

Midwives in Teaching

THE MINT PROJECT

Annex 5.5

Newly Qualified Midwives, Preceptors & Supervisors of Midwives

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Glossary of Terms : see Main Report

1 INTRODUCTION

The aim of the MINT project is to evaluate whether Midwife Teachers (MTs) bring a unique contribution particularly in the context of outcomes for women and families. This aim is being achieved through:

1. Identifying the various models for delivery of pre-registration midwifery education in the UK.
2. Gathering information about specific contributions made by midwife teachers.
3. Evaluating whether these variables affect the quality of care that qualified midwives can provide to mothers and their babies.
4. Determining the value brought by midwife teachers regardless of the model of education provision.
5. Developing quality indicators to demonstrate the value brought by midwife teachers.

The project was completed in three phases over the 18-month period (March 2009 – October 2010). Each phase focuses on particular project objectives while still contributing to the overall aim.

Phase 1 : On-line UK wide survey of Lead Midwives for Education (LMEs), Midwife Teachers (MTs), and Local Supervising Authority Midwifery Officers (LSAMOs) (May – August 2009)

Phase 2 : Case study research (June 2009 – March 2010) undertaken within six UK universities to include: data collection through questionnaires & Focus Group Interviews (FGIs) with senior students; completion of Activity Analysis Tool & Focus Group Interviews with Midwife Teachers (MTs); and individual interviews with pre-registration Programme Leads (PLs) and Lead Midwives for Education (LMEs)

Phase 3 : Prospective Diary study (October 2009 – October 2010) of newly qualified midwives during the first three – six months in their first post, supplemented by questionnaires to their respective Preceptors and Supervisors of

Midwives (SoMs) and follow up joint validation interviews with a selection of preceptors and preceptees.

The collection of prospective data from newly qualified midwives (NQMs) during Phase 3 of the MINT project is designed to provide evidence for answers to objectives 3 and 4 of the project (see above)

Data from NQMs, who graduated from six UK case study site universities and who were employed in multiple NHS midwifery provider units, were gathered during an extended time period, commencing in October 2009 and completing in October 2010.

Questionnaire evidence from Preceptors and Supervisors of Midwives provided validation data. LSAMO data from the Phase 1 survey also provides validation information. Follow up joint interviews with a selection of one Preceptor and matched Preceptee from all of the six case study sites provided additional summary evidence.

This report gives an outline of the methods used and the main findings.

2 METHODS

This section presents an overview of data collection tools, sampling, response rates and the organisation of the analysis process. In order to complete this particular phase of the study, the research team had to obtain ethics approval for a UK wide study within NHS maternity provider services through the co-ordinated IRAS system

(ref: <https://www.myresearchproject.org.uk/signin.aspx>). It was also necessary to gain separate Research & Development (R&D) governance approval from all the NHS providers where potential participants would be employed as NQMs. This involved a protracted process that is described in more detail in the main report. Approval was granted by 18 NHS providers across the UK. Each of the providers has a variable number of maternity units available as potential employment sites for NQMs.

2.1 Data collection tools

For the prospective study of NQM experiences, a semi-structured diary tool was designed that would primarily allow participants not only to describe and reflect on their experiences, but would, more importantly, need them to evaluate their midwifery education in relation to their ability to cope with a self selected event. In addition the tool facilitated commentary on support available to the NQM during their first months in post. A section also allowed collection of data on feedback received from whatever source to include mothers and/or their families (see Appendix 1). The diary format was designed and approved by the collaborative research team.

The aim was for participants to complete a weekly entry for the first three months in post as a registered midwife and then every two weeks for the second three months, making a total of 18 potential entries over the six month period. Because of time constraints, the majority of participants who had completed the shortened programme were only able to complete up to three months of weekly entries once in post (April – September 2010).

The diary collection tool was made available for completion via three methods; via a hard copy, using a USB stick, or via WebCT access through one university site (the HUB – see main report for organisation of the project). When senior student midwives (in the final six months of their programme) were recruited to the prospective phase of the project, they were given the choice of method for completion. The majority choose the diary format of a pre-loaded USB, followed closely by the choice of WebCT entry with reminders sent weekly from the WebCT team. A small minority choose to submit using a hard copy. A final method of data collection emerged during the study, which helped to facilitate compliance, and this was oral entry via telephone contact with a member of the research team. The diary transcripts, using the oral format, were then sent back to the participant for validation. Collaborative Site Researchers (CSRs) from the MINT team were allocated to follow up and encourage participants from their particular research site (see description of methods in Main Report)

A short validation questionnaire was designed for completion by the allocated Preceptor and the SoM of each of the participating NQMs (see appendix 2 & 3). NQMs were asked to obtain the consent of their respective Preceptor and SoM in order to submit their names. Questionnaires were then sent as hard copies to prospective respondents towards the end of the participant data collection period. Stamped addressed envelopes were included so that respondents were free to complete or not complete. Preceptors were also asked to indicate whether they would be willing to participate in a joint interview.

In order to obtain summative data on overall experiences as a NQM and to incorporate more in depth preceptor commentary on progress, further data were collected through a semi structured summative joint interview with a convenience sample of Preceptee and Preceptor partners at the end of the diary collection period. Appendix 5

provides an outline of the prompt questions used to facilitate an open-ended discussion of experiences of both participants.

Statutory supervision of midwives is overseen by local supervising authorities (LSAs). The LSA is responsible for the protection of the women and babies using midwifery services in its area. To enable it to carry out this function the LSA is required to appoint an LSA Midwifery Officer (LSAMO) as laid down in the Nursing and Midwifery Order (2001). The LSAMOs are practising midwives with experience in statutory supervision; they are responsible for the appointment of supervisors of midwives in defined geographical areas; and provide leadership, support and guidance on a range of matters including professional development. The LSAMO receives reports of all investigations of alleged misconduct and/ or lack of competence. They are therefore well placed to provide data on the competence of midwives in their LSA.

There have been anecdotal reports that newly qualified midwives are not always fit for practice and should not have 'passed' their pre-registration course and be able to register with the Nursing and Midwifery Council. Factual information was therefore sought from the LSAMOs as to how many supervisory concerns were reported to them involving newly qualified midwives in their first year of practice and the subsequent outcomes. Initially this data was provided via the on-line/postal questionnaire (see Appendix 4) and was subsequently followed up through the LSAMO network.

2.2 Sampling and response rates

An outline of sampling and response rates is given for all four groups of participants to include; newly qualified midwives (NQMs); Preceptors; Supervisors of Midwives (SoMs); and Local Supervising Authority Midwifery Officers (LSAMOs)

2.2.1 Newly Qualified Midwives (NQMs)

Participants were recruited from those completing both three year programmes from all six case study sites and those completing a shortened programme from four of the case

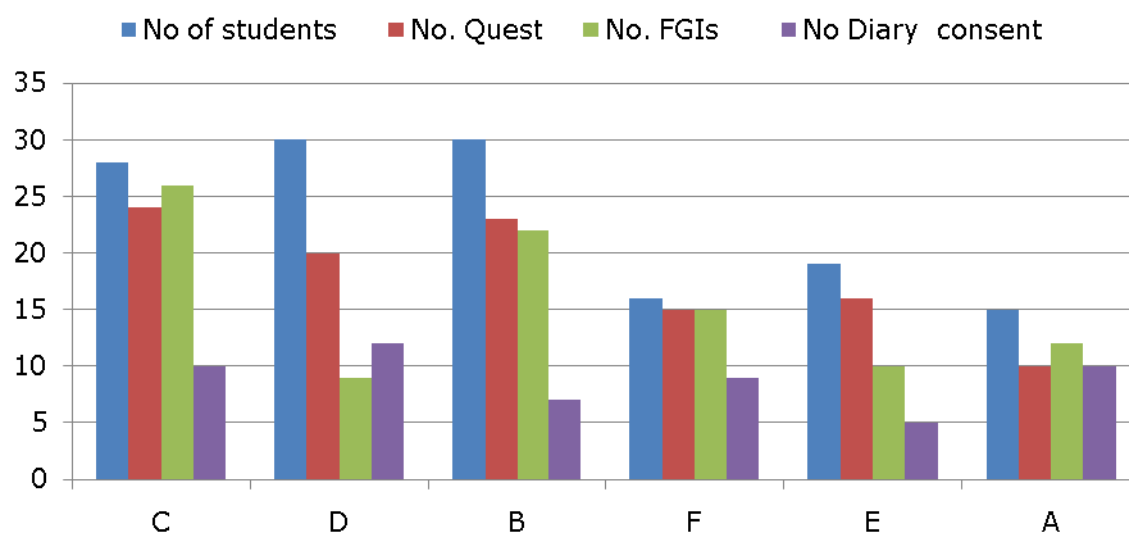
study sites. Because of the variability in programme completion dates and the securing of employment in first jobs post qualification, the collection period for all participants ranged from October 2009 to October 2010.

During Phase 2, senior students completed the student questionnaire on line or via a hard copy. The whole group was seen by a CSR, given verbal and written information about the study, were given the opportunity to complete the questionnaire and then volunteered to participate in a follow up Focus Group Interview (FGI). They were also given information about Phase 3 of the study. All potential participants for Phase 3 were given time to consider their decision and once agreed were consented and contact details taken for follow up by the appropriate CSR once they were registered as midwives and in their first posts as NQMs. Only those employed in an NHS provider service that had given the team R&D approval could be approached to complete the study. There was a time lapse of approximately three to four months between consent to participate and the need to actually start completing the diary. Table 1 and Fig 1 indicate the relative recruitment rate across all six sites for all data collection methods for three year programme participants completing in autumn 2009 & spring 2010. A second cohort of 12 three year programme students were approached at one site in spring 2010 of which 11 gave consent to participate in Phase 3 alone (no data collected via questionnaire or FGI).

Table 1 : Relative recruitment rates for Questionnaire, FGI and Prospective Diary Study per Case Study Site – 3 Year Programme (Autumn 2009).

Sites	No of students	Completed Qs	FGIs no. of participants	Diary Study - consent
C	28	24 (86%)	26 (93%)	10 (36%)
D	30	20 (67%)	9 (30%)	8 (27%)
B	30	23 (77%)	22 (73%)	8 (27%)
F	16	15 (94%)	15 (94%)	7 (43%)
E	19	16 (84%)	10 (53%)	5 (26%)
A	15	10 (67%)	12 (80%)	10 (67%)
Totals	138	111 (78%)	94 (68%)	48 (35%)

Fig 1 : Relative recruitment numbers for Questionnaire, FGI and Prospective Diary Study per Case Study Site – 3 year programme (Autumn 2009).



Recruitment of senior students from the shortened programme was completed on four of the six case study sites. Out of a total of 71 students 76% (n=54) completed the questionnaire; 32% (n=23) participated in the FGIs. Because of time constraints for data

collection for Phase 3, out of a total number of 51 who were eligible, 40% (n=22) gave their consent for the diary study.

In summary for both the three year and the shortened programme the recruitment rate for Phase 3 was around 40% of available sample. However, the time lapse between recruitment and subsequent registration and employment had an effect on actual participation rates; although an initial number of 57 (includes September 2009 & April 2010 recruits) from the three year programme and 22 (April 2010 recruits) from the shortened programme gave their consent, the actual numbers who made a start to their diary inputs was significantly less than anticipated by the research team (see Table 2a and Table 2b). Three from each grouping were ineligible to participate because they had obtained employment with a service provider where R&D clearance had not been obtained. A total of five had either started maternity leave or had to complete examination re-sits. Final completion rates were 52% for the three year programme and 38% for the shortened programme participants.

Table 2a : Phase 3 Consents, Eligibility and Completion Rates : 3 year Programme

Site	Consents	Ineligible	Eligible	Completed	% completion rate
F	7	0	7	5	71%
B	8	0	8	5	63%
A	10	1	9	3	33%
D	8	2	6	3	50%
E	5	0	5	2	40%
C	19	0	19	10	53%
Totals	57	3	54	28	52%

Table 2b : Phase 3 Consents, Eligibility and Completion Rates : Shortened Programme

Site	Consents	Ineligible	Eligible	Completed	% completion rate
B	4	0	4	2	50%
A	7	3	4	1	25%
E	5	0	5	2	40%
C	6	0	6	2	33%
Totals	22	3	19	7	37%

A tracking system was set up by all the CSRs, who reported progress to the research co-ordinator. Reasons for non-completion were recorded and any diaries completed even over a short time period could be retrieved from the participant. Monthly contact was made using e-mails, text and/or verbal messages and phone calls. Although repeated messages were never responded to by a small number of participants, the majority responded in some way, even if it was to opt out of the study. The reasons for opting out included one or other of the following ;

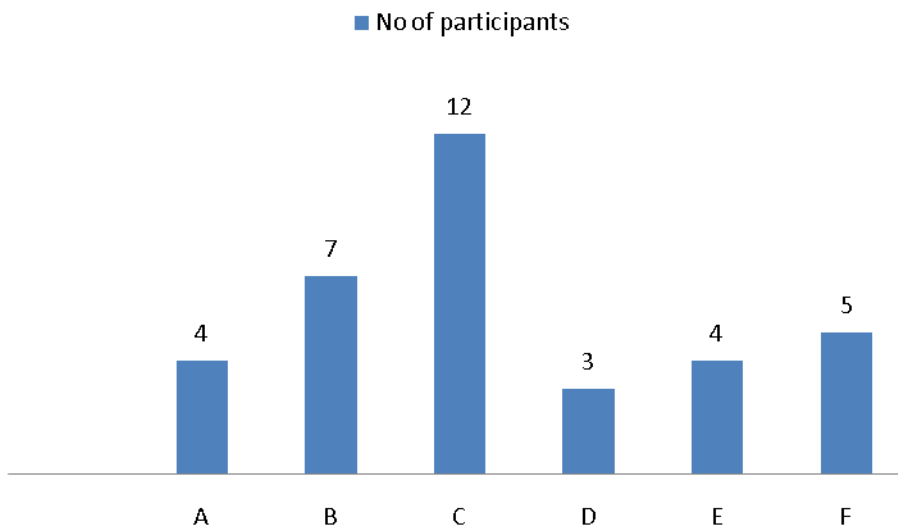
- Family illness or crisis
- Adjustment to new role was more stressful than they anticipated
- Demands on time within and outside their first post as NQMs meant no time for diary completion
- The extra demands of completing the academic work necessary to obtain a 'top up' degree soon after qualifying as a midwife

Through a process of regular contact and encouragement a total of 48% (n=35) of those eligible to participate from both programmes completed diary entry information ; 52% (n=28) from the three year programme and 38% (n=7) from the shortened programme. Some participants started to complete their diaries and then found other pressures too great, but were prepared to 'catch up' via an oral entry facilitated by their respective CSR. Others were only able to provide data through a summary oral diary entry, a number of which were completed on a monthly basis.

The profile of participants included all UK case study university sites (see Fig 2).

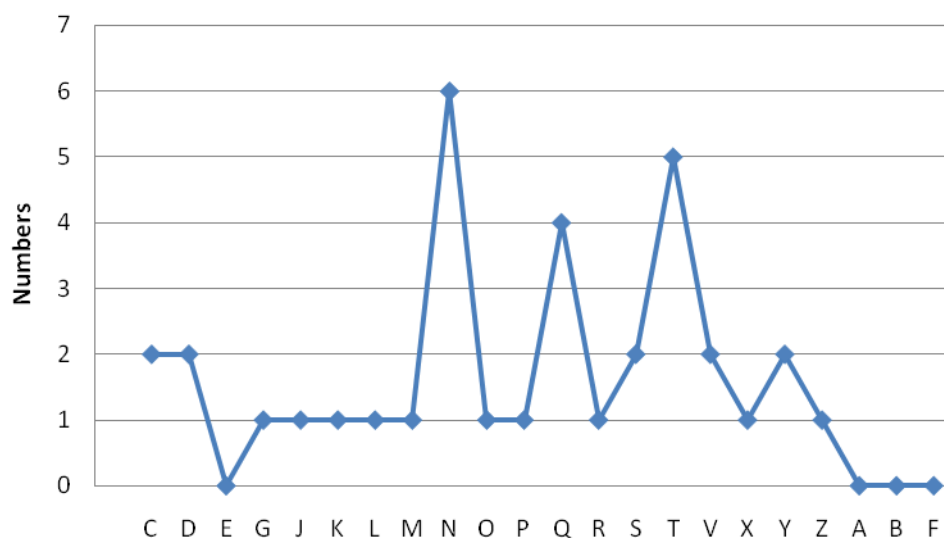
University site C had recruited the second cohort of the three year programme students, hence the greater number completing Phase 3.

Fig 2 : Number of participants per university case study site (n=35)



While 18 NHS providers had given R&D governance permission, the potential for employment was in approximately 22 separate maternity units, of which 4 had no participants, 10 had one participant each, 5 had two and three had 4 to 6 participants (see Fig 3)

Fig 3 : Number of participants per hospital/NHS Maternity site in UK (n=35)



2.2.2 Preceptors, Supervisors of Midwives (SoMs) & LSAMOs

Not all NQMs provided the research team with the contact details of their Preceptor and SoM. For some this was because they had not had one allocated but for other NQMs they either did not want to participate in this part of the study or their preceptor or SoM did not give them consent to pass on their contact details. At the close of data collection eleven different provider unit midwives (Preceptors or SoMs) representing all four UK countries participated in completion of questionnaires and/or a joint interview relating to the capabilities of newly qualified midwives.

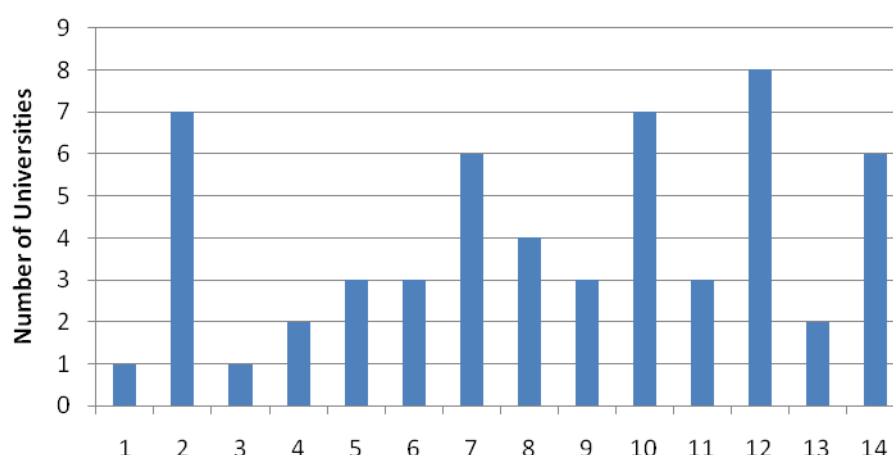
Thirteen preceptors from ten different provider maternity services gave consent to be sent a questionnaire (Appendix 2). Nine preceptors (69% of available sample) from seven different providers returned questionnaires (one incomplete) and all nine indicated either on the questionnaires or via their Preceptee that they were prepared to participate in a joint interview.

Fourteen Supervisors of Midwives from twelve different provider maternity services gave consent to be sent a questionnaire (Appendix 3). Although stamped addressed envelopes were provided, only seven SoMs (50% of available sample) from five different providers returned questionnaires.

Seven joint interviews with newly qualified midwife and preceptor pairs were carried out. The shortfall of two interviews in comparison with consents was because within the time frame of the study it was not possible to arrange a suitable date for interview. Two pairs of those interviewed were NQMs from the shortened route and the remaining five were from three year programmes. Interviews were held in all four UK countries and sampled at least one NQM who had graduated from each of the six case study universities. Most of the NQMs had secured jobs where they had spent at least some of their programme, but for two of those interviewed they were in a maternity unit that was new to them. An online/postal questionnaire was issued to all Local Supervising Authority Midwifery Officers (LSAMOs) in the UK (n = 16). The response rate to the questionnaire provided data from 14 LSAMOs (88%) which included all four UK countries. As each LSAMO is

responsible for a specific geographical location related to maternity services, they have contact with varying numbers of universities, ranging from one to eight (Figure 4).

Fig 4 : Number of universities providing Pre-registration programmes per LSAMO area



2.3 Analysis processes

Initial analysis of diary data was completed by CSRs using guidelines (see Appendix 6) that would ensure consistency of approach across the research team. Interpretation of the raw data was cross checked by the Collaborative Site Leads (CSLs) from each site prior to submission to the HUB team for amalgamation and synthesis work. The primary focus of the analysis was on evaluation of the impact of midwifery education in helping NQMs deal with the specific events they chose to record in their diaries. Each individual NQM was treated as a single 'case study' before doing some cross comparison of 'cases' within each site. Any differences between the experiences and reactions of NQMs who had completed the three year or the shortened programme was noted. Eventually all data were amalgamated to present a typology of events and the relative impact of midwifery education with particular emphasis on the role of midwife teachers in the NQM's competence and confidence in dealing with the event. For reasons

of maintaining anonymity and confidentiality, findings do not demarcate and/or compare results from individual case study sites or countries of the UK.

All data from SoMs and Preceptors were analysed and validated by members of the HUB research team.

The on-line LSAMO survey results were analysed using Survey Monkey along with input from the LSAMO member of the project team.

3 FINDINGS

Findings are presented under three main headings to include:

- A descriptive overview of the experiences of NQMs
- Evaluation of the Midwife Teacher (MT) impact through event analysis
- Feedback on the quality of care delivered by NQMs

3.1 A descriptive overview of the experiences of NQMs

This section provides an overview of the experiences of NQMs during their first three to six months in post following graduation from the six case study sites. The findings are presented under the following headings:

- Employment, Location & Rotation
- Induction and support systems
- Preceptorship
- Supervision from Supervisor of Midwives (SoM)
- Perceptions of progress

3.1.1 Employment, Location & Rotation

The majority of NQMs obtained employment in maternity units that had been part of their placement circuits during their pre-registration programme. A small number moved to other sites, however almost all remaining within their own country and convenient to their homes. The majority also commenced in their posts before, at, or soon after their registration with the NMC, many having been recruited while still completing their programmes. There were delays (up to 8 weeks in a few cases) for some due to Human Resources (HR) activities undertaken by the employers. One NQM had to delay taking up employment for three months because of illness. A small number had been seconded and so could return immediately to their original employment site. However, because of lack of employment opportunities at one site, not only was there a delay of up to 4-5 months in obtaining posts, those on offer were part time and with

temporary contacts. Three NQMs applied for and obtained employment in a busy city unit in another country of the UK (for which R&D approval had been obtained).

All participants' diaries made reference to a rotation system in their places of work. What varied was the length of time between rotations, some six months, some three months and on a few sites NQMs were moved after their first six to seven weeks. There was an example of an induction programme rotation of completing 4 weeks on Labour Suite, two weeks ante/post natal ward and two weeks community before returning to the Labour Suite. Another example of induction rotation included the pattern of two weeks in the three areas of ante natal, intrapartum and post natal. On one site, because allocated to a midwifery team, the NQM moved between ante-natal, intrapartum and post-natal care settings on a daily basis.

'Thereafter I visited all areas each week, day and night duty. Regular rotation to all areas helped to build confidence in all clinical areas including day and night'
(PE65)

There was also variability in where the NQM was working during their first weeks in post. Experiences were reported on from all the units/wards where maternity care would be delivered within an institution setting; ante/post natal wards, Labour suites both high risk and low risk (stand alongside unit) ; Midwifery led units; Day Obstetric Unit and Clinics. There was only one example where the NQM had her first job placement as part of a community team.

3.1.2 Induction and support systems

Participants were not asked directly to provide information on their induction or support systems but during analysis it was possible to pick out patterns of support in their description of their early weeks in post.

Overall, the majority of employers provided a programme of orientation to the organisation, labelled by some as 'corporate' induction or 'Trust' induction. Depending on when the participant took up their post, this might have been provided in the first

week or any of subsequent weeks up to week eight. A varying number of days were on offer and content was applicable to all professional staff.

'Corporate induction during week three covering topics such as infection control, manual handling, blood transfusion, a lot of the talks were not applicable to role, but some were important reminders of things taught during training'. (PE41)

Alongside the corporate induction, a specific programme, applicable to the maternity unit was provided. Typical content could include; CTG monitoring; breast feeding; resuscitation of the new born; risk management and skills drills.

Given that participants were not asked specifically to describe their induction, from analysis of the 35 participant diaries, eight of the NQMs provided no evidence of a formal induction/orientation programme. It was possible to pick out contrasting examples between what could be termed a comprehensive induction and one where the NQM had to fully rely on colleagues for support during their first weeks in employment.

One particular maternity unit had a comprehensive structured induction programme that covered approximately five to six weeks with a mixture of supported shift experiences as a supernumerary NQM, a Trust orientation, a Midwifery orientation and a life support orientation development programme. As six of the diary participants from two of the Case Study sites were employed in this maternity unit, it was also noted that for their first rotation post, they were treated as supernumerary, working alongside an experienced midwife for at least their first two weeks. There were many staff development/training sessions during the 20 weeks described by one informant and skills drills occurred on a regular basis for high risk situations.

The above structured support system contrasts strongly with the experience of an NQM at another maternity unit where she was required to be active within the team from day one. Although there was evidence in the diary of a 'Trust Induction' week after seven weeks in post, orientation and support during the first weeks was almost non-existent.

'I was given an induction pack by line manager, no explanation given. The Trust had come to the university to 'sell' their induction programme. I felt there was nothing really. No preceptor named no supervisors name yet. A sense of 'you're qualified now get on with it' from the manager at least.' (PE45)

Whether they had a positive or a negative experience of induction, the majority of participants commented on the positive support given by members of the midwifery team wherever they were allocated.

'.....the support I received from the Matron and other midwives was amazing. I knew that I could ask any of them anything and was frequently asked how I was doing and given reassurance'(PE15)

'Terrified most of the time but it was brilliant. Enjoyed it ,as was so well supported , as stated above, felt more supported than at any time during training'(PE16)

For those taking up employment where they had spent time as a student, there were negative and positive reports. One midwife reported the difficulties with being accepted as a midwife and not a student. A few reported that they were expected to 'know' certain things as they had worked there before. However, a number commented on the advantage of gaining employment for their first posts as midwives in a familiar unit.

'Feel that assumptions were made about the need for a formal orientation as I had trained in the unit - feel a bit abandoned by the managers' (PE41)

'I felt nervous about starting into a new job, but because I had my training in the same hospital, it meant I was familiar with the staff, policies and procedures, making it easier for me to settle in'(PEs153)

3.1.3 Preceptorship

As part of their personal analysis of the key events described in the diary, all NQMs were asked whether their Preceptor had been involved. From scrutinising this data and also from their descriptive overview of each of the weeks submitted, it was possible to gain information on preceptorship activity for all 35 participants.

A total of 26 (74%) indicated that they had experienced preceptorship in one form or another. The majority had a named 'Preceptor'; two participants indicated that they had not a 'preceptor' per se but were allocated an 'assessor' to 'sign off' their skills development booklet. Eight NQMs (23%) were not allocated a Preceptor and information on preceptorship was not available from one NQM. Of those not allocated a Preceptor, one NQM indicated that she knew when she took the post in the community that the

service provider did not allocate preceptors and that she would have to use experienced colleagues in the team for advise and help in coping with her case load.

Overall, where available, it would appear that the timing and quality of preceptorship is very much tied in with how structured and well organised the induction and orientation processes are managed within individual institutions. Where there was time set aside for induction, NQMs were often allocated their Preceptor and either had an initial meeting or in the best case scenario, were allocated to work alongside their Preceptor for the first week/s in post. A number mention meeting with their Preceptor at a set interval, generally at three months post commencement in post, for a review of progress. Those institutions, who adhered to the requirements of the Knowledge and Skills Framework (ref NHS KSF - www.dh.gov.uk), organised a formal review (by the Preceptor and/or SoM) of the individual NQM's development, using relevant documentation which would provide evidence for re-grading of the employee at the end of their first year in post (e.g. Band 5 to Band 6).

'First placement on AN/PN Ward ... pleased to have been met at the door by preceptor and allocated to work first 3 shifts with preceptor which made me feel supported ... found transition from student to midwife difficult' (PE74)

'The Preceptor and SoM were allocated and reviewing progress on regular basis – joint meeting at 10 weeks. Objectives set for Year 1 – part of NHS Knowledge and Skills Framework for re-banding' (PE16)

However, in contrast to a structured approach to preceptorship, there was evidence that in the majority of cases it was an ad hoc informal arrangement and meetings had to be initiated by the NQM. A number had Preceptors allocated who were on long term sick leave or who left the employment or who worked in a different environment, so that the NQM, after initial introductory contact, had no further contact unless they themselves made an effort to rectify the situation.

'Preceptor who was allocated was off sick for total period of diary (10 weeks)' (PEs133)

'No Preceptor identified until week 6 when the NQM needed to talk with someone following a key event relating to the birth of a baby with congenital abnormality, the event was discussed with a senior midwife who then offered to act as her

preceptor. No further involvement with a preceptor was described in the diary' (PE45)

In summary, NQMs appreciated the involvement of their Preceptors especially in helping them gain confidence during their early weeks as midwives. As stated previously, participants accessed support from the midwifery team on a daily basis and in the analysis of key events, there was relatively little support/feedback from Preceptors recorded. In most cases, where available, the onus was on the NQM to initiate contact. Exceptions to this rule were evident where there was a structured system to monitor staff development within individual service providers.

3.1.4 Supervision from Supervisor of Midwives (SoM)

Similar to the Preceptor, the diary tool required participants to indicate whether their SoM was involved in any of the key events they recorded (see Appendix 1).

Results revealed that although the majority (n=31) of NQMs were eventually allocated a SoM, there was relatively little contact during their first three to six months. However, a number did indicate that they had formal appointments for review of progress at six months. Again where there was a structured support system, the SoM was included in the induction processes.

'Met with SoM in week two who provided clarity on role and what would be expected of a NQM' (PE41)

A small number of participants had informal contact as their SoM was working within their workplace midwifery team.

'I have introduced myself to my SoM and made her aware of the fact that I am her supervisee. Have had informal contact with her during shifts when she has asked if I am OK but no formal contact' (PE 06)

Where there was initially no evidence of a SoM being allocated, the catalyst for appointment was a key event where the NQM felt the need for guidance and support. The overall pattern was of the NQM initiating the first contact. It was interesting to note

that one participant, who had difficulties, and had not been allocated a SoM, utilised a MT to review a key event.

'Role of SoM stressed by MTs. SoM accessed by NQM to discuss workload and associated stress incurred' (PE04)

'Received support from a MT, who is also a SOM, following a difficult key event' (PE36)

The lack of appointment of a SoM was highlighted by one NQM when stressed by events that she might have wished to discuss with her SoM, if available.

'There was no named SoM allocated at the beginning, in week 4 a diary entry stated 'Completed incident form for PPH. No contact from SOM' and in week 13 'Still don't know who my SoM is! (Must make a point of finding out)' (PE45)

In contrast to the above situation, one unit had organised a support group for NQMs led by a SoM

'The unit has recently started a 'reflect and learn' group for NQMs. The group meets every two weeks; it is protected time and is led by a SoM'. (PE17)

Finally, one NQM, who changed her employment after three months in a unit where she felt well supported, commented, on her return to a busy ante/post natal ward in a unit which she had experienced during her programme, that

'Perhaps a deficit of the course is some information on how to use your SoM. Some universities bring in the use of a SoM for their students while on the course, we did not have that. There is a gap in knowledge here on when it is appropriate to go to your SoM or the 'on call' SoM when you are unhappy about something.' (PE57)

3.1.5 Perceptions of progress

At the start of each diary entry, participants were asked to describe their week and then reflect on the week (see Appendix 1). This final section presents an overview of the participants' perceptions of their progress drawn from their weekly reflections. It is important to note that the range of time over which diaries were completed did vary from between 5 – 25 weeks, so no conclusions can be drawn. However, it is possible to recognise the impact of contexts of work on the development or otherwise of confidence

in the NQMs. However, the quality of support systems available to the NQMs interacted with personal feelings of confidence in coping with any of the contextual situations experienced.

Contextual issues that affected the development of confidence were related to:

1. The choice of maternity unit for first post
 - 'home' unit or 'away' unit
2. The timing and order of rotations
 - Weekly, two monthly, three monthly, six monthly
3. Labour Ward to ante/post natal or vice versa
 - Changes in expected experiences because of unexpected work place movements to cover for staff shortages in busy units
4. Portfolio of previous experiences

There were two different responses to working in a 'new' maternity unit as opposed to one which had been experienced during the pre-registration programme. Anxiety and concern because not knowing the team, the environment and the policies and procedures meant that it took the NQM potentially longer to gain confidence

'A bit shaky as never worked in Trust before – policies, paperwork etc. All team very supportive. Happy with midwifery skills – administration work needed the advice mainly' (PE57)

An alternative reaction to above came from a NQM who appeared to relish the fact that she had moved to a different service provider to obtain her first post. She felt that she had become autonomous quickly.

'it was having that confidence really to be autonomous as a practising midwife, and I did actually feel fairly autonomous, and fairly comfortable with doing things, and whether that was because I didn't actually know any of the midwives that I was working with I think I probably would have felt that I'd got more of a safety net in my old unit, and I might have actually asked questions that I didn't necessarily need to ask' (PE63)

Rotation systems definitely had an impact as stability within a particular work environment helped to build confidence and change is always destabilising.

'Out of my comfort zone! I have become accustomed to term babies and their care so needed to re-think my care of these specialist babies. I required lots of support and felt very out of my depth particularly the first and second shift. I felt more confident at the end of the week, but still have much to learn' (PE11)

Although working in the Labour Suite did provoke feelings of anxiety, when well supported, NQMs gained confidence and in fact found movement on to a busy ante/post natal ward more challenging. This was particularly the case for those who completed the three year programme

'Shock to my system! Lots of obstetric and neonatal problems. Lots of babies in need of transitional care and lots of observations. It is hard going, lots of fragile babies, unwell and small often 34 weeks gestation on delivery being tube feed, all quite frightening ... place so busy'. (PE57)

'First couple of evenings we were really really busy and a bit fed up with the whole thing, overwhelming, heavy work load, sheer volume of women in a 62 bedded ward, can be full and that is not counting the babies!' (PE06)

It was interesting to note the impact of moving to an area where the participant felt that her skills and competence as a midwife could be better applied.

'I became confident, quicker and more organised as time went on. Deficits from student experience are around managing a case load of women and their babies. Change to Antenatal after first rotation – loved it – feeling very competent and dealing with cases with confidence – early pregnancy care clinic great for midwives' (PE47)

For those participants already settled and comfortable in the wards or clinics and waiting to gain experience in the Labour Suite, the return of anxiety and lack of confidence was apparent. One participant commented at 10 weeks, that although she was beginning to feel more confident on the postnatal ward she was still struggling with the reality and responsibility of practice as a NQM.

'I feel that going to labour ward is going to kill me. There is another new midwife who started the same day as me, she went straight to the labour ward and we compare experiences and I am very, very worried.' (PE36)

As work and responsibilities during intrapartum care is so challenging, movement between Labour suite and ante/ post natal ward on a daily/weekly basis presents a 'roller coaster' experience. NQMs who experienced this pattern record both an increase in confidence after a sustained period of positive experiences (over two/three shifts) on

the Labour Suite followed by a loss of confidence when there is a time lag between experiences. There was no time to consolidate confidence. NQMs exposed to this pattern of work allocation were still expressing lack of confidence in their diaries even up to 20 – 24 weeks post registration (PE03, PE73)

As a direct contrast, a participant allocated to her first six months on a Labour suite in a maternity unit in a different country to her pre-registration practice experiences, had already been allocated a first year student midwife to supervise (at 10 weeks) and had also had a medical student observing her intrapartum care. At 20 weeks, this NQM was being supervised in undertaking triage within the Labour Suite and felt safe and confident in that role (PE44)

Because of staff shortages and the unpredictability of work load particularly in Labour Suites, many of the participants were allocated at short notice, to complete one off shifts in areas outside their allocated workplace. Some found this particularly challenging as NQMs and felt that they should not be the choice of midwife in being moved at short notice.

'Post natal ward first allocation – stressed when busy or when asked to provide 'cover' to Labour suite or Admissions/Assessment Unit – refused first time after 3 weeks in post – had to go to provide relief cover after 5 weeks in post and was 'petrified' and finally had to spend a couple of hours there to be used as 'pair of hands' for post CS monitoring at 8 weeks. Feels Labour Suite should be the first rotation for NQMs' (PEs133)

The most striking difference in the confidence of those completing the shortened programme was related to managing their workload in ante/post natal care. Previous experience as a nurse was very helpful but as soon as they moved to other areas of maternity care, their level of anxiety and confidence appeared the same as those completing the three year programme (see PEs133 above).

'I was happier dealing with post natal from nursing experience – had to push myself to do antenatal – no experience of inductions' (PEs193)

'The clinic is a very busy unit and I sometimes feel that because I am a new member of staff I take too long with each appointment and find that sometimes appointments are then running slightly behind, as a result I feel that I am hurried in my practice and would be worried about missing something' (PEs153)

'Labour suite was a 'baptism of fire ', otherwise was confident about providing care'. (PEs122)

Diary entries did provide evidence of development of positive feelings over time with a concurrent acknowledgement of the impact of their midwifery education

'My training was everything that is what got me where I am so it's 100%, it's made me feel confident that I can do the job. I love the job.' (PE17)

'Things are becoming more automatic which is so lovely; it makes me feel quite grown up now!'(PE94)

'On delivery of the baby, the baby was born in the fluids with membranes intact. This was the most amazing sight I have seen!! She had physiological management of the 3rd stage of labour. It was a beautiful experience and it reminded me why I first had such a desire to do my midwifery training' (PEs133)

3.2 Evaluation of the MT impact through event analysis

The description of key events and their analysis forms the core data in evaluation of the MT's role. Although the final number of participants contributing to Phase 3 were relatively low in comparison to the initial recruitment figures, a total of 263 events were available for analysis (see Table 3).

Table 3 : Number of Key Events per university site

Programme	Site A	Site B	Site C	Site D	Site E	Site F	Total
3year	15	52	96	22	10	35	230
Shortened	10	6	10		7		33
Totals	25	58	106	22	17	35	263

The following table (Table 4) and figures (Fig 5 & 6) provide detail on the focus of key events described as well as giving an indication of their percentage frequency for both groups of NQMs. Whilst normal midwifery events were selected by some NQMs because they illustrated for them their competence and confidence to practise as registered midwives this was not always the case; similarly, key events that suggested complexity by their nature were not necessarily recorded to highlight something that had had a

negative impact on the NQM; indeed in many instances complicated events provided an opportunity for them to reflect and affirm their knowledge and ability. The unequal distribution of normal and complicated events does not therefore illustrate areas where NQMs felt better or worse prepared for practice. Prevalence of key events presented for both groups of participants in Fig 5 & 6 should also be treated with caution as their focus is dependent on the pattern of work placements.

Table 4 : Focus of Key events with examples

Focus of Key Event	Examples
Normal, low risk midwifery	Spontaneous labour and birth, physiological third stage of labour, home birth, water birth, perineal repair, postnatal care and providing breastfeeding support.
Complicated antepartum	Antepartum haemorrhage, pre-eclampsia and premature rupture of membranes
Complicated intrapartum	Induction of labour, epidural analgesia, Caesarean section, forceps delivery, shoulder dystocia, fetal complications including congenital abnormality, caring for women with concurrent medical problems such as diabetes, heart disease or HELLP syndrome and working in a high dependency environment.
Complicated postpartum	Care following Caesarean section, stillbirth or neonatal death, caring for mothers with mental health problems, breastfeeding problems and neonatal jaundice.
Management issues	Workload, dealing with medical staff, being the lead midwife, completing incident forms, drug errors, omissions in care, inadequate supervision on high dependency unit (HDU) and dealing with difficult mothers or fathers.
Psychosocial issues	Child protection and drug / alcohol misuse.

Fig 5 : Percentage of event occurrences – Three year programme

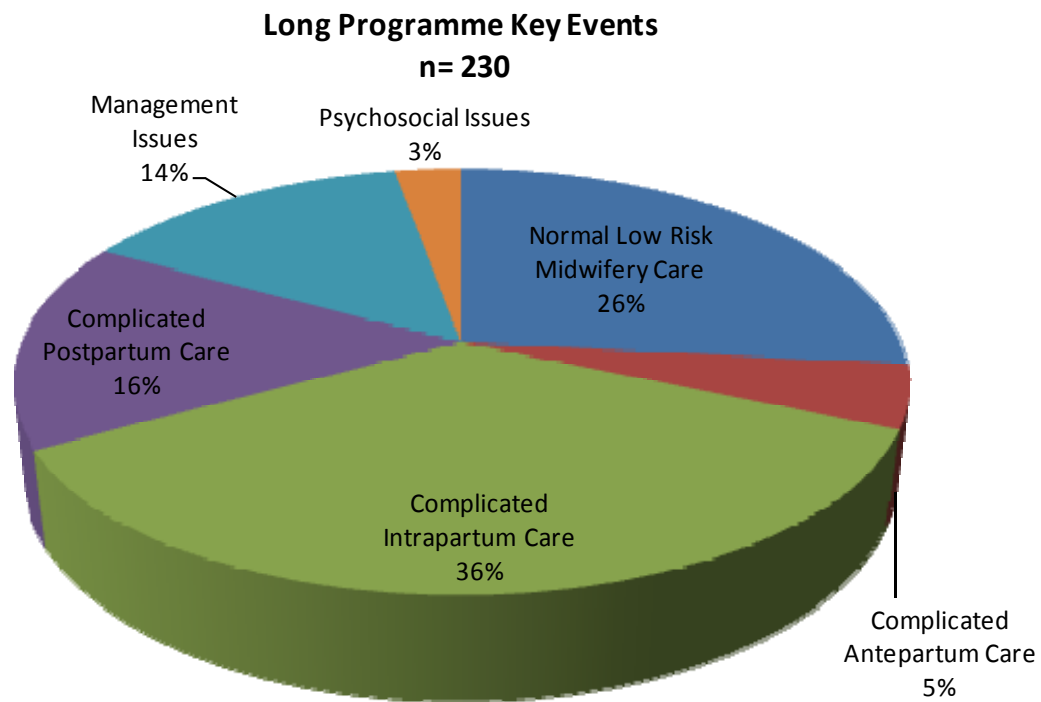
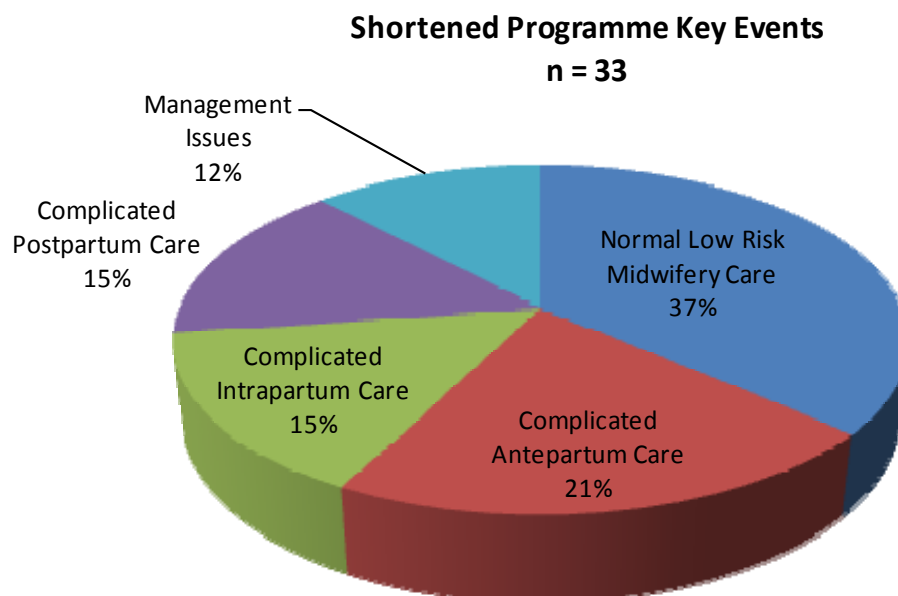


Fig 6 : Percentage of event occurrences – Shortened programme



Findings from the analysis of key events are presented under three main headings to include:

- Categories of key events (3.2.1)
- Coping with key events (3.2.2)
- Impact of Midwife Teachers (3.2.3)

It should be noted that not all questions around the self analysis of key events were answered by participants so that where there is reference made to frequencies in the following section, these may not match directly to the number of events overall (see Table 3)

3.2.1 Categorising key events

Key events and the NQM's response can be more helpfully categorised as events that

- Focussed on Confidence
 - Reinforced areas of confidence
 - Demonstrated lack of confidence due to status as an NQM
 - Illustrated the impact of experience as an NQM on confidence
- Identified gaps in knowledge / experience
- Articulated frustration, conflict or distress

3.2.1.1 Key Events that focussed on confidence

Confidence was a significant feature in the key event description that reflected how NQMs felt about themselves as professional midwives. Confidence was not a static or developing concept for all NQMs but was influenced positively or negatively by changing clinical work area and by encountering new or challenging situations. The responsibility associated with being a registered midwife became a reality for NQMs when they had to make decisions based on their own assessment or answer the telephone as 'midwife X'.

It was not always possible to extrapolate from the diary entry whether confidence or competence was the overriding feature. In one diary entry an NQM expressed concerns

about her ability to do the job and when these feelings were explored agreed that it probably stemmed from lack of confidence and experience rather than lack of competence and knowledge as she made the right decisions when faced with challenging events.

'it's hard to know that you are competent isn't it? because I don't think you can ever be a 100%, because you never get something right every time, so confidence is definitely my issue, I suppose if you do it then it is a confidence issue, and an experience issue'. (PE04)

Analysis of the diary entries demonstrated that key events were used to reinforce areas of confidence, describe having knowledge & experience but lacking confidence due to status as an NQM and to describe how experience as an NQM impacts on confidence.

Reinforced Areas of Confidence

Where the NQMs were in low risk settings delivering normal antenatal, intrapartum and postnatal midwifery care, they all reported feeling confident with their skills and abilities; this reflected the curriculum focus on normality and low risk care which was evident in many of the statements made:

'I knew how to deliver low risk women's babies. Midwifery care at its fundamental stage. I used the call bell when the vertex was visible!!' (PE11)

'On my second shift I was allocated 3 postnatal women to care for in the morning. These were low risk women following spontaneous vaginal deliveries. Although I was working on my own and wasn't being counted as supernumerary I felt confident in delivering midwifery care... During my training a great deal of emphasis was placed on providing care to low risk women.' (PE31)

'I have had some beautiful deliveries, little primips, who have had amazing deliveries with intact perineums when they were really petrified and I thought this is what it's about.' (PE94)

Confidence in providing care for women with high risk conditions or complications was influenced by being familiar with the layout of the practice area, knowing the protocols and feeling supported by senior staff. They also coped with high risk care more confidently when they knew the mother and her case history well.

'I initially felt somewhat apprehensive about caring for J during her LSCS as I never feel relaxed in theatre. Additionally whilst our theatre is located on labour ward, it is slightly removed from the main ward and thus I felt that I would be isolated, without the other midwifery staff.....The procedure went smoothly as did J's recovery period. I am pleased that this LSCS was elective rather than an emergency as it was very calm and ordered. I had also had time previous to entering theatre to prepare myself and ensure I knew what would be required of me. Whilst I realise that there is plenty of room for improvement in terms of my efficiency, I feel that I performed to the best of my current ability on this occasion' (PE15)

'There was an elective c-section happening and I offered to go with the midwife in order to gain my confidence with going on my own. I was able to prep the woman and took her down for a c-section. The midwife was happy just to observe and help if needed. I was really pleased as I felt confident and well-prepared. The section went well and I recovered the lady.' (PE93)

A good knowledge base combined with experience as a student provided confidence to deal with clinical events including caring for women with complex needs.

'Exhausted, uplifted and relieved. My first delivery was quick and very glad to have got the 'first' one out of the way so to speak. 'Specialled' 2 women on labour ward. Pre-eclamptic and BMI 58 with Gest Diab. Surprised myself on how much I knew and how confident I was in looking after them.' (PE52)

NQMs completing the shortened programme cited their previous experiences as a registered nurse as a factor influencing confidence in management of key events in areas of antenatal and postnatal care.

'Confident due to ward experience as nurse' (PEs193)

'I had seen abruptions as a student and this situation was more like my experiences where I had worked as a registered nurse. I knew all the emergency procedures for someone who was bleeding, ABC, cannulation etc and was comfortable with that.' (PEs112)

One key event involving an induction of labour provided an example of knowledge and experience giving an NQM the confidence to resist pressure from the obstetric team to intervene.

'I felt I could justify my lack of intervention and although she was technically 'consultant led care' she had a definite midwife led labour!' (PE41)

Although supervising student midwives and medical students initially created some anxiety for NQMs they generally found it a positive experience which reinforced confidence in their knowledge base and generated positive feedback from the student.

One participant gained confidence from teaching a medical student after being registered for 12 weeks and also sufficient confidence over the time of her first six months in the Labour Suite to be able to work as the triage midwife at 20 weeks post registration.

'Although I am not very experienced I feel happy about having students as they are enthusiastic and willing and talking through what we're doing is helpful to me and them' (PE65)

'Confident to teach normal parameters and supervise.....Nervous with the teaching responsibility as I had done so few deliveries on my own myself' (PE44)

Had knowledge & experience but lacking confidence due to status as an NQM

These key events illustrated that although NQMs felt they had the knowledge and the skills, they were aware of their status as an NQM which adversely affected their ability to be sufficiently assertive to deal with the event; main examples were around findings on vaginal examination (VE), dealing with potential complications during the second stage of labour and also in interpreting CTG recordings.

*'On finding an undiagnosed breech in labour.....
Did well, it was lack of confidence that made me get a more experienced colleague to check – but she was wrong and was 'kicking' herself for getting it wrong..., had sufficient knowledge, but had lack of confidence in my own opinion because of my lack of experience' (PE34)*

*'Diagnosing an 'anterior lip' on VE but not confident enough to insist it was present with the obstetrician on call (vindicated by Registrar later)...
I felt that I had been vindicated on the accuracy of my VE. The registrar talked the SHO through it as she had got it wrong and agreed with my initial findings' (PE57)*

*'and confirming onset of the second stage of labour.....
She started spontaneously pushing, at which stage the doctors suggested I perform another examination to see if she was in second stage. Although I was quite reluctant to do this, due to her spontaneously pushing and most probably in second stage, I felt I should because of being newly qualified and inexperienced. With consent I did so, and found her cervix to be fully dilated.' (PE85)*

'I had a crisis of confidence in the first 2 weeks, it was stupid things, things that I know I know but I doubted myself e.g. I had a 35 weeker come in with a normal pregnancy and I wasn't sure whether I should do a CTG or not, I was doubting my own knowledge, I feel I was still in student mode wanting my mentor to confirm what I should do. It's different working under your own PIN, it's now mine not my mentors.' (PE94)

The impact of previous experience on confidence

Confidence in responding to key events was affected by the experience of working as an NQM, the clinical events encountered, the expectations of colleagues and the support provided, for some this was a positive impact and for others it had a negative impact. One NQM reported a loss of confidence for the second stage of labour when she requested assistance but due to a breakdown in communications, no one came to her aid. Others included:

'At the beginning of the week I was feeling nervous about commencing practice the following week however I felt much reassured by the end of the week having discussed both mine and others' expectations of me and realising that I will be very well supported throughout this transitional period' (PE15)

'I had settled in well as had already been there as a student and as a maternity assistant. Did encounter some problems regarding the staff having to struggle to accept my position as a registered midwife, i.e. accept my opinion as a midwife. Did also have an encounter with an Assistant M who had been there for many years who made a comment on 'did I not know how they do things here?' (PE34)

'When I was first sent to labour ward I felt a bit sick and frightened as I had thought when you first went there you would be extra, not sent because they were short staffed and busy. On that day three of us were newly qualified and were sent to help and the co-ordinator looked at the three of us and said '...is that all I've got?' (PEs112)

3.2.1.2 Key Events that identified gaps in Knowledge / Experience

The inter-relationship of knowledge and practical experience made separation of the two components difficult when analysing responses to some of the key events; for those where the omission was clearer, experience was more often the missing component.

The following statement summarises the symbiotic relationship of theory and practice

'I am more aware now of why I have been taught what I have been taught...I can now see why that's important. There are lots of things now that are making more sense, although I had the knowledge before I can now see the purpose of that knowledge.' (PE94)

Had knowledge but lacked experience

NQMs felt that they did have a good knowledge base around complications and high risk maternity care, this knowledge often came from university lectures or skills teaching and simulations but they had not had to deal with these events in practice until they were

NQMs. Intrapartum emergencies dominated these events with fetal distress and shoulder dystocia being prime examples. The speed at which events could happen and have to be dealt with in obstetric emergency was daunting especially as many NQMs commented that they were 'slow' at getting the work done in their early weeks post qualifying. Key events involving obstetric emergencies also highlighted that mentors shield students by 'taking over' and therefore the NQM had never experienced the need to prioritise and manage all that was required.

One participant, who was based on the labour suite, reported feeling 'physically sick' and 'dreading going to work'. She had had little or no experience as a student in more complex care such as going to theatre or applying a fetal scalp electrode (FSE). The feelings of being out of her depth were compounded by a lack of support from colleagues.

'We do not have experience in theatre in our training and I think there should be. In fact, I don't feel we had enough labour ward experience at all as a student, and that experience all depends upon our mentors.' (PE84)

Other examples include:

'Gaps were time management and multi-tasking. These are difficult to teach – experience helps you to acquire them' (PE11)

'When emergencies happen during training mentor takes over so don't learn to assess priorities etc until you do it for yourself.' (PE94)

The impact of experience on speed of response was also highlighted in a key event relating to a heavy vaginal blood loss following a normal labour and birth

'I felt I knew what to do but due to my inexperience was a bit slow... The co-ordinator came in and took over. I felt useless!' (PE45)

Lacked knowledge and experience

The gaps in both knowledge and experience did highlight where NQMs felt there could be better preparation during the programme. These included specific drugs, knowledge as well as methods of administration, and prioritising and managing care in a busy postnatal unit. Social concerns and care of mothers with mental health problems were also cited. One off concerns were around adequate knowledge of antenatal screening

tests and their consequences and also dealing with babies who had congenital abnormalities. Although induction of labour might be taught on the programme, there was lack of knowledge as well as experience in dealing with the actual processes and timings of events during an induction of labour.

Two key events focussed on making errors, in both instances the error involved medicines administration and highlighted that although drug calculations had been addressed in the pre-registration programme there was a need for increased knowledge of specific medicines and medicine administration.

3.2.1.3 Key Events that articulated Frustration, Conflict or Distress

The majority of incidents in this category were reported because the NQM was dealing with a situation that was challenging to them both in terms of lack of experience combined with heavy workload but also because there was the additional pressure of staff shortages. Frustration was underpinned by a feeling of not being able to give optimal midwifery care. The correct completion of paperwork was specifically mentioned as a stressor.

'I feel that there is little or no normality on the ward now, which I had thought was the focus of midwifery care and little time is available to provide care and support women feeding as I had done earlier in my training. There is much referral to protocols and liaison with medical staff which is interesting however I'm not sure it is what I signed up for.' (PE84)

'The week was again very busy and short staffed. I found myself on a shift with a full 30 bedded ward and being one of 2 midwives on duty. It was very busy and I felt that I could not provide the level of quality care that I wanted to because the postnatal women were all keen to go home plus I had to prepare a woman for a category 3 section due to rising anti-e titres at 34 weeks.' (PEs102)

Another diary entry from a busy postnatal ward with 21 mothers and babies cared for by two midwives stated:

'Managed care to as high a standard as possible - very aware of effect of shortage of midwives especially on first time mothers who need support' (PEs133)

Frustration and distress relating to staffing levels on labour suite often related to difficulty in securing advice or a second opinion, a feeling that busy colleagues were irritated by being asked questions was a feature of many of these diary entries

'I felt exhausted! Two of the nights I had no break. I felt very unsure at times. Challenging most of the time. Although a lot of the time I felt that support was available if I asked for it, much of the time it was so busy that I felt a nuisance if I asked.' (PE45)

Omissions in care that caused anxiety and distress were caused by lack of experience in managing a busy postnatal ward.

'There was another crazy day where I felt I had not been the best midwife, there were so many demands on me, I didn't feel that I had seen the women as often as I should, There were call bells ringing and telephones going and things that needed doing and at the end of the day I felt that I had done everything then I suddenly remembered there was a woman who should have had her haemoglobin checked and I hadn't done it and I felt really, really bad about it.' (PE17)

3.2.2 Coping with Key Events

NQMs were asked to describe how they delivered midwifery care in relation to the key event and to identify what helped them in the delivery of care (see Appendix 1). Overall there were more positive than negative responses to the key events with knowledge, skills and experiences gained during their pre-registration midwifery programmes being important for NQMs in coping with these events.

For those NQMs who had completed the three year programme, when asked to indicate what education and experience helped them to deal with key events (n=230) there was almost an equal balance between the number of times they indicated that university learning and/or practice learning were important in helping them deal with the event with mention of mentor influence. Practice within a skills laboratory setting was also recognised as relevant. Support and learning during their current post was gained from senior midwives, the mother and family, specialist midwives and induction / staff development study days. Previous career, education or personal experience was cited for a small number of events. In contrast for those who completed the shortened programme, from 33 events analysed, practice learning experience was cited more

frequently than university input. Practice in a skills laboratory and previous experience as a nurse also had an impact.

In reviewing the responses to key events from both sets of participants, those completing the shortened programme appeared to highlight more deficits in both their knowledge and experience than those completing three years. However there must be caution in interpreting these results as contextual issues are important and exposure to the same set of events could produce similar results for those completing the three year programme.

Examples of deficits from both sets of participants include; knowledge of screening tests and their significance; dealing with late termination of pregnancy and bereavement; coping with babies who are born with birth defects; dealing with emergencies during intrapartum care ; and working in HDU with very ill post natal mothers and babies .

Some specific skills were also highlighted such as using a Pinard stethoscope to listen for the fetal heart and interpreting vaginal examinations (VEs) done on full term women who were not in labour.

It is important to note that the majority of participants recognised the symbiosis between theory and practice and the significance of each in their competence as NQMs. Knowledge gained from university lectures was usually supplemented by practice experience.

For some key events, knowledge was described as a process that Midwife Teachers and Mentors in practice were both involved in, whereas for other events the responsibility was seen to lay with practitioners. Where this demarcation between theory and practice was described it was attributed to Midwife Teachers not being involved in practice or there was no expectation that they should undertake this aspect of preparation for practice.

'Pre-eclampsia - Had covered in theory in university and also in practice experience.' (PEs153)

'Midwife lecturers gave me a basic knowledge on CTG interpretation to become competent which was then developed in practice'. (PE31)

'We weren't taught many practical skills and there weren't teachers in the workplace that could help with skill teaching, it was just left to the mentors who are not always the best ones to get the best information and advice from. They are not always the most up to date; this is where teachers in practice would be really helpful.' (PE36)

'I think overall the lecturers were there to teach us how to provide more low risk care than the HDU care needed in the above event...I learnt my skills and knowledge from my colleagues in practice which was the appropriate way in this event.' (PE31)

The memorisation of a mnemonic or a skills drill, learned in university, was significant in mental rehearsal for dealing with certain high risk situations (e.g. shoulder dystocia or resuscitation of the newborn)

3.2.2.1 Coping with Key Event - Factors which Helped

Participants provided an insight into the specific knowledge and experiences that helped them cope with events. The following section lists the specific factors that helped with illustrations from the diary included in Table 5.

Knowledge gained in University

Knowledge most frequently mentioned related to anatomy and physiology, normal parameters of progress and recognition of deviation from normality. Having to research topic areas for written assessments also helped, e.g. essays written on counselling topics. Mention was also made of the UNICEF Baby Friendly package and study days being used by University teachers to develop knowledge and skills for breast feeding support.

Practice placements undertaken as a student midwife

Practice experience undertaken during the pre-registration programme prepared NQMs to respond to key events by exposing them to a range of placements. In addition to core antenatal, intrapartum and postnatal placements, specialist areas were also cited as beneficial. The value of experience with indirect supervision was noted for building

confidence particularly in relation to low risk intrapartum care i.e. offering confidence cases.

Practice placements as a registered nurse (shortened programme)

Students on the shortened programme cited previous nursing experience as transferable for some of the key events

OSCEs / skills drills / skills practice as a student in a skills laboratory

Where practice experience was not available or appropriate, the use of skills practice and simulation in a university skills laboratory setting was cited as helpful. Learning suturing skills was the most frequently cited skills laboratory activity reported by both long and shortened programme NQMs. Other skills included neonatal resuscitation and cannulation. Maternity service provider policy influenced whether students could or could not then go on to practise skills such as suturing, cannulation, and medicine administration including epidural 'top-up' and induction of labour during their placements.

However whilst the role of simulation and use of models have a part to play in preparation for practice they are not always the solution and responses clearly pointed to there being no substitute for reality, the following suggestion was made by one student in relation to cannulation:

'That fake arm is one thing but a real arm is something else... It would help if we could use a real arm. I think students would be happy to practice on each other unless they have a needle phobia, I wouldn't mind. My colleague suggested we practice on each other.' (PE94)

The availability of MTs to oversee practice in a skills laboratory was recognised as an asset to learning that was missing when staff student ratios were reduced

'When we were practising suturing, the people at the front, the lecturers were just sucked in and they never got to us and we were just sat there with our bits and pieces,' (PE04)

Rehearsing for emergencies and complications was most often undertaken using OSCEs. The key events most frequently cited to demonstrate the role of OSCEs and mnemonics in preparation for practice were shoulder dystocia and resuscitation of mother and baby.

OSCEs were an integral part of the assessment process where a module on complications was provided in the curriculum; however their effectiveness in motivating learning was compromised for some students if they were steered towards selected complications

'The module we have on complications is very good and does include a lot but then we are tested on known topics. We are given three scenarios, then you are told that you will be tested on one of these, so you learn these three well and neglect other complications.' (PEs112)

Mentors during Pre-registration programme

The role of mentors in facilitating practice experience was recognised both in terms of exposure to learning experiences and as role models. One NQM stated that she visualised her mentor sitting on her shoulder telling her what to do.

University and placement

The complementary role of university learning and practice experience was evident in most of the key events analysed. One NQM identified practice learning team (PLT) meetings as a helpful resource that brings theory and practice together.

Support at the time of event

Support played a significant role in determining how the NQM responded to the key event. If they felt that support was available their confidence increased even in events where they did not actually have to access it. In many instances being told that she was 'doing OK' was enough to help the NQM cope with a challenging situation.

'I had never done it before and needed some help. When I discussed with the sister in charge, she wasn't helpful and couldn't believe that I had never done one. I talked the procedure through with some other colleagues and managed it.' (PE84)

'Yes I did need some support in the above event, it was useful to get some reassurance that I was doing things right.' (PE31)

Table 5 Coping with Key Event – Examples of what helped

Knowledge gained in University	<i>Basic midwifery skills. Monitoring maternal wellbeing- BP, pulse, temp, lochia etc fetal wellbeing and observations. Recording observations appropriately. (PE11)</i>
	<i>Knowing deviations from the normal i.e. shivering, pyrexia, preterm labour... Helped me feel competent about the observations and knowing that something was not right with the preterm labour lady. (PE85)</i>
	<i>The knowledge that people have differing levels of understanding according to varying factors including their education, age, culture, ability/disability, area of expertise etc, and the skill of pitching communication according to level of understanding in order for it to be most effective. (PE15)</i>
	<i>Mainly from university - advocacy for mothers and selves - confidence from course re professional responsibility (PE57)</i>
	<i>One lecturer gave us in depth knowledge of lactational amenorrhea - something I had not heard of prior to my training. I now regularly recommend this as a method of contraception. (PE41)</i>
Practice placements undertaken as a student midwife	<i>I think it was my midwife in practice that gave me the most confidence, and I was proactive and went down as a student to many c-sections to gain that confidence(PE93)</i>
	<i>Dealing with Theatre list for CSs - Learned this type of knowledge through experience on placements BUT lots of paperwork involved - can only learn by doing (PE06)</i>
	<i>4 weeks placement on induction unit in 2nd year, busy unit, gained all skills needed so confident (PE44)</i>
	<i>Time on fetal maternal medicine helped me learn about gastroschisis (PE65)</i>
Practice placements as a registered nurse	<i>Experience looking after high risk women and also nursing experience (PEs193)</i>
	<i>Time management good from nursing experience (PEs193)</i>
	<i>This situation was more like my experiences in A & E (PEs112)</i>
OSCEs / skills drills / skills practice as a student in a skills laboratory	<i>Practice episiotomy and suturing in skills laboratory (PEs122)</i>
	<i>We had a suturing workshop as a student which got us used to handling instruments etc.(PE31)</i>
	<i>OSCE suturing in school (PE73)</i>
	<i>Intrapartum care and recognition of fetal distress learned all on course. Baby resuscitation from OSCES (PE57)</i>
	<i>Providing me with a basic understanding and appreciation of safe practice in this type of incident. I was able to draw on role play scenarios and discussion in uni to inform my practice. (PE52)</i>
Midwife mentors during pre-registration	<i>The practical elements were taught by mentors and they helped me to have the confidence to understand the specific process as set out by hospital policy. (PE03)</i>

programme	<i>Practice as a student, mentor input specifically when she would say if everything is normal treat your woman as normal. (PE11)</i>
	<i>I feel that mentors / midwives you work with in clinical environment have a greater impact on my competency than lecturers and it is difficult for them to do this when they are not working with you in the clinical environment (PE31)</i>
	<i>During my midwifery training and the experience I had within the midwifery led unit. I also thought back to the interactions I had with my mentors and how I had learnt to deliver (PE44)</i>
	<i>I was very lucky because I had some fantastic mentors, who would strive to give excellent care, being really meticulous in their record keeping, I worked with very good midwives and I just feel that I was set a very good example (PE63)</i>
University and placement	<i>Caring for a woman following a stillbirth - Some things had been covered in training, we had a midwife with personal experience come in to talk to us about her feelings and what happened and the protocols etc, we had also had the chaplain come in to talk to us so all that gave the principles of what needed to be done but it couldn't all be done in the classroom but what I had was preparation for me to then have this experience (PE17)</i>
	<i>Breast Feeding - Knowledge gained in university up to date and evidence based. Skills in university practical sessions and on placement (PEs133)</i>
	<i>Shoulder dystocia -Learn in university and had experience as student plus mnemonic! (PE12)</i>
	<i>At my trust they run Practice Learning Team (PLT) meetings and I found they were excellent to discuss problems / skills etc. with midwife mentors and teachers alike to foster knowledge and proficiency and wish they would facilitate emergency skills for students through this where we can learn from mentors/ other midwives who have had experience with it. (PE73)</i>
Support at time of event	<i>I had never done it before and needed some help. When I discussed with the sister in charge, she wasn't helpful and couldn't believe that I had never done one. I talked the procedure through with some other colleagues and managed it. (PE84)</i>
	<i>Yes I did need some support in the above event, it was useful to get some reassurance that I was doing things right. (PE31)</i>

3.2.3 Impact of Midwife Teachers

NQMs were asked about the impact that the MTs had on how competent they felt in dealing with the key event. They were also asked if there was anything more that MTs could have done to prepare the NQM to deal with the event.

When reviewing responses to this question, participants recorded the key influence of their practice learning experience, acknowledging that learning to suit the event being described could be best obtained through experience. However, they also indicated clearly where there had been a major impact from their university learning, where there might have been some deficits and more importantly where one method of learning informed the other, i.e. theory supporting practice learning.

3.2.3.1 Making a strong impact

Participants appreciated the MT input on the foundations of normal maternity care as well as input on how to deal with high risk and emergency obstetric situations. Social skills in empathy and communication were emphasised and social care around child protection issues were mentioned. 'Nil more needed' or 'could do no more' was repeated often and MTs were regarded as pivotal in providing confidence for the NQM to onward refer when more complex needs developed. NQMs stated the benefits of underpinning knowledge of anatomy and physiology when assessing likely progress of events.

The provision of emotional support throughout the course was mentioned by one respondent which may allude to the Personal Tutor role and its significance to that individual.

The illustration below provides an example of how one MT had, through a variety of means, been pivotal to the learning of midwifery students.

'The lecturer who led the CI module made a significant contribution to my practice. She delivered dynamic and fascinating lectures on a range of topics which we had input into selecting, she made extensive use of the university intranet system, setting up and actively participating in discussion forums, encouraging us to read widely on the topics to support our pieces from which we selected those for assessment, in addition to making herself available to provide academic support and a listening ear. She stimulated our thirst for learning,

offered support and advice on issues faced in practice and prompted us to seek out learning opportunities in practice. We learned extensively about multi-disciplinary working and were encouraged to actively participate in this on placement.' (PE74)

The contribution of MTs to the tripartite meeting and assessment in practice was not included in all the diaries; of those who did comment there were mixed responses. Some NQMs were very positive about the MTs involvement and stated that the tripartite meeting added fairness and rigour to the process, however there was evidence from other NQMs that there were flaws in the system and the presence of a MT at a meeting was often lacking.

'we would meet over coffee or something and we would just talk through the assessment and through my progress and then if my mentor had any concerns they could discuss without me or, normally we all sat together and it was quite open we would chat together and be quite open about it, we never did any assessment as a group of three, it was always done between myself and my mentor but the lecturer certainly could have her input there... I always did quite well. Possibly because I am quite chatty, but there were times when there was something I had been over scored and when I was questioned I thought perhaps I am not quite there and there was a time when a whole assessment document was taken and started again because I had been underscored quite a lot and that was felt by one of the lecturers so we worked through it... you are banking everything and it is really important for your course on one mentor and if they are not 100% sure of the booklets, and bless them they are changing all the time, so they think they are doing the right thing by you, so it's worth having the lecturer coming and saying actually do you realise that means you will be giving her a D- and do you feel that is where she is at? and they say oh gosh no that's not what I mean at all, so it's invaluable.'(PE04)

'I feel the practice assessment is a joke. You just have to tick the right boxes. I tried to get my mentors to think about it a bit more although it wasn't always in my interest to do this! But I felt that much of it depended on how well you got on with your mentor and if you know your theory you can appear to be competent. I can link it in my head, I have the knowledge but that doesn't always mean that I can apply it to practice...' (PE36)

3.2.3.2 Deficits and suggested improvements

Participants, through doing their own key event analysis, did recognise that there were some deficits in their respective courses that could be corrected in future and provided some suggestions on how these could be done. As participants were from six different university sites in the UK, it is important to note the general trends overall in what might

be important to include in future changes to the curriculum. NQMS did also acknowledge the crowded curriculum that currently exists.

'The midwifery course is very intense with a big focus on achieving your numbers, I am unsure if there would have been enough time to dedicate time to high dependency care.' (PE44)

'More practise with complication scenarios but it would be difficult to do more in a 78 week programme, not that I would have liked the programme to be longer.' (PEs112)

An increase in practice sessions which were supervised by MTs either in university or in practice placements was requested by NQMs from both programmes. Knowledge of drugs and experience in delivering drugs particularly via the intravenous route was a deficit for the three year programme students. Prioritisation of care workshops/ simulations was advocated so that these could help them in high pressure situations particularly in intrapartum and post natal settings. Relatively more input on high risk, high dependency care activities though it was recognised that experience in dealing with these cases would be more beneficial.

Suggested areas where the NQMs felt the MTs could do more can be summarised as:

- More involvement in practice
- More practical skills sessions in a skills laboratory
- More emphasis on complications (see Table 6)

TABLE 6 : Suggested areas where the MTs could do more

More involvement of Midwife teachers in practice	<i>Need practice sessions with groups in practice setting from MTs (PE22)</i> <i>EBL was not sufficient; our tutors should have come out and taught us in practice (PE84)</i>
	<i>More regular visits may help or one to one meetings to discuss clinical events (PE31)</i>
	<i>Would have been nice to have someone do a delivery or a shift (PE112s)</i> <i>Work with you in practice because they understand mechanics of teaching (PE22)</i>
More practical skills in a skills laboratory	<i>CTGs should have a high profile. (PEs112)</i>
	<i>Drug rounds and dispensing medicines (PE55)</i> <i>Medicines administration and knowledge of drugs (PE16)</i> <i>IV drug administration (PE44)</i> <i>Drug calculations and administering IVI antibiotics(PE22)</i> <i>Preparing sliding scales & IVI running rates(PE31)</i> <i>Cannulation(PE44) (PE04)</i>
	<i>Role play around grief and loss (PE44)</i>
	<i>Neonatal resuscitation. Need more practice on dummies(PE55)</i>
	<i>Cardiac monitoring specific to pregnant and labouring woman. (PE44)</i>
	<i>How to scrub for a Caesarean Section (PE45)</i> <i>A theatre drill in an empty theatre (PE65)</i>
	<i>Perineal suturing (PE04)</i>
	<i>Application of fetal scalp electrode(PE94)(PE41)</i>
More emphasis on complications	<i>More practice with complication scenarios (PEs112)</i>
Uncommon situations	<i>use of group reflection/case study discussion to share the cohort experiences (PE63)</i>

3.3 Feedback on the quality of care delivered by NQMs

In order to acquire answers to objectives 3 and 4 of the project (see 1.1), an evaluation of the quality of care delivered by NQMs is an important proxy measure of the impact of MTs on their preparation to become registered midwives. This section of the report provides an analysis of data from the following sources;

- Diary data from NQM to include feedback from :
 - Mothers and families
 - Colleagues and Senior Midwives
 - Preceptors

- Combination of others
- LSAMO questionnaire
- Preceptor and SoM Questionnaire Results
- Joint Interviews with Preceptors and NQMs

3.3.1 Evaluation from NQM diary entries

As part of the description of key events, the diary structure asked participants to outline any feedback from mothers and families, their colleagues, their Preceptor and their SoM (see Appendix 1). The majority of recordings in this section of the diary were from senior midwives and/or colleagues and then with decreasing frequency from mothers, then preceptors and/or SoMs as these latter two were not seen very often during the time frame of diary entries.

Feedback from mothers and families are reported first, results should bear in mind that a birth is usually a very happy event for all concerned so critical feedback is highly likely to be influenced by the event.

Mothers and Families

The total portfolio of key events demonstrates that NQMs were expected to deal with the whole range of normal to high risk maternity care. The feedback, where recorded, was in the main positive from mothers and their families.

First job placements in Labour Suites and or/in Midwifery led units facilitated a one to one relationship so that feedback was personal to the NQM dealing with the mother, baby and family (Table 7).

Table 7 : Mother & family feedback : Labour Suite

NQM Code	Feedback Statement
PE44	<i>Positive feedback from mother and the student midwife</i>
PE15	<i>'Y was thrilled that she had delivered without any pain relief and was full of thanks and praise for me in helping her to achieve this'</i>
PE45	<i>Colleagues told her she had done the right thing (dealing with 3rd stage PPH). Mother thanked her and bought her a large bunch of flowers after discharge</i>
PE41	<i>Mother rang manager and sang my praises and said I should be paid double and was fantastic!</i>
PEs123	<i>I received a thank you card and photo of baby which was really lovely, felt I had been a positive part of their experience</i>

Where the job placement was on a busy post natal ward, there was little individual feedback recorded by participants, though there were exceptions.

'Mothers see lots of midwives, not one to one but generally good feedback ' (PE22)

'Yes -positive - I cheered them up and my pelvic floor exercises they would remember forever !!' (PEs193)

However there were events where there was appreciation of individualised care, the most common being when the NQM helped mothers with breast feeding

'Mother very happy and sent her a thank you card' (PEs133)

'Family said that 'I was the most kindest midwife', that my help was really appreciated and that 'I am a star'. It was really encouraging to hear all this. (Breast feeding)' (PE55)

A mother and baby who had had additional support from the NQM because the baby had congenital abnormalities

'Mother found her a great support and continued to contact her by phone after discharge for additional advise'(PEs133)

There were one or two examples where the participant felt they had not dealt with the situation very well and although no action had been taken by the mother and/or family, the NQM felt 'devastated' and 'guilty'. A NQM working on an antenatal ward where a woman diagnosed with schizophrenia was admitted with a tentative diagnosis of being in early labour. However the midwifery team had handed over that they thought she was

'attention seeking'. However, she was in labour and had to facilitate her own delivery by making her own way to the labour suite from the ante-natal ward, because she was not believed.

'Felt terrible as the woman was in labour and I was not believing,.... thought there might have been a formal complaint from her, but learned a lot from the event' (PE06)

Feedback from colleagues and senior midwives

In analysing the key events, the majority of support and feedback was given by midwife colleagues, in particular those in senior positions within the team. The feedback was generally encouraging with a debriefing and open discussion of events in order that all could learn. Table 8 provides examples from NQMs completing their first work placements in the Labour Suite

Table 8 : Feedback from Colleagues – Labour Suite

NQM Code	Feedback Statement
PE44	<i>'Very positive feedback from team. I received feedback from the risk management team as any shoulder dystocia delivery is automatically referred to them for auditing of notes. I was pleased that my documentation received praise and that this feedback was disseminated to the head of midwifery and my supervisor of midwives'.</i>
PE73	<i>Good feedback and encouragement of development midwife supported me well throughout my bad experience and facilitated me to suture again by saying every experience even if bad is an experience and you learn more from the bad ones than the good ones</i>
PE94	<i>Co-ordinator explained next day alternative sources of help e.g. Dr to help with putting on electrode. Gave praise for things she had done right in managing other women. Asked NQM if it was workload or not getting help that made her flustered - first few weeks labour suite</i>
PE93	<i>I got feed back from the ward co ordinator who said I needed to have stated my case clearer to the labour suite co ordinator and pushed further to have got the ctg reviewed. She was more giving me advise for next time. She said I had done the right things just not been assertive enough!</i>

Diary participants who had completed their first work placements in other areas such as post natal wards or antenatal clinics overall provided less commentary on feedback

received from colleagues. Reasons could be linked to the busy nature of the work load with lack of consistency in different midwives working together because of rotation systems and the 12 hours shift system that was very prevalent across the data received from all the sample. The following are examples of praise and criticism.

'Encouragement and praise to have tackled the work load with little back up as unit busy and asked appropriately for assistance where unsure' (PE73 – week 1)

'Praised for doing well in assessing a small for dates gestation' (PEs153)

'Told she should have taken a coffee break by first m/w in charge. Told she was getting in a flap by second M/W in charge & was not offered reallocation of workload - Week 4 – busy post natal high risk mothers and babies' (PE36)

'No one knows me well enough to be able to give me any feedback because I am moving so often as are many of the other staff.'(PEs112)

Feedback from Preceptor

The number of instances for specific feedback from preceptors is limited by the amount of contact time with the NQM. The two examples here reflect time spent working alongside their preceptor during the first few shifts/weeks in post

'Preceptor gave me positive feedback on how I dealt with C`s case who also thanked me for my care whilst she was in hospital which felt genuine. Informal feedback going through the events verbally and positively appraising my actions documentation and communication skills' (PE11)

'my perceptor informed me that I had done well and that I needed to have more confidence in my own ability ' (PE93).

Feedback from multiple sources

For some of the examples of feedback recorded in the diaries, it is hard to separate out under the above categories as they came from multiple sources. However, these accounts provide an insight into how important any feedback was for confidence building for the individual NQM.

'I received good feedback from my colleagues which included praise for undertaking the water birth, as many midwives are uncomfortable with water birth. I also received praise that I had tried my best to deliver the placenta. Of course the most valuable feedback was from the 2nd midwife who provided alternative suggestions for delivering the placenta. L and her partner were both

extremely disappointed and visibly upset that the delivery had not gone according to their plan, however they were very thankful for the care I had provided' (PE15)

'I got very positive feedback from the SIC on both shifts, for my work with both the woman and the rest of the MDT. I think this was encouraged by nursing experience in busy emergency units where concise communication with the MDT is essential. I was so pleased to have positive feedback from the woman I worked with which I feel was also represented in early breastfeeding and expressions of satisfaction after the birth from the woman who had delivered. It was really reassuring getting this feedback from the mother, and also the constructive feedback from the SIC, as it made me feel I was starting to work to the standards of a RM I wanted to with direct suggestions on how to improve my paperwork' (PEs123)

'Matron complimented me on being able to pick up on the signs and involve the whole team early on (Abnormal CTG, cord prolapsed)... referred to in case conference also and complimented on making a good judgement call. Got nice flowers and a card from mother' (PEs122)

3.3.2 Evaluation from LSAMO survey

Before providing further evaluation data related to the current sample of NQMs (n=35) it is useful to review the findings of the LSAMO survey (see Appendix 4) which covered feedback on NQMs during their first year of practice within the time frame of April 2007 to March 2010. Over the three year period a total of 22 incidents involving midwives in their first year of practice had been reported to the LSAMOs. Of these, 14 midwives were required to undertake a developmental programme and 6 required a supervised practice programme. None of these newly qualified midwives had subsequently been referred to the NMC for lack of competence.

What was not always clear from the data provided was whether the newly qualified midwives involved in incidents had delays between qualifying and securing employment and whether they had posts as agency midwives or held a substantive contract.

Some of the LSAMOs provided further information which related to five of the development programmes and three of the supervised practice programmes. For instance one of the incidents reported to an LSAMO involved a midwife who took up her post one year after qualifying as there were no posts available at the time; this midwife needed both a development and supervised practice programme. A second midwife who needed a supervised practice programme had also not worked for the first year following

qualification. A further three of those reported had only worked a few bank shifts or as agency midwives. Only one of the incidents reported to an LSAMO involved a newly qualified midwife who gained employment immediately following qualification.

3.3.3 Evaluation from Preceptor and SoM Questionnaire

Questionnaires to Preceptors (n=9) asked respondents to rate their preceptee's capabilities in relation to eleven items on a 5 point scale from 1 (limited capability) to 5 (very capable) during their first month of practice and again at six months (see Appendix 2). All preceptors gave their NQMs scores of 3 or above for all items at the one month point, with most items scoring 4 or 5. In relation to the '3s' scores, two students were scored 3 for 'decision making', one scored 3 for 'diagnosing abnormalities' and 'being knowledgeable' and the only shortened programme NQM whose preceptor had responded was rated 3 for 'knowing own limitations' and an 'unsure' for 'being safe in an emergency'. For those who had completed six months at the time of completion of the questionnaire, they were all rated 4 or 5 for every item. Most of the preceptors provided additional comments, either their own or feedback from mothers, all were positive. The following are examples:

'I have taken over care of women and they have commented how nice and confident my preceptee is. They felt she had listened to their needs.'
(PreQ3/PE44)

'Mothers really like (name), great feedback...very respectful, very kind and considerate...' (PreQ3/PEs122)

'Mothers love our new midwives. There have been no negative comments...antenatally, in labour or postnatally.' (PreQ3/PE34)

'...is showing good qualities as a midwife – she has entered the maternity services at a difficult time as we have had severe staff shortages. During the early weeks she has dealt with an emergency on the ward and coped well.' (PreQ3/PE11)

'My preceptee was an excellent team member and was able to communicate effectively with the MDT. One consultant was very impressed at her knowledge and was surprised to find out she was newly qualified.' (PreQ3/PE44)

'I have received feedback (all very positive) from other midwives and managers.' (PreQ3/PE45)

'She was open and honest about her limitations. Could be trusted to ask for help or confirmation/reassurance on her decision making.' (PreQ3/PE15)

'My NQM had to help resuscitate a 28 week gestation; I wasn't there but heard she was very competent.' (PreQ3/PE34)

SoMs (n=7) were asked to rate their supervisee's capabilities in relation to eleven items on a 5 point scale from 1 (limited capability) to 5 (very capable) during their first month of practice and again at six months (see Appendix 3). At the one month point all but one SoM said their NQM had a score of 3 or more for all items except 'taking responsibility' and 'decision making skills'. However by six months this one SoM stated her NQM scored 3 for 'decision making' skills but was still only given a score of 2 for 'taking responsibility'. No further comments were added but the SoM stated that the NQM was safe and knows her own limitations. For the remaining NQMs most had ratings of 4 or 5 by six months for many items, with one NQM being rated 5 for all items. Only three SoMs said they were aware of comments from mothers and/or their family members and those received were in the main positive, especially about being 'caring, kind and attentive'.

There was only one questionnaire response for a shortened programme NQM and at the one month time frame there was very little difference in rating between this NQM and that for a three year programme NQM working in the same provider service.

3.3.4 Evaluation from joint interviews (n=7) with Preceptee (NMQ) and Preceptor pairings

Overall there was strong agreement between both the preceptor and preceptee about their competence and confidence. Preceptors found that the NQMs had been rigorously prepared and had sound knowledge to equip them for their role.

'You won't come across everything...there is always the unknown...academically, they seem to be quite rigorously prepared.' (PreI3/PE11)

It was not a surprise to the preceptors that the NQMs, both three year and shortened programme students, were initially anxious about taking responsibility for caring for women in labour. The preceptors who had known the NQMs when they were students believed they had a tendency to underestimate their abilities and knew they would ask for help if in doubt. Shortened programme students were particularly anxious about intrapartum care because their programme was so short and placements on labour suite were limited.

'When I was doing my training, the three yearers...are confident, we feel like the poor relatives...they seem super confident...' (NQMs/PEs193)

Comments were made by preceptors that it would be beneficial, but they recognised not feasible, if all NQMs could be allocated on to the labour suite initially. This they felt would be particularly helpful when a NQM is required to accompany a woman who was transferred from a midwife led unit to a busy labour ward.

'I think they need to be in delivery suite first of all because girls like xxx haven't had an awful lot of delivery experience in this hospital...and if they're looking after a lady who suddenly becomes high risk, they have to go down there and they're very much thrown in the deep end.' (PreIs/PEs133)

Preceptors expressed no concerns about their preceptees in providing care for women whose labour was straightforward and any feedback they had received from mothers was positive. Comments were made that a few women had shown surprise that the midwife was recently qualified. Newly qualified midwives found it really encouraging when mothers gave them positive feedback and gave them *'...cards and things to keep'* (NQMI3/PE44).

Preceptors attempted to diffuse anxieties about 'fear of coping with something new' by explaining that no midwife can experience everything and that midwifery is about life-long learning. They discussed the importance of even experienced midwives asking for a second opinion if unsure about a diagnosis. Very positive comments were made by preceptors about NQMs' enthusiasm to keep on learning.

'It's so good to hear that you go home and read about these things and look into it. There are lots of them (more experienced midwives) that don't...in a couple of years you'll be a Band 7, believe me, you will be.' (PreI3/PE44)

A lot of time in the early months as a new midwife was taken up with the NQM learning to practise skills not acquired as a student. They discussed changes in what students were allowed to do now in comparison with the greater flexibility in some of the preceptors' own training. It was agreed that it would be much better for students to practise many of these skills under supervision of their mentor (e.g. setting up IVI, drug administration) before programme completion.

'...we are not able to connect pumps up. I know all the principles...but we have not actually used them...' (NQMI3/PE11) '...in the past the student would connect up the drip and do it all...OK still supervised...I need to do something hands on...I think they should be doing that as they go along in their training...' (PreI3/PE11)

One interview pair discussed the fact that although their NHS provider did allow students to put up IVIs under supervision, not all mentors permitted their student to do so.

'...I mean A (mentor) was quite good letting me do it, but a lot of other mentors don't necessarily allow you to do it...and it's just getting the confidence...it's more measuring up whatever it is...and flushing and things like that...' (NQMI3/PE45)

One area where there should be sufficient opportunities to practise as a student was the interpretation of CTG recordings. However both interviewees in a few of the pairs discussed the NQM's lack of confidence in this area and suggested there could be more input from MTs although a lot of experience post qualification is also important.

'I think CTG interpretation is you know quite a big thing...the midwife says the trace is absolutely fine...you don't want to knock someone's confidence...at the same time it's all about safety...I mean it comes with experience...I am still learning every day...' (PreIs/PEs193)

'...and CTG interpretations, you don't cover that in your training really...it should be introduced a lot earlier and you should have some classroom background work as well...' (NQMI3/PEs193)

Suturing skills was another area where a few NQMs and their preceptors thought could have been facilitated during the pre-registration programme and they were aware that some had received these skills sessions whereas they had not.

'...there wasn't a specific suturing lesson. They said that was something you would get when you were out in practice'. (NQMI3/PE44)

'...I think it's something (suturing workshop) they could be exposing people to a lot earlier really, at the time that they even start undertaking deliveries.'
(Pre13/PE45)

Preceptors and NQMs discussed the different amount of practical skills training student midwives had received in the university. Because opportunities to do emergency drills and even basic skills like making up feeds were variable in practice and dependent upon the mentor, they agreed there should be more opportunities provided in the university. This would give NQMs more confidence when faced with a complication they had not observed in the practice areas and to avoid embarrassment when unable to undertake skills even support staff could do.

'...yes, and sometimes there's a newly qualified and they'll say 'I've never done that before and I think how did you get through your training without never having done that. . yeah maybe clinical things, and it's not really complicated things, it's maybe simple things like setting a women up with an express pump. A lot of our auxiliaries do that job, but I think in your training it's important that you know how to do that, and I have come across a few people...maybe it's just that the opportunity hasn't come up, but I think that's something when you qualify.. you'll be using and advising mum's a lot and you need to know how to use it...' (Pre13/PE74)

There was also surprise at the lack of learning opportunities in accompanying a mother to theatre for a caesarean section as this was something they would frequently need to do in their first post. Both three year and shortened programme students believed some of the theoretical content of their university based programme could have been omitted to make more space for skills teaching and greater knowledge to deal with complex care, in particular for women with medical as well as obstetric complications.

Most of those interviewed mentioned 'complications' modules as being particularly helpful in providing them with the knowledge they were likely to need to participate in caring for women with complex needs. However one pair of interviewees thought that more could have been done in the university to ensure students had sufficient knowledge about some of the complications likely to be encountered in the maternity services. The NQM blamed the way in which PBL had been facilitated and her preceptor agreed that some topics lend themselves to having more input from an expert in that field.

'To me going away and researching what diabetes is or is not, I would rather someone tell me what it meant, because at the end of the day that's what I will be dealing with. I could be looking at the wrong book and if the book is out of date...' (NQM3/PE74)... '... You can have that taught session and can then go and look at some research and look at how it has come on...' (PreI3/PE74)

Besides knowing more about dealing with complex care needs, one of the preceptors emphasised the importance of students having a breadth and depth of knowledge to enable them to be more assertive and participate in the politics of care as well as the immediacy of care delivery.

'I think all the stuff you think is irrelevant now will come into play later...I don't want people churned out from a midwifery school not thinking about the bigger picture and not knowing about the management of change...you come out as a thinking person who at some point will stand up and say you are doing this the wrong way...you need that vision...' (PreI3/PE11)

What was difficult for three year programme route NQMs was the workload when in the ward environment. As a student they might have been given responsibility for perhaps four women and their babies, but once qualified they could be responsible for half the ward, especially if another midwife went 'off sick'. Shortened programme students were less surprised about this need to balance competing priorities as most had this experience as a newly qualified nurse and hence felt better prepared.

"I think managing a case load is quite a challenge maybe because you just go from a bay where you have 4 patients and your mentor...to you are part of the numbers and suddenly you have got 8 or 12... (PreI3/PE11)... '...perhaps lacking is prioritising care on a busy work place...people need you to get your piece of work done...I feel less supported on the wards...I did a night shift and I had 12 patients...I kept thinking alright I am going to be going home soon, which is not what I want to be thinking, but it was an awful night...' (NQMI3/PE11)

'I am more confident in a ward environment, down here (labour ward) I find it a bit daunting...feel out of your depth sometimes' (NQMIs/PEs193)

Not all three year programme students found the wards daunting but the preceptor to a particular NQM, who had not done her midwifery placements in her maternity unit, was very impressed with her preceptee's' capabilities, especially being able to 'multi-task'.

'...I was quite comfortable with my kind of antenatal and post-natal checks...I also offered to do the elective caesarean sections every day that I'm on shift...' (NQMI3/PE44). '...you could see how good she was...especially a busy unit like this because she was able to multi-task, and whatever you told her she absorbed straight away and you didn't have to tell her twice...' (PreI3/PE44)

Shortened programme students also mentioned that they were relied upon to undertake a lot of the post-operative care when the maternity unit was short-staffed and this could delay their placement on labour wards. It also transpired that senior midwives forgot they had not been to labour ward for a long time and expected them to know what to do even though they had received no orientation.

'...when you're transferred to help out...and they know you're six months trained now and they're like, you should know what to do and I've never had an orientation there...that's really scary...' (NQMs/PEs133)

As well as the time delay once in post in gaining experience in a different area, the preceptors also supported the concerns of NQMs that the time delay between qualifying and gaining employment affected their confidence.

'...if you could just finish as a student and then come straight into it. That time difference you start building your fears up and 6 weeks is a long time and you haven't forgotten it but you are afraid that you have.' (PreI3/PE41)

In looking back to their pre-registration programmes, NQMs and preceptors were in agreement that they would have benefitted from a greater presence of midwife teachers in the practice areas. This they felt would enable the university staff to understand 'the bigger picture' of working in the NHS and would enable them to assist the mentors in spotting and remedying deficits in learning opportunities.

'...I think there's definitely students.... There's one sort of side who are very eager and will take every opportunity, they'll hear that a doctors away to do something and they'll automatically say can I go, and you'll have the other one who won't, who will sit and you can see these differences when they come through as midwives...' (PreI3/PE74)

'MTs wouldn't know when we have changes...they won't have the bigger picture of what morale is like and what work practices are like on...'(PreI3/PE11)...MTs tell you about how it should be done which is lovely...but it is like only 30% of my role...' (NQMI3/PE11)

There was good agreement that it would be advantageous if teachers sometimes worked with students.

'...it would be lovely if they all (MTs) did do some sessions in practice...even if you had some link so that the person they see in the university is also the person you see on the ward...they are more able to pre-empt problems for when you qualify

because they actually have got a working flavour of the ward...they (mentor) would be quite happy for a lecturer to come and take a student for the afternoon; you know help a student through, it makes their job easier in some respects'. (PreI3/PE11) '...I would have loved it...yea, I would have done...' (NQMI3/PE11)

Whilst the preceptors were very positive about these study NQMs and welcomed teachers working with them they found it invaluable to have the teacher's support when they had doubts about students.

'...and students can be quite intimidating at times...she tells me (link lecturer) that she will be able to come and help me...' (PreIs/PEs133)

'I know that sometimes if the student has been incompetent, in the past, they (midwife teachers) have come along and worked with the student and that is good and just the feedback they get as well and you know the tripartite meetings that is very useful and there is a lot of positive comments that come out of that...' (PreI3/PE41)

Where there was a lack of visibility of midwife teachers in practice, one of the preceptors attributed it to the reduction in teacher resource that she had noticed when studying and the demands placed upon teachers by the university.

'...When we were in the university, the number of lecturers we had was cut very dramatically, when we were there and we felt that and they were doing their own research. They had too much to do.' (PreI3/ PE74)

The lack of teachers in the practice areas was suggested by one pair of interviewees to not only affect the equity of support students received but it could adversely affect the reliability of assessments.

'...some (midwife teachers) were better than others...actually that was one thing with (name of maternity unit)...she was off a lot...that did cause a bit of a problem for some of the girls...' (NQMI3/PE45)

'...I was the student rep for three years...I felt that the scoring was absolutely meaningless, because there was no mediating voice...so I always felt that if you cosied up to your mentor a bit...' (PreI3/PE45)

However well prepared student midwives are through their pre-registration programme, the participants agreed that you cannot be totally prepared for the transition to qualified midwife and the responsibilities that entails. What both NQM and preceptor noted was the differences in how much mentors 'let-go' and allowed their student to practise with

minimal supervision. This they felt was easier if there was continuity of mentor. One of the preceptors questioned the advisability of students moving to a new unit in their final year as this limited opportunities for them to be allowed to do as much on their own.

'...in my third year she did as much as possible to prepare me for being a qualified midwife...she gave me quite a long rein...' (NQMI3/PE44)

'...if you don't get that opportunity to be doing care, doing your notes, planning care, that decision making, if you don't get the opportunity to do the whole job on your own, it can come as a big shock when you're newly qualified...I always thought it was a very strange time to change (third year)...when you should be getting to grips with working independently...if you are going to change (sites), change after the first year...' (PreI3/PE45)

Both NQMs and preceptors thought more could be done to give frequent simulated practice in core skills to give confidence in dexterity and help in speed of participation when a new situation arises. As NQMs are concerned about gaining in confidence and learning to provide competent care when women have more complex needs, participants believed it was of benefit for the NQM to gain employment soon after qualification in the provider service where they had gained experience as a student. This, it was suggested, enables the routine things to be done automatically so that new things can be assimilated.

'...but you need a lot of things ticking along without taking too much notice so that you can take on board the new stuff.' (PreI3/PE11)

Preceptors also added that if they had worked with the NQM when they were a senior student, then they knew how much support they were likely to need when they took up their first post.

'I was very aware of xx's ability as a student, so I could kinda gauge what I could leave her to do, even just qualified, you know there was certain things she was tasked to do as a student so I had no worries about leaving her to do it as a newly qualified midwife'. (PreI3/PE74)

In contrast one of the preceptors to a NQM who had moved areas suggested that the initiative of the NQM was key and provided the employer ensured that appropriate support mechanisms were in place and a good induction was provided, then there was not a problem.

'...what is good about you is the fact that you know what you want...you set yourself goals and we work out quickly how you are going to achieve them...we knew you were scared but not petrified but you seemed to cope very well. New city, new hospital, new job – that's pretty good going...you should be proud of yourself...' PreI3/PE44

As well as having good preceptorship, this NQM also had good support from her SoMs.

'...my supervisor came and introduced herself...I had some feedback on a delivery which was lovely...I had a shoulder dystocia...she emailed to give me feedback on my note-taking, which I thought was really nice...' (NQMI3/PE44)

Having good support from a SoMs was not the experience of all the NQMs. One said she had difficulty identifying who was her SoMs, others said they had not been allocated one. Induction programmes were also variable and one of the preceptors said that where support was lacking she knew of maternity provider sites '

'...where their NQMs haven't lasted six months' (PreI3/PE45).

She said she had also worked hard to stop situations occurring in her own work environment where NQMs were moved to help out in areas where they had not yet been orientated.

Preceptors and NQMs reflected back on the pre-registration programme and the particular value of midwife teachers. They agreed that those teachers who were up to date with what was going on in practice now were the most effective. Of most importance was good communication between the university and practice. They welcomed teachers visiting practice regularly, working with students and supporting and advising mentors. This was most essential if the mentor had concerns about a student and to monitor assessment decisions.

4 SUMMARY OF FINDINGS

The following section outlines a summary of findings under the three main results headings.

- A descriptive overview of the experiences of NQMs
- Evaluation of the Midwife Teacher (MT) impact through event analysis
- Feedback on the quality of care delivered by NQMs

4.1 Overview of experiences

Apart from NQMs from one university site, the majority, within 8 – 12 weeks of completing their programme, gained employment with service providers who had been part of their learning circuits for practice placements. Where employment was not available locally, a number of NQMs moved country to gain their first work experiences. Others waited 4-6 months for temporary part time employment with their local service providers.

Induction programmes were available for the majority of NQMs even if variable in start time, length of programme and content. A generic employer focused programme was supplemented with specific maternity care inputs. All participants experienced rotation systems within a hospital based provider unit, moving between Labour Suite, Ante and Post natal care and Clinics. Experience in the community during a rotation programme was minimal (two weeks) mentioned by only one respondent. One participant chose her first employment with a community team.

Apart from one provider site, supernumerary status during first weeks in employment was rare, being evident for a maximum of two shifts at the most. Participants frequently commented on the positive support received from their fellow midwives and from senior midwives in the team. Although Preceptors were allocated to and/or were requested by NQMs, their overall experience of preceptorship was generally 'ad hoc' with the participants often initiating feedback. Exceptions included where service providers had

formal development programmes that required evidence for job re-banding (Knowledge and Skills Framework) at the end of one year in post.

Contact with SoMs, where they had been allocated, was minimal and unless a meeting was initiated by the NQM in response to an 'event', any formal meeting was planned for the end of first six months in post.

Perceptions of progress over time were strongly linked with personal feelings of confidence, the degree of support available and the timing and order of work rotations. Frequent changes of work location were described as a 'roller coaster' ride. First work placements in the Labour Suite and/or a busy ante/post natal ward presented differing challenges for NQMs. For the former placement, it was dealing with complex, high risk maternity care and for the latter, it was managing and prioritising the allocated workload. Those NQMs who had been nurses said they coped better with the latter but not the former.

Quality support was important to NQMs gaining confidence and there was evidence that stability and positive feedback during the first work placement provided for a more satisfying experience and feelings of confidence. Positive feelings and perceptions of confidence and competence were consistently linked to participating in normal labours and with having time to provide quality ante natal and/or post natal care, in particular supporting the mother in breast feeding.

4.2 Evaluation of Midwife Teacher impact

NQMs all reported feeling confident with their skills and abilities whilst working in low risk settings delivering normal antenatal, intrapartum and postnatal midwifery care; this reflected the curriculum focus on normality and low risk care. NQMs described having a good knowledge base related to high risk cases but confidence in providing care for women with more complex needs was influenced by limited or no previous experience of managing complications as a student. The level of support offered to the NQM by senior staff when dealing with the event also impacted on confidence.

The complementary role of university learning and practice experience was evident in most of the key events analysed.

Through exposing them, as students, to a range of core and specialist placements, practice experience undertaken during the pre-registration programme prepared NQMs to respond to key events.

The value of student experience where there was indirect supervision was noted as important for building confidence but was not made available in all practice learning placements.

Where practice experience was not available or appropriate, the use of supervised skills laboratory exercises and simulation were cited as helpful. However, even if the profile of cases available might facilitate students gaining the relevant experience, maternity service provider clinical risk management policies influenced whether students could then go on to practise these skills or not in placement areas.

The efficacy of learning through skills practice and simulation exercises was influenced by having sufficient MTs to support learning and having MTs who were up to date with contemporary practice.

Most frequently cited deficits in knowledge and/or experience that impacted on the NQMs confidence and competence related to:

- Dealing with high risk /complex situations
- Managing workload and prioritisation
- Knowledge/experience of drugs and methods of administration
- Working in high dependency and theatre environment

Other areas highlighted depended on meeting the needs of women and families with more specific problems to include:

- Women with concurrent medical conditions e.g. diabetes
- Women with mental illness
- Babies with special needs
- Ante-natal screening tests and their consequences

- Complex psycho-social problems

Suggested areas where the NQMs felt the MTs could do more can be summarised as:

- More involvement in practice learning
- More practical skills sessions in a skills laboratory
- More emphasis on complications
- More encouragement in the development of students' personal qualities e.g. initiative, assertiveness.

The involvement of MTs in the tripartite meeting and assessment in practice was noted to have the potential to enhance the process as MTs are in a better position to be more understanding of the assessment criteria and are able to monitor the fairness and validity of mentors' assessment judgements.

4.3 Feedback on quality of maternity care

A UK wide survey of LSAMOs revealed that during a three year period (April 2007 – March 2010) no first year NQMs had been referred to the NMC for lack of competence. However there were a number who required a developmental programme and/or a supervised practice programme. Of these NQMs, the majority had up to a year's delay in obtaining their first posts after completing their pre-registration programme.

In relation to the participants in this study, mothers and their families were very positive in their feedback to the NQMs, whether in the labour suite or in the wards or clinics.

Senior midwives also provided positive feedback along with advice and encouragement to the NQMs.

Overall both preceptors and SoMs were very positive about the NQMs who were participating in this phase of the study. No negative feedback had been given and they knew of many women, other midwives and consultants who had been particularly complimentary about them.

Preceptors and SoMs recognised that NQMs would be anxious about the transition from student to midwife but had every confidence in their abilities to provide care to women whose pregnancies and labours were straightforward.

Concerns were expressed about the variability of support provided for NQMs, but where this was good, they saw them grow in confidence and able to provide care to women with more complex needs.

Preceptors expressed concern for those NQMs who had delays in finding employment, had no preceptor, did not know which SoMs was allocated to them and were moved about between wards and labour ward without receiving an orientation to the new area.

From a synthesis of feedback from all sources, it would appear that the NQMs who adapted best were those:

- who gained employment soon after qualifying
- were employed in units where there was good support and a well organised preceptorship period
- whose mentor (when students) had 'let go' to enable them to practise with minimal supervision when care was straightforward and also gain experience in caring for women with complications
- who took the initiative to learn new skills and knowledge
- who were able to prioritise activities appropriately
- from universities who
 - had provided sufficient and appropriate skills sessions,
 - balanced normality teaching with complexity
 - and had good teacher support whilst in practice.

APPENDIX 1: MINT PROJECT: PHASE 3 – DIARY TOOL

(Please Note : 'White space' has been removed so diary format does not take up so much space in this Appendix)

The MINT Project : Diary Study

Guidelines for completion of diary

General guidelines

- Decide on what method you are going to use to keep your diary
- Start to complete the diary tool when you receive your NMC registration number and commence your first post working as a qualified midwife
- Complete an entry to the diary at least weekly during the first three months; then at least every two weeks for the second three months
- Ensure you write your allocated code and the week number each time you complete an entry
- Do not name specific clinical areas or specific people; to ensure confidentiality label people and places with a pseudo name
- Diary entries will be collected by the researcher every month for safe data storage
- If you have any questions/problems please contact your named researcher

Guidelines for completing Section 1

This entry should include a summary statement of what has happened during the week to include :

- Description of area where you were working
- What shifts, hours etc.
- Focus of work for the week e.g. pre-natal, labour suite, post-natal, community etc
- Contact with Preceptor
- Learning events during the week
- How you felt about the week

Guidelines for completing Section 2

- Pick out an event or case or day during the week which you would like to reflect on in more detail
- Describe the event and the people involved

Guidelines for completing Section 3

- Go through the listed questions and make an attempt to answer all of them
- If you cannot answer some questions please give a short explanation on why you are unable to comment

Code :

Date of entry:

Week post qualification :

Section 1 Please complete a summary description of your week

Describe how you felt about the week

Section 2 Pick particular event(s)/ day(s)/case(s) and describe how you worked to deliver midwifery care

Section 3 : Making progress as a newly qualified midwife

Taking the above description please answer the following questions:

1. What specific knowledge and skills helped you to deliver midwifery care in the Section 2 event (s)
2. Did you feel you had sufficient knowledge and skills for the particular event (s)
3. Where did you gain your knowledge and skills to deal with the above event(s)
4. What impact did midwife teachers/lecturers have on how competent you felt in dealing with the above event (s)
5. What more could your midwife teachers/lecturers have done to prepare you to deal with the above event(s)
6. Did you feel you needed support to deliver midwifery care during the above event(s)
7. Who provided the most support to you at the time of the event (s)

8. What gaps in your knowledge and skills (if any) were highlighted by the above event(s)

9. How was your preceptor involved

10. Did you get feedback from your Preceptor and/or your colleagues and/or the mother/family involved?

11. If yes - Please describe the feedback.

How much contact, if any, did you have with your Supervisor of Midwives over the above event(s)

APPENDIX 2: PRECEPTOR QUESTIONNAIRE

MINT Phase 3 Q6 Preceptors

1. Midwives IN Teaching- The MINT Project. Research commissioned by the Nursin...

A major aim of our study is to evaluate the effect that midwife teachers/lecturers have on student midwife outcomes and on the quality of care that newly qualified midwives can provide for mothers and their families. This short questionnaire is to allow you to comment on your experience as a Preceptor in supporting a newly qualified midwife

Your responses are highly valued, therefore, we are very grateful for your time and effort in completing this questionnaire.

ALL RESPONSES WILL BE TREATED IN COMPLETE CONFIDENCE. YOU OR WORKPLACE WILL NOT BE IDENTIFIED IN ANY REPORTS ARISING FROM THE STUDY

2. Default Section

Section 1

Information collected in this section is to describe the sample of Preceptors and ensure representativeness. No individual or area will be identifiable in any reports

1. What is your job title

2. Is your employment in this post

☐ Full time

☐ Part time

If part time, please indicate FTE (eg. 0.2/0.5 etc)

3. How many years have you been practising as a midwife

☐ 0-1

☐ 2-5

☐ 6-10

☐ 11-15

☐ 16-20

☐ Above 20

Any comment on response

4. Estimate how many times you have provided preceptorship support to newly qualified midwives

MINT Phase 3 Q6 Preceptors

5. Where is your current work location. Please tick area

- ☐ South West England
☐ London area
☐ East Midlands
☐ Wales
☐ Scotland
☐ Northern Ireland

Section 2 : Questions regarding the progress of your preceptee

6. Please rate your preceptee's capability in the following areas during her/his first month as a newly qualified midwife

	1 (limited capability)	2	3	4	5 (Very capable)	unsure
Being knowledgeable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Communicating effectively	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seeking advice appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knowing their limitations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Demonstrating competence but are not over-confident	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking responsibility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Decision making skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diagnosing abnormalities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having the personal qualities that can adapt to women's individual needs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Working in a team	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being safe, or predicting they would be, in an emergency	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. Describe whether your preceptee demonstrated any particular strengths or deficiencies in midwifery skills that you would expect from a newly qualified midwife?

MINT Phase 3 Q6 Preceptors

8. Please rate your preceptee's capability in the following areas at the end of their six months in post

	1 (limited capability)	2	3	4	5 (Very capable)
Being knowledgeable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Communicating effectively	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seeking advice appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knowing their limitations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Demonstrating competence but are not over-confident	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking responsibility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Decision making skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diagnosing abnormalities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having the personal qualities that can adapt to women's individual needs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Working in a team	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being safe, or predicting they would be, in an emergency	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. Have you received any feedback on the performance of your preceptee from mothers and/or their families

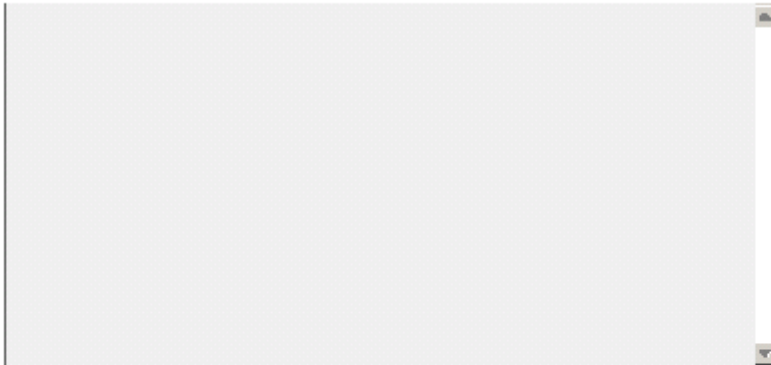
☐ Yes

☐ No

If yes, please describe

MINT Phase 3 Q6 Preceptors

10. Please add any further comments you would like to make

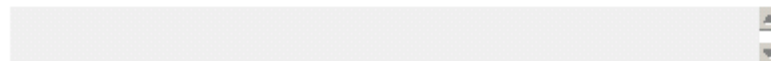
A large, empty rectangular text area with a light gray background, intended for the respondent to provide additional comments. It has a small scroll bar on the right side.

11. Are you willing to take part in a joint interview with your preceptee in order to explore in more depth the experiences of both of you during the past six months. The interview will take between 30 - 60 minutes of your time

☐ Yes

☐ No

Any comment

A small, empty rectangular text area with a light gray background, intended for the respondent to provide any additional comments related to question 11. It has a small scroll bar on the right side.

Many thanks for your support in taking part in the MINT project.

APPENDIX 3: SUPERVISOR OF MIDWIVES QUESTIONNAIRE

MINT Phase 3 Q7 Supervisorsof Midwives

1. Midwives IN Teaching- The MINT Project. Research commissioned by the Nursin...

A major aim of our study is to evaluate the effect that midwife teachers/lecturers have on student midwife outcomes and on the quality of care that newly qualified midwives can provide for mothers and their families. This short questionnaire is to allow you to comment on your experience as a Supervisor of Midwives in supporting a newly qualified midwife

Your responses are highly valued, therefore, we are very grateful for your time and effort in completing this questionnaire.

ALL RESPONSES WILL BE TREATED IN COMPLETE CONFIDENCE. YOU OR WORKPLACE WILL NOT BE IDENTIFIED IN ANY REPORTS ARISING FROM THE STUDY

2. Default Section

Section 1

Information collected in this section is to describe the sample of Supervisors of Midwives and ensure representativeness. No individual or area will be identifiable in any reports

1. What is your job title

2. Is your employment in this post

☐ Full time

☐ Part time

If part time, please indicate FTE (eg. 0.2/0.5 etc)

3. How many years have you been practising as a Supervisor of Midwives

☐ 0-1

☐ 2-5

☐ 6-10

☐ 11-15

☐ 16-20

☐ Above 20

Any comment on response

4. Estimate how many times you have provided supervision support to newly qualified midwives

MINT Phase 3 Q7 Supervisorsof Midwives

5. Where is your current work location. Please tick area

- ☐ South West England
☐ London area
☐ East Midlands
☐ Wales
☐ Scotland
☐ Northern Ireland

Section 2 : Questions regarding the progress of your supervisee

6. Please rate your supervisee's capability in the following areas during her/his first month as a newly qualified midwife

	1 (limited capability)	2	3	4	5 (Very capable)	Unsure
Being knowledgeable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Communicating effectively	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seeking advice appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knowing their limitations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Demonstrating competence but are not over-confident	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking responsibility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Decision making skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diagnosing abnormalities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having the personal qualities that can adapt to women's individual needs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Working in a team	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being safe, or predicting they would be, in an emergency	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

MINT Phase 3 Q7 Supervisorsof Midwives

7. Please rate your supervisee's capability in the following areas at the end of their six months in post

	1 (limited capability)	2	3	4	5 (Very capable)
Being knowledgeable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Communicating effectively	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seeking advice appropriately	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knowing their limitations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Demonstrating competence but are not over-confident	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking responsibility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Decision making skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diagnosing abnormalities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having the personal qualities that can adapt to women's individual needs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Working in a team	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being safe, or predicting they would be, in an emergency	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. Have you received any feedback on the preformance of your supervisee from mothers and/or families

- ☐ Yes
- ☐ No

If yes, please comment

9. Please add any further comments you would like to make

Many thanks for your support in taking part in the MINT project.

APPENDIX 4: LSAMO QUESTIONNAIRE

1. Midwives IN Teaching- The MINT Project. Research commissioned by the Nursin...

A major aim of our study is to identify the various models for delivery of pre-registration midwifery education in the UK with particular focus on the specific contributions made by Midwife Teachers. This questionnaire is being sent to all LSAMOs throughout the UK. Your responses will be highly valued, therefore, we are very grateful for your time and effort in completing this questionnaire.

Definition of Terms:

Midwife Teacher: This term denotes a university employed midwife who has gained or is working towards gaining an NMC recordable teaching qualification. Most universities use the term 'Lecturer' instead of 'Teacher'

ALL RESPONSES WILL BE TREATED IN COMPLETE CONFIDENCE. YOU OR YOUR AREA WILL NOT BE IDENTIFIED IN ANY REPORTS ARISING FROM THE STUDY

2. Default Section

SECTION 1: INFORMATION ABOUT YOUR AREA

Please note we need this information to ensure representation from all countries in the UK. Your area will not be identified in any reports.

1. Where is your location

	England	Scotland	Wales	Northern Ireland
From the country selected, use drop down menu and select your region (if appropriate)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

2. How many universities/organisations provide pre-registration midwifery programmes in your area

3. Which pre-registration midwifery programmes are currently provided by universities in your area

- ☐ Three year degree (F/T)
- ☐ Shortened degree (F/T)
- ☐ Three year Diploma (F/T)
- ☐ Shortened Diploma (F/T)
- ☐ Other

Other (please specify)

4. What is the average number of students accessing pre-registration midwifery programmes annually in your area

- ☐ 20 - 30
- ☐ 31 - 40
- ☐ 41 - 50
- ☐ 51 - 60
- ☐ 61 - 70
- ☐ Above 70
- ☐ If above 70, please indicate number

5. How many Maternity Services Providers provide practice placements for pre-registration midwifery students in your area

- ☐ 1 - 3
- ☐ 4 - 6
- ☐ 7 - 10
- ☐ 11 - 15
- ☐ 16 - 20
- ☐ Above 20

Any comment

SECTION 2 : EVIDENCE FROM LSAMO AUDITS

6. Please rate the following statements

	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Midwife Teachers do not provide support to students while in practice placements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Midwifery students are satisfied with experiences gained in their practice learning placements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mothers express appreciation for the care they receive from midwifery students	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Students are satisfied with the support they receive from Midwife Teachers when in practice placements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Support for students from mentors/qualified midwives is good	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The SoM provides support for midwifery students	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There are complaints from mothers about the care they receive from student midwives	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other (please specify)

7. Please provide comments on any feedback obtained from mothers on care received from student midwives

8. Please provide comments on any feedback obtained from mothers on care received from newly qualified midwives in their first year of midwifery practice

SECTION 3 : ANNUAL AUDIT REPORT

9. From your most recent annual audit, please provide the numbers recorded/involved (where applicable) within each timeframe for midwives in their FIRST YEAR OF PRACTICE.

Please use the 'drop down' menu to give your response within each of the time frames

	0 - 3 months	4 - 6 months	7 - 9 months	10 - 12 months
Incidents reported	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Development programmes set up	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Supervised practice programmes established	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Referred to the NMC for lack of competence	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Referred to the NMC for misconduct	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Removed from the NMC register	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Other/please comment

10. Please indicate and comment on whether any midwife involved in any incidents during their first year had gap time of three months or more between qualifying and taking up their first post as a registered midwife

SECTION 4 ; Supervisor of Midwives AS MIDWIFE TEACHER

11. There are SoMs who are also Midwife Teachers

☐ Yes

☐ No

☐ If yes, how many in your area

12. Which of the following roles does the SoM who is also a Midwife Teacher undertake

- ☐ Takes a case load as a clinical midwife
- ☐ Manages a midwifery team
- ☐ Provides theoretical input to pre-registration curriculum
- ☐ Currently acts as a Supervisor of Midwives
- ☐ Works alongside a midwife student in practice

Other (please specify)

13. Please comment on how teachers who are also SoM have an additional impact on student outcomes.

14. Please comment on how being a SoM as well as a teacher impacts on the team of Supervisors of Midwives in the Trust

15. Please add any further comments regarding any topic/aspect of this questionnaire

THANK YOU VERY MUCH FOR TAKING TIME TO COMPLETE THIS QUESTIONNAIRE

PLEASE ENSURE YOU PRESS 'DONE' WHEN YOU ARE FINISHED COMPLETING ALL QUESTIONS

APPENDIX 5: JOINT INTERVIEW SCHEDULE: PRECEPTOR AND PRECEPTEE

The MINT Project : Phase 3

Joint Interview Schedule with Preceptor and Preceptee

The joint interview will be tape recorded (after obtaining formal consent from participants). The schedule will focus on the following themes:

- Perceptions of current capability and confidence of the midwife six months after qualification
- Exploration of areas of knowledge and skills where the preceptee felt confident and competent at the start of their first post and what had the most impact on these feelings
- Review of areas of knowledge and skills where the preceptee felt anxious and unsure about dealing with during their early weeks as a newly qualified midwife to include the participants opinions on what input was needed to increase confidence and competence
- Perceptions on current responses of mothers (and families) to the midwifery care provided by the newly qualified midwife.
- Summary on what, from their pre-registration programme and the input from their midwife teachers/lecturers, makes the most difference in developing the knowledge and skills of the newly qualified midwife
- Exploring the differing perceptions of preceptor/preceptee

APPENDIX 6: GUIDELINES FOR DIARY ANALYSIS

The MINT Project : Phase 3 (Diary Study)

GUIDELINES FOR DIARY ANALYSIS & SYNTHESIS

In order to focus on the aims of the study, analysis of the diaries must focus on answering the key aim of evaluating the effectiveness of current education programmes for pre-registration midwifery.

There will be other areas of interest to report BUT initial analysis and synthesis work must focus on the above aim.

The analysis should be completed in two stages with each individual participant being treated as an individual CASE within each CASE STUDY SITE

Stage 1 : Key Events for INDIVIDUAL diary participant

Step 1 : It may be helpful to use an excel Table to

- record a summary of each event and the particular week post registration in which experienced
- record how participant responded to the event
- reflections on how education preparation prepared the participant for dealing with the event – please note MT input

Step 2 : Develop a typology of 'key events' for each case to include answers to the following :

- What were they about ? (e.g. 'positive feedback'; developing good relationships with colleagues; as well as coping with clinical situations)

- What experiences and/or education helped participants to deal with the type of event
- What would they have liked to have had to deal with the event
- Feedback from Mothers and family

Step 3 : Impact and feelings about 1st post following registration for each participant

Please include commentary on the following:

- Variations in experiences which may be related to NHS job site
- Variations in what seems to be expected from a newly qualified midwife by the service team
- Type of support from Preceptor and/or SoM and/or others such as midwifery team
- Variations in support systems available to newly qualified midwife

Stage 2 : Case Study Site Synthesis through cross comparisons between participants to include both long and short course newly registered midwives

Complete a Report that includes:

- Commentary on the profile of key events and whether there are similarities and differences across the participants
- Discussion on any positive evaluations of education input to deal with events
- Commentary on any curriculum deficits highlighted by participants
- Summary of feedback from mothers and families
- Discussion on overall experiences and support systems available to newly qualified midwives.

Each Case Study Site Report will then be used to do cross comparisons for all six sites in the UK for those completing the three year programme and for all four sites completing the shortened programme.