Discuss and identify the University perception of the problem and impact on their work. (Appendix 2a university contacts)
- Hold focus groups with students and graduates to explore their views on the current situation, how they are managing through this difficult period and what support they require. Ask the key beneficiaries, discuss with them the acceptability of any proposals designed to enable them access paid employment.
- Identify areas of innovative practice and visit a sample of organisations, to discuss what has been achieved and how. (Appendix 2b)
- Benefits (the softer outcomes of any project work) were identified firstly with the SHA Task Group and then with the universities.
- Contact NHS and partner organisations to ascertain the broader knowledge and understanding of the issues.

## **Risks**

Initial risks identified at the start of the project were: -

- Raise unrealistic expectations of University staff and undergraduates that jobs will be found in the NHS in time for Graduation.
- Possible costs to the recommendations and any identified good practice.
- Accuracy of information gathered as mechanisms currently in place not sufficiently robust.

Should the project develop other risks may be identified and a risk log should be started so that as events and circumstances change the project can alter accordingly.

## **Benefits realisation**

At the outset of this piece of work it was agreed that a process of attaching numerical value to the perceived benefits would aid decision-making.

A tool more usually applied to projects in the construction industry, which will readily lend itself to this project, is to be used. This Tool is known as 'Simple

Multi Attribute Rating Technique Value Engineering' (SMART). (Appendix 2c).

The key benefits identified by the SHA task group were: -

- Improve Employment prospects
- Geographical -Keep the graduates in location of employer
- Job Market and careers/ Audit /Tracking
- Retain Educational expertise. (Lecturers, Mentors and preceptors)

The stakeholders then agree by what measures the benefits can demonstrate success. Any proposals or projects are reviewed to see if, and by what percentage, the proposals are likely to meet the measures. From this a numerical value can be attached to each proposal and can be used as part of the decision-making.

Tables 1-4 and the notes in Appendix 2c explain how this process works. Further reading: A SMART Methodology for Value Management. (Green, S. D. 1992)

Following discussion during each visit the 'SMART' document was sent to each university with explanation and request to return by 5/3/07. To date four have been returned.

An initial significant finding was the difference between the perceived benefits as expressed by SHA task group (Table 1) and those of the University Staff. (Table 2)

*e.g. SHA Task group rated the 'Paid in other sectors' of no benefit at all and rated the section a zero, University staff saw this as a distinct possibility and gave it a higher rating than working as a Health care support worker.*

It is important to note that universities are scored on their success at graduates moving in to employment on graduation. A job in any sector is better than no job and therefore graduates are encouraged to look out side the healthcare labour market at the current time.

Simple Multi attribute rating Technique  
Value engineering

**SHA**

Wt – Weighting assigned

Total- each block adds up to a whole number of 1

1 Wt	2. The what	3. Wt	4. The How	Final wt
0.35	Improve Employment prospects	0.3	Pd employment in Qualification	0.105
		0.5	Pd employment in related Discipline	0.175
		0.2	Pd employment in HSC sector (Support Worker etc)	0.07
		0.0	Pd in non HSC sector	0.0
		<b>Total 1</b>		
0.1	Geographical -Keep the gradates in location of employer	0.4	Yorkshire and Humber	0.04
		0.3	England	0.03
		0.2	G Britain	0.02
		0.1	Overseas	0.01
		<b>Total 1</b>		
0.25	Retain Educational expertise. (Lecturers, Mentors and preceptors)	0.4	Develop new roles in education delivery/ contribute to inter-professional learning	0.1
		0.2	Maintain level of commissioning	0.05
		0.4	Support Uni Lectures understanding of sector and employment prospects (flow Chart)	0.1
		<b>Total 1</b>		
0.3	Job Market and careers/ Audit /Tracking	0.1	Job Shops/seminars	0.03
		0.1	Improve student and U Staff knowledge re the job market	0.03
		0.2	Monitor student employment	0.06
		0.6	Employer engagement	0.18
<b>Total 1</b>		<b>Total 1</b>		

Table 1

**Table 2 - Simple multi attribute rating technique**  
**Based on estimated number of graduates requiring support in to employment**

criteria	weigh ting	SHA-Solutions					
		1	2	3	4		
Pd employment in Qualification	0.105	7 0.74 %	90 9.45 %	60 6.3%	15 1.56%	<p>The cost and numbers below are based on availability of £600,000 ring fenced to support graduates into employment this 2007 academic year .</p> <p>Assumption – 50% graduates unemployed with out intervention Equates</p> <p>Number of places depends on cost of each scheme.</p> <p>1 = guaranteed part time employment for 6 months to enable preceptorship: 66 Places /annum</p> <p>2 = uplift band 3to 5 at cost £600 each :960 places /annum</p> <p>3 = ring fenced posts at £300 cost for 1,300 places will cost £390,000 resistance providers</p>	
Pd employment in related Discipline	0.175	7 1.23 %	90 15.7 5%	60 10.5 %	60 10.5%		
Pd employment in HSC sector (Support Worker etc)	0.07	30 2.1%	90 6.3 %	60 4.2%	65 4.55%		
Pd in non HSC sector	0.0	70 0%	5 0%	40 0%	45 0%		
Yorkshire and Humber	0.105	50 5.25 %	90 9.45 %	90 9.45 %	60 6.3%		
England	0.175	70 12.25 %	100 17.5 %	100 17.5 %	70 12.25 %		
G Britain	0.07	70 4.9%	100 7%	100 7%	70 4.9%		
Overseas	0.0	30 0	0 0	0 0	30 0		
Develop new roles in education delivery/ contribute to inter-professional learning	0.1	10 1%	50 5%	50 5%	40 4%		
Maintain level of commissioning	0.05	30 1.5%	50 2.5 %	50 2.5%	70 3.5%		
Support Uni Lectures understanding of sector and employment prospects (flow Chart)	0.1	20 2%	40 4%	40 4%	40 4%		
Job Shops/seminars	0.03	40 1.2%	60 1.8 %	60 1.8%	70 2.1%		
Improve student and U Staff knowledge re the job market	0.03	30 0.9%	60 1.8 %	60 1.8%	40 1.2%		
Monitor student employment	0.06	40 2.4%	80 4.8 %	80 4.8%	30 1.8%		
Employer engagement	0.18	10 1.8%	80 14.4 %	80 14.4 %	40 7.2%		
<b>Total utility</b>		<b>37.3 %</b>	<b>98%</b>	<b>89.3 %</b>	<b>63.9%</b>		
<b>Cost £000s</b>		<b>600</b>	<b>600</b>	<b>600</b>	<b>300</b>		
<b>Value index (utility/£)</b>		<b>.0000 62</b>	<b>.000 16</b>	<b>.0001 5</b>	<b>.00021</b>		

The Utility (Achievement of benefits) – Best solution is 2, then 3, 4 and last 1  
The value index (return for each £ spent) Solution 4, 2, 3, and 1 lowest return

Based on these figures the recommendation from SHA perspective is solution 1 if low cost is the only consideration how ever this does not take into account the feelings of the graduates ,universities and the employers who could see this as exploitation and concerns about role drift.

For the SHA solutions 2 and 3 compared favourably and should be considered in light of the findings of the report.

Simple Multi attribute rating Technique  
Value engineering  
**UNIVERSITY**  
Wt – Weighting assigned  
Total- each block adds up to a whole number of 1

1 Wt	2. The what		3. Wt	4. The How	Final wt
0.45	Improve Employment prospects		0.45	Pd employment in Qualification	0.49
			0.25	Pd employment in related Discipline	0.11
			0.1	Pd employment in HSC sector (Support Worker etc)	0.05
			0.2	Pd in non HSC sector	0.09
			<b>Total 1</b>		
0.15	Geographical -Keep the gradates in location of employer		0.3	Yorkshire and Humber	0.05
			0.2	England	0.03
			0.35	G Britain	0.05
			0.15	Overseas	0.02
			<b>Total 1</b>		
0.2	Retain Educational expertise. (Lecturers, Mentors and preceptors)		0.3	Develop new roles in education delivery/ contribute to inter-professional learning	0.06
			0.4	Maintain level of commissioning	0.08
			0.3	Support Uni Lectures understanding of sector and employment prospects (flow Chart)	0.06
			<b>Total 1</b>		
0.2	Job Market and careers/ Audit /Tracking		0.2	Job Shops/seminars	0.04
			0.3	Improve student and U Staff knowledge re the job market	0.06
			0.1	Monitor student employment	0.02
			0.4	Employer engagement	0.08
<b>Total 1</b>			<b>Total 1</b>		

Table 3

**Simple multi attribute rating technique  
Based on estimated number of graduates requiring support in to  
employment**

criteria	weighting	University -Solutions						
		1	2	3	4			
Pd employment in Qualification	0.49	7 3.43 %	90 44.1 %	60 27.6 %	15 7.35%	<p>The cost and numbers below are based on availability of £600,000 ring fenced to support graduates into employment this 2007 academic year.</p> <p>Assumption – 50% graduates unemployed without intervention Equates to 1,100</p> <p>Number of places depends on cost of each scheme.</p> <p>1 = guaranteed part time employment for 6 months to enable preceptorship: 66 Places /annum</p> <p>2 – uplift band 3 to 5 at cost 620 each for 6 months 967 places.</p> <p>3= uplift band 2 to 5 at cost £1,500 each for 6 months :400 places /annum</p> <p>4= ring fenced HCA no uplift appr experience at £300 cost for places will cost £390,000</p> <p>NO additional on costs in these figures</p>		
Pd employment in related Discipline	0.11	7 0.77 %	90 9.9%	60 6.6%	60 6.6%			
Pd employment in HSC sector (Support Worker etc)	0.05	30 1.5%	90 4.5%	60 3%	65 3.25%			
Pd in non HSC sector	0.09	70 6.3%	5 0.4%	40 3.6%	45 4.05%			
Yorkshire and Humber	0.05	50 2.5%	90 4.5%	90 4.5%	60 3%			
England	0.03	70 2.1%	100 3%	100 3%	70 2.1%			
G Britain	0.05	70 3.5%	100 5%	100 5%	70 3.5%			
Overseas	0.02	30 0.6%	0 0	0 0	30 0.6%			
Develop new roles in education delivery/ contribute to inter-professional learning	0.06	10 0.6%	50 3%	50 3%	40 2.4%			
Maintain level of commissioning	0.08	30 2.4%	50 4%	50 4%	70 5.6%			
Support Uni Lectures understanding of sector and employment prospects (flow Chart)	0.06	20 1.2%	40 2.4%	40 2.4%	40 2.4%			
Job Shops/seminars	0.04	40 1.6%	60 2.4%	60 2.4%	70 2.8%			
Improve student and U Staff knowledge re the job market	0.06	30 1.8%	60 3.6%	60 3.6%	40 1.6%			
Monitor student employment	0.02	40 0.8%	80 1.6%	80 1.6%	30 0.6%			
Employer engagement	0.08	10 0.8%	80 6.4%	80 6.4%	40 3.2%			
<b>Total utility</b>		<b>29.9 %</b>	<b>94.8 %</b>	<b>76.7 %</b>	<b>49.05%</b>			
<b>Cost £000</b>		<b>£600</b>	<b>£600</b>	<b>£600</b>	<b>£300</b>			
<b>Value index (utility/£)</b>		<b>.0000 5</b>	<b>.0001 6</b>	<b>.0001 3</b>	<b>.00016</b>			

Table 4

The Utility (Achievement of benefits) – Best solution is 2, then 3, 4 and last 1  
The value index (return for each £ spent) Solution 2 &4 equal ranking then 3  
lowest return solution 1

Based on these figures the recommendation from university perspective would be solution 2 this would depend on ring fencing sufficient post at Band 3 as these are in the minority in a large number of NHS organisation.

The possibility of supporting Healthcare organisations outside the NHS should be considered.

## **Information gathering/Fact finding Visits**

Consultation has taken place with universities, students and graduates from nursing and physiotherapy programmes and employers.

### **Higher Educational Institutions**

The Deans of the nine regional universities were contacted with an explanation of the project and a request to nominate a representative to be involved in the work. The institutions put forward one at least one person to speak on behalf of their organisation and two pulled together several Lecturers for the discussions.

The interviews were semi-structured followed by a period of open discussion. This enabled the author to gather comparable information from each institution. The aim of this piece of work was to ascertain if there were any differences in practice in preparing students for the job market. If so, has this led to higher numbers of graduates gaining employment? Visits lasted between one and a quarter to two hours depending on the number of staff present.

At the time of reporting visits have been made to the nine universities in the region and discussion with 19 Lectures and Deans has taken place.

The University of Bradford  
The University of Huddersfield  
The University of Hull  
The University of Leeds  
The University of Sheffield  
Sheffield Hallam University  
Leeds Metropolitan University  
York St John University  
The University of York

### **Graduates and Students**

Eight focus groups have been held with cohorts of the universities listed below. The focus groups comprised a mixture of learning disability, Child, mental health and Adult branches of nursing and physiotherapy. In total over 151 graduates and students have been involved. In addition meetings have been held with one graduate representing the views of her cohort, and five postgraduates unable to attend focus groups. One University held a focus group on behalf of the author and fed results in to the audit. Unfortunately it has not been possible to meet with a cohort of midwives.

The University of Bradford  
The University of Leeds  
The University of Sheffield  
Leeds Metropolitan University  
York St John University

The Undergraduate and postgraduate focus groups were timed to last two hours. Due to the difficulty of setting up the groups, three were reduced to one hour.

The focus groups followed set format: -

- An introduction and explanation of the work to be undertaken.
- The reason for the focus group.
- Group work with feedback.

The focus groups of two hours duration were split into groups of 4/5 and each group given a sheet of questions to discuss, recording comments on the sheets, which were collected in to be collated. Opportunity was given for feedback and open discussion with all groups. Any additional comments noted on flipchart. The process repeated for the remaining question sheets. (Appendix 4)

The results of these sessions revealed students and graduates to be extremely despondent, feeling cheated (promised jobs would be no problem), unvalued and ignored. There was anger that the situation had developed and at the lack of opportunity. The barriers that existed preventing them applying for many jobs exacerbated the anger. Examples of these barriers are;-

- Ring fenced jobs for internal staff only
- Requiring experience
- NHS jobs require PIN number to process the applications

Students talked openly about the lack of information and dismissive comments of some of the employers.

These are a sample of the comments made by students during the focus groups. Appendix 5 is the collated information from the focus groups.

“Disheartened”,

“We were excited but with the current job situation are angry about having to fight for a job after we had to fight to get on the course.”

“Looking forward to employment, not the fight. Exhausting”.

“If there were jobs available we would feel excited and happy about moving into the working world. However, in the current situation we don’t really feel very motivated and under pressure to perform if we were to get an interview.”

“Worried that we’ll have to settle for a job in an area that we don’t want to work in”

Several students mentioned that due to having potential degree 'status', their skills would be valued outside the NHS.

Approximately half of the students were willing to look outside the area for NHS jobs - the rest had family ties to this area.

In at least one local Trust, the students claimed the Sept. 04 students had been advised there would be recruitment for bank work only. At least 20 out of 25 of the students suggested that bank work was not what they wanted as it was not a reliable income. The general feeling was that 'part time' bank work was no good and several expressed the view that it would be better for them to move completely out of nursing rather than have to supplement earnings from bank work with another job.

## **Employers**

Any organisations identified by the universities as being particularly helpful or innovative in supporting students in to work have been followed up. Where it has not been possible to arrange a meeting or telephone conversation contact details have been taken for further work after 31<sup>st</sup> march 2007. To capture any innovation or supportive measures in NHS organisations all Directors of HR were circulated by email outlining the work and asking four questions:-

- Have you considered this problem in your organisation?
- Do you have a staff member with designated responsibility for this?
- Have you a special initiative in place?
- Would your organisation consider supporting a special initiative?

Ten of the thirty-five organisations responded immediately. Twenty-two organisations have not responded.

Representatives from organisations have been interviewed and the suggestions as to how the problem may be addressed shared for comments. Innovative ideas explored as well as any concerns that the organisation may have. To date discussions and visits have taken place with NHS Professionals, Leeds NHS PCT, Kirklees NHS PCT, Leeds Teaching Hospitals NHS Trust, Bradford Foundation Trust, Barnsley Hospital, Yorkshire Ambulance Service, Harrogate District Foundation Trust, Leeds Mental Health Trust, Blood Transfusion Service, Wilf Ward Association, Northern Lincolnshire and Goole Hospitals Trust, North Yorkshire and York PCT and Skills for Care Northern Region.

## **The findings**

### **Cohort Numbers**

With the merger of three SHAs into one, the information regarding number of commissions is presented in different formats making collation of numbers difficult. The numbers below may not be totally accurate and work is currently taking place in the organisation to resolve the discrepancy/possible duplications.

From the statistics available the following information has been drawn: -

Expected graduations 2007

- Nurses all branches            1823
- Midwives                            114
- Physiotherapy                    210

These figures include Part time and seconded graduates. There is also some confusion in regard to the statistics collected; are they expected finishers (West Yorkshire) or are they intake numbers for each year (NEYNL & South Yorkshire).

It is recommended that the SHA establish uniform data information system across the Yorkshire and Humber in agreement with the HEIs.

### **Part Time Graduates- additional funding**

Workforce Development Confederations supported backfill monies for candidates seconded in to nursing and physiotherapy training. West Yorkshire and North East Yorkshire and Northern Lincolnshire also support Foundation degree students with replacement costs. There were reports that managers were failing to claim backfill monies where this was part of the seconding arrangement. Reasons for this were cited as: -

- Managers unable to find replacement
- Managers claiming the funds but not backfilling due to financial pressures.
- Managers not always aware that they could claim backfill.

It is recommended that future staff support costs for these and other graduates to be offered in terms of a named graduate. The 'replacement' graduate will be also offered CPD.

### **Tracking of Graduates post graduation**

All universities track graduates with in the first three months of graduation largely by questionnaire on completion and one university during the graduation ceremony at which "about 80% of completers will attend on average". All universities felt they had a fairly accurate picture on the first tracking unfortunately subsequent tracking (up to 6 months after graduation) with a very poor response rate was said to be unreliable.

An interesting observation arose out of this question, which was: the students see themselves more closely aligned to the "Trust Home base" than the university. This was given as a reason for the poor response to the six-month tracking. The author asked this question of other universities and found that in those universities whose student population were linked to one 'home trust', the loyalties of the students were felt to be aligned to the NHS. Those who placed students rotationally across a number of trusts felt that the student group saw their loyalty to the university. This was reflected in the focus groups held with the graduates and undergraduates.

Maintaining contact with the students once they have graduated is difficult. When asked, they preferred to be contacted through the university and suggested they kept their university email address for six months. Another suggestion was a web page, dedicated to this issue. Any new relevant information uploaded which would give unemployed graduates quick access to relevant developments. It was important to keep it 'clutter free' for ease of access.

NHS Employers at the time of reporting developed a 'Talent Pool' through which Graduates can register. This should enable monitoring of unemployed graduate numbers therefore; no further work has been done on recommending a tracking system.

### **First Destinations**

As tracking graduates has already been shown to be difficult it follows that the following table (Table 5) will have gaps. The information has been supplied by the HEIs.

Table 5

Numbers securing employment on graduation						
HEI	Cohort size Discipline	Destination unknown		In Employment		Graduation date
University of Bradford	No data	<b>23</b>	<b>40%</b>	35	60%	2006
University of Sheffield	MH-15	<b>9</b>	<b>66%</b>	6	34%	2006
	PT-15	<b>10</b>	<b>69%</b>	5	31%	2006
	MW-12	<b>10</b>	<b>83%</b>	2	17%	9-2006
	PG A-17	<b>3</b>	<b>18%</b>	14	83%	9-2006
	Child-14	<b>8</b>	<b>57%</b>	6	14%	9-2006
	LD-20	<b>4</b>	<b>20%</b>	16	80%	9-2006
	MH-Post Grad- 15	<b>3</b>	<b>20%</b>	13	80%	2-2007
Sheffield Hallam University	Phys-111	<b>21</b>	<b>19%</b>	90	81%	9-2006
	?P/T-16	<b>11</b>	<b>69%</b>	5	31%	?
York St John University	Phys -59	<b>46</b>	<b>78%</b>	13	22%	9-2006
University of York	MH-15	<b>12</b>	<b>80%</b>	3	20%	3-2007
	A-28	<b>24</b>	86%	4	14%	3-2007
University of Leeds	No data					
Leeds Met University	Phys-20	<b>18</b>	<b>90%</b>	2	10%	2-2006
	Phys-51	<b>28</b>	<b>55%</b>	23	45%	-
	A-50					
University of Huddersfield	No data					

Note- Universities report a poor response rate to 6 monthly tracking. This makes the above figures unreliable.

At first glance, some cohorts are gaining employment better than others (Learning Disability Nurses and Postgraduate Cohorts in Sheffield as well as the Physiotherapy graduates from Sheffield). These are graduates from September 2006 and have now been in the employment field for six months. Only two sets of data revealed the destination therefore the number of respondents that gained jobs in health care is unknown.

The only available data for graduations in 2007 shows a worrying picture, especially when the softer evidence gathered during focus groups is taken in to account. Child branch Nurses graduating March 2007, cohort size 14, only one had employment to go to, the remainder had been told by the local employer there will be no jobs in the foreseeable future. Mental health Students graduating March 2007, 5 had secured employment and 7 had interviews but knew there were many applicants. Physiotherapy students in York presented a similar picture.

A graduate from a PG Mental Health course representing the cohort's views had a more positive picture in terms of employment. Thirteen of the fifteen graduates have secured employment, either in support work awaiting qualified posts, or as qualified workers. Of these however, only three had secured work in the NHS and a third had moved geographical location to find work. Almost all will be working in secure units and the majority in the private sector. The graduates had previous degrees and work experience in sociology, health sciences, marine biology, physiology, criminology and psychology and moved

into mental health nursing as a means of securing a career path and work in the NHS. The graduate also made the observation that it was only by their own efforts at being proactive and knowing where to look for jobs led to success. As all had worked prior to training the graduate felt they had the experience to search for work but did say that knowing the area helped and being aware of private sector developments. The new secure unit opening in Doncaster was one example.

All the focus groups were very despondent as they were hearing at first hand from previous cohorts about the lack of appropriately banded jobs and difficulty of finding work. A number though, made reference to graduates who had taken jobs as support workers, and after a few months had found jobs in the same organisation as a result of 'getting known'. Those that were applying are discovering the reality of few jobs and rejection.

This is an area that requires standardised collection of Data and close monitoring. Change for these and other disciplines could go unnoticed for a few months. Concerns regarding radiography and occupational therapy are being voiced though there is no hard evidence as yet. A chance discussion within the University of Leeds has highlighted serious concerns regarding the plight of a cohort of 50 speech and language students. These students due to graduate in July 2007, have been told it is highly unlikely they will get jobs in the profession. This information came from a third year student.

### **Information on future employment**

The information advice and guidance regarding future work is not normally approached until well in to the final year. Two universities do raise this subject in the first semester, with one continuing to discuss on an ongoing basis through the programme although this particular institution (Leeds Metropolitan University), did not appear to have a higher rate of success in graduates securing employment.

Over the last twelve to eighteen months all institutions had develop links with, and involved, the University Careers Advisory service, as well as holding job fairs. They did report that this was a new area to the Advisory service as "there had never been the need" in the past.

On questioning about the market most university staff only referred to the NHS and when the possibility of the work in the independent, voluntary and third sector was suggested in two areas it was seen as "unethical" or "morally wrong" as the "Bursary had come through the NHS". The students reflected the view that the NHS was the "first and only option of employment on graduation".

This issue was compounded by the need to gain preceptorship or in the case of the Physiotherapy graduates supervision. Concerns were raised as how they would gain this necessary support outside the NHS. This was also a concern of university staff. The suggestion was; if they could use CPD allocation differently, university staff could deliver supervision/preceptorship.

The graduates welcomed this suggestion, as did some of the employers. A concern raised by one employer regarding the governance issues of an outside body delivering Preceptorship for their employees. This needs consideration if use of support worker posts is to be an option.

All universities recognised the need to widen the employment opportunities available for graduates but needed support. Whilst it is easy to contact the local NHS, and all had good links, it was a tremendous job to contact all the independent, voluntary and third sector market in one area. However from discussion with graduates there are a large number of jobs particularly in the new secure and mental health units opening up in the private sector.

A further issue highlighted was the feeling of “being out of the Loop”. Eighteen months ago there were not sufficient staff for the posts with the NHS was recruiting from abroad: to a situation today of oversupply. The question constantly asked “how has this happened?”

The providers echoed these comments. A large number of those contacted had not understood the scale of the problem and felt they could have done more had they been made aware of the problem sooner. The lack of intelligence meant it was not on their ‘Radar’. Opportunities have been missed to secure employment.

Following discussion, organisations unaware of the issues, were mostly positive and keen to be involved in any way they could open up employment opportunities for graduates. However, there is the sense that these organisations need some support and direction from a strategic level.

Closer links and communications channels need to be established between HEIs, SHA and employers.

### **Job applications and job Bulletins**

As well as students expressing difficulty finding vacancies, University and students pointed out that a number of Band 5 jobs asked for experience and therefore they were unable to apply for them.

The author carried out a desktop review of several different NHS job bulletins from across the region. Unless applicants have access to broadband there would be difficulty in downloading some large bulletins.

Other observations made: -

- Large Images and logos makes downloading slow.
- There is no set format to layouts of Job Descriptions (JD), making a quick search difficult.
- Trust Bulletins (30- 40 pages) will have a mix of different jobs scattered throughout rather than grouped together.
- No set format for the information
- Jobs can be ‘buried’ at the end of a previous lengthy job description.

- JD and Person specification (PS) had to be sent for or requested via email.
- Closing dates short.
- Jobs with a number of posts did not always show this clearly; other jobs in the same bulletin would place this information at the top and easily seen.
- Closing dates after a specified number of applications- an application would have to be submitted to find out if the number had been reached.

Students also appeared to be largely unaware about the need to continually up dating a CV as well as recording and storing evidence that could enhance job applications. Both the author and co-facilitator were surprised at the amount of note taking that occurred when this topic was broached during focus groups. Comments were received at the end of the session on how it had given a wider perspective to the job market and “made me think differently about my skills” and “presenting them”. The students felt that they would benefit from having more sessions, similar to the focus groups, and guidance on completing CV. They were also unsure about informal visits and whether they should ask for them. Their observation of the work areas – clinical managers too busy to see endless people for one job. This view was reflected by some service side managers who have been inundated with applications and requests for informal visits. Other employers expressed surprise that prospective candidates did not seek informal contact and stated that many application forms were poorly written and did not meet the JD or PS. No wonder the student is confused.

A ‘How to apply for job’ flow chart was suggested as a means of helping universities stay in touch with what was happening in the sector. This will give useful contact information and standardise an approach on applications. If this recommended that informal visits are requested then the managers are aware and visa versa. This suggestion gained approval from other institutions.

## **Jobs**

All universities had a high proportion of mature students who would be unable to consider relocation due to family ties and responsibility. Although many required full time employment, a significant number of students are willing to accept part time work, especially if this was linked to preceptorship and CPD to protect Registration.

Across the region there is a number of organisations already aware of the problems and have systems in place to manage “their Graduates”.

Initiatives are: -

- Ring fencing Band 5 jobs
- WTE into P/T
- Offering Support Worker roles with CPD
- Guaranteeing 3 shifts a week on ‘in-house banks’
- Voluntary work in exchange for preceptorship

From the work carried out and the data collected it would appear that these areas are supporting the universities with the higher graduate to employment success rates.

### **Support and Direction from the Top.**

Even though individuals within organisations maybe aware of the employment issue and taking action to create employment opportunities, the reality in one organisation was found to be one of in-action further down the ranks. Any initiatives need support and direction from the highest level in the organisation to be effective.

### **Band 5 posts**

Students and universities cite examples of Band 5 requiring experience of the applicant. On challenging organisations the reason was explained that Band 5 encompasses the 'D' and 'E' grade, the latter required a more experienced worker. Community sector also stated the Band 5 did not have the necessary skills and practice to be able to practice in community setting or if using Band 5 'community' required experience. However another PCT indicated that they would be looking for newly qualified staff and felt the days of asking for experience with the changing Healthcare provision was no longer justified. The students articulated concerns about working in primary care as they had little experience in community settings. Despite the Myths regarding private sector paying less, the post graduate starting work in a private low secure mental health unit would be starting on over £24,000/annum. This informant indicated this was the norm for the sector, although pension arrangements were not so attractive as the NHS, and there was no unsocial hour enhancement.

Both Students and employers felt that a band between 4 and 5 would be useful (AfC Band 5a, 5b). The PCT who felt that community workers required experience suggested that the students worked their final placement in community or completed a 3-month course to 'Polish them'. This would aid the transition from secondary care (where most of their clinical placements had been) to primary care.

Splitting posts from WTE to part time, providing more opportunities was regarded as a satisfactory option. Trusts were concerned at the additional workload and expenditure in provision of preceptors and on-costs. The Universities were keen to provide preceptor support and take a more active role through the use of CPD.

### **Support worker roles.**

There were many cases cited of graduates working as support workers at Bands 2 and 3. Whilst these opportunities were welcomed, worries were raised about reducing opportunities for support workers. Problems created in

recruiting to posts knowing the graduates would leave as soon as they secured a Band 5 post were raised by service side. A caused for concern with all parties (university, students and employers) that the Graduates could be exploited. As was 'role Drift'. A graduate may inadvertently act out of role or be expected to work at a higher level than that for which s/he is employed. Reports of the latter were made during focus groups. These issues need to be acknowledged and addressed as areas are ring-fencing support worker posts to provide employment to graduates.

Whilst this may be a means by which to keep the graduates in employment and engaged with the sector systems must be in place to protect both employee and employer. This could be achieved by topping up the support worker post to a band four or five. Although this has a cost to it, given the amount invested in graduates to date, this is a small additional expenditure.

The average cost of training current graduates according to WDC statistics is £37,911 for bursary student to £63,000 for the seconded route. (source WDC)

Based on 2006/7 salary costs the difference between: -

- Top AfC band 2 (£15,107) and bottom AfC 5 (£18,039) = £2,932
- Top AfC band 3 (£16,799) and bottom AfC 5 (£18,039) = £1,240

A six month preceptor ship programme topping up a support worker role would cost an additional £1,466 or £620 respectively an additional increase of 3.8% and 1.6% on the cost of training the graduates to date. (Based on 2006/7 figures).

A period of six months has been recommended based on table 5 showing an apparent increase in the number of graduates gaining employment over a six-month period. This theory is supported by the fact that Band 5 posts have been released in a steady trickle in the job bulletins sampled, An Acute Trust had 45 such posts, an average of 15 per bulletin, in three two weekly bulletins. February 28<sup>th</sup>, March 2<sup>nd</sup>, March 16<sup>th</sup>. This was common in all Job Bulletins sampled. As graduates move from the 'preceptorship programme' to Band 5 equivalent employment, another unemployed graduate could fill the released place.

### **Benefits of the Support preceptorship period**

As already stated the focus groups comprised both undergraduate and post graduates. Of the postgraduates, a number were working as Support workers on a preceptorship programme at Bradford Foundation Trust. They all had positive experiences and felt that they had greatly benefited through the Programme and could recommend this to others. Three out of four had achieved Band 5 posts as a direct result of their experience.

The benefits were described as: -

- Consolidated their learning and enabled them to practice skills.
- Improving communication skills, particularly with staff and client groups.
- Increased knowledge of local policies, a concern to graduates moving to new organisations.
- Improved knowledge of local documentation, making them more confident now they have secured a Band 5 post.
- Better understanding of the support worker role and the full potential of the worker

Students and graduates expressed anxiety at taking a first job and almost all thought this would be a desirable stepping-stone to full responsibility. It is from this discussion that the students raised the suggestion of an intermediate Banding.

A further benefit would be maintaining contact with graduates until vacancies arose. Retaining these graduates reduces the numbers that may have to be trained in future years through any shortfall created in the plans as a result of losing a high percentage of graduates the NHS has already invested in.

### **Bank staff**

NHS professionals have run a small pilot employing 6- 8 graduates on the bank in the North West. A guaranteed 3 shifts a week with preceptorship. This has worked successfully with positive reports from managers with some of the staff gaining employment as a result. The down side of this scheme is that the cost was estimated to be £6,000 per candidate inclusive of overheads and support costs. There is also a time delay in starting due to CRB checks.

A large number of Partner organisations run in-house Bank schemes. The author has spoken to two areas running a similar scheme to NHS professionals. Whilst there is an additional cost involved and the main issue appears to be the resource risk of preceptors or supervisors. If the provision of preceptorship/supervisor could be supported in part, this could be rolled out to other organisations. A District Care trust regularly recruits 10 -12 people a month on to the bank but had not thought of offering opportunity to graduates.

### **Geographical relocation**

Moving to a new geographical area was considered by approximately a quarter to one third of students and the same number expressed interest in working overseas. However a number of students expressed concern at moving away from family, friends and a working environment that they were familiar with. When asked if they would like some information or course to support them make the transition the students felt it would be helpful, particularly if a 'Buddy' scheme was available to show the newcomer around.

## University Staff- Impact and Morale

When asked about the impact the situation was having on schools of Healthcare study and on the delivery of education the following comments were made: -

- The financial deficit has knock on effect on the workload of the university.
- The demographic time bomb will affect the universities as well as other sectors of the healthcare as the teaching population is aging. “It is not attractive at the moment for people to leave the clinical areas to become university lecturers”. Other university staff made similar comments. There are increased concerns regarding the ability to meet demand in the future.
- All Universities stated there was ‘no redundancy policies’ in place at the institutions, but were able to cite areas in the country where redundancies have occurred. This is having an effect on the morale.
- There was a real issue of redeployment to other departments in the universities resulting in the long-term loss of expertise in health care departments.
- Although there is no redundancy policies in place the feeling by a large number of staff is that commissioning will be cut and with the anticipated loss of programme/s and training places, jobs will go
- The feeling of being “out of the Loop” with the NHS changes was voiced and frustration at need to plan year on year rather than for the three year cycle of the course.
- The Chartered Institute of Physiotherapy Society raising awareness of problem is very high profile, which has the effect of further increasing student and staff anxiety; it was seen to be a double edge sword.

During the focus groups the students talked about the concerns and morale of the staff, which further increased their own anxieties. This coupled with the universities having to encourage graduates to look outside of healthcare for future work (because of their own funding targets) is increasing the problems.

Despite feeling very anxious, universities on the whole were keen to stress the value of working with the SHA and, were grateful for the initiative to support them in addressing the issues.

All staff spoken to are keen to develop CPD programmes and provide preceptorship or Supervisory practice for the graduates through this period. There is the recognition that with the change from secondary to primary care provision the emphasis will change. Graduates may need support in delivering

community care as the majority will have had only one community placement. A thought voiced by the some of the community providers (although not all) as well as student groups. A common complaint was the number of Band 5 jobs requiring experience. Work needed to done to improve the perception and alter custom and practice of the employers around suitability of practice removing the need for experience in Band five posts.

The common theme that until last year there had been no need to involve the careers services and now the current situation has caught them out. All recognised that they would have to start thinking differently about student preparation for the jobs market, the timing and organisations that may involve.

To keep the universities in touch with the changes in provision of healthcare, it would be useful to provide information and education for University staff. These could take the form of seminars and initially could focus on the employment options available, as well as developing a flow chart which could be updated on a regular basis. This would widen the perspective on employment choices/availability.

A number of institutions have opened up a limited number of opportunities. Two have set up clinics for use by staff and students and others employing graduates as teaching support. This raised the issue of self-employment. There is a view that students could become self-employed, as could healthcare professionals with experience. Sessions could be developed to give interested parties the information about self-employment and developing entrepreneurial skills.

### **Preceptorship**

Students are very anxious about their ability to gain preceptorship or supervisory practice in the timeframe required by the registration bodies. This has real implications should they fail to gain employment at a registered level and they could find themselves in a position of completing a return to practice programme before securing a job.

Providers are concerned that if they create additional posts (Ring fencing support workers posts or turning WTE into P/T) they will be faced with additional costs not only in overheads but the provision of supervision and release for mandatory training. The organisations that were supporting graduates in this way felt they had additional cost pressures because of their willingness to help.

These points have real resource issues for organisations who all cited financial constraints and cut backs as the cause of the current situation. Job freezes and the need for developing services differently are all having a direct impact. Furthermore, managers complained that they were being asked to 'create' employment opportunities which had a negative effect on the development of skill mix. Debbie Shakespeare (Northern Lincolnshire & Goole Hospitals NHS Trust) acknowledged that they were "*poor at succession*

*planning because of the constraints and constrictions placed on us*". How ever this organisation works hard to ensure that all 'their graduates' are placed or supported in some way with some paid employment. Other organisations laid the blame at the door of the DH and SHA for poor workforce planning, financial constraints and increasing changes in the provision of care. One thing has become clear however, that is that the Band five jobs are the ones first targeted when facing cuts.

### **NHS Jobs**

Of those organisations using NHS jobs for recruitment issues, only one was aware of the talent pool and how it worked. Some organisations were unhappy with the structure of the general site and use of the documentation on the site. The author, in accessing the site found a statement for applicants that stated as the site had been updated (with no date of when this occurred), they may need to resubmit application forms. The mandatory requirement to input registration number rendered it useless to those looking for employment pre registration. These points will need to be addressed if the site is to be effective. The problem remains however, that there is a reliance on organisations to use the site, otherwise it will not be effective.

### **At Risk register**

To enable more accurate tracking and ensuring that graduates see all the jobs available the suggestion that they should be registered on the at risk register was met with enthusiasm.

### **Other issues**

During the focus groups and meetings a number of ideas for creating opportunities were discussed to gauge reactions (Appendix 4). Some have already been mentioned but others of special interest are: -

### **Sabbaticals**

The suggestion that a national programme for sabbaticals or career breaks could be developed was on the whole thought to be a good idea. This would release staff to work abroad as voluntary organisations that are actively looking for younger professionals to work overseas. This would free up places in the work place for graduates to step into on secondment, in the case of a Band 6 or 7 post holder taking part, enable secondment opportunities for staff in lower bands that have hit a glass ceiling because a lack of available opportunities. If it becomes a national or regional initiative there will be credibility and tie in with the programme. In addition number of places available could be expanded and contracted year on year providing a flexible adjustment to work force plan issues. A suggestion of awareness sessions regarding issues around working abroad, for example Australia or New Zealand or third world countries, was thought to be a positive move in moving this agenda forward.

An area of concern however was the reaction of service side who expressed anxiety that they would lose experience staff, albeit on a temporary basis, and have to rely on less experienced to manage the work load.

### **Backfill for Staff release for training**

Anecdotal evidence from universities and providers highlighted the poor compliance with releasing staff booked on to CPD programmes due to reduced staffing levels. When backfill has been provided this is not used for the purpose for which it was intended. All parties thought it would be advantageous to backfill with graduates on preceptorship programmes.

### **Guaranteed employment.**

This was raised by students and has been discussed in the national forum. The Scottish Office use this but report that it is viewed by the graduates as a last option. The focus groups were only partly accepting of this suggestion, stating that they wanted a real job and to feel they were in a post that was needed, not one that had been created to keep them in work. Service side thought that this would just move the problem in to another time period.

### **Competition**

Managers in clinical areas whilst sympathetic to the plight of the graduates did welcome the situation that gave an element of competition to those seeking work. Anecdotal evidence around a minority of students failing to perform to the level expected, either during training (failing to arrive on time or at all because they were supernumerary) or during interview but securing employment regardless of these issues. There is a feeling that some competition is healthy and will serve to improve the standard of delivery of care.

### **New areas of work**

Discussions were held with a small number of Non traditional employers exploring possibilities of opening up new ways of working and job roles or identifying employment bulletins in the statutory, private, independent third sector.

These were: -

- NHS Professionals
- Yorkshire Ambulance Service
- National Blood Transfusion Service
- Wilf Ward Trust
- Skills for Care

The National Blood Transfusion Service did not feel that the service would be able to support any graduates, as the number of registered nurses employed in the service was low.

All other services thought there was opportunity to either develop new roles and were currently developing Business cases, or could see great advantage in employing Nurses and Physiotherapist in the services or supporting a number of smaller like minded services employ a graduate in a part time role. This would be especially welcome if support could be provided for preceptorship/supervision. An example of this would be eight small residential, nursing homes or Learning difficulty homes/services, employing a Physiotherapist half a day a week each, which with CPD one day a week, would provide a Full time post.

### **Overseas workers**

The Nursing and Midwifery Council statistics published August 2005 shows a decline in the number of registrants from overseas in 2004/5 over the 2003/4 figures. There is no information on the number of overseas workers who are on short term contracts.

Changes to legislation now allow these workers extended work permits providing they do not move in to another post. However should the overseas registrants, who were recruited to meet the staffing crisis, return to their country of origin, the NHS could find it's self in staffing crisis once again: particularly if we fail to retain the graduates trained in preparation for the loss over overseas temporarily recruited staff.

### **Social Care**

Regional Skills for Care working with other local/regional organisations are developing web site for the use of care managers. Useful information enabling care managers deliver improved services. This is an area that should be explored to assist with the issue of making this sector aware of the opportunities available through partnership working and employing registered staff to work differently.

### **Conclusion**

The graduate unemployment has raised many issues not all of them negative. Awareness has developed in service, universities and the SHA that there is a need for change. The information gathered in this report sends a clear message about the need for improved lines of communication, keeping all parties fully informed in current situations. Service side have to consider the impact of job freezes on the labour market. If education commissioning is reduced, as direct result of current graduates failing to secure employment due to an apparent over saturation of the market, this could have a significant impact on future workforce plans.

Organisations are too quick to lay the blame at the door of education and commissioning for failing to 'plan numbers' effectively. Their own part in workforce planning needs, the changes that have made because of their own financial deficits and changing provision that has been driven centrally are seen in isolation and not part of the cause but an effect of what is the current state.

Complaints of staff not fit for purpose have to be met with Why? If graduates are not 'polished' sufficiently to work in community, is this then, as a result of too few community placements. If so what can be done to open up more placements to new students whilst supporting current workers to achieve the desired standards. There are 'new sources' of employment and opportunity out side the NHS and these have to be explored as well as partnership working to provide some pilot sites.

There are programmes of support that can be introduced at a local, regional and national level and these should be worked on simultaneously and in conjunction with each.

The authors view is that, despite the problems there is good will in the NHS and other provision. Statistics on post graduation tracking, although questionable because of poor returns, suggests that over a period of six months employment appears to be gained by about an average 80% of graduates. What we do not know however, are the numbers dropping out of healthcare into other industries. If additional mechanisms are introduced and the unknown element retained this may bring cost savings in commissioning in the future. Education can be developed in consultation with service side, to support the development of new services.

## **Recommendations**

### **1 Key proposals/solutions identified and value estimated through SMART analysis and taking into account softer evidence.**

Top up the Support Worker post to a Band four or five. Employ graduates on a temporary six month contract, with additional CPD if required and a preceptorship programme. Graduates should be encouraged to apply for full/part time posts during the programme which if successful will release the top up for other graduates.

Ring fence a proportion of Support worker jobs based on headcount across the region for use to support graduates. Ensure the job description reflects the graduate status in an effort to protect employee and employer. This will need further exploration and consultation.

Develop a short term (3 Month) Community programme for graduates to widen employment opportunities in the community. Further work needs to be done to identify appropriate numbers.

Develop partnership working and support for the Private, Voluntary and Third sector healthcare providers to open up new job areas.

## **2 Short Term**

**The following recommendations should be core to any proposal and take immediate effect .**

To establish uniform data information system across the Yorkshire and Humber in agreement with the HEIs.

A complete review of all Professions Allied to Medicine (PAMs) in relation to first destination in employment following graduation.

Develop simple web page that graduates can access for easily assimilated information on new developments.

Identify the number of Trust running in-house banks and consider expanding the schemes.

For future backfill for these and other graduates to be offered in terms of a named graduate and supported with CPD.

## **3 Recommendations considered as a short to medium term**

Follow up leads identified for areas of best practice or opening up the job market. Additional work to complete scoping exercise in particular identifying and exploring areas of good practice.

Improve the liaison and working arrangements between the institutions of Higher Education, SHA and future suitable employers.

Assist Universities improve on information advice and guidance for the students. The range and type of Information Advice and Guidance (IAG) offered to the students.

Develop a flow chart for use by those in education for advising students on employment opportunities and how to seek/apply for them.

Enable undergraduates to understand the range and value of transferable skills they have gained and if necessary utilise them in job roles in the wider Health and Social care industry. (Public health, transfer into other related health course where there are shortages etc)

Increase motivation and support for the University staff faced with possible job losses (Publicity sparking this)

Widen the spectrum and thinking on job outcomes for these students (thinking differently, workforce modernisation)

### **National Initiatives**

Sabbaticals should be set up to release experienced staff for work overseas; either in countries of temporary shortage or Voluntary work in third world. This would also require a short programme to equip the workers with key knowledge of the new environment, before they leave these shores.

### **Bibliography**

*Green, S. D. (1992) A SMART Methodology for Value Management, Occasional Paper No. 53 Chartered Institute of Building, Ascot, 46+vi pgs. ISBN 1-85380-0554.*

*The Smith Institute. (2006), Public service reform 2006 – 2010, available <http://www.smith-institute.org.uk/pdfs/reform.pdf> last accessed 14/3/06.*

**Appendix 1a** *University contacts*

Name	Organisation	Tel	Email	Discipline	Comments
Dr Pat Pearcey Prof Linda Shields	The University of Hull	01482 464524	<a href="mailto:P.A.Pearcey@hull.ac.uk">P.A.Pearcey@hull.ac.uk</a>		6 <sup>th</sup> Feb 07 Cottingham road Hull
Aiton Marr Director of the Undergraduate Division School of Nursing and Midwifery, The University of Sheffield, Bartolome House, Winter Street Sheffield	The University of Sheffield	0114 2229704	<a href="mailto:a.m.marr@sheffield.ac.uk">a.m.marr@sheffield.ac.uk</a>	Nursing and Midwifery	App 30/1/07  Jill Jesper setting up Groups Children's branch 28/2/07 Mental health  Juliet greenwood Dir nursing Contacted as proactive org
Linda Terry Paul Evans LD Kathryn Brittan MW Mathew Jacobs St records manager	The University of York	01904 321301	<a href="mailto:imt3@york.ac.uk">imt3@york.ac.uk</a>	Nursing and midwifery	Email response 23/1/07 Visited Meeting 12/2/07 Student focus group 26/2/07 LD, MH, Adult branch
Sharples, Paul	Leeds met	0113	<a href="mailto:P.Sharples@leedsmet.ac.uk">P.Sharples@leedsmet.ac.uk</a>	Physio/nursing	P Sharples 9am 5 <sup>th</sup>

Transitional projects coordinator Leeds Met Uni Faculty of Health Tel:	University	2832600 Ex 3869			Feb LMU Focus group held 11 grad and post grad nursing /physio
Barbara Wood Hd of Adult and Children's Nursing Studies University of Huddersfield Queensgate Huddersfield HD1 3DH	University of Huddersfield Queensgate Huddersfield HD1 3DH	01484 473409	<a href="mailto:b.wood@hud.ac.uk">b.wood@hud.ac.uk</a>	Nursing and Midwifery	Unavailable had to cancel but Cath O'hallan represented Barbara views
Cath O' Halloran Hd dept Clinical & health Sciences University of Huddersfield, Queensgate, Huddersfield HD1 3DH	University of Huddersfield	01484 473028	<a href="mailto:c.o'halloran@hud.ac.uk">c.o'halloran@hud.ac.uk</a>	Nursing and physio	Met 5/2/07 pm
Joan Maclean The university of Leeds Baines Wing University of Leeds LS2 9UT	The university of Leeds	0113 3431267 3431178	<a href="mailto:j.maclean@leeds.ac.uk">j.maclean@leeds.ac.uk</a>	School of health care Nursing and Physio	13/2/07 meeting Focus group 22/2/07 Physio and Adult nursing

Simon Rouse (S.Rouse) The University of York St Johns Lord Mayors Walk York YO31 7EX	The University York st Johns	01904 876901	<a href="mailto:S.Rouse@yorksj.ac.uk">S.Rouse@yorksj.ac.uk</a>	physio	Meeting 24/1/07  Focus group 6/2/07 11am – 2pm ish Focus group 2.30 4.30pm Jill wickham
Jean Flanagan <a href="#">Acting Assistant Dean Academic Development</a>  Faculty of Health and Wellbeing Sheffield Hallam University 13 - 15 Broomhall Road Sheffield S10 2DR	Sheffield Hallam University	<a href="#">Tel. No: 0114 225 5611</a>	<a href="mailto:J.Flanagan@shu.ac.uk">J.Flanagan@shu.ac.uk</a>	Nursing/MW physio	Meeting 8/2/07 11 -1  Gill best as Jean on S/L Good discussion Focus group Colligate campus
Gwendolen Bradshaw Dean health care Heather Marshall care	University of Bradford	01274 236408	<a href="mailto:g.bradshaw@bradford.ac.uk">g.bradshaw@bradford.ac.uk</a>	Nursing mw physio	Met 1/3/07

Brian Walker rehabilitation Linda Gatecliffe Fd					
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**Appendix 2b organisational contacts**

**Graduate Employment Issue**

Organisation	Contact	Contact details	Date	Outcome
Hull & East Yorkshire Hosps NHS Trust	Stephen Morrison <i>Dir HR</i>	Stephen.morrison@hey.nhs.uk	12/2/07	Negative email
	Norah Flood <i>Therapy mger</i>	Norah.flood@knowsley.nhs.uk 01514301880 Lancs		Bank for physio
Northern Lincolnshire & Goole Hospitals NHS Trust	Glenda Brigs <i>Acting Trust Therapy Lead (physio)</i> Debbie Shakespear <i>Ass Div Mger Midwifery</i> Dorothy Hulme <i>Ass Dir Nursing Site mger</i>	01724282282 x 7630  0174282282 x 5477 <a href="mailto:Debrah.shakespeare@nlq.nhs.uk">Debrah.shakespeare@nlq.nhs.uk</a>  017424 290154	28/2/07	Very aware of problem employing Grad on bank and finding three shifts/week Worry re role drift for those employed as HCA Would welcome central support
National Blood	Gill Travis	0114 203 4844	26/2/07	Only employ small numbers

transfusion service	<i>National Resourcing Manager</i>		t/c	(20/30 )nurses across patch at band 6 see no openings as very exposed environment
YAS	Gill Moss <i>HR Manager</i>	07730426126 07881922713	21/2/07	Positive – major restructuring and definite possibility of new roles in light of White paper ? pt transport services ? ambulance Service needs further discussion with Glynis Learmouth and Possibly K Cooper
	<i>Glynis Learmouth</i>	01904666010 08451241241	7/3/07	Glynis Learmonth Positive meeting to be taken to the Directors group
	<i>Karen Cooper</i> <i>Asst dir Bus servr ??</i>	01709820520	None yet	
NHS Professionals	Cathy Winn Project lead	01904 582054	8/2/07	Pilot in East SHA 6-8 candidates well received ?expensive cost attached
Barnsley District Gen Hosp NHS Trust	Julie Greenwood	01227 777701	6/2/07	Advised MM to split F/T posts to increase up take Only done in one are
Leeds Mental Health Teaching NHS Trust	Maria Warner Lead on graduate issues	07711871851	8/2/07	Advised by M she is not the best contact but will take this forward in the trust and report back Recognises it is an issue the trust has to pick up
		07960 727030		<b>To be contacted</b>

	Victoria Bretton			
Bradford Teaching Hospitals NHS Foundation Trust	Gill Gregson Physio Practise base community	01274 364251	27/2/07 t/c  1/3/07with grad HCA	Very positive and ring fences posts Also HCA posts with CPD HCA graduates appreciate and value the ability to consolidated training with out pressure/responsibility Finding jobs  Gill will ring fence jobs at qual level and HCA (employ 70 with approx 15% T/Over /y) Will coordinate with graduation periods  Would value Restricted jobs register as an aid /time saver in contacting students
Maria Neary	Midwifery <b>To contact</b>			
Wilf ward Trust	Steve Liddle  Jane Barnes	<a href="mailto:traing@wilfward.org.uk">traing@wilfward.org.uk</a> 01751 474740  01904 520562 69 green lane York YO24 3DJ j.barnes@wilfward.org.uk	12/2/07  7/3/07	T/C very positive  Met with Jane Barnes –operation and development manager  Salaries would be prohibited but looking at a new piolot for those client groups now becoming more dependant (Dementia etc)

				and will take this intelligence to the piolot meetings to discuss
Sheffield Uni	Gary Albutt	0114 2229701	12/2/07	T/C awaiting outcome bid to Alumni funds £10,000 to support unemployed graduates on to further studies (degrees)
Leeds Teaching Hospitals NHS Trust	Angela Kitson Works employment Planner Oncology unit	0113 206 4032	20/3/07	T/C meeting arranged 20/3/07 Have been recruiting over three years and training on ongoing basis would welcome bands 5a 5b
NEYNLSHA	Sheila Duckett <i>RR&amp;R team</i>	07961975128	15/2/07	Most trusts recruited independently of the SHA No records but knowledge of bringing in Overseas nurses on short term contracts ? numbers <b>* need to contact Trust HR to see if they have figures</b>
North Yorkshire & York PCT	Racheal Ingham Jones Assoc Dir HR	01904 724058	22/3/07	Wants to involved
Harrogate and District NHS Foundation Trust	Phillip Marshall <i>Dir HR</i>  Heather Chapman Acting Dir Therapy services Lesly Harris	01423 554440  01423 554426  01423 553050	12/3/07	Wants to be involved not yet able tmc  T/C with heather Chapman had to reduce service by band 5 post due to cuts Recruits internally for graduates (PHYSIO)

	Angela Monaghan <i>Chief Nurse</i>	01423 555532		P/T difficult need F/T people Overseas applicants active(200) applicants Would welcome drive to ensure all organisations took a percentage based on capita. Do not ask for Experience B5 Telephone help line need to be organisational Band 4 assistant Pract good idea New job roles to be designed Issues re exploitation and Voluntary work (Grad asking for it) Run in-house CPD courses well received
Leeds PCT	Paul Morrin Dir of operations		31/1/07	No special initiative not considered it as problem would assume a responsibility for supporting initiative/s. <b>See notes</b>
Neil Simpson	Making Leeds Better	Neil.simpson@nhs.net 07960727403	14/3/07 14/3/07	<b>Nurse directors meeting Paul Morin Contact for this work</b>  To meet with Nursing Directorate discuss
Scarborough & N. E. Yorkshire Healthcare NHS Trust				
Airedale NHS Trust				

Sheffield Children's NHS Foundation Trust				
Rotherham Foundation NHS Trust				
Sheffield Teaching Hospitals NHS Foundation Trust				
Doncaster & Bassetlaw Hospitals NHS Foundation Trust				
Hull & East Riding Comm. Health NHS Trust				
Calderdale & Huddersfield NHS Trust				
Doncaster and South Humberside Healthcare NHS Trust				
Mid Yorkshire Hospitals NHS Trust				
South West Yorkshire Mental Health NHS Trust				
Bradford District				

Care Trust				
Sheffield Care Trust				
North East Lincolnshire PCT				
North Lincolnshire PCT				
Rotherham PCT				
Calderdale PCT				
Barnsley PCT				
Leeds PCT				
Kirklees PCT	Sheila Dilks Dir patient care and professions  Tracy Small	<a href="mailto:Sheila.Dilks@kirkleespct.nhs.uk">Sheila.Dilks@kirkleespct.nhs.uk</a>  Tracy.small@kirkleespct.nhs.uk	01484466226	Positive response to be involved in any future initiative email in file
Wakefield District PCT				
Sheffield PCT				
Doncaster PCT				
North Yorkshire & York PCT	Gail Brook head of Physio (Hgte & craven PCT)	01423 5536768		
East Riding of Yorkshire PCT				
Hull PCT				
Bradford & Airedale PCT	Sharon Parker Placement coordinator/Annette Mellor acting	01274 228301  363822		Ring fencing posts For MH and PLD 80% graduates have some work

	personnel Manager			
Barbara Mitchell	Skills for care			

## Appendix 2c

### Benefits Realisation

#### **'SMART'** **Simple Multi attribute rating Technique** **Value engineering**

Dear colleagues

Thank you for meeting with me to discuss and share your organisations perceptions on the issue of employment prospects for the Nursing, Midwifery and Physiotherapy Graduates. As you are aware I am undertaking this piece of work on behalf of the NHS Yorkshire and the Humber SHA, Graduate Employment Task Group.

During my recent conversations with you I discussed the possibility of attaching numerical value to the perceived benefits using a tool more usually applied to projects in the construction industry but which I feel will readily lend itself to this project. This Tool is known as Simple Multi Attribute Rating Technique Value Engineering (SMART).

As I have outlined during our meetings, this process would normally be managed in group sessions, allowing a consensus of opinion. Due to the time scales and difficulty of every one being able to meet I will collate your weightings on the understanding that the Task Group accept that this has had to be the process.

This tool is an aid to ordering or ranking the proposed solutions to a problem, and is used in conjunction with other information (in this case the report) not in isolation.

I would be grateful if you would give the attached explanation and chart your consideration complete and return it to myself as soon as possible but no later than the 5<sup>th</sup> March 2007.

Thank you in anticipation

Gill Gibbons  
Yorkshire and Humber NHS  
East Villa  
109 Hesslington Road  
York YO10 5ZH

Tel 01904 420323  
Mobile 07930983343

*Appendix 2c cont.*

**Benefits Realisation - Health Care Graduation Employment**  
**'SMART'**  
**Simple Multi attribute rating Technique**  
**Value engineering**

Please give the following statements your consideration and attach weightings to the chart below.

**Column 1**

In this column weight each of the four statements in Column 2, the combined weights of which will total 'One'.

**Column 3**

In this column weight each of the statements in each of the Four groups (each group are the methods by which the benefit in column 2 will be achieved. 4, the combined The combined weight of the statements in EACH GROUP will total 'One'.

See sample page

**Simple Multi attribute rating Technique  
Value engineering**

**Wt – Weighting assigned  
Total- each block adds up to a whole number of 1**

1 Wt	2. The what		3. Wt	4. The How	Office use
	Improve Employment prospects			Pd employment in Qualification	
				Pd employment in related Discipline	
				Pd employment in HSC sector (Support Worker etc)	
				Pd in non HSC sector	
			<b>Total 1</b>		
	Geographical -Keep the gradates in location of employer			Yorkshire and Humber	
				England	
				G Britain	
				Overseas	
			<b>Total 1</b>		
	Retain Educational expertise. (Lecturers, Mentors and preceptors)			Develop new roles in education delivery/ contribute to inter-professional learning	
				Maintain level of commissioning	
				Support Uni Lectures understanding of sector and employment prospects (flow Chart)	
			<b>Total 1</b>		
	Job Market and careers/ Audit /Tracking			Job Shops/seminars	
				Improve student and U Staff knowledge re the job market	
				Monitor student employment	
				Employer engagement	
<b>Total 1</b>			<b>Total 1</b>		

Please complete and return either by email or fax to :-

[gillian.gibbons@yorksandhumber.nhs.uk](mailto:gillian.gibbons@yorksandhumber.nhs.uk)

Fax 01904 420321  
Thank you Gill Gibbons

**SAMPLE ONLY FOR GUIDENCE**

<b>1 Wt</b>	<b>2. The what</b>		<b>3. Wt</b>	<b>4. The How</b>	<b>Office use</b>
0.3	Benefit 1		0.2	How 1	
			0.4	How 2	
			0.1	How 3	
			0.3	How 4	
			<b>Total 1</b>		
0.4	Benefit 2		0.5	How 1	
			0.2	How 2	
			0.1	How 3	
			0.2	How 4	
			<b>Total 1</b>		
0.1	Benefit 3		0.4	How 1	
			0.1	How 2	
			0.5	How 3	
			<b>Total 1</b>		
0.2	Benefit 4		0.2	How 1	
			0.5	How 2	
			0.1	How 3	
			0.2	How 4	
<b>Total 1</b>			<b>Total 1</b>		

## Appendix 2d

### Graduate focus group Questions to consider

#### First group session

**How do you feel about moving from education into employment?**

**When did you start thinking about this?**

**What do you think is suitable employment?**

#### Second group session

**What have you done so far to seek employment?**

**Who has helped you to seek employment and how have they helped and/or what have they done to assist you?**

**What could others do to help you find employment?**

#### Third group session

##### **Proposed ideas and suggestions Please comment**

1. Create opportunities for graduates to backfill for P/T and Foundation degree courses and provide mentorship/CPD programme
2. Provide CPD programmes for graduates in part time employment or who have not yet secured a health industry post.
3. Create support/learning schemes to assist students to adjust to living outside their familiar geographical area and/or away from family support.
4. Change the perception and custom and practice of some employers who ask for a period of post grad experience before offering employment.
5. Temporary posts eg to cover for a sabbaticals or career breaks (for example to release staff to work abroad eg for voluntary organisations who are actively looking for younger professionals to work overseas).

6. Provide awareness sessions about what is involved in working abroad, for example Australia or New Zealand.
7. Register Graduates on restricted NHS Jobs Register and web site.

#### **Final group session**

**What do you now think is suitable employment?**

**Has anything we've discussed today given you different ideas?**

**What approach do you prefer us to use to keep in touch?**

## **Appendix 3**

### **Case study**

From a very early age I had been diagnosed with profound dyslexia and was quite pleased to leave college with a couple of reasonable A Levels. I did however realise that these would not be sufficient to secure me a place on a University course to study Physiotherapy. Following my natural inclinations, I decided to apply to Edge Hill to undertake a Sports Science degree and upon successful completion of this degree I was able then to apply to the University of East London, who made me an unconditional offer to study Physiotherapy.

I completed my Physiotherapy degree in 2006, but since qualifying I have been unsuccessful in obtaining a Junior Rotational post within the NHS, even though I have applied to various areas of the country and on a very regular basis. I did however manage to secure employment as a gym instructor, registering with the Register of Exercise Professionals and soon set up a business as a personal trainer. I continued working within the leisure industry and applied for and was successful in obtaining a part-time post as an Exercise Prescriptionist, working for my local Leisure Trust on a scheme funded by one of the local PCTs. I have been able to use my skills as a physiotherapist, setting up specialist classes for the Trust including core stability and cardiac-rehabilitation.

For the past 12 months I have been the Physiotherapist for a local rugby club, attending matches as well as providing Physiotherapy assessments and treatments for the team. This has enabled me to continue to practice my skills as well as encouraged me to attend a variety of Continuing Professional Development courses.

I was asked by the Chartered Society of Physiotherapy to speak at a University Admissions Tutors Conference on the coping strategies which I used for my extreme dyslexia, during my degrees. This has led to my being invited to other University led events speaking on the same subject. I have also, been a guest speaker on a couple of occasions at local schools, speaking on securing a place at University and the importance of health and safety in the workplace. I must admit that I even surprised myself at my ability to stand up in front of large groups of people and deliver a lecture.

Fate has further lent a hand and I was invited to lecture at a local College of Further Education, teaching remedial massage and human physiology and health and will be taking over as module leader when the course recommences after the summer. Where will all this lead, well who knows but I know that my skills are being used, that my abilities are being stretched and that I am continuing to develop – who could ask for more?

## Appendix 4

### GRADUATE EMPLOYMENT COSTS

<u>INVOICE NO.</u>	<u>ORGANISATION</u>	<u>AMOUNT</u>
70001596	East Riding of Yorkshire PCT	15,000
235608	Bradford Teaching Hospitals	20,000
264266	Leeds Teaching Hospitals	9,953
9057109	Airedale NHS Trust	8,000
M052215	Mid Yorkshire Hospitals	20,000
520423	Scarborough & NE Yorkshire	14,000
236574	Bradford Teaching Hospitals	18,000
H106170	Harrogate & District FT	2,250
90108123	University of Leeds	250
270843	Leeds Teaching Hospitals	9,953
1800001753	University of Sheffield	40,000
168566	Bradford Teaching Hospitals	24,000
124646	Calderdale & Huddersfield NHs Trust	20,000
6028103	Leeds Metropolitan University Rotherham, Doncaster & South	25,000
0000046138	Humber	21,000
40001741109	Sheffield Teaching	14,000
07-35	Making Sense	100
2007739	Humber Mental Mental Health	30,000
2100052612	Sheffield Care Trust	30,000
1000343	Airedale NHS Trust	10,000
962031	Leeds Partnerships NHS Trust	30,000
1000694	Airedale NHS Trust	9,000
246475	Leeds Teaching Hospitals	9,953
277436	Leeds Teaching Hospitals	9,953
08-17	Making Sense	150
705592	South West Yorkshire Mental Health	669
523255	Scarborough & NE Yorkshire	22,000
	<b>Total</b>	<b>413,229</b>

**Appendix 5**

**A Stakeholder Evaluation of a Non-medical Graduate Preceptorship Pilot  
Project in Six Mental Health Trusts**

**Final report to the Yorkshire and Humber Strategic Health Authority**



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**July 2008**

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## **Abstract**

This report was commissioned by the Yorkshire and Humber Strategic Health Authority to evaluate a non-medical graduate preceptorship initiative involving six Mental Health Trusts in the north of England. It is based on a preceptorship model agreed by all of the Trusts that was designed to maximise employment opportunities for newly qualified graduates. This report provides background policy and workforce contextualisation, outlines the aims and scope of the evaluation, and presents findings from statistical returns and from interviews with different stakeholder groups, including graduates, mentors and Trust leads. Lessons from the evaluation are reported.

## **Contents**

### **1. Introduction and background**

### **2. Structure of this report**

### **3. The pilot preceptorship model**

### **4. The evaluation**

#### **4.1 Participants**

#### **4.2 Aims and objectives**

#### **4.3 Methodology**

#### **4.4 Recruitment of graduates**

#### **4.5 Timescale**

#### **4.6 Ethics**

### **5. Findings**

#### **5.1 Provider perspectives**

##### **5.1.1 Setting things up**

##### **5.1.2 Early expectations**

##### **5.1.3 The talent pool**

##### **5.1.4 Reflecting on the experience**

##### **5.1.5 Summary**

#### **5.2 Graduate perspectives**

##### **5.2.1 Employment success**

##### **5.2.2 What graduates were doing previously**

##### **5.2.3 Talent pool**

##### **5.2.4 Attractions of the preceptorship pilot**

##### **5.2.5 Part-time or full-time?**

##### **5.2.6 Study days**

##### **5.2.7 Supernumerary status**

##### **5.2.8 Becoming the accountable practitioner**

##### **5.2.9 Summary**

### **6. Limitations**

### **7. Conclusion**

### **References**

### **Appendices**

## 1. Introduction and Background

According to the Social Partnership Forum Action Plan (Department of Health 2007), since 2005 it has become increasingly clear that for the first time in a generation, the available job opportunities in the NHS are exceeded by the number of people seeking employment in the NHS. Competition for posts is much more challenging and students in many professions are finding it increasingly difficult to find their first job post qualification. In spite of this, the projected numbers of retirements expected amongst healthcare professionals against five year plans for healthcare delivery indicate that the NHS still needs to employ a considerable number of newly qualified healthcare professionals over the coming years.

In its latest recommendation for 2006-07, the Workforce Review Team has noted that there will not only be a slowing down in workforce growth but also a reduction in some areas due to financial problems:

‘A small number of SHAs will almost certainly be unable to achieve financial balance in 2005-06 and, further, a large group will find this very challenging. It is anticipated that the entire first group and many of the second will need to either control or reduce their total workforce’.

And:

‘Many SHAs plan to maintain or reduce staffing levels overall. It is entirely possible that the rate of workforce growth will drop back (rather than slow) in 2006-07 to levels at or below the previous trends. We already have evidence that newly trained staff are having difficulty in finding jobs in a number of specialities and staff groups’.

According to Foley (2007) it is anticipated that across Yorkshire and the Humber approximately 2,700 health professional students will graduate in 2007/08. Between August and October 2007 there were estimated to be 183 mental health and 63 learning disability diplomats/graduate nurses qualifying, plus a significant number of AHPs hoping to work in mental health or learning disability services.

Gibbons (2007) states that over the past two to three years there have been increased anecdotal evidence that significant numbers of nursing, midwifery and physiotherapy graduates are failing to secure paid employment in the healthcare labour market on the completion of their studies. Graduates from these professions are finding it increasingly difficult to find work of suitable hours – sufficient to allow them to gain the required preceptorship or supervisory practice.

Graduate unemployment figures vary between universities and disciplines and it has been difficult to gauge the exact scale of the problem. The transferable skills of these graduates make them very attractive to other industrial sectors and there is a real danger that these graduates will gain employment in an

alternative sector, becoming lost to the health care sector permanently. Gibbons (2007) concludes that this is a national problem.

The pilot project described in the following pages was self evidently taking place at a time of unprecedented change in the NHS with major shifts away from centralized planning systems that, according to some commentators, have overlooked team building, costs and economics, and quality (Bosanquet et al. 2006). These same commentators suggest that the transition to a different human resource approach will be difficult, and that productivity gains associated with the NHS reforms will mean that staff numbers are likely to reduce by 10 per cent, representing a sharp change in policy direction. This change in job opportunities significantly affects the demand-supply relationship in the labour market, leading to an over supply in the short-term, of new graduates. The longer-term prospects of the NHS reforms are considered to presage a system with greater flexibility, local initiative and scope for team building that will ultimately create conditions where better job satisfaction and professional pride can flourish (Bosanquet et al. 2006).

Among its many recommendations, The Social Partnership Forum Action Plan (Department of Health 2007) suggests that NHS Trusts should review their temporary staffing policies, stopping or dramatically reducing reliance on agency staff and making particular use of newly qualified healthcare professionals through flexible pools internally, and redeploying staff when vacancies or opportunities arise. It was further recommended that NHS Trusts should consider ring-fencing jobs for newly qualified healthcare professionals who have been unable to secure their first permanent post in the appropriate band in relation to the job evaluation scheme. These recommendations illustrate the gravity of the situation, and serve to highlight the serious intent behind the preceptorship pilot as one way of addressing this problem.

It can be seen that the NMG preceptorship pilot emerged from recognition that, in the short-term, something needed to be done regionally, and urgently, to address the temporary over-supply of newly qualified graduate mental health and learning disability nurses and AHPs.

The case for preceptorship has been argued elsewhere and shown to be worthy of investment (Gerrish 2000) in order to equip the neophyte graduate to become an accountable practitioner. Over 10 years ago Bain (1996) in her review suggested that though there was evidence to support the view that preceptorship can help retention and recruitment of staff, there was a need to avoid preceptorship programmes becoming 'crash courses in survival within nursing' (p.106). At the time there was little evidence about preceptorship experience. The subsequent study by Allen (2002), based on a stakeholder evaluation of preceptorship in mental health nursing, showed that implementation issues could be problematic, especially a supportive culture towards preceptorship, the content of preceptor preparation packages, preparation for preceptorship roles, the ease with which support for preceptors can be overlooked, and the need for ring-fenced or protected time.

On the other hand, Gibbons (2007) reports that postgraduates working as support workers on a preceptorship programme at one Trust all had positive experiences and felt that they had greatly benefited through the programme and could recommend this to others. Three out of four had achieved Band 5 posts as a direct result of their experience.

The benefits were described in the following ways:

- consolidated learning that enabled them to practise skills;
- improved communication skills, particularly with staff and client groups;
- increased knowledge of local policies, a concern to graduates moving to new organisations;
- improved knowledge of local documentation, making them more confident now they have secured a Band 5 post;
- better understanding of the support worker role and the full potential of the worker.

Students and graduates expressed anxiety at taking a first job and almost all thought preceptorship would be a desirable stepping-stone to full responsibility. A further benefit was considered to be maintaining contact with graduates until vacancies arose.

There is clearly a mix of differing perspectives about the value and operation of preceptorship programmes, but the prevailing workforce projections and the apparent downturn in the availability of front-line posts had propelled preceptorship to the foreground once again.

These, in summary, were the key background factors informing the pilot evaluation.

## **2. Structure of this report**

Having described the background to the pilot project the remainder of this report is split into linked sections, as follows:

**The Pilot Preceptorship Model** - describes the scope and parameters of the project.

**The Evaluation** - outlines the participants, aims and objectives, methodology, recruitment strategy, timescale and ethics.

**Findings** - presented in two sections:

(i) provider perspectives based on interviews with Trust education leads and preceptors that describe how preceptorship arrangements were organised, early expectations, experiences of the talent pool, reflections on the experience, and summary.

(ii) graduate experiences of employment success, what graduates were doing previously, the talent pool, the attractions of the pilot, part-time vs. full-time experience, study days, supernumerary status, becoming an accountable practitioner, and summary.

**Limitations of the evaluation**

**Conclusion** - in which the main findings are summarized and implications considered.

### 3. The Pilot Preceptorship Model

At a meeting of the Yorkshire and Humber Directors of Nursing for the six Mental Health and Learning Disability Trusts/Care Trusts it was agreed to adopt a Yorkshire and Humber wide approach to graduate recruitment, to agree a model of preceptorship that would be applied to nurses and AHPs across the six Trusts and to develop and evaluate the pilot as a pilot starting in Autumn 2007. It was made explicit that there should be a collective commitment to the solutions from all stakeholders.

Each Trust agreed to recruit a fixed number of graduates from the total pool and provide them with a learning contract. The contract was designed to ensure that they fulfilled the preceptorship requirements of professional bodies and maximized their opportunities to secure employment.

It was agreed that graduates would receive the following from the designated Trust:

- A 2 day induction/mandatory training course
- Preceptorship workbook
- An identified supervisor
- A number of shifts in practice (depending on availability) paid at Agenda for Change band 5
- Pre-employment checks
- Exposure to a range of settings to support the shift from student to staff nurse/basic grade AHP
- Access to CPD opportunities/modules from local universities

The pilot was designed to offer new graduates 2.5 days (18.75 hours per week). In advertising the pilot, Trusts underscored the advantages to participants. Typically these included becoming more attractive to employers when vacancies arose, opportunities to apply for substantive positions advertised internally within each Trust or even the NHS, and continuing access to university programmes with a view to completing degrees or continuing professional development.

The costs associated with running the pilot over a six month period were to be shared on a 50:50 basis between the SHA and the Trusts.

As part of its commitment to the Social Partnership Forum Action Plan, the Yorkshire and Humber SHA established a Newly Qualified Profile Pool (Talent Pool) of all new qualifiers seeking their first post, through the use of NHS Jobs, to identify and quantify newly qualified healthcare professionals seeking employment. A guide, written for graduates (NHS Careers 2007), has been widely circulated. The primary purpose of the talent pool was to enable direct communication between undergraduates/graduates, the SHA and NHS employers. Graduates have to renew their profiles every three months if they have not obtained employment and wish to remain on the pool.

## **4. The Evaluation**

### **4.1 Participants**

The trusts participating in the pilot scheme are:

- Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust (RDaSH).
- Leeds Partnerships Foundation Trust (LPFT).
- South West Yorkshire Mental Health Trust (SWYMHT).
- Bradford District Care Trust (BDCT).
- Sheffield Care Trust (SCT).
- Humber Mental Health Trust (HMHT).

The preceptorship model is one that applies to nurses and Allied Health Professionals (AHPs) across the Trusts.

The Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust (RDASH) are responsible for coordinating the evaluation with Professor Grant leading the evaluation.

### **4.2 Aims and objectives**

The main aim of this project is to evaluate the preceptorship arrangements that have been put in place for non-medical nursing and AHP graduates. The objectives are to assess:

- (i) How the preceptorship model is implemented in each Trust;
- (ii) What variations to the model are necessary and what local conditions give rise to this;
- (iii) How the preceptorship model is experienced by stakeholders within and between participating Trusts;
- (iv) Connectivity and workforce issues.

### **4.3 Methodology**

#### **(i) Project management**

Each Trust nominated a lead person to support the evaluation. The Trust leads, together with a representative from the SHA and the evaluation team (Helen Oldknow and Gordon Grant), constituted a project management group (PMG) with responsibilities for giving advice and in holding the evaluation team to account (project management group membership, Appendix 5a).

The PMG assisted preliminary work and:

- agreed the aims, objectives, methods and timescale for the project;
- confirmed numbers of non-medical graduates involved (10 at each site), and made available basic information about preceptorship arrangements at each site;
- collated relevant Trust policy documents or position papers relevant to the above.

## (ii) Field methods

Three stakeholder groups were identified from whom data were obtained:

non-medical graduates (NMGs),  
 their preceptors/mentors,  
 Trust leads.

Telephone interviews (aide memoire, see Appendix 5b) were carried out with NMGs and their preceptors/mentors. This was considered to have distinct advantages over self administration questionnaires (which can suffer low response rates, complicated logistics and problems with validity) whilst face-to-face interviews can be time-consuming and costly. However, face-to-face interviews were arranged with a sub-sample of participants (at RDASH) to strengthen the trustworthiness and authenticity of the findings. Issues for discussion included: what NMGs are learning, what they think is useful to their future careers, their views about the work environments as possible suitable places of employment.

With other stakeholders the focus of the interviews was more about the supervisory and organisational arrangements, their seamlessness/disruptiveness, and costs.

Face-to-face interviews were held with all participating Trust leads (see Appendix 5c) in order to obtain a provider view of the preceptorship arrangements. The interview data, together with local documentary evidence, helped to build up a picture of how preceptorship was organised at the local level and what challenges were involved. These face to face interviews were tape-recorded. This report, and the interim report that preceded it, were fed back to Trust leads so that they can check and validate findings based on their experiences, in line with constructivist research principles (Rodwell 1998).

Trust leads accepted responsibility for contacting NMGs and supervisors so as to inform them locally about the evaluation, paving the way for introductions from the evaluation team.

The project can be looked upon as a mixed methods qualitative service evaluation project involving face-to-face interviews, telephone interviews and analysis of documents. Interviews were guided by an aide memoire.

### (iii) Data analysis

A value-relative stance was adopted, meaning one where an evaluative position was created from an analysis of the perspectives and experiences of the main stakeholders - the newly qualified non-medical graduates, their supervisors and relevant Trust leads. This took us towards triangulation of methods and data sources which is generally seen as a good way of maximizing methodological rigour in projects of this kind (Seale 1999).

With the NMGs a process evaluation approach was considered to work best. This meant doing the evaluation prospectively but also asking participants to reflect on their recent experiences. All interview transcripts and notes were analysed independently for emergent themes by each of the authors. These are used as a vehicle for reporting the findings.

The evaluation took place at a time of considerable workforce changes in the NHS, with the inevitable job and career insecurities that arise. It was anticipated that some of the NMG participants would complete their preceptorships before we knew if they had been able to secure employment. We recognised that it may not be possible to keep track of this. Early intelligence indicated that recruitment to NMG preceptorship posts may also be difficult at some sites, suggesting the need to be alive to different agendas as the evaluation unfolded, for example exploring why people fail to present themselves for interview or the circumstances surrounding their leaving before completing their placements.

#### **4.4 Recruitment of NMGs**

Job advertisements were placed in each of the study sites for Band five preceptorship placements on a fixed term six-month contract (see example Appendix 5d). This was in most cases preceded by negotiations with local universities and presentations to graduating students.

Due to the take up being less than expected in some Trusts the graduates have been able in these cases to opt for clinical settings of their choice.

#### **4.5 Timescale**

The proposed timescale for the evaluation was originally agreed to be for a period of six months. However it quickly became evident, due to the phased implementation of the preceptorship arrangements and some unanticipated difficulties with recruitment to the project in some sites that the project timescale would need to be extended beyond March 2008. Interviews with graduates were completed by late April 2008. An interim report based on statistical returns and interviews with Trust education leads, focussing on implementation issues, was submitted to the SHA in March 2008.

## 4.6 Ethics

The Project Management Group considered the project to be service evaluation rather than research since it was primarily concerned with identifying local lessons rather than generalisable knowledge. However, given that data collection was to involve NHS staff, ethical considerations were still important. It was decided to address this by scrutinising the arrangements for fieldwork at the RDASH site since this was being carried out as part of a Master's project at Sheffield Hallam University (SHU) by a member of the evaluation team (HO). This was scientifically peer reviewed and gained ethical approval from the university. Since the RDASH fieldwork was being replicated at the other five sites, the approach can be viewed as being validated for its science and ethics.

Participants were provided with information sheets about the project and asked to complete consent forms. Assurances of confidentiality and anonymity were given to all participants. Pseudonyms or other non-attributable methods were used when reporting participants' comments in this report.

## **5. Findings**

### **5.1 Provider perspectives**

In this section of the report we consider the experiences of Trust education leads and preceptors.

#### **5.1.1 Setting things up**

As can be seen (Table 1) there were core components of the preceptorship arrangements that were common to all of the participating Trusts. This was predictable given the commitment of the Trusts to a shared practice model. The core components were:

- Induction as an integral part of corporate induction arrangements
- Induction as area specific
- Pre-employment checks including CRB and health screening
- Access to a qualified preceptor
- Supervision at practice location
- Access to CPD

The graduates had supernumerary status at four of the six Trusts. AHPs were recruited in one Trust where they had exposure to a range of settings during their six-month preceptorships. Nurse graduates typically remained in the same practice setting. Across the region the Trusts were linked to different universities and worked out their workforce requirements and recruitment strategies in close conjunction with them. Two of the Trusts had entered into an agreement with local universities to run monthly sessions for the graduates on topics like the Mental Capacity Act, Mental Health Act, professional standards, risk assessment and ethics. With a third Trust the graduates had an opportunity to have 1-1 meetings with the Assistant Director of Nursing and Clinical Governance.

With some minor variations relating to settings and supernumerary status, the basic preceptorship model was adhered to very closely by all the participating Trusts.

Concealed within these arrangements was a huge amount of work by the Trusts who had to work to a very tight deadline to capture the new graduates. Negotiations with local universities, presentations to graduating students, securing HR and management clearances to proceed, negotiating with Trust managers about suitable placements, advertising and organising of interviews with all the associated pre-employment checks, and handling of pre-interview informal enquiries were among the more obvious of the tasks involved – all of them labour-intensive.

It was not only the sheer volume of tasks that needed to be undertaken but the challenges of coming up with convincing arguments to win over managers and colleagues to invest time and money into the pilot:

**Table 1 Preceptorship arrangements by Trust**

Non Medical Graduate Preceptorship Trust Arrangements						
	<b>RDASH</b>	<b>Bradford</b>	<b>Sheffield</b>	<b>Humber</b>	<b>Leeds</b>	<b>SWYMHT</b>
Induction corporate	✓	✓	✓	✓	✓	✓
Induction area specific	✓	✓	✓	✓	✓	✓
Pre employment checks:						
CRB	✓	✓	✓	✓	✓	✓
Health Screen	✓	✓	✓	✓	✓	✓
Qualified Preceptor	✓	✓	✓	✓	✓	✓
Supervision at practice location	✓	✓	✓	✓	✓	✓
Supernumerary Status	✓	✓		✓		✓
Exposure to a range of settings	AHPs ✓			✓		
Access to CPD	✓	✓	✓	✓	✓	✓
Trust specific	Commissioned University of Sheffield to do preceptorship course (with SCT)		Commissioned University of Sheffield to do Preceptorship course (with RDaSH)		Meeting with the Associate Director	
University link	Sheffield, Sheffield Hallam	Bradford	Sheffield, Sheffield Hallam	Hull, York	Leeds, Leeds Met	Huddersfield

We were struggling to understand the model ourselves and it makes it quite difficult to explain it to other people how it might work. When you're saying to people you know, your budget at this point in the NHS is incredibly rigorously monitored and closely held, it's very difficult to go in there and say, I think we've got this, this is what it looks like, can you sort of give us a big chunk of money....?

However, arguments were won and investments made, so what were the early expectations?

### **5.1.2 Early expectations**

The project was premised on national and regional evidence that there were job shortages in mental health and learning disability nursing and also in allied health professions. The preceptorship project was therefore designed as a short-term workforce investment initiative to give newly qualified graduates a period of six months in which to develop their work competences and confidence with the aim of enhancing their prospects for securing permanent jobs in the NHS and social care services.

Given the disjunctions between the number of newly qualified graduates becoming available for work and the job market, it was anticipated that there would be few problems recruiting to preceptee posts. It quickly became evident that things would not be so straightforward. As will be seen, experience with respect to expressions of interest, selection interviews conducted with candidates, acceptances, retention and progression to employment (Table 2) were very varied. Each site had its own story to tell, as can be seen below.

RDASH, Bradford, Leeds and SWYMHT all encountered high levels of attrition from initial expressions of interest to people remaining in post. Though the figures are patchy in their coverage, it can be seen in Bradford's case that 7 of those who accepted preceptee posts managed to secure employment internally or externally. In RDASH the level of acceptances was low, apparently only 3 out of 10, whereas in Leeds and SWYMHT there were only a handful of people who presented themselves for interview.

It is difficult to produce hard evidence to explain these outcomes. A pessimistic view would be that a part-time, fixed-term post is not as attractive as a full-time post, that this prompts individuals to look further afield outside the area or region, or that pro tem they consider other career options. Gibbons (2007) reports for example that between a quarter and a third of the students in her study were contemplating moving out of area to obtain employment, with a similar proportion considering moving overseas. On the other hand there was evidence that some of those accepting preceptee posts were successful in gaining employment very shortly afterwards, suggesting that the pilot was fulfilling its primary intended purpose in helping individuals to become more employable.

**Table 2. Preceptorship recruitment and retention statistics**

Non Medical Graduate Preceptorship Pilot Trust Recruitment Figures						
<b>Nurses</b>	<b>RDASH</b>	<b>Bradford</b>	<b>Sheffield</b>	<b>Humber</b>	<b>Leeds</b>	<b>SWYMHT</b>
Expressed Interest	29	18-20	24	16	5	5
Interviewed	10	10	15	16	3	2
Accepted Post	3	8	11	16	1	1
Start date	Dec 07	Oct 07	Oct 07	Jan 08		Jan 08
Still in post	1	1	10	16	0	1
Gained employment	1 internal 1 external	5 internal 2 external				1 internal (pt)
<b>AHPs</b>						
Expressed Interest	54					
Interviewed	6					
Accepted Post	3 Physios 1 O/T					
Still in post	3 Physios					
Gained employment	1 OT					
Variations to contracts	6 Month fixed term 18.5 hrs  (1 nursing post from Salford)	6 Month fixed term 18.5 hrs	6 Month fixed term	Full time substantive posts  (4 posts from Manchester)	Considering 3mth F/T Fixed term contract	On scheme on 10 hr contract, secured 27.5 hr substantive post in Trust

Trust leads generally adopted this more optimistic position as this typical comment illustrates:

Int: In a curious way it's a sort of inverted success story?

Resp: It is..... in essence because people are actually securing employment through traditional routes and going out there and getting themselves substantive employment either in your organisation or another organisation, you have to remember that that's the end point anyway.

Interestingly, the same Trust lead suggested that, based on conversations with the local HEI, this experience may well be replicated with the next student cohort:

Certainly I've had some discussions with the mental health and learning disability links up at the university about the cohort which is actually qualifying as we speak at the moment, in February/March, and what they are saying is that all of them to their understanding have either secured a substantive post or have an interview lined up, and that they're fairly hopeful that they can secure a substantive post.

With Sheffield and Hull (Humber) there was a contrasting outcome, with all or even excess preceptee places being taken up.

In Sheffield the operation of a flexible workforce system has meant that it has been possible to offer individuals extra hours to supplement their 2.5 days. As the Trust lead observed: 'I'd say about 6 out of the 10 or 11 are actually working more hours than they were originally employed (to do)'. Some individuals were recruited as flexible workers or support workers in the Trust or who were secondees. The Trust had also been able to put in place arrangements to more actively support CPD. These conditions are very likely to have improved recruitment to this pilot project.

In Humber it was possible to offer individuals full-time posts since there were appointable students graduating. As can be seen it was possible to recruit 16 people. We cannot be sure whether Humber's location and the employment conditions around Hull (high unemployment relative to most other areas in Humber and Yorkshire) were factors influencing this experience.

Consider also the contrast with the efforts made by one Trust (RDASH) to recruit AHP graduates. From the 54 expressions of interest, only 6 were interviewed (several individuals having failed to turn up or to notify the Trust that they were not following through their stated intention to attend for interview), 4 accepted offers, and at the time of writing only 3 remain in post. Physiotherapists of course have occupational pathways open to them (leisure and sport industries, private practice) that do not apply quite so readily to other occupational groups so some haemorrhaging is to be expected. From the ballpark figures reported here however we have no way of being able to confirm this – it is equally possible that individuals found jobs in the NHS but

outside the region. Nevertheless, this gives an early signal of the administrative work required of Trusts to attract a minimally acceptable number of interviewees.

In another Trust (SWYMHT) there were similar experiences in recruiting nurses:

Our intelligence from the university early on was, to be honest, quite vague really. They found it quite hard to predict as to how many graduates at that time were going to struggle to secure posts, so we were expecting a figure of anything between a handful and possibly half the cohort.....

As it happened, when we advertised the post we had expressions of interest from, I think my understanding was about 5 or 6 people expressed an interest. By the time it came to submitting applications, that was down to 3 or 4 people, and by the time it came to interview only 2 people decided to attend. What was happening was that as time was moving on individuals were securing posts.

In the end one of the two secured a post, leaving only one to take up a preceptee position.

Without exception all the Trust leads confirmed how inexact a science workforce planning is against the backcloth of NHS reforms, trends in educational provision and labour market conditions. Further, databasing inadequacies do not help. Gibbons (2007, p.30) provides a telling example:

Statistics on post graduation tracking, although questionable because of poor returns, suggests that over a period of six months employment appears to be gained by about an average 80% of graduates. What we do not know, however, are the numbers dropping out of healthcare into other industries.

### **5.1.3 The talent pool**

As mentioned earlier the talent pool was established to create more direct communications between newly qualified graduates, NHS employers and the SHA. Despite lots of promotional work to publicise the talent pool, it was not actively used by Trusts taking part in the preceptorship pilot. Various reasons were given for this:

- ❖ alternative arrangements had been made to recruit directly from cohorts identified with local universities;
- ❖ lack of awareness by Trusts of the talent pool and its parameters;  
time constraints.

One Trust lead summed up the situation well:

Int: In the build up to this did you make use of the talent pool?

Resp: No I don't think we did. I think it was a bit of 'suck it and see'. The other thing that I'm quite mindful of in terms of this project was that it all moved incredibly quickly. We were all, very quickly, having to go into organisations, sell the model within our organisations, try and secure the matched funding with our organisations. It was a paradigm shift in the way of thinking for many managers around the traditional way they brought people into the organisation, so whilst we were doing that, writing papers to show directors and what have you, we were also trying to progress this, have conversations with the HEI and what have you, so in terms of the time frames we were a bit limited at what we could do. We also had, it's fair to say, no real idea as to what the demand was going to be for the model. We didn't use the talent pool simply because of the time constraints rather than anything else, and the logistics of setting the thing up constrained us to what we could do within the available time envelope.

Another Trust interviewee suggested that there were too many layers of access involved in using the talent pool and this deterred them from using it. A further interviewee similarly confirmed that the talent pool, as presently set up, was not useful to them, and that Trusts could work better by sharing information about localities and specialisms with respect to new graduates (though it could be claimed that this is what the talent pool is partly set up to do).

As will be seen, these views about the talent pool reinforced what turned out to be a virtually unanimous response from the graduates interviewed.

#### **5.1.4 Reflecting on the experience**

Trust leads and were asked a series of questions designed to draw out their attitudes to the pilot project and how well it had been working from their point of view.

All were of the view that:

- ❖ they expected initially to recruit to target numbers
- ❖ the pilot would help people become more employable
- ❖ it should be of help to those least likely to get employment (though all were quick to say that recruits were either all employable or likely to be employable)
- ❖ it was worth the investment of time and resources, despite significant attrition in 4 Trusts

Some typical comments:

I think it's worth the investment of time..... . If you take one graduate off the street and put them into employment, and if it results in them securing employment and going on to have a career, you've maybe set a Chief Exec on the road....

At some point in the future we are going to have to do something about the nature of this scheme, and maybe this is an early toe dip in the water really as to how to tackle this.

There were however some qualifying comments and observations. Judging success in a more holistic or comprehensive way was accepted as difficult because:

- ❖ statistics on dispositions were incomplete;
- ❖ interpreting attrition (in people presenting for interview, in accepting offers or in completing placements) was problematic;
- ❖ the consequences of changing environmental factors (labour market forces, national policies) were hard to accommodate in constructing and evaluating locally tailored preceptorship arrangements.

Views diverged on some other issues. For example, not everyone was sure that six months was sufficient to give people a useful experience. Some individuals were in locations where they had to specialise immediately, though this was the direction in which mental health policy had been moving in recent years. Whether this was likely to constrain people's employment prospects was hard to gauge. Time-limited preceptorships were deemed by one Trust lead to be problematic in work with people with long-term conditions where there was premium on maintenance of relationships with clients. The principle therefore of rotating people around different directorates or work areas was under review.

Another Trust lead was of the view that the pilot should possibly not be made permanent for political and economic reasons:

It's a political thing. If it's permanent it limits us and I think people would ultimately say, well, we're not going to put any money into this because we're going to some for this. If somebody says we're going to get £25-30k per year to employ new nurses, that's £30k taken out of the nurse's budget. That's my anxiety. If there was some way we could ring fence that and basically say over and above any employment, and you have to prove it, and we can nail the finance director's ears to the floor if he gets it wrong, then we should do.

It was felt that the pilot had been quite disruptive to set up, largely because it was done in response to a looming crisis that required speedy action. With hindsight, for most of the Trust leads the crisis had disappeared, or apparently so for the moment, but there were nevertheless potentially valuable lessons to be drawn from implementing the pilot and evaluating its outcomes.

One person definitely saw the pilot as a stopgap measure. Simply put, there were people leaving university but there were no jobs for them, and something had to be done. Although conscious that financial parameters limited the pilot to 2.5 days per week, he viewed this as the minimum and that ideally more time was required to prepare mental health nurses as fully fit for practice.

Another Trust lead read this in terms of underlying moral tensions. He thought that it was immoral to train people when there are no jobs, but accepted the need for a preceptorship scheme of some kind in the expectation that things would change. He also drew attention to the impact of the private sector that created moral dilemmas:

(The private sector has) a legitimate place in the market you know, but if they don't contribute to the training for people. they're using NHS money as a stop gap..... we've got to start taking some responsibility and get out of the problem with the lack of contribution towards people that they employ.

In short, the NHS was considered in these respects to be subsidising private sector talent and profits.

The preceptors we interviewed were asked questions more directly related to their own roles as preceptors in the pilot. Like Trust education leads they were generally enthusiastic about preceptorship, judging it to be a good way of helping graduates to take the last steps towards being ready for professional practice:

Although Sally was with us for a short time, I think some of the experiences she got were kind of more in the real world.

Access to in-service training and study days were considered a key and valuable part of this final preparation for practice for new graduates:

When we interviewed a lot of graduates (we found that) they don't seem to have much knowledge of Government drivers, policies.... We had a representative professional body come up, and I did the in-service training on core standards of practice and professional conduct.

This last respondent considered that graduates needed to be better acquainted with the kinds of issues that employers might ask them about, NICE guidelines for example, and that the study days laid on were a good way of helping to familiarise graduates with these.

One preceptor strongly endorsed the value to graduates of having a named person as mentor and guide for the duration of their placement, since this allowed the essential elements of relationship building and trust to be developed – key conditions if individuals had any concerns or ambiguities that needed attention:

It helps to have one reference point in terms of a supportive person. I think it's less confusing, confidence-building... and getting to know the team it's nice to have that one person to have a trusted relationship to support them through that time.

This same preceptor considered that the experience helped to provide graduates with greater familiarity with local policies and their implementation, but:

Maybe that's something we take for granted. I know policies are discussed as part of their induction, and I suppose a lot of what we do becomes mechanical and routine, and what have you, without saying this is done this way because of policy.

Implied here was the idea that policy-practice connections are a bit like osmosis, where the clarity of the connections become clearer with continuing practice, reflexivity and good preceptorship arrangements.

Opinion was rather split about the part-time 18.5 hours per week commitment. An OT preceptor commented that:

All the studying they need to do, mandatory or statutory training they need to do... initially that does take up quite a lot of time, especially if only working part-time.

### **5.1.5 Summary**

The findings based on interviews with providers suggest support for the view that preceptorship as implemented in this pilot is:

- ❖ a necessary response to a challenging workforce problem where the available evidence suggested an over supply of graduates;
- ❖ useful in helping to retain a qualified, fit for practice and accountable workforce, even if the numbers are few;
- ❖ more likely to work if variations in the practice model can be accommodated to take account of local workforce needs;
- ❖ likely to work even without use of the talent pool;
- ❖ almost impossible to evaluate in quantitative terms because of difficulties associated with tracking graduates.

As a result of a combination of circumstances associated with timing, organisation and workforce planning itself, implementation challenges were not easy to resolve, especially:

- ❖ predicting take-up at almost every stage of the process from gauging expressions of interest, interview attendances, post acceptances and starting – this was demonstrated graphically with AHPs at one Trust;
- ❖ communications between graduates and NHS employers;

- ❖ making a part-time commitment to preceptorship viable for everyone;
- ❖ implementing the pilot under pressure not to lose graduates from the cohort whilst still having to educate or convince NHS colleagues about how the pilot would work;
- ❖ getting people to buy into the talent pool;
- ❖ the idea that the scheme was subsidising the private sector.

Other studies have shown how central the preparation of preceptors is (Allen 2002) to the success of schemes like this since they, perhaps more than anyone else, are in positions of significant influence in mentoring the graduates in practice settings. The experiences of preceptors, and the graduates themselves, are therefore absolutely core to understanding whether this pilot has been worthwhile.

## 5.2 Graduate perspectives

### 5.2.1 Employment success

Follow-up telephone interviews with Trust education leads provided some interesting, though still incomplete, data about the successes of graduates in securing employment. The figures for each Trust are shown below.

Humber start	16 were offered substantive contracts from the start
Sheffield	4 were offered substantive contracts, and 6 given extended full-time temporary contracts
RDASH of post given extended bank job (external)	3 nurses were offered substantive contracts (one of these external); 1 OT has a temporary (ft) (external); 2 physiotherapists were temporary contracts and 1 a
Bradford	8 gained employment (2 external, 6 internal)
SW Yorkshire	1 graduate recruited still looking for work
Leeds	1 graduate recruited left to return to country of origin

These figures do suggest that, judged against the key outcome criterion of success in gaining employment, the pilot project was instrumental in helping most graduates to move to this next and important stage in their professional careers. As far as can be gauged from these data, most of the nurses were able to secure substantive posts, and many of these individuals did so within the first two or three months. The scenario for AHPs was rather different, none having secured substantive posts.

Sixteen graduates were subsequently interviewed, these numbers reflecting relative successes in recruiting and retaining participants. The distribution of participants between Trusts is shown below:

Humber	4
Sheffield	4
RDASH	6
Bradford	1
SW Yorkshire	1
Leeds	0

These figures require some brief explanation. Of the 16 Humber graduates that were recruited, only 4 were interviewed as it became clear very quickly that they all had similar accounts. Put another way, data saturation was reached in the sense that no additional emergent themes were arising. In Sheffield, Bradford and RDASH roughly half of the graduates were interviewed, reflecting their availability for interview due to shift patterns, clinical work and sickness absence. South West Yorkshire only has one individual on the scheme. Leeds was late starting so there were no graduates in place and available for interview at the time (since the completion of the evaluation 2 AHPs (both occupational therapists) have been recruited to the pilot).

Of the 38 nurses recruited into the pilot, 28 found substantive employment at their host Trust; 6 were offered extensions to their preceptorship contracts. Three found posts in external Trusts and one is still seeking employment. Judged by this key criterion the pilot can be considered as well fulfilling its primary purpose of helping newly qualified graduates to secure employment.

The outcome for AHPs was not so rosy. Of the 4 AHPs, one OT found employment external to the Trust, two physiotherapists had their preceptorships extended, and the remaining physiotherapist found employment at an external Trust with an 'as and when required' post.

### **5.2.2 What graduates were doing previously**

By definition most of the graduates interviewed had recently graduated from university-based non-medical graduate professional qualifying courses

Ten of the 16 participants were previously students. One person, a physiotherapist, had been working as a volunteer overseas. Two people had taken time out to look after dependent relatives. One person, a physiotherapist, had two part-time jobs working as a physiotherapy assistant. One person had been working in a nightclub. The final person had been doing temporary office work.

Of the ten who were previously still students, two stated that they had been employed as bank/agency nursing staff.

### **5.2.3 Talent pool**

Only one of the 16 participants had heard of the talent pool. Even in her case she did not know much about it:

Erm... I don't know a lot about it, only that it is to do with the SHA, and it's meant to.... if you register with it... it is meant to contact you if there are any jobs that come up in your area – I think. But I haven't registered with them... it hasn't really led anywhere.

Of the remaining participants, the following suitably brief comment about the talent pool was typical:

The what?

If confirmation were needed, this provides good evidence to support what the Trust education leads had to say about the talent pool, their own and graduates' lack of knowledge about it.

### **5.2.4 Attractions of the preceptorship pilot**

Before asking graduates about their experiences with pilot preceptorships, we sought their views about what attracted them to apply.

First and foremost the main attraction of the pilot initiative was that it provided people with a job. This was emphasised by almost everyone. Secondly it was seen as providing a structured opportunity to complete preceptorship requirements and get a foot in the door to completing the next stage of professional careers. For one or two individuals the short-term, part-time elements of the scheme were not attractive, but seen as preferable to alternatives like being a support worker.

The following comments were typical:

Get a job and opportunity to complete preceptorship.

A job, to get a foot in the door.

Wasn't attracted – it was an option to get into a qualified post. Without it, it would have been more difficult.... Gave up a full-time band 3 support worker post to do this.

Nothing else available; either that or be a support worker.

### **5.2.5 Part-time or full-time?**

Opinion was split on the virtues of the pilot offering 18.5 hr posts. Personal circumstances dictated people's views and preferences about this.

On the one hand there were those like Mo and others for whom it was almost perfect because it allowed them either to maintain other part-time jobs or to fulfil parenting or caregiving roles at home:

It allowed me to keep my other part-time job and it was quite flexible... which was quite good for me. I can see how for other people that has not been enough for sometimes you only work two and a half days and you can't really get stuck in. (Mo)

For other participants like Carol and Anna however, the part-time commitment was not sufficient. In Carol's case juggling jobs to make up the hours, and by implication the income, was not easy:

You have got to take anything as a newly qualified physio, but I would much prefer full-time work, but at the moment I have been trying to juggle three jobs, just to make up the hours. So yes it does put me off. (Carol)

With Anna the logistical difficulties of matching part-time jobs whilst also hoping to accumulate experience towards being a fully accountable professional made things more exacting:

I didn't see it as an issue before I started, but once I started trying to find another part-time job that was really difficult because most part-time jobs only offer like all mornings and weekends and things, and it's just really difficult to get a part-time job. I think it would be better if it was full-time just to provide more experience because if you are only there part of the week you don't quite see the full extent of what goes on. (Anna)

There were some indications that it was easier for AHPs to locate other jobs to complement preceptorship experience, largely because of opportunities provided by the private sector, but even here things were not straightforward, as Anna's experience attests:

I got that job (personal assistant) a month ago, and have been working ever since December, started off by doing some temping, waitressing but that didn't work out, so yes it was really difficult, and I did go down lots of different avenues of retail and sports centres and everything else. (Anna)

### **5.2.6 Study days**

There were mixed views about study days. Reactions at two of the Trusts to the university-provided study days were rather negative. On the whole this was put down to a failure of communication between the named university and the Trusts to pin down the study day content:

Not worth University days, rather spend time doing practical work or better training, than reflection, just spent three years reflecting.

Study days not what was expected, could have been better used.... would have been useful if better communication between University and preceptorship scheme.

It was a waste of time really.

### **5.2.7 Supernumerary status**

The graduates were all given supernumerary status. However the length of this status varied, and was often dependent on the clinical setting and local arrangement for the preceptorship:

Yes for one week, made me learn the job quicker

No the advantage of this is I learnt a lot more, thrown in at the deep end, sink or swim. I swam, the disadvantage of this is that it was very daunting.

Had own caseload supported by supervisor.

Couldn't be counted, as we were not allowed to be left. We were not allowed to see patients unsupervised, there were times when we could have taken classes or could have done a role and they have been short- staffed and we were not allowed to fill in.... it's not made any difference to them, which is a bit of a shame really.

### **5.2.8 Becoming the accountable practitioner**

Participants had most to say about what the experience contributed towards helping them to become accountable practitioners. A number of themes were stressed:

#### **(i) confirmation of vocational or professional interests**

Without exception all the graduates stressed the value of the pilot in confirming or reinforcing their professional interests. Almost all were quite specific in naming what specialism or type of service in which they wanted to work.

Liked community work as a student. This has confirmed it.

I was not really sure where I wanted to work to be honest, rehab and recovery something I had thought about.

I didn't realise you know there was an area of mental health for physio, yes it has developed my understanding and I would consider being in this particular field in the future.

(ii) hope and positive expectations about securing a professional post

Despite the negative press about job shortages, all the graduates were hopeful of securing posts in their chosen specialisms. Indeed some were able to assert that they were in the very process of accepting jobs, some in the Trusts where they had been placed and some in other localities within South Yorkshire. The following was a typical comment:

I have got a permanent post at xxxxx, just waiting to find out a start date. I want to do my 998, to become a mentor... and would like to move on to community.

Another dimension of these positive expectations was the aspiration to move into a full-time permanent post. This was fairly typical of how graduates crystallised what they were looking for. Far from being a pipedream, it appeared to be the product of a quite detached calculation of what was possible. Judged by this criterion the pilot could be said to have well served its purpose.

(iii) building confidence in practice skills

Confidence building essential to the proper deployment of practice skills was emphasised as a key element of the experience. Access to a good, knowledgeable, approachable preceptor prepared to act as a sounding board and a professional confidante was an essential part of this.

Gained confidence learnt about knowledge into practice, not enough of this is done at university

(iv) experiencing being part of a team

Experiencing team working in action was another important ingredient in people's experience that was raised in discussion. The increasing policy and regulatory requirements for things like adherence to care pathways, health and safety standards, person-centred care and effective practice placed a high premium on becoming and being part of a (typically multidisciplinary) team, albeit under controlled preceptorship conditions.

The ward I was on, really, I could get a job there – you know what I mean - things just happened there, did not have to be prompted, and I liked the way they communicated with clients, yes it was a proper place for my preceptorship... it was a good team.

#### (v) Confusion

In a small number of Trusts some clinical areas did not have a preceptorship packs, and this may be the reason for the graduates' colleagues' lack of awareness of what the graduates were permitted to do. This seemed to result in confusion for both the clinicians and graduates. Two of the graduate mentors expressed this rather well, and crystallised what a number of graduates said:

My role seemed to be a little confusing for the other qualified staff on the ward. Could they give me the drug keys? I am a qualified nurse.

No preceptorship pack, made own up incorporating all the things needed to learn in this area, looked at it together to see timescale appropriate. No guidance on what we were supposed to be doing.

It seems evident from these typical comments that in some Trusts further guidance about preceptor roles and responsibilities needs to be made available, and that sharing of good practice about the design and content of preceptorship packs would be useful.

#### **5.2.9 Summary**

Based on interviews with the graduates the following findings were most in evidence:

- ❖ The main reason graduates became involved in this scheme was to gain employment;
- ❖ Direct and indirect evidence showed that the pilot was serving its primary purpose of enabling graduates to secure employment;
- ❖ Additionally the pilot enabled graduates to (i) confirm their vocational interests, (ii) maintain hope about securing a permanent post, (iii) build confidence in their practice skills, and (iv) experience being part of a team;
- ❖ The experience of university study days did not evaluate well, apparently for reasons to do with the failure of communication between the university and Trusts involved;
- ❖ However all had access to CPD and this was received well;
- ❖ Whilst helpful to a minority, the part-time nature of the scheme did not suit most;
- ❖ Graduates were unaware of the talent pool;
- ❖ The pilot preceptorship scheme was viewed in a positive light, and almost everyone would have recommended it to their peers.
- ❖ Roles and responsibilities of preceptors were not always as clear as they could be;
- ❖ There was variability in the availability, form and effectiveness of preceptorship packs.

## **6. Limitations of the evaluation**

The evaluation provides a snapshot of a 'rapidly moving target' and in this sense it is one-dimensional. Though interviews with stakeholders made it possible to capture retrospective experiences, the full range of temporal data was not available. This was largely to do with the fact that the pilot was a victim of its own success – some graduates moved on to employment very quickly but it was difficult to track them, and a number of graduates applying for posts did not turn up for their selection interview, so it was not possible to take their experiences into account.

We do not know if those failing to present at selection interviews were able to secure posts of their choice without going through the kind of preceptorship experiences described in this report. Future evaluations of initiatives like this might look prospectively at pathways to employment via different models of preceptorship, including also no preceptorship, otherwise there is a danger of overstating what preceptorship contributes to people's employability.

This report does not include employer perspectives, another potentially valuable source of knowledge about the value of preceptorship, though insofar as some of the graduates were taken on by the same Trusts participating in this pilot, the views expressed by Trust leads and mentors can be viewed as proxies for these.

The number of people interviewed, face-to-face or by phone, was relatively small and both the graduate and mentor samples should be seen as convenience rather than statistically representative samples. However, in both cases these samples are viewed as fit for purpose.

## 7. Conclusion

On two levels – securing of substantive posts and subjective appraisal of the initiative - the pilot can be judged as a success. Of the 38 nursing graduates involved, 28 secured substantive posts. Given the prevailing concerns about job shortages nationally and regionally this is very encouraging, and suggests that preceptorship has a key enabling role to play in helping newly qualified graduates to secure employment. Of course there is no way of knowing whether individuals would have enjoyed the same level of success in securing employment without the experience of preceptorship. The second main criterion for judging the success of the pilot was how the experience was evaluated. Encouragingly, all stakeholder groups – graduates, mentors and Trust leads – assessed the pilot in very positive terms. Given the short timeframe for planning the pilot in response to a reading of the rapidly changing (deteriorating) employment opportunities for nurses and AHPs in the latter part of 2007, this can only be judged as a pleasing outcome.

Overall the findings lend support to what Gibbons (2007) reported, notably that preceptorship supported consolidated learning, enabling graduates to practise their skills, whilst at the same time enhancing knowledge of local policies and procedures, and more generally helping individuals to feel more confident about being fit for professional practice.

Inevitably there were implementation challenges – short timescales led to a certain amount of guesswork about take-up and Trusts had to work out local recruitment strategies as things moved along; building a business case was not straightforward so the securing of matched funding from Trusts was not unproblematic; and ‘reading the local labour market’ proved to be as much an art as a science. Indeed there was some early revising of assumptions about whether or not there was a crisis in helping new graduates to find and retain substantive posts.

There were mixed views about the value of the pilot as a part-time undertaking for the graduates. It suited some more than others, due largely to personal circumstances.

Overall the findings underline the value of preceptorship, and arguably suggest a case for it to be a permanent part of standard practice rather than something that is optional. Funding Trusts to pay for preceptorship is believed to be under discussion as part of the NHS Next Stage Review.

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## **Appendix 1b**

### **Project Management Group Members**

**Elizabeth Foley**, SHA Lead

**Susan Sparks**, Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust.

**Jan Marshall**, Humber Mental Health Trust.

**Norman McCelland**, Leeds Partnerships Foundation Trust.

**Tony Flatley**, Sheffield Care Trust.

**Mathew O'Connor**, Bradford District Care Trust.

**George Smith**, South West Yorkshire Mental Health Trust.

**Gordon Grant**, Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust. Evaluation Lead

**Helen Oldknow**, Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust. Evaluation Team Member.

## **Appendix 5b**

### **Aide memoire for interviews with graduates**

#### **Non-medical graduate preceptorship study**

#### **Telephone interview with graduates – prompt sheet**

### **Personal**

Confirm (i) name, (ii) name of Trust/employer, (iii) locality/service.  
What doing before taking up current preceptorship

### **The experience**

- Induction
- Named worker
- Pre-employment checks
- Supervision arrangements
- Ability to access CPD
- Single/multiple placement localities

Why preceptorship attractive to you?

Talent pool – experience of

Supernumerary status – advantages and disadvantages

The environment – fitness as a place to:

- Test and develop professional skills
- Demonstrate capacity to meet professional standards
- See how Trust policies are put into practice
- Develop teamworking relationships and skills
- Confirm vocational interests
- Continue working in

### **Next steps**

- What considering as next step in career?
- What would the ideal job be?
- How has preceptorship helped decision-making about this?
- What see self doing a year from now?

Would you recommend preceptorship to others?

Anything else you want to tell us about your experience?

## **Appendix 5c**

### **Topic guide for interviews with Trust leads**

#### **1. Local preceptorship arrangements**

Can you tell me if your local arrangements include:

- induction
- named mentor throughout
- supervision at each practice location
- pre-employment checks
- exposure to a range of settings
- access to CPD
- anything else (specify)

How well have these arrangements worked so far, in your experience?  
What have been the main challenges putting these arrangements in place?  
Can you say how you overcame these?  
How useful has the talent pool been to you?  
Would you describe the preceptorship arrangements as giving graduates a quality experience?  
What is your view of your trust's preceptorship so far?

- genuinely helping people to become employable
- mostly of help to those least likely to get employment
- too short an experience for individuals to be worthwhile
- disruptive to set up and maintain
- not worth the investment of time and resources to set up
- should be a permanent part of what we offer to retain people

#### **2. The graduates**

Originally did you fully expect to recruit the target numbers (10)?  
What are the main reasons for (i) (the) much lower recruitment numbers, (ii) people failing to turn up?  
What local factors are involved do you think?  
Do you have a view about the 'types' of graduates presenting themselves for the scheme?

#### **3. Wider issues**

How does preceptorship impinge on the Trust's capacity to deliver seamless, personalised care?  
Is it a useful device to retain a skilled, local workforce? Is there a risk that preceptorship will be seen as a stop gap (i) for the person concerned and (ii) the Trust

## Appendix 5d



### **Band 5 Preceptorship Placements**

Six-months Fixed Term Contract based within a number of Directorates

Salary: £19,166 pa pro rata

**Hours: 18.75 per week**

#### ***Post Ref:***

Rotherham Doncaster and South Humber Mental Health Trust, along with other Mental Health Trusts within Yorkshire have agreed to offer a number of newly registered nurses the opportunity to work for six months to enable individuals to complete a period of preceptorship and provide them with period of clinical practice.

Successful applicants will be provided with a Learning Contract. The Learning Contract will ensure that you fulfil the preceptorship requirements of professional bodies and maximise opportunities for you to secure employment.

The preceptorship model works in tandem with the Yorkshire & Humber Practice Learner Facilitator strategy to maximise and support learning opportunities

You will receive:-

- 2-day Induction/mandatory training course
- preceptorship workbook
- an identified supervisor within the Trust
- a number of shifts in practice (depending on availability)

- exposure to clinical settings to support the transition from student to staff nurse
- access to continuous professional development opportunities/modules from local Universities

**These posts are available for recently registered nurses who,**

- registered in Spring 07 or who will be registering in September 07
- have not completed a period of preceptorship
- are not in secured employment as a registered nurse

***ALL EXTERNAL APPLICANTS WILL BE SUBJECT TO AN ENHANCED CHECK WITH THE CRIMINAL RECORDS BUREAU.***

- ① **If you would like further information please contact Sue Sparks-Sidey, Head of Learning and Development on (01302) 796208**

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① **Closing Date: Friday 28<sup>th</sup> September 2007**

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***We are an Equal Opportunities Employer***

## **Appendix 6**

### **Bradford Teaching Hospitals NHS Foundation Trust. TNR/Preceptorship Scheme Evaluation Report**

#### **Background**

Bradford Teaching Hospitals NHS Foundation Trust has provided newly qualified nurses with an employment scheme since March 2005. Nurses who were interested in joining this scheme received fast track processing and mandatory training. Many stepped off the scheme as soon as they secured employment. The remaining nurses work regularly on this scheme in an area (wherever possible) that they have worked within their training, thus aiming for continuity for the nurse and the practice setting and completion of their preceptorship pack that they had been issued with.

This scheme has now been evaluated; the following illustrates the findings.

#### **Method**

The Adult and Child branch newly qualified student nurses from the September 2007 intake at the University of Bradford group were targeted for the purpose of this study. Thirty two nurses were processed to join this scheme but only 11 actually worked here, as many stepped off once they had secured employment, therefore 11 questionnaires were sent out to complete. All these 11 nurses were from the Adult branch.

The Matrons/Sisters/Charge Nurses from all the practice settings that may utilise nurses entered on this scheme were also sent a questionnaire to complete. Fifty one questionnaires were sent to the leads in the practice areas to complete.

#### **Results**

Of the 11 nurses on the scheme targeted for the purpose of this study only 1 responded initially. The ones yet to respond were contacted by telephone to request their responses. Still no completed questionnaires were received so telephone interviews were then conducted to complete this study. Only 2 out of the 10 telephone interviews were unable to be conducted. Therefore the analysis of the questionnaires from the nurse on this scheme only relate to 9 responses.

Regarding the practice setting questionnaires, of the 51 sent out, 15 were returned and completed where nurses had worked on this scheme; however 31 were returned from areas that did not utilise nurses on this scheme. Regarding the missing 5 questionnaires – these areas were contacted via the telephone; they had not been completed as had no nurses working in their

areas on this scheme. All the areas that had completed the questionnaires were completed by the sisters on the wards/departments. Therefore the analysis of the questionnaires from the practice areas only relate to 15 responses from the sisters.

## **Analysis**

The 9 responses from the nurses on this scheme were analysed, **see Appendix 6a** for the main findings/themes commented on by the nurses on this scheme.

The 15 questionnaires returned and completed from the sisters in the practice areas were analysed. **See Appendix 6b** for the main findings/themes commented on by the sisters from the relevant wards/departments.

## **The role of the Practice Learning Facilitator**

The Practice Learning Facilitator (PLF) provides a “long-arm” preceptorship approach in conjunction with mentors in the practice setting to support this scheme.

In relation to this the PLF was in contact with the nurses registered on this scheme and was available to ensure the practice settings were also supported here, in combination with the TNR and other departments.

The PLF was contacted approximately on 20 occasions by the nurses registered on this scheme (some in person others via telephone or email), the nurses would refer to the PLF for advice relating to interview preparation, induction assistance, uniform issues, career advice, training support, clinical issues in relation to preceptorship support, competencies sign-off, personnel issues and TNR related concerns. The PLF would usually be able to respond to their concerns and resolve their issues or if not to direct them to the appropriate persons/departments.

Managers/Matrons/Sisters of the relevant wards/departments also contacted or discussed in person (whilst the PLF visited their areas) with the PLF any issues related to this scheme, this happened on a regular basis. Some of the issues raised were in relation to training needs, professionalism, recruitment issues, suitability, drug administration, continuity of shifts, preceptorship pack and competencies, TNR and personnel issues etc.

Some nurses on this scheme were visited and supported in practice by the PLF, especially where for example the nurse had never worked in our organisation before, or where issues or concerns arose.

## **Recommendations**

It is important that the nurses on this scheme have continuity for their own preceptorship period and also to provide continuity for the placement setting. Therefore I would recommend that these nurses continue to be placed in the same setting for as many shifts as possible.

Furthermore it is very important that the nurses registered on this scheme ensure that they take their preceptorship pack with them on placement, this is particularly stressed at induction.

Where the setting can support these newly qualified nurses it is important that they can be signed off for as many competencies as possible in relation to their preceptorship pack, furthermore if this area can also ensure they complete their safe administration of medicines assessment as soon as possible.

Only those practice settings that can support newly qualified nurses should be utilised for nurses on this scheme.

Once the practice areas have invested some time, staff and resources into these newly qualified nurses the benefits far outweigh the initial concerns.

### **Conclusion**

Overall the scheme has enabled newly qualified nurses to continue to consolidate their knowledge, skills and expertise. It has allowed them to have paid employment, provide evidence of preceptorship, mandatory and continued training.

This scheme has assisted many newly qualified nurses secure employment in and outside the Trust, it has often acted as a stepping stone until the posts materialise.

Without this scheme there are no alternatives locally for these newly qualified nurses as they cannot even engage in bank work until they have completed their preceptorship period.

I would therefore suggest that this programme continues to support newly qualified nurses where there is a climate of reduced employment opportunities for this profession locally.

Sherree Hamburg  
Practice Learning Facilitator  
April 2008.

## Appendix 6a

### Summary Analysis of the Evaluation of the TNR/Preceptorship Programme - nurses on the schemes perspective

The table below illustrates the newly qualified nurse's responses to the questionnaires completed by them on this scheme. 11 nurses were registered on this scheme, the following table represents 9 responses from the 11 nurses (- 82% response).

Questions Asked	Yes		No	
	No.	%	No.	%
1. Did you feel well prepared to work on this scheme?	9	100%	0	-
2. Did you feel that the process of fast tracking your application to join this scheme was processed effectively?	9	100%	0	-
3. Had the induction and mandatory training provided before going on placement prepared you well for your experience?	9	100%	0	-
4. Was there anything else you would have liked to see included in the induction/mandatory programme?	1	11%	8	89%
5. On arrival to your placement setting was the nurse in charge aware that you were a newly qualified nurse on this scheme?	8	89%	1	11%
6. Did you introduce yourself and explain you were on this scheme with the nurse in charge when you arrived for each shift?	9	100%	0	-
7. Is the preceptorship pack adequate for your needs?	7	78%	2	22%
8. Were you preceptored/mentored effectively?	7	78%	2	22%
9. Did you have any competencies signed off whilst on practice?	1	11%	8	89%
10. Did you encounter any issues/problems whilst on placement?	0	-	9	100%
11. Did you experience any issues/problems with the Personnel Dept?	0	-	9	100%

12. Did you experience any issues/problems with the TNR Dept?	9	100%	0	-
13. Did you experience any issues/problems with the Training Dept?	0	-	9	100%
14. Do you prefer the continuity of shifts in one placement setting?	3	33%	6	67%
15. Would you have preferred more shifts offered?	4	44%	5	56%
16. Were you registered on the TNR as a Health Care Assistant prior to entering this scheme?	8	89%	1	11%
17. Have you worked in numerous specialties on this scheme?				
18. Has this scheme helped inform your choice in applying for posts in areas not considered before?				

**Comments on the main positive findings/themes by the nurses on this scheme are illustrated below:-**

- The nurses stated that the fast tracking process, induction and training was excellent and well organised; this prepared them well for working on this scheme.
- They all felt that this scheme had enabled them to secure employment, in some cases the actual placement area where they had worked on this scheme.
- Many found it beneficial to be placed on this scheme where they had worked as a student nurse, as the staff knew them, they knew the staff and they helped one another.
- The nurses also commented that the scheme provided them with a wealth of confidence and opportunity, many secured employment in areas that they would have not normally applied for, but whilst engaged on this scheme they had been exposed to working in these areas.
- The preceptorship pack provided was well liked, enabling them to show evidence that many competencies had been achieved, and they also liked the fact that the pack was transferable across many settings.
- Those nurses who were previously on the TNR said it had been very useful as they had been familiar with the way that the TNR works. One nurse recommended that all student nurses from year 2 of their training join the TNR.
- Most nurses on this scheme questioned had worked between 31-40 shifts in a three month period; they liked the continuity of the shift

patterns in one area that they were often familiar with. All the nurses questioned suggested that work was available for them; this was especially so if they showed an interest and they were well motivated about working on this scheme.

- One nurse said she would give this scheme 110%, another stated that the TNR staff were very friendly; another commented that the scheme provided great flexibility for work.

**Comments on the main areas for improvement as mentioned by the nurses on this scheme are illustrated below:-**

- Some experienced problems having their competencies signed off – especially so for the medicines assessment competency. The nurse needs to be working continuously with one preceptor in one area regularly to have this competency signed off. In some very specialised settings there are limited qualified nurses to assess these students too, so it depends on the nurse's placement as to how they can have competencies completed.
- One nurse would have liked Phlebotomy and I.V. Skills training provided with the other mandatory training provision.
- One nurse also commented that she would have liked a rotational plan of shifts with 3 months in surgery and 3 months in medicine
- One nurse requested that her pay slip could be delivered to her home address or area of work, rather than the TNR office, (the new system will not allow delivery to a home address, it is also difficult here as a TNR nurse will be working in different areas too and therefore the pay slip cannot go to one practice area).
- Another nurse commented that the new uniforms on order for her took 4-6 weeks to arrive, during this period the nurse couldn't work.
- One nurse stated that she would have liked more shifts in one particular area providing continuity, but she appreciated it was where these shifts were available that she would need to work.

## Appendix 6b

### Summary Analysis of the Evaluation of the TNR/Preceptorship Programme - manager's perspective

51 questionnaires were sent out to the matrons/sisters of the relevant wards/departments to complete, 36 of these could not comment as these nurses had not worked in their areas recently, so the responses only relate to 15 views here.

The table below represents the 15 sisters responses here:-

Questions Asked	Yes		No	
	No.	%	No.	%
1. When booking a TNR were you informed that this nurse was a newly qualified nurse?	13	87%	2	13%
2. Were the nurses on this scheme up-to-date with their mandatory training?	15	100%	0	-
3. On arrival to your area did the nurse introduce themselves and explain that they were newly qualified on this scheme?	10	67%	5	33%
4. Did the nurse attend their shift with their preceptorship pack?	5	33%	10	67%
5. Were these nurses professional e.g. punctual, adhere to uniform policy?	14	93%	1	7%
6. Did the nurse seek help when required?	14	93%	1	7%
7. Were you able to provide preceptorship/mentorship for the newly qualified nurses?	12	80%	3	20%
8. Did you or your staff sign any competencies off for the nurse within the preceptorship pack?	5	33%	7	47%
9. Did the nurse's performance meet your expectations?			3 did not know	20%
	14	93%	1	7%
	15	100%	0	-
	7	47%	8	53%
	8	53%	7	47%

<p>10. Would you prefer the same TNR nurse to attend shifts available where possible for continuity?</p>				
<p>11. If you encountered any issues/problems with these nurses did you inform the TNR office?</p>				
<p>12. Has this scheme assisted you with any recruitment in your area?</p>				

**Comments on the main positive themes/findings by the sisters of the relevant wards/departments are illustrated below:-**

- When the wards/departments booked a TNR on this scheme the majority stated that they were informed that the nurse was newly qualified and registered on this scheme.
- All the areas reported that all these nurses on the scheme were up-to-date with their mandatory training.
- The majority of nurses introduced themselves to the practice settings and explained that they were on this scheme.
- All the nurses on this scheme appeared professional, except one nurse who wore jewellery and was asked to remove this.
- The majority of the nurses asked for help when required and learnt from their practice experience.
- The majority of sisters stated that between 1-10 nurses on this scheme had worked with them over the past 3 months.
- Only 5 sisters commented that they had signed off some of the preceptorship pack competencies, 7 said they hadn't and 3 did not know.
- The nurses' performance on this scheme met the wards/departments expectations except for one nurse whose basic skills appeared poor.
- All the responses requested that the same nurse on this scheme needs to attend the shifts available in their area for continuity.
- In 7 cases the wards/departments had to contact the TNR with issues around these nurses on the scheme, none of them commented on what these issues were.
- 8 areas said this scheme had assisted them with recruitment in their areas.

**Comments on the main areas for improvement as mentioned by 4 sisters on the relevant wards/departments are illustrated below:-**

- The areas book TNR's to cover sickness, absence and vacancies, where a nurse is allocated from this scheme they require additional

support, training, time and resources and cannot function as a qualified nurse immediately and function independently.

- It is also difficult if the allocated nurse has never worked in this setting previously.
- The areas don't have time to sign off their competencies and need to work with them on a continual prolonged period of time to assess these.
- The nurses also cannot complete drug administration until they have been deemed competent and assessed accordingly.
- Some areas commented that they would book a TNR Health Care Assistant instead of a newly qualified nurse to save money to their directorate, as the nurse on this scheme is limited in what they can do.
- Some comments suggest that their areas are not suitable for a nurse on this scheme as they cannot provide suitable preceptorship and meet the nurse's needs due to time restraints etc.
- Some sisters suggested that the nurses should be supernumery in a full-time post on one practice area for a 3 month period to provide appropriate preceptorship, funded by the university or Trust.
- Of these respondents they all agreed that where they need to book a TNR nurse it is because they are short-staffed and don't have the time to offer preceptorship here, they expect that this nurse can work independently and perform at the level required of a qualified nurse – not newly qualified.