BEING AND BECOMING A DIAGNOSTIC RADIOGRAPHER

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Abstract

The response to social, economic and political influences has resulted in the radiography profession undergoing significant change, increasing service demands and a requirement for graduates to possess a much wider range of skills. The changing role of the radiographer has also been as a consequence of fast evolving technology and the subsequent demand for radiography services. Due to the increasing role that diagnostic imaging now plays in many patient pathways, a wider range of procedures are undertaken in vaster quantities and this brings with it more complex patient cases. Consequently, it has been suggested that radiography is a 'profession under pressure'.

The aim of the study was to explore the experience of newly qualified practitioners in their first post as a radiographer in a range of diagnostic imaging departments in the NHS. There is a clear need for new insights and updated knowledge about this transition experience in radiography in order to raise awareness of these challenges within the profession.
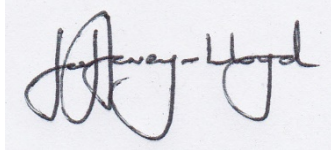
An interpretive phenomenology methodology was used. This research design was a longitudinal, qualitative prospective study. Following ethical approval, data were collected from a group of nine newly qualified radiographers who had commenced employment in the NHS. Three interviews were undertaken with each participant; at three months, six months and twelve months post qualification. All participants had graduated from one university, and had entered employment within an NHS Trust in which they had not worked as trainees. Thematic analysis was utilised to ensure that there was a thorough examination of each individual experience, commonalities and relationships, including the identification of differences across the participants.

The six main themes identified included; needing support, settling in, developing confidence, becoming established, feeling useful and looking forward. The impact and influence of these themes on the participant experience varied across the twelve month journey and between each participant. The sub-themes offered further insight into the experiences and these were enhanced by the final interviews at twelve months which utilised a theme board allowing some visual representation of the participants' feelings. The anticipated contribution to knowledge will be an increased understanding and awareness of the demands of this transition period and will inform future curriculum planning, management of the student experience, and support for the newly-qualified radiographer.

Declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed:

Dated: 18/9/2017

Glossary

Accident and Emergency department (A&E) or Emergency Department (ED) - A department specialising in acute care for patients presenting without appointment. These departments are generally found in acute hospitals or other primary care centres.

Accident and Emergency (A&E) X-ray room(s) - specific X-ray room(s) located in the A&E department.

Allied health professions (AHPs) - A group of health professions distinct from medicine, dentistry, nursing and midwifery. They make up around 60% of the healthcare workforce and include professions such as radiographers, physiotherapists and occupational therapists.

Agenda for Change (AfC) - The restructure of the pay and working conditions for NHS workers placing them onto a single pay spine.

Assistant Practitioner - A member of healthcare staff who assists radiographers and radiologists with radiographic examinations during their day-to-day practices. This is a band four post.

Baby Boomers - A term used to describe those born between 1946 - 1964 who are thought to have similar attitudes, emotions, beliefs and preferences towards work and career. They are thought to make up 25% of the current NHS workforce.

Computed Radiography (CR) - Computed radiography uses a cassette which houses an imaging plate containing photostimulable phosphor. The X-ray image that is taken is transferred onto a computer system to be viewed.

College of Radiographers (CoR) - The charitable subsidiary of the Society of Radiographers. The College's objectives are directed towards education, research and other activities in support of the science and practice of radiography.

Computed Tomography (CT) - Computed tomography is an imaging method using X-rays to produce tomographic images. It can examine body organs and structures which can be enhanced using contrast agents.

Continuing professional development (CPD) - Healthcare professionals are required to maintain their competency. CPD allows professionals to do this by attending courses, reading articles and reflecting on their clinical practice. Each radiographer is required to maintain a CPD portfolio by their statutory regulatory body.

Diagnostic Imaging Department - A department in a hospital that consists of varying imaging modalities such as X-ray, Computed Tomography (CT),

Magnetic Resonance Imaging (MRI), Ultrasound, Mammography and Radionuclide Imaging (RNI).

Diagnostic Radiographer - An AHP who employs a range of different imaging techniques and sophisticated equipment to produce high quality images in order to diagnose injury or disease.

Direct Digital radiography (DDR) - DDR captures the X-ray image of the patient directly onto a flat panel detector without the use of a cassette. This image is transferred directly onto a computer system removing the need to leave the patient and process any images elsewhere.

General X-ray - The main part of the imaging department where projection imaging is undertaken.

Generation Alpha - A term used to describe those born from 2010 onwards who are thought to have similar attitudes, emotions, beliefs and preferences towards work and career. They are still within the primary education system and research is currently being undertaken to understand more about them. What is known is that they will receive the most formal education, they will have utilised the most technology and will potentially be the wealthiest generation ever.

Generation X - A term used to describe those born between 1965 - 1980 who are thought to have similar attitudes, emotions, beliefs and preferences towards work and career. They are thought to make up 40% of the current NHS workforce.

Generation Y - A term used to describe those born between 1980 - 1994 who are thought to have similar attitudes, emotions, beliefs and preferences towards work and career. They are thought to make up 35% of the current NHS workforce.

Generation Z - A term used to describe those born between 1995 - 2010 who are thought to have similar attitudes, emotions, beliefs and preferences towards work and career. They are new into the NHS workforce, having left Higher Education approximately two years ago. The proportion of Generation Z in the current NHS workforce is unknown.

Health and Care Professions Council (HCPC) - The Health and Care Professions Council is a UK statutory regulatory body set up to protect the public. It currently regulates sixteen professions including Diagnostic Radiography.

Imaging modalities - Different methods of imaging the body, for example projection radiography using X-rays and ultrasound are different imaging modalities.

Interprofessional learning (IPL) - Interprofessional learning allows people from different professional groups to learn with, from and about one another.

Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R 2000) - Radiographers must adhere to these regulations by keep radiation doses 'as low as reasonably practicable.' These regulations were introduced to protect patients.

Magnetic Resonance Imaging (MRI) - An imaging modality that uses a strong magnetic field and radiofrequency waves to produce sectional images of the body in more than one plane images of the body.

Mammography - An X-ray imaging procedure using low-energy X-rays to examine the human breast and is used as both a diagnostic and screening tool.

Mobile radiography - this is when radiographic images are acquired by the use of a mobile X-ray machine outside of the diagnostic imaging department e.g. on a ward or in an operating theatre.

On-call - a term that refers to diagnostic radiographers working out of hours or overnight; with significantly limited numbers of DID staff undertaking imaging procedures.

Out-of-hours - Outside the hours of 8.30 – 17.30 Monday to Friday.

Picture Archiving and Communications System (PACS) - PACS uses a combination of hardware and software dedicated to the short and long term storage, retrieval, management, distribution, and presentation of medical images. Electronic images and reports are transmitted digitally via PACS.

Practitioner - A practitioner is someone who is engaged in a specialism including medicine. Radiographers are often regarded as practitioners and are required in accordance with IR(ME)R 2000 to justify requests for radiological examinations prior to undertaking imaging.

Protocol - Protocols govern the choice of diagnostic examinations utilised in the diagnostic imaging department. They provide local guidance to individual radiographers and assistant practitioners to practice in accordance with the employers' rules.

Radiographic projections - relate to the diagnostic images produced; based on a detailed description (technique) of how to position the patient, image receptor and X-ray tube in order to achieve an image.

Radiographic reporting - the production of a report to identify any findings from the radiographic images obtained from an imaging procedure. Every imaging procedure must have an associated report.

Radiographic technique - The radiographic technique is undertaken to ensure an optimum radiation level is given to the patient in order to obtain an image of diagnostic quality.

Radiologist - Doctors specially educated to utilise an array of imaging technologies to diagnose or treat disease.

Radionuclide Imaging (RNI) - an imaging modality that uses a range of techniques to image the body with the use of radio-isotopes.

Red dot system - A red dot can be placed on an image by a radiographer to indicate an abnormality.

Radiotherapy - Uses high levels of radiation doses to treat cancer and other diseases.

R*eferring clinician (referrer)* - A health care practitioner who refers the patient for a radiographic examination and completes the X-ray request form in accordance with IR(ME)R 2000.

Super-user - In this context this refers to a diagnostic radiographer who is trained to the highest level on the Direct Digital radiography (DDR) system. There are generally responsible for training, trouble shooting and supporting other users.

Society of Radiographers (SoR) - The Society of Radiographers is a trade union that represents more than 90% of the diagnostic and therapy radiographers in the UK. It was founded in 1920.

Society and College of Radiographers (SCoR) – When the charitable subsidiary of the SoR known as the CoR works alongside and with the SoR.

Ultrasound – An imaging modality using ultrasonic frequencies to produce images of the body, commonly used to image pregnant women but can be used to treat and diagnose other diseases.

1.0   INTRODUCTION

This chapter provides the reader with a rationale for the study and the reasons behind my interest in the concept of transition. In order to contextualise the thesis, the history of radiography and radiography education is outlined followed by a discussion of the current role of diagnostic radiographers today and the challenges faced by diagnostic imaging departments across the UK. A brief description of the degree course that the participants completed is given, identifying key differences compared to other courses in the UK. Finally, the research question, aim and objectives are stated followed by a brief outline of the subsequent thesis chapters.

1.1   Rationale

The healthcare environment in the UK is rapidly changing and the demand for healthcare services is increasing. In 2014, the NHS Confederation presented seven key challenges facing health and care which are illustrated in Figure 1.
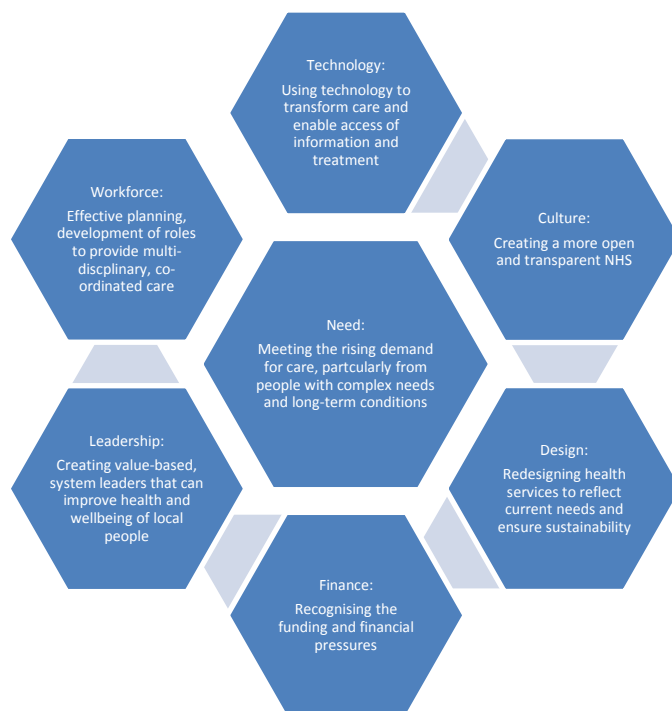
Figure 1: The NHS Confederation Challenge Declaration (2014)

Meeting the rising demand for care remains a key priority for the NHS as the UK population is increasing, people are living longer and are having to manage long term conditions and a combination of co-morbidities. The challenges now faced by healthcare professionals as highlighted above are multidimensional and complex requiring a very different workforce and service than delivered in previous years.

Due to the changing landscape, the pressures now being placed on newly qualified health and social care practitioners has initiated research in both nursing and medicine which has focussed on the transition of student to practitioner. This has been in response to concerns about the level of preparedness to practise in the ever demanding healthcare environment and the complex issues that practitioners now face (Ross and Clifford, 2002; Mooney, 2007).

In response to the social, economic and political influences the radiography profession is undergoing significant change with, for example, increases in service demands and as such there a requirement for graduates to possess a much wider range of skills (Decker, 2009). The changing role of the radiographer has also been as a consequence of fast evolving technology and the subsequent demand for radiography services. The setting of targets and new ways of working consistently challenge the resilience and commitment of radiographers (Scholes, 2008). More specifically the work has become more technically challenging and the underpinning knowledge required more demanding. Due to the increasing role that diagnostic imaging now plays in many patient care pathways, a wider range of procedures are undertaken in vaster quantities and this brings with it more complex patient cases. Consequently, it has been suggested that radiography is a *'profession under pressure'* (Brown, 2004, p213).

Several studies in radiography have alluded to lack of preparedness to practise of student radiographers (MacKay et al., 2008; Feusi et al., 2006). Areas of concern were identified as the ability to justify request forms for X-ray examinations and readiness to carry out imaging procedures in theatre

unsupervised. The increased demand for diagnostic imaging services results in employers requiring newly qualified practitioners to *'hit the floor running'* and to adapt to a dynamic working environment (Decker, 2009, p76). This often stretches graduates in skills of team working, interpersonal communication and interprofessional working (DH, 2004; Gopee and Galloway (2009). At the inception of this thesis, the Society and College of Radiographers' Student Survey (SCoR, 2011) highlighted that 83% of student respondents (16%) who graduated in 2010 did not feel prepared for their first job (SCoR, 2011). However, this has changed substantially as the Society and College of Radiographers' Student Survey (SCoR, 2014) found that 82% of radiographers who qualified in 2013 indicated that their radiography course prepared them sufficiently for their first job. The quality of clinical placements was highlighted as being vitally important in this preparation, although it was acknowledged by the respondents that it is impossible to feel completely prepared. It was also felt that there was insufficient experience in the operating theatre during their student placements. The response rate to this survey however was low at 16% so it is difficult to establish the exact nature of the current situation.

Registration with the Health and Care Professions Council (HCPC) requires radiography graduates to be competent in numerous areas of practice and practitioners tend to accelerate through the Knowledge and Skills Framework (DH, 2004) now at a much quicker pace. This not only requires the time and support to reinforce existing knowledge but the ability and resilience to acquire new skills in a stressful and challenging work environment.

The trigger for this research came from the minutes of the 'Heads of Radiography' (HoR) meeting dated July 2011. This meeting is attended by all UK Higher Education Institution (HEI) providers of undergraduate and postgraduate radiography education and one of the issues raised at the meeting was that some qualified staff considered graduates' skills to be insufficient. There was not however, any further evidence provided to clearly illustrate what 'insufficient' meant in this context. It has to be therefore acknowledged that this evidence of insufficient experience is anecdotal but it

is not the first time that this has been raised as an issue. The lack of concrete evidence regarding this matter led me to question the validity of the comments and prompted me to consider and explore this issue further. Firstly, to what skills are the HoR referring, how are these judgements being made and by whom? If these judgements are based purely on the performance of newly qualified radiographers then it must be recognised that performance is multi-dimensional and not merely the demonstration of a set of skills. This led me to consider this issue from a more humanistic and holistic perspective and to ask the following questions. Why it is that graduates are not performing at the expected level? What is it that influences their performance in their new and often unfamiliar environment? What is their experience really like in the early days following graduation?

1.2   The history of radiography and radiography education in the UK

X-rays were discovered on the 8th November, 1895 by Wilhelm Roentgen, a Professor of Physics, in his laboratory in Germany (Assmus, undated). Many other scientists had observed the effects of X-ray beams prior to this but Roentgen was the first to study and analyse them in-depth. Through additional experiments, he discovered that the beam would pass through most substances casting shadows of solid objects on pieces of photographic sensitive film. The new ray was named X-ray, because in mathematics "X" is used to indicate an unknown quantity. Two weeks after his discovery he produced an image of his wife's hand which has become widely distributed and well known.

The news of the discovery of X-rays travelled quickly and scientists were able to quickly replicate his work to produce X-rays. In early 1896, X-rays were being used for medical purposes in the United States for such things as bone fractures and gunshot wounds.

This swift uptake in the use of X-rays for medical use resulted in the need for operators to be employed to use the equipment in order to produce the medical images required by doctors and thus the dominance by the medical profession

of radiography began (Hogg et al., 2007). In 1910, the first hospital training programme for radiographers began which was closely followed in 1917 by the first formal teaching programme and in 1922, 70 radiographers held Hospital Training Certificates in the UK.

In 1920 in the UK, the Society of Radiographers (SoR) was founded and in 1922 the first examination of the Society was held when they became responsible for the theoretical syllabus alongside practical training in local hospitals (Burrows, 1986). The medical dominance of radiography continued and doctors (radiologists in particular) were very much in control of the use of X-rays for a range of purposes with radiographers fulfilling the role of technician/operator. Radiographers remained passive in this relationship and their lack of assertiveness allowed others to use their power to control them (Yielder and Davis, 2009). This behaviour is still evident in radiographers and the recent study by Strudwick et al. (2011) found that radiographers still have a tendency to take the blame for mistakes even though it may not be their fault. In 1944, radiographers were viewed as *'just someone who took pictures of people's insides'* (Dinsmore cited in Bentley, 2005, p49). Although radiography achieved professional recognition in the UK in the early 1960's it is still perceived by many as a technical role, supervised by doctors (Nixon, 2001). Moreover, as recently as 2003, radiographers were described by Coombes et al. as *'button pushers'* (Coombes et al., 2003, p19).

As early as 1925, there is evidence of disputes between radiographers and radiologists over the division of labour. The outcome resulted in non-medical members of the SoR being prevented from reporting on X-ray images. This situation remained for several years but in the 1970's it became apparent that *'radiographers had well defined roles in medical image acquisition using a range of scientific principles and technologies'* (Hogg et al., 2007, p55). It was around this time that the Society Diploma in Radiography (DSR) was replaced by the Diploma of the College of Radiographers (DCR). During this period the training of a radiographer was very much akin to an apprentice-style training as the Diploma education was hospital-based and students undertook technical training whilst being part of a department (Harvey et al., 2012). In

the late 1970's to early 1980's the two year Diploma evolved into a three year Diploma where the first eighteen months was common to both diagnostic and therapeutic radiography. At this time there was also an array of post-basic/post-qualifying courses available; and radiographers through further education and experience were beginning to challenge long established boundaries of their clinical practice.

In the 1980's there were approximately 55 Schools of Radiography in the UK, the vast majority of which were based in hospitals. After much debate and political wrangling, the DCR was replaced by a BSc (Hons) degree in radiography, the first of which was validated in 1989 at Portsmouth Polytechnic. The transfer of radiography education into Higher Education Institutions (HEIs) resulted in the amalgamation or closure of approximately 50% of the Schools of Radiography in the UK. The College of Radiographers remains responsible for the accreditation of all undergraduate radiography degree programmes in the UK alongside the Health and Care Professions Council (HCPC). There are currently 31,966 professionals on the HCPC register with the title of diagnostic radiographer, radiographer or therapeutic radiographer.

1.3   Diagnostic radiography today

Diagnostic radiographers use a range of imaging modalities to produce images that can be used to diagnose disease, illness or injury. This includes the use of general imaging, computed tomography (CT) scanning, magnetic resonance image (MRI) scanning, ultrasound, radionuclide imaging (RNI), mammography and dual X-ray absorptiometry (DXA) bone density scanning. Radiographers then employ a range of techniques using each of these imaging modalities to answer the clinical question posed by the referrer as required by local hospital protocols and in adherence to the Ionising Radiation Medical Exposure Regulations (IR(ME)R, 2000).

Over the years, diagnostic radiography (now more often referred to as diagnostic/medical imaging) has undergone significant technological

advancements which has meant that radiographers need to be responsive to change. Many of these advancements have been with regard to image acquisition and processing and these are mapped in the diagram below:

| Wet film developing in a darkroom

1st stage of development | → | Roller type X-ray film development - darkroom still needed

Circa 1950 | → | Automatic daylight loading processing

Circa 1969 | → | Digital radiography (DR)- computed radiography (CR)

Circa 1980 | → | Direct digital radiography (DDR)

Circa 1990 |
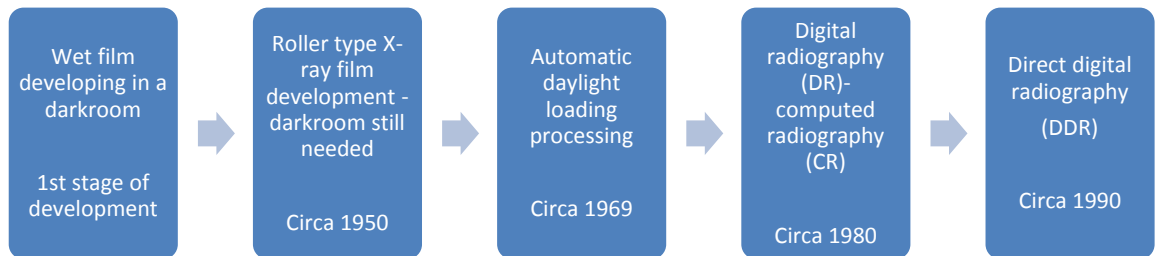
Figure 2: The advancements of image acquisition and processing

The development of Computed Radiography (CR) and Direct Digital Radiography (DDR) technology has had a significant impact on the profession in that the advancement of technology has resulted in a different skill set being needed by the radiographer. The day to day operation of the technology has become much easier whilst the complexity of patient needs and their care has become much more challenging. As a consequence of the move to digital imaging it is thought that there are several advantages such as *'higher patient throughput, increased dose efficiency, and the greater dynamic range of digital detectors with possible reduction of radiation exposure to the patient'* (Korner et al., 2007, p676). The use of digital detectors enables images to be processed and displayed to the radiographer within seconds of the X-ray procedure being performed. It also allows images to be stored on a fully digital picture archiving system (PACS) in a digital format allowing them to be easily distributed and viewed at any time and at multiple locations.

Having been a radiographer and educator for some years, it has been my experience that diagnostic radiographers are mainly employed in acute NHS Trusts but there is an increase in the number of private companies now providing diagnostic imaging services. The majority of newly qualified radiographers however, take up posts in the NHS as this offers them a wider range of experience.

Although much of their work is undertaken in uni-professional teams and alongside radiologists, radiographers also work interprofessionally with for example, nurses, doctors, operating department assistants and a range of support staff. The work environment is also varied as radiographers tend to work in many different areas across the hospital such as operating theatres, wards and emergency departments (ED). Diagnostic imaging services provide a 24 hour emergency service and therefore radiographers are required to work at nights and weekends, sometimes alone or with much smaller teams than those that work between 8.30 – 17.30 Monday to Friday. The push from the government to provide a 24/7 service in response to the publication by NHS England entitled Everyone Counts: Planning for patients 2014/15-2018/19 (NHS England, 2013) has prompted many diagnostic imaging services to redesign their services and also their staffing mix and many radiographers are now required to work shift patterns in place of the long established on-call systems.

As previously stated, newly qualified radiographers are now expected to cover a much wider set of skills and many practices that were once considered specialised are now part of first post competency (HCPC, 2013; Ferris, 2009). As well as the level of technical knowledge and the ability to work and communicate across a wide range of teams, radiographers also have a professional responsibility for educating and mentoring and as well as supervising assistant practitioners (Society of Radiographers, 2013). Some years ago, preceptorship was proposed by the Association of Radiography Educators on behalf of the SoR (undated) as a way of supporting newly qualified radiographers during this transition period. However, the uptake in departments was small and diminished further, following amendments to Agenda for Change resulting with the removal of the linked grade relating band five to six. Those that have provided preceptorship often use this model or its updated version (Appendix I) which is predominantly product-driven instead of process-driven and rather mechanistic in approach. The focus is on twelve aspects which the preceptee needs to complete. It does not appear to address other common issues related to transition such as professionalisation, developing confidence and the importance of reflective practice. It is my

opinion that the model is limiting in terms of professional development and is heavily linked to outcomes. Although the Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals was introduced in 2010, radiography as a profession does not seem to have embraced this approach.

In 2012, the Centre for Workforce Intelligence (CfWi), produced a workforce risks and opportunities document for diagnostic radiography. There were four key points raised; the risk that an increase in demand for services could lead to staff shortages, difficulties identified regarding staff attrition, in-course attrition rates at universities still remain high and finally that employers should maximise the potential of the four tier career progression model and preceptorship to improve staff retention.

The Diagnostic Workforce Report 2016 (CoR, 2016) states that at the census date of 1st May 2016 there was a 13.1% WTE vacancy rate in comparison to 7.8% in the September 2014 census. This is across the whole workforce, however, the vacancy rate at band 5 was 27.5%. Approximately 90 providers of diagnostic imaging services took part in this census and it was also found that of the 69% of respondents, 51% use diagnostic radiography agency staff to fill the shortfall.

In the year up until 31st March 2016, 40.7 million imaging tests were reported in England. This was a 2.1% increase on the previous year. Of these procedures plain radiography (X-ray) was most common with 22.6 million procedures, followed by ultrasonography (8.92 million), CT (4.46 million) and MRI (3.08 million) (NHS England, 2016). In January 2017, further figures were published that indicated in the year to November 2016 there were 21.0 million diagnostic tests performed in England's hospitals. This is 35% higher than in the equivalent period five years ago (the twelve months ending October 2011). The number of MRI scans has increased by 52% in this period, the number of CT scans by 48%, and the number of non-obstetric ultrasounds by 26%. In October 2016, an average of 61,500 diagnostic tests were performed each day (HoCL, 2017).

These figures clearly demonstrate the pressures that diagnostic imaging departments are currently under and how many people are imaged on a daily basis. The working environment of a diagnostic radiographer allows little time for error and speed and accuracy is of the essence.

1.4 The BSc (Hons) Diagnostic Radiography degree course

As previously stated diagnostic radiography became an all degree entry profession in the early 1990's with the first degree programme being validated in 1989. The degree programme at the University in this study was first validated in 1991 and has successfully run ever since. The move into Higher Education (HE) allowed HEIs to design their own courses and for the first time, the curriculum was not a national programme. There are currently 23 universities offering a radiography degree programme nationally all of which differ in length of course, type of subjects studied and clinical placement time. However, they all have to meet the requirements set by the CoR and HCPC.

The participants in this study undertook a 44 week course each year beginning in September and graduating at the end of June. 60% of their time was spent at their clinical placement, 18 weeks in the first year, 20 weeks in the second year and 24 weeks in their final year. A copy of the attendance pattern can be found in Appendix II. As well as the large amount of clinical placement time, each student was placed at the same clinical site for the duration of the three years and was supported by a dedicated radiography practice educator at that site. There is a wide variance across the UK in the amount of time radiography students spend in practice during their degree course and how often they are in placement. In some HEIs students are placed at different sites over the course of the three years and alternative support mechanisms are used (Harvey et al., 2012).

The practice educator (PE) is a clinically-based member of staff who is employed in that role for a certain amount of time each week depending on the number of students placed at that particular clinical site. For instance each PE will be employed for WTE 0.1 per student per year, therefore if a clinical

site has four students placed at their department in each year, the PE will be on a 0.4 WTE contract. The role of the PE is to teach, supervise and assess students in their clinical department.   They also provide pastoral support, organise the practice-learning rotas and undertake staff training. One of the most important facets of this role is the strong partnership link it provides between the university and the Trust, ensuring that there are effective and open lines of communication. The host university and validation panels have always perceived this role as a strength of the course in preparing the students fully for their first post in radiography and from professional experience it is no longer a model used by many other HEI providers.

1.5   Research question

The focus of my research is the transition period for newly qualified radiographers in the National Health Service (NHS). For the purpose of this thesis transition is defined as the period or process of change from one role to another and in this context the change from being a student diagnostic radiographer to practitioner.   The DoH (2005) recommends six to twelve months' preceptorship which is a strong indicator that newly qualified practitioners need support during this time. Therefore, this thesis examines the experience of radiographers during their first crucial 12 months as they adjust to life as a registered radiographer and make the necessary transition from student to practitioner.

Research Question:
What is the transition experience of graduates as they become diagnostic radiographers?

Aim
To explore the experiences of newly qualified practitioners graduating from one HEI during their first year in post as radiographers in a range of diagnostic imaging departments in the NHS

Objectives

• To describe and interpret the experiences of newly qualified radiographers

• To utilise the findings in order to gain an understanding of what it is like to be a newly qualified radiographer and what factors influence the experience

• To discuss what can be learned from the experiences of the newly qualified radiographers to inform the transition period for others in the future

1.6 Introducing the thesis

The following sections will give an overview of the chapters contained in this thesis in order to navigate the reader through this study.

1.6.1 Chapter 2.0: Literature Review

In chapter two, current literature is critically debated and discussed using a thematic approach. The search protocol is clearly explained and the literature has been sourced from across all health care professions and led to the identification of some key areas during the transition period; complexity of role transition, preparation, support, environment and confidence.

Other key influential factors are also explored from a theoretical perspective. This section covers resilience, workplace culture, being and becoming and professional socialisation.

It is evident from this review that role transition is a complex and multi-dimensional experience which has been investigated by a range of professions utilising a variety of different methodologies. The period of transition from student to practitioner has been found to be a challenging and at times a stressful experience. However, with regards to radiography, research into role transition is still extremely limited and this literature review

identifies a gap in research in this topic and some unexplored areas. This review strengthens the need for further research to explore this phenomenon and add to the body of literature akin to other professions such as nursing, occupational therapy and physiotherapy.

1.6.2 Chapter 3: Methodology

Chapter three discusses the research approach undertaken to explore the experience of transition in newly qualified radiographers. It begins with a discussion of my role and position as the researcher and how my life experiences will influence the study. The use of interpretive phenomenology allowed me to explore the experience of nine newly qualified radiographers in-depth as they navigated their way through their first year in practice. Interviews were undertaken at critical periods; three, six and twelve months utilising two additional data collection tools to ensure that as much of their experience was captured and shared as possible. Within the chapter the impact that I had on the research is discussed alongside the significance and importance of reflexivity throughout this process.

1.6.3 Chapter 4: Findings

This is a short chapter which presents the overall findings under six main themes. These are subsequently discussed in the three following chapters with the aid of direct quotations and images from the theme boards.

1.6.4 Chapter 5: Needing Support and Settling In

This chapter presents the first two themes identified in the research findings collected throughout the study with the use of semi-structured interviews. The majority of the newly qualified radiographers experienced reality shock which came out as a range of emotional reactions. There was very little structured support offered to the newly qualified radiographers and often what was given was in the form of either an induction programme or a preceptorship scheme which focussed on competencies and tasks. Whilst some of the graduates

found their radiography colleagues supportive some did not and they felt under pressure to perform and prove themselves. Their main coping mechanism at this time was the use of peer support which was highly valued by nearly all the participants

Having to become acquainted with departmental protocols and use a range of unfamiliar equipment seems to have caused the participants a high degree of stress. They were heavily reliant on protocols to guide their practice and struggled with the autonomy required/expected at times.

The stress they were experiencing was found to be exacerbated by the pressure they felt not to make mistakes (which often came from themselves) and they had an overwhelming fear of being struck off. This was intensified by the responsibility they were now feeling, the tiredness they were experiencing, workload pressures and the increase in working hours and working patterns.

1.6.5 Chapter 6: Developing Confidence and Becoming Established

This chapter presents the themes of developing confidence and becoming established. It was encouraging to find that all the participants felt fully prepared for their roles and praised their educational and practice experience. At the beginning, a lack of feedback was an issue for some of the participants as they had been used to receiving continuous feedback throughout their radiography degree programme. However, as the graduates progressed in the first few months their confidence increased and they began to gain independence.

The majority of participants discussed the period of adjustment from having their images checked by a supervising radiographer to now having to make the decision to accept them themselves and the burden of that responsibility. As with other studies, the graduates quickly noticed the hierarchy within the department which at times led to them feeling undermined, powerless and vulnerable.

Most of newly qualified radiographers felt confident when communicating with a range of healthcare professionals. However, there were some challenges to overcome in terms of professional standing, the lack of support from other professional groups and the lack of awareness that other professionals had about the role of the diagnostic radiographer. There was a mixed reaction to the responsibility of supervising and teaching students so early on in their career and it was felt that they could have been more effectively prepared and supported for in this role.

1.6.6 Chapter 7: Feeling Useful and Moving Forward

The final two themes; feeling useful and moving forward are considered in this chapter. Under these themes the graduates discussed the importance of contributing to the team and how their self-worth was influenced by being valued as part of that team. For most participants this did not seem to happen until at least the six month period and could be linked to the lack of feedback they received.

The way in which the graduates in this study coped with the expectation to work independently and use their own initiative was encouraging, especially their enjoyment of working in the operating theatre. As they began to enjoy their independence, establish their own way of working they developed into professionals who are proud of what they do.

The necessity to survive was identified as a key feature and for some personal resilience was an important aspect of this. It was surprising to find how quickly some of the newly qualified radiographers were becoming bored and struggling with the monotony of the role. This may be due to the very different needs and expectations of Generation X.

As students, the participants admitted that they really did not pay much attention to wider issues within the NHS but they had now started understand the implication of some of the changes within their profession and the NHS.

Better preparation for students to deal with a range of issues in an environment of constant pressure needs further consideration.

Some of the participants were clearly very ambitious early on with three of the participants considering moving hospitals, and one was also thinking of leaving the profession altogether. The other newly qualified radiographers seemed settled and were happy to stay as they were, consolidating their knowledge and experience.

Caring for patients was only mentioned by three of the participants which may indicate that they had competing priorities at this time. However, they all felt that effective communication with patients is key to a positive outcome and experience.

1.6.7 Chapter 8: Conclusion, Limitations and Recommendations

In this chapter a summary of the findings of this thesis is presented and the implications of these will be linked to both the practice and campus-based settings in order to enhance the experience of students and graduates.

I have also taken the opportunity to reflect on my journey whilst undertaking this research and how this has developed me both personally and professionally in my various roles. The strengths and limitations of the study are also be discussed and how they may have influenced the findings.

Finally, this chapter summarises my methods of dissemination to date, my future plans to share my work and also areas that I wish to explore further as a consequence of the findings of this thesis.

1.7 Summary

In this chapter I have presented a rationale for my thesis and explored my choice of topic. In order to help the reader understand more about the profession of diagnostic radiography I have provided a brief history of radiography and radiography education. This is followed by a discussion of the current role of diagnostic radiographers today and the challenges faced by diagnostic imaging departments across the UK.

There was a brief description of the degree course that the participants completed and there was some identification of key differences across the UK. Finally, I presented my research question, aim and objectives which are followed by a brief outline of the subsequent thesis chapters.

2.0   LITERATURE REVIEW

2.1   Review of Current Literature

2.1.1 Introduction

Many authors describe the literature review as being a generic element of all research projects (Walliman, 2011, Aveyard, 2010; Oermann and Hayes, 2010; Moule and Goodman, 2009). There are however significant differences to the purpose, approach and contribution that a literature review makes to the research process in the qualitative and quantitative paradigms (Shi, 2006; Fry et al., 2017).

In quantitative research, the literature review is a detailed, structured and systematic review with a clearly stated purpose (Grant and Booth, 2009). It is often used to formulate the hypothesis around which the research project is designed (Punch, 2005). Conversely, in a qualitative study, the literature review tends to be more flexible and is used to inform the researcher of previous studies allowing them to locate their research within the current body of literature and underpins the rationale (Cluett and Bluff, 2006).

It is evident that even within the qualitative paradigm there is much debate as to the role that the literature review should play within the research process (Fry et al., 2017; Creswell, 1994). This issue is often raised by grounded theorists and phenomenologists, some of whom consider that the literature review itself could in some way influence the researcher and limit their engagement with their data (Fry et al., 2017; Shi, 2006).

Having given this further consideration, I decided to divide this literature review into two sections. The first part was undertaken at the start of the research process, whilst the second part was undertaken following the initial analysis of the data. This was to ensure that the literature underpinned the thesis continuously throughout the research process. In the first section the literature was used to frame the phenomenon of interest within existing literature and

allow a thorough review. The second section presented the literature as a basis for comparing and contrasting the findings once the data had been analysed, supporting an inductive process. This decision was informed by Cresswell (1994) who outlines three different uses of the literature in a qualitative study which informed my decision.

The first section of the literature review was exploratory; however it followed a systematic approach to make certain that relevant studies were identified to ensure that the topic of interest was fully investigated. There were several aims of this first section; it allowed me as the researcher to critique previously published literature in order to understand the topic in detail thus increasing my awareness of and sensitivity to existing ideas and concepts that previous studies had used to explore the phenomenon of interest (Shi, 2006; Cresswell, 1994). The second aim was to explore the range of methodologies and methods adopted in other studies, allowing common themes to be identified for further discussion. This in turn directly informed the choice of methodology and methods for this research which are discussed more fully in the following chapter (Robson, 2011; Aveyard, 2010; Nieswiadomy, 1998). Lastly, this section allowed me to identify whether or not there were any gaps in knowledge on the topic, thus allowing me to set the scene for this thesis and provide a strong and well justified rationale for its need (Robson, 2011; Walliman, 2011; Moule and Goodman, 2009). It also enabled me to orientate to, articulate and define the phenomenon of interest.

By adopting my phenomenological philosophical standpoint at this point I was not seeking any theoretical framework to guide my study as I felt that this would unduly influence my relationship with the data. It was essential throughout that I paid attention to adopting a phenomenological attitude by approaching the data collection and analysis in an open and honest way, allowing myself to see things with fresh eyes (Finlay, 2008). Although this is adopted more readily by descriptive phenomenologists, I have still embraced certain elements of this to ensure that this study followed an inductive process to the data collection and analysis (Maxwell, 2006; Cresswell, 1994). By sensitising

myself to the literature presented in this section this enabled me to stay true to my underpinning philosophical beliefs.

As previously stated, the second part of the literature review was undertaken after the initial analysis of the data. At this stage, a further search was undertaken in response to significant topics which had not arisen in the first part of the literature review chapter and enabled further, in-depth discussion of relevant theories (Fry et al., 2017). This then allowed me to make links between my interpretations of the findings and certain theories which then underpinned my discussion and helped me to make sense of the participants' worlds and their experiences within it.

Finally, before moving to the first section of this literature review, it is important to reinforce that although the literature review is presented in a discrete chapter within this thesis it has underpinned, informed and shaped my thesis from beginning to end. This is summarised in the flow diagram (Figure 3) below:
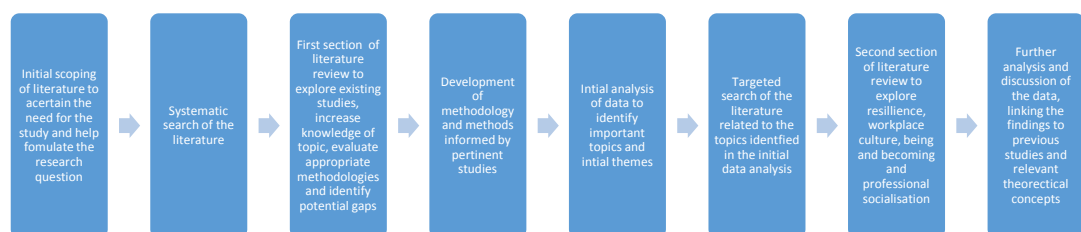
Figure 3: A flow diagram to illustrate the role of the literature review in this study

2.1.2 Search Protocol

An extensive literature search was undertaken on 24th April 2014 using the following databases; Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus, ProQuest Health and Medicine, Science Direct and Medline. In addition the host HEI search tool 'Summon' and the peer-reviewed journal Radiography were also searched separately. Alerts were set up on each of these databases to allow this section to be continually updated until near to the submission of this thesis.

In order to generate a set of relevant keywords to structure the search, the Population, Exposure and Outcome (PEO) tool was used (Appendix III). This tool is widely used in health research to help manage the searching process and helps to identify the key concepts in the research question. The aim of the tool was to translate the research question into an effective search strategy by considering each element in turn and is generally utilised in qualitative research (Khan et al., 2003).

According to Timmins and McCabe (2005, p44) *'the use of keywords is the cornerstone of an effective search'*. The keywords and search terms used were as follows:

radiograph*	*OR*	allied health professional*	*OR*	nurs*	*OR*	midwife*
AND						
newly qualif*						
AND						
newly experienc*		OR		transition*		

The use of the * symbol at the end of the words automatically widens the search parameters, for instance radiograph* will find all words starting with that stem e.g. radiographer, radiography, radiographers. Inserting a * symbol into a word will allow for different spelling versions e.g. Americanisms (Walliman, 2011). The utilisation of Boolean operators such as 'OR', 'AND' and 'NOT' allow the search to be more specific and enhance the sensitivity of the search (Bettany-Saltikov, 2012). As previously mentioned, EBSCO email alerts were also set up to ensure that I was informed of any new relevant publications for the duration of the research.

2.1.3 Inclusion and Exclusion Criteria

All duplicated articles were removed at this stage prior to the application of the specified inclusion and exclusion criteria below. The use of inclusion and

exclusion criteria allows the researcher to focus the literature to specific dates, countries, types of studies and enables the elimination of knowledge which is not entirely relevant or current (Whittaker and Williamson, 2011). The use of the inclusion and exclusion criteria allows the initial literature to be filtered further using a systematic and transparent process (Aveyard, 2010).

Inclusion Criteria	Reason for Choice
Literature published between 1990 to current	Radiography education changed from a Diploma of the College of Radiographers in Diagnostic Radiography to a BSc (Hons) Degree programme. This underpinned substantial changes in mode of delivery, teaching, learning and assessment strategies and clinical placement attendance patterns (Decker, 2009).
Articles published in peer reviewed or professional readership journals	The process of the studies undergoing a peer or panel review process is thought to ensure that there is validation of the quality of the research (Soloman, 2007).
Grey literature	The inclusion of grey literature accesses, for example, PhD theses, published abstracts, conference proceedings, current polices; ensuring that relevant sources of evidence can be considered for inclusion (Bettany-Saltikov, 2012).

Table 1: Search protocol inclusion criteria

Exclusion Criteria	Reason for Choice
Studies not focussed on working within an acute hospital environment unless scientifically related	Much of the literature focuses on working in the community setting and this is usually with much smaller teams and therefore not directly transferable to an acute NHS Hospital Trust.
Research undertaken outside of the UK, Europe, Australia, New Zealand, Canada and the USA.	The cultural differences and the modes of health delivery in other countries make it difficult to relate the findings to this study.
Studies not written in English	Due to the time and cost in translating articles not written in English and the potential cultural differences.
Research focussing on the experience of transition into areas of specialist practice	Several studies focussed on the transition period of new roles in specialist practice. These staff tend to already be experienced practitioners and as such are not classed as newly qualified.

Table 2: Search protocol exclusion criteria

It can be seen that this search produced a wide range of articles and therefore to reduce these further and ensure that the most pertinent studies were included in this chapter, the articles were read by the researcher and selected for inclusion in this review on the basis that they were directly applicable to the research question. All reference lists from the chosen articles were also reviewed as this often leads the researcher to more relevant literature which may have not been identified in the original search (Walliman, 2011). There was one article that was not identified in the original search which is included in this review due to the nature of veterinary science being comparable in many ways to radiography.

The literature will be discussed using the following themes; the complexity of role transition, preparation, support, environment and confidence.

2.1.4 The complexity of role transition

The pressure on new graduates to fit in and to be able to increase their knowledge base quickly is mirrored across a range of health professions. The level of responsibility given to newly qualified practitioners from day one is a concern acknowledged across health professions, as is the level of support given during this transition period. Gilling and Parkinson (2009) explored the transition from veterinary student to practitioner and labelled the first year after graduation as the '*make or break*' period and the findings of their study led us to consider how certain factors influence the transition period and how they directly contribute to the '*make or break'* experience (ibid, p209).

In nursing it has been highlighted that the transition period for newly qualified nurses remains stressful and preparedness for practice seems to be inadequate (Ross and Clifford, 2002). Although now dated this still seems to be the case in nursing and several other studies have produced similar findings (Gerrish, 2000; Tryssenaar and Perkins, 2001; Mooney, 2007; Mackay et al., 2008; Boychuk Duchscher, 2008; Decker, 2009; Black et al., 2010 and Fenwick et al., 2012). Boychuk Duchscher (2008) explored the first stage of role transition in newly graduated nurses in Canada. Using a grounded theory approach she developed a conceptual framework of transition in an attempt to try and convey the complexity of role transition. In her work she combined ten years of research with her most recent study in which she followed 15 newly graduated nurses for 18 months, interviewing them at one, three, six, nine, twelve and eighteen month intervals. In identifying that transition shock still occurs, her theory suggests that the experience is multifaceted and involves physical, emotional, intellectual and socio-developmental aspects. These are influenced by the roles, relationships, responsibilities and knowledge required by the role and the personal emotions felt by the newly qualified practitioner such as loss, confusion, disorientation and doubt.

This work suggests that preparedness for practice should not focus solely on the achievement of skills or competencies but also prepare graduates for the

experience of role transition itself. It is the complexity of role transition that initially captured my interest and whilst many studies focus on the skills and competencies that are needed my interest lies in what the newly qualified practitioners actually experience during this time and what it is that contributes to that experience. Sharing stories of the experience so that we are better able to understand the transition period will allow us to better prepare the graduates for what is to come.

The research undertaken by Decker (2009) is a seminal piece of literature in relation to this research topic. Using a phenomenological approach, the lived experience of newly qualified radiographers who qualified between the years of 1950-1985 was investigated by the use of oral history. Interviews were conducted over a four year period between 2001-2005 and the 24 participants were purposively sampled. The results provided some insightful data which was analysed using three methods; NVivo 7, inductive analysis and choreography metaphor.

The narrative data provided Decker (2009) with common trends across the decades. It was identified that *'being a newly qualified radiographer could be a very emotional and anxious phase'* (p73). This was linked to the sudden responsibility of accepting their own *'films'* and undertaking on-call duties single-handedly. This is the first time that the participants will have had to assess and approve their own images (films) without the support of a supervisor. Once they are assured that they have answered the clinical question they are required to send them to be reported by a radiologist/reporting radiographer.

A general expectation of '*get on with it'* (Decker, 2009, p74) was suggested as the norm within the profession which also reinforces the findings of the studies by Ross and Clifford (2002) and Brown (2004). Participants described their feelings and emotions at this time as *'scary, terrifying, daunting and strange'* (Decker, 2009, p74). There seemed to be a general sense amongst the participants that they had more hands on experience during their training as a radiographer than today's students and therefore were better prepared to deal

with the everyday challenges. However, this seemed to focus very much on the technical side of the role as the radiographers interviewed felt that today's students are more confident in terms of their interpersonal communication. Despite the expectations of the profession none of the participants described the transition period as stressful. The professionalisation process in this case seemed to have developed resilient practitioners who reflected on the steep learning curve within those first few months.

It should be noted at this point that this study was undertaken using Diploma educated radiographers and the data were collected some years after they had qualified. Firstly, as discussed earlier in this thesis the training model of Diploma educated radiographers was very different to that of undergraduates and therefore the preparation will have differed significantly. This will no doubt have had an effect on the transition experience. Secondly, the recall of specific events and their experience at the time may not be fully accurate due to the time that passed since the experiences and as such the intensity of their feelings at that time may have altered. It is difficult to know whether this may have increased or decreased the intensity but the latter is thought to be most likely.

Despite the limitations noted above, the study's findings do have implications for my research with some important themes emerging from this work such as; the emotional experience of transition, the burden of responsibility, expectations and preparation. One of the recommendations from Decker's study was the need to ensure that an adequate support structure was implemented for newly qualified radiographers. It was also proposed that further research be conducted into the experience of newly qualified radiographers.

Role transition in nursing has been widely explored. In conducting a grounded theory study, Mooney (2007) examined the perception of nurses during their transition period. Twelve participants were interviewed and the data were coded and analysed using axial coding. The participants were purposively selected from two cohorts all employed at the same acute hospital. Again, to

ensure academic credibility, member checking, a detailed data analysis methodology, peer assessment and audit trails were all evident. As with all grounded theory studies, data were collected until saturation but it is impossible to know from such a narrow sample whether or not this was the case. The findings of this study can be grouped into three main categories; great expectations, no time for nursing and facing the trepidations. All respondents felt that high, and at times, unreasonable expectations had been placed upon them. It was also established that the novice practitioners placed high expectations on themselves and became despondent when these were not met. They felt that unforeseen challenges took them away from the skills of nursing and spending time with the patients. The participants also raised concerns regarding not only their own ability but also the ability of others in terms of levels of patient care.

It is unclear at what stage the participants were interviewed as the study states that the nurses were all within one year of graduation. As each participant was interviewed only once, it offers a snapshot of their experience all of which could have been conducted at different times along the transition journey. This makes the data difficult to compare and contrast as does the fact that the twelve nurses came from two different cohorts, each of which could have graduated at different times and been exposed to different preparation. There is also no clear explanation of the relationship between the researcher and the participants which will have influenced the study from the outset.

Mooney (2007) went on to discuss the mismatch between perception and reality and the fact that newly qualified nurses, alongside ward managers, patients, relatives and doctors had high expectations of themselves in terms of knowledge and competence. There were also interesting issues raised about the tensions that exist between students' supernumerary status and how this effectively prepares them for graduation. It was also acknowledged in this study that the development of skills and confidence is determined by a range of factors some of which can be more easily managed than others such as staffing levels, stress in relation to accountability and responsibility, patient self-awareness and insight (ibid). Again, this would have been heavily

influenced by the fact that the participants were all based at the same hospital. The findings of this study go some way to explore transition but as previously discussed because of the data collection methods it is difficult to get a sense of the transition journey of the participants and this is the gap in knowledge that this study addresses.

Much of the published literature regarding the experience of transition from student to practitioner is attributed to Occupational Therapy (OT) and it is evident that as a profession OT has been studying this phenomenon for some time. A seminal piece of research often referred to in both OT and Physical Therapy (PT) publications is that by Tryssenaar and Perkins (2001). A phenomenological study, its aim was to examine the lived experience of final placement students and their first year of practice. Although this study was undertaken in Canada the findings can still be can be transferred to the UK due to the commonalities identified. The participants included a mix of both OTs and PTs who were asked to keep journal entries at least every two weeks during this time. These entries were then responded to by the researchers by way of comments and trigger questions. Twelve students initially agreed to take part in the study but six failed to complete the journal entries leaving three OTs and three PTs. An interview with a newly qualified OT after four months of practice provided the researchers with possible areas to explore when analysing the data.

Thematic analysis of the journal entries took place using the highlighting technique as suggested by van Manen (1998) and an independent researcher was also employed to read and code the data in order to provide some rigour to the study by way of triangulation of the data. At this stage, it is important to note that the researchers found it impossible not to become part of the research as the responses they often gave to the participants, were advisory, empathetic (including the sharing of their own personal experiences) and challenging.   The research identified four key consecutive stages in the journals; transition, euphoria and angst, reality of practice and adaptation. These stages are commonly referred to throughout subsequent OT and PT publications and as such have become a framework for further research.

Throughout these four stages, six recurrent themes were also found; great expectations, competence, politics, shock, education and strategies. Again, these are often referred to in subsequent literature and provide useful insights in to the experience of the newly qualified practitioner. The findings of the study suggest there was a gap between expectations and the realism of practising as a qualified therapist. Support in some form seemed to enhance the participants' ability to cope with the challenges of workload, time management and paperwork. It is also recognised as essential when assisting the novice with professional socialisation, a difficult process which has been acknowledged by several studies e.g. Oleson and Whittaker (1968); Howkins and Ewens (1999).

Although it is recognised that this study had several limitations; sample size (due to high dropout rate), sampling method, and researcher involvement it did highlight some important issues for consideration. The first of these is that there is a lack of supervision/mentoring for newly qualified therapists. Secondly, the importance of reflective practice cannot be ignored as a way to increase metacognitive awareness in order to benefit novice practitioners and in this study it was felt that the journal entries promoted this process (Cust, 1995). Thirdly, it was recognised as with many other studies that there remains a discrepancy between education and practice - the link between theory and practice and lastly, students need to be educated about the transition period, encouraging and allowing them to develop resources and strategies to help them cope with the challenges that this may bring.

'Successful transition is fundamental to becoming a competent practitioner' (Seah et al., 2011, p104). Competence is a much debated and complex subject, however, despite this there are several aspects which directly influence it such as underpinning knowledge, the ability to reason, skills set, values and beliefs and personal attributes. Therefore, it can be established that educational programmes can prepare students *for* practice and employers can support newly qualified practitioners *in* practice. A phenomenological study by Seah et al., (2011) was undertaken to explore the lived experience of eight newly qualified OTs in Australia. A single semi-structured face to face

interview was used in order to explore a range of topics relevant to role transition. Bracketing was used to remove researcher opinions and bias and an inductive thematic analysis was undertaken. Several mechanisms were used to ensure rigour including member checking, detailed field notes, and independent analysis of the scripts. The use of metaphors by the participant to describe their experience produced common elements such as excitement, expectation, adaptation and the changing nature of work.

This study focussed on graduates of a pre-registration Master's degree in OT and this will have undoubtedly influenced the four themes which emerged from the interviews; valuing maturity, being new, needing skills and pursuing satisfaction. It was felt that previous work experience assisted the participants in several ways. Firstly, it was sensed that they placed value on their work and that they were aware of the work ethic/code and making the transition experience less stressful. Secondly, they actively sought out more challenging work and this aided in their development. Certain key skills were also identified in order that successful transition may be achieved. These included flexibility, a good work-play-rest balance, a hardworking and proactive approach and a positive attitude (ibid). This differs to the findings of Sutton and Griffin (2000) who found that BSc graduates tended to lack generic skills during the transition period however, professional socialisation, preparation and job satisfaction were all highlighted as influential factors on role transition.

During the time scale of this study, a PhD study by Naylor (2014) has been completed. This study explored the transition from student to practitioner in diagnostic imaging by investigating the expectations and experiences of new graduates and occurred alongside the data collection stage of this study. A focus group was utilised in the initial stages of this study using four students prior to graduation to explore students' expectations pre-employment. In discovering how this group of students felt about employment during the focus group, these data were then utilised to develop themes from which the semi-structured interview questions were designed. Eight students were selected for the longitudinal part of the study and were interviewed just before graduation and at three, six and twelve months. All students were purposively

selected from one HEI and the interviews were undertaken by telephone. At the twelve month interview stage only five participants remained in the study, representing a 37% attrition rate. Using Interpretive Phenomenological Analysis four super-ordinate themes were generated; experience, fitting in, identity and supporting the transition. In discussion of the findings it was concluded that the period of transition remains stressful but also exciting. Additionally, the high pressured environment in which new graduates are entering means that the graduate not only needs be able to manage expectations and make sense of their experience to both develop and also rapidly make the transition to practitioner.

The use of the initial focus group in this study (although well justified by the author) may well have had some influence on the conduct and thus outcomes of this work. Asking the participants prior to starting a post about their expectations may firstly have influenced their experiences as they had already started to think about them beforehand. Secondly, it may have led the researcher to focus her initial questions on the anxieties and concerns perceived by the chosen intake rather than the wider body of literature. This could have introduced some bias at this stage. Another point of note is all participants in the study by were employed by departments in which they had previously been placed in as students. It is difficult to ascertain the effect this may have had on the findings but as highlighted in the environment section of the literature review this could have had a significant impact on the experiences as all graduates would have been familiar with the environment in which they were entering. This may well be the reason that there was no evidence to suggest that any of the participants experienced reality shock (Kramer, 1974).

The attrition rate of the participants also needs to be taken into account as this would have influenced the findings particularly the interviews at six and twelve months when only five graduates took part. The data analysis combined the results from the focus group and the interviews and therefore at times it is difficult to establish where some of the themes were most influential across the time period.

2.1.5 Preparation

Following the introduction of HEI based degree programmes for a range of health care professionals such as radiographers there have been concerns raised over the preparedness of newly qualified practitioners (Nisbet, 2008; Mackay et al., 2008; Decker, 2009; Higgins et al., 2010; Whitehead et al., 2013 and Avis et al., 2013). In radiography specifically, areas of concern were identified as the ability to justify request forms for X-ray examinations and readiness to carry out imaging procedures in theatre. The increased demand for diagnostic imaging services results in employers requiring newly qualified practitioners to *'hit the floor running'* and to adapt to a dynamic working environment (Decker, 2009, p77). This often stretches graduates in skills of team working, interpersonal communication and interprofessional working (DH 2004; Gopee and Galloway 2009).

The study by Mackay et al., (2008) aimed to explore how prepared radiography graduates felt for their first clinical posts. Using a mixed methods approach, they used a combination of questionnaires and structured interviews. Postal interviews were sent out to 29 new graduates and 25 work supervisors. All the graduates were from one HEI and were working in 16 hospitals in the Greater Manchester region. The questionnaire was devised utilising a series of standards which were used to directly compare how well the graduate felt they had been prepared to how well the supervisor felt that had been prepared. Structured interviews followed the questionnaire for seven students and their supervisors where the results had been noticeably different, or low or a significant gap in two questions. The results demonstrated that in general the work supervisors ranked the students more highly than the students ranked themselves, and that there appeared to be no difference in the performance of students that were still working at the hospital where they trained. More specifically areas of weakness were identified as dealing with multiple trauma cases and skull projections and the ability to justify examinations (correlating with the study by Decker, 2009). Areas of strength however were identified as the degree of image interpretation and levels of patient care. The study concluded overall, that graduates were well prepared for their role although

there were some areas for further curriculum development identified such as justification of X-ray examinations and anatomy and pathology of the chest and abdomen.

The use of postal questionnaires may have affected these findings due to misinterpretation of the questions and this was picked up at the structured interviews. However, this only occurred with the 14 participants called to interview and as such many of the other participants may have also misunderstood the questions thereby not providing honest responses. It was also acknowledged by the authors that attempting to measure preparedness for a role at one point in time has limitations due to experience, confidence and the ability to judge and as such it is a complex area to investigate (Mackay et al., 2008).

The study by Hutton and Eddy (2012) set out to investigate the factors that influence job satisfaction for band five/six therapy radiographers. It was a qualitative study undertaken in two departments using focus groups selected from the 34 participants. Thematic analysis of the findings resulted in one main theme being identified - Continuing Professional Development with four sub-themes; teamwork, workload, organisational support and transition phase. Although not intentional some interesting themes in their study directly related to transitioning into role. Exploring this further it was apparent that some graduates felt a lack of preparation for their first few months of work and some disparity was noted between expectations of the job and the reality once in post, this is commensurate with the findings of Mooney (2007). Interestingly, some graduates found the transition period challenging due to this mismatch whilst others found it repetitive as the realisation of the role became apparent. Preceptorship followed by mentorship is suggested as an effective way to support new graduates during this time and the authors recognise that the role of the team in supporting new staff should not be underestimated. Again, the need to prepare the graduates not just for the role but in developing strategies in dealing with the challenges that transition into a role can bring is highlighted. This correlates with the findings of the study by Boychuk Duchscher (2008) which also recommended preparing graduates for the experience of transition.

In her discussion paper exploring the need for preceptorship in radiotherapy, Nisbet (2008) identified the challenges in preparing graduates to meet the competing needs of the stakeholders involved in the educational process of radiographers and indeed other healthcare professionals. The needs of the employers for graduates to be fit for purpose, the HCPC for the graduates to be fit for practice and the needs of the HEI for the student to be fit for award all add to the complexities of preparing graduates to enter the workplace. The need for the graduate to move from novice to competent in a short period of time has never been more evident (Brown, 2004; Decker, 2009; Nisbet, 2008). Nisbet (2008), suggests that the technocratic model of education on which the BSc programmes have been largely based has caused issues in the integration of theory to practice. This combination of a lack of continuity in practice and a lack of clinical time due to module frameworks has resulted in a separation of knowledge in the students and subsequently graduates.

Although preparation is not identified as a theme in her study, Naylor (2014) does highlight experience as a main theme. In exploring this further, many of the participants discuss feeling concerned about working in areas of imaging where they have had a lack of experience. This may have been specific areas of specialities and one area that was identified was the operating theatre. This correlates with the study by Feusi et al., (2006) which found that newly qualified radiographers lacked readiness to carry out imaging procedures in theatre.

However, the main issue highlighted with regards to experience was that the participants had limited exposure to working outside of 'normal working hours' during their degree course. Further on in this study 'normal working hours' is loosely defined as primarily 8.30 – 17.30 Monday to Friday. Thus preparation for working extended days, nights, weekend days and lone working seems to have been minimal with this group of participants and resulted in them feeling unprepared for and anxious about working shifts and on-call duties. This is also noted by Brown (2004) who identified that graduates were ill prepared to undertake on-call duties when there were no colleagues to offer support or to consult with regarding decisions.

Gerrish (2000) undertook a comparative study to explore the perceptions of transition of nurses qualifying in 1998 to those that qualified in 1985. This follow up study was undertaken after the introduction of the Project 2000 curriculum and to see if the issues identified in the original study with regards to pre-registration nursing education had been addressed (Gerrish, 1990). In this work, Gerrish raised concerns with respect to the inadequate preparation for the qualified nursing role and utilises one of the original themes *'fumbling along'* as the focus for this work (Gerrish, 2000, p473).

In using existing data from her grounded theory study, a secondary data analysis was undertaken on the 10 in-depth interviews with staff nurses that had been qualified for three to six months in 1985. Using the same interview schedule, 25 nurses qualifying in 1998 and who had been working as staff nurses for four to ten months were also interviewed. Following these interviews, comparative analysis was undertaken to explore if the theme *'fumbling along'* was still pertinent (ibid).

The findings suggested that although the nurses who qualified in 1998 felt that their course had prepared them in terms of knowledge base and had provided them with a varied clinical experience there were still some areas of concern. These were identified as constrained clinical learning opportunities due to short duration of clinical placements which resulted in a lack of reinforcement of learning for some and limited opportunity to practice essential clinical skills.

It was acknowledged by both groups that there are difficulties in preparing nurses for the role and it is only once you are qualified that you are truly exposed to the realities of the workplace. The differences between the groups appeared to be the way in which they mastered their new skills and responsibilities. The nurses that qualified in 1985 were reluctant to seek help from their managers due to a fear of losing credibility. They felt that coping without assistance was seen to be the sign of a good staff nurse. However, the nurses that qualified in 1998 were generally much more open about disclosing their limitations and were confident in seeking advice and guidance. It was also interesting to note that they did not expect to know all the answers

at this stage of their career and were able to reflect on their experiences, readily adopting the concept of lifelong learning.

The study concludes that although the transition period continues to be stressful, it seems to have been less difficult for those qualifying in 1998. However, shortfalls in the curriculum were identified as being the development of managerial, clinical and organisational skills which are all essential today in the high pressured NHS environment. This needs to be addressed by HEIs to ensure that nurses graduate as fit for purpose.

2.1.6 Support

The need for support of newly qualified nurses is evident in order for them to deliver skills and confidence in times of poor staffing levels, increasing patient demands/needs and the pressure of responsibility and accountability (Mooney, 2007). In the current climate, this can be mirrored across all healthcare professions within the NHS and is a common theme throughout the literature.

In 2005, the Department of Health (DH) introduced preceptorship for all newly qualified professional staff in the National Health Service (NHS). Morley (2006) discussed how the introduction of preceptorship could build on the existing expertise of clinical supervisors in OT. Reviewing relevant sources, she argues that the first year is a crucial time of adjustment for new staff and although OT has many existing support mechanisms in place, preceptorship may well enhance this support and improve the experience of the newly qualified practitioner. Preceptorship schemes bring together consolidation of practice, development of new skills and knowledge, development of professional identity, feedback and support, reflection and goal setting (ibid). Therefore, the importance of preceptorship or an alternative cannot be ignored during this vital time.

In the study by Gerrish (2000), the nurses qualifying in 1998 had all been allocated a preceptor and had been supernumerary for a period of time. When

this was foreshortened due to staff shortages this only occurred for up to four weeks during which they worked alongside their preceptor receiving support and feedback. The majority of the newly qualified nurses stated that this had been a positive experience and the provision of constructive feedback on their performance had been essential to their development.

The need for a structured learning experience for new graduates was also highlighted by Black et al., (2010) in order to support the transition from student to therapist. They also identify how little is known in terms of workplace learning during this time and recognise the multidimensional complexity of competence and expertise (ibid). In investigating the learning and development of promising novice PTs, Black et al., (2010) undertook a multiple qualitative case study approach with the use of grounded theory. Twelve PTs across four different education institutions in the USA were purposively sampled and eleven took part in the final study. The aim of the study was to explore the experiences and development of novice PTs including areas such as learning and thinking. The participants were a mixture of pre-registration students from BSc (Hons) and Master's degree programmes. The data collection methods consisted of a demographic interview, guided reflective journals (bi or four weekly) and a series of semi structured interviews (one baseline then every three months up to one year). Inductive data analysis took place using a variety of strategies associated with several qualitative analysis traditions. Triangulation of data, receipt of reflective journals directly from the participants and member checking of interview transcripts were all utilised to ensure academic rigour. Both the interviews and reflective journals were thematically coded and from the data a preliminary conceptual model was formulated (Appendix IV).

This model provides a comprehensive overview of the process which novice PTs go through during their first year of practice. The emergence of professional identity and role transition is central to this process and closely linked to growing confidence. The core concepts identified and illustrated with the model are; clinical environment and practice community, learning through

experience, growing confidence and professional identity formation and role transition.

The clinical environment and practice community was shown to have a major impact on the novice practitioner. The primary focus of learning the ropes took precedence over the development of other skills. Some of the participants were well supported by mentors and those that were not felt that it constrained their development and learning opportunities in some way. All participants identified the value of learning through experience and some had used multiple sources of learning. It was established that they often used these to develop their confidence particularly in respect of decision making. Again, those with mentors felt that they had progressed more quickly than if this support had not been available.

During the first year it was recognised that the novice PTs increased in confidence and independence. The participants identified that they felt that their confidence had most grown in the area of communication skills. This included talking to patients, carers and colleagues, listening skills and the ability to interpret information given to them. Positive interactions with others were often thought to increase confidence as did successful resolution of situations and performance appraisal meetings. The improvement of communication skills was noted to be most prominent at between six to twelve months.

The nature of professional identity formation and role transition was most deeply influenced by the growing respect from patients and colleagues. It was also affected by the ability to navigate through each working day and being able to cope when working outside of one's comfort zone. As the novice PTs progressed they recognised the value of their role and began to take on additional responsibility and roles. In some environments, the novices reported high levels of stress that decreased as confidence grew. Others reported low levels of stress whilst others a mixture of the two.

Although the main findings of the study suggest that the majority of learning and changes occur within the individual (resulting in an increase in ability and confidence), the impact of the clinical environment was shown to have a powerful influence on the novice. The clinical settings providing mentorship enhanced the learning and experience for the newly qualified practitioner during the transition period. Integration into the practice community strongly influenced the novice's professional identity and positive engagement with the community was shown to enhance self-confidence and trust in their knowledge and abilities.

The limitations of the study cannot be ignored. It was a small scale study using purposive sampling. The participants had all been identified as promising novices which in itself places bias on the findings. The students worked in very different environments and received varying levels of support. However, the findings of this study do corroborate those of similar studies which have concluded that the first year of practice is a challenging one and although all participants did report an increase in confidence during the transition period, support did play an important part in their development.

In response to the challenges faced by newly qualified midwives and nurses during the transition period, a national development programme known as the Flying Start NHS was introduced in Scotland in 2006. The programme consists of ten units and is a web-based or CD-ROM programme which aims to develop the confidence and competence of newly qualified nurses and midwives during their first year of practice. The units are: communication; clinical skills; teamwork; safe practice; research for practice; equality and diversity; policy; reflective practice; professional development and career pathways. It allows practitioners to map their progress against the KSF, supporting professional and personal development. Aiming to provide a positive learning environment it is also hoped that this programme will enhance recruitment and retention within the NHS (Hickie et al., 2007). An early evaluation by Roxburgh et al., (2010) identified that many nurses had received poor career advice and a focus on aspiration was needed. It also highlighted the need for a supportive learning environment in order to promote a sense of

worth in the new graduates. This study used a relatively small sample (97 newly qualified nurses) which was conveniently selected and this needs to be taken into consideration when discussing the findings. It was also reliant on self-reporting which may have resulted in less reliable data than if a more objective measure had been used.

Further evaluation of the Flying Start NHS programme was undertaken by Banks et al., (2011) to establish the impact of the programme on the confidence, competence and career development of the newly qualified practitioners. Following an initial scoping exercise which provided background information regarding the day to day operation of the programme, including support for the mentors. Focus groups and telephone interviews were carried out with 95 newly qualified practitioners and 22 mentors. The findings were then used to develop an online survey to capture the opinions of the 9500 new graduates. Out of the 9500, the researchers were unable to establish how many were undertaking the Flying Start NHS programme and therefore a response rate was not reported.   However, in total; 547 newly qualified practitioners completed the survey comprising of 334 nurses, 20 midwives and 193 AHPs. Of the total respondents 15 were diagnostic radiographers (2.7%) making a proportion of 7.8% of the AHP section. It is evident from the study that the newly qualified practitioners are still facing several challenges during their transition. Although approximately 75% of respondents were allocated a mentor to provide support whilst undertaking the Flying Start NHS programme, they waited between 4-9 weeks for allocation with AHPs waiting longer on average than the nurses and midwives. However, the satisfaction with the support received from mentors was mixed with a higher proportion of midwives stating that the support received from their mentors had been good or very good. Support from mentors in the community was also more positively rated than in the acute setting. There were no separate figures given for the AHPs due to small numbers.

Overall, the study concluded that the majority of the newly qualified practitioners taking part in the study found completing the programme helpful in terms of developing confidence and clinical skills. The most useful learning

units were learning the job, becoming a member of the team and orientation/induction to the clinical area. Many of the respondents however, reported difficulties in completing the programme due to time constraints and a lack of support/partnership and this is a concern if the programme is to fulfil the aim of improving recruitment and retention. Unfortunately the number of AHPs and in particular diagnostic radiographers that took part in this project were small but overall the programme was positively evaluated and could be considered as a support mechanism for new graduates in England in the future.

The case for structured support has been made by several studies (Gerrish, 2000; Black et al., 2010; Roxburgh et al., 2010 and Banks et al., 2011). However, the phenomenological study by Seah et al., (2011) exploring the lived experience of eight newly qualified OTs in Australia found that although the participants in the study valued support during the transition period they preferred a less structured and more interdisciplinary supervision approach. This questions the ethos of a one fits all model and it may be that each individual newly qualified practitioner is given a range of support options to choose from that can be tailored to their own needs and preference to help ease the transition period.

In response to concerns that allied health professional education is not adequately preparing students for role transition in Australia, an Allied Health Graduate Program was designed and delivered to fourteen new graduates from a range of health disciplines. Twelve two hour sessions were offered over a ten month period, aiming to foster various skills such as reflective practice, peer support and to assist the graduates in personal development and interprofessional awareness (Smith and Pilling, 2007). The range of disciplines included occupational therapy, physical education, physiotherapy, podiatry, social work and speech therapy. As part of the development process of the programme, key stakeholders were consulted including healthcare managers and recent graduates. Thirteen graduates completed the programme and overall, the programme received positive feedback and the graduates stated that it supported them during their transition period. It also

offered them an opportunity to reflect, learn, critique practice and work with others.

It was noted that the programme seemed to have the biggest impact for the participant during the first four to six months and after that time the engagement decreased slightly. The facilitative nature of the workshops encouraged a positive learning environment which allowed the graduates to explore a range of issues from varying perspectives. The importance of this programme is that educational institutions and employers worked in partnership to develop it and following some modification, it has now been built into the Allied Health Directorate. It is anticipated that this programme will help to attract, recruit and retain staff through support and education and that in the future the programme may be opened up to include nursing and medicine. Again, this opens up a debate as to whether a graduate transition programme should be considered in England.

Hutton and Eddy (2012), identified that there was often a tension between new graduates getting things signed off as competent and the opportunity to do so during their transition period. However, they did recommend the use of preceptorship to support and guide the graduate through the challenges of transition and in the development of new roles. They also acknowledge that the support of the team and of others should not be underestimated at this stage. The role of the preceptor in teaching and providing learning opportunities, supervising in initial stages, assessing performance and giving feedback were all highlighted by Nesbit (2008). She also recommends moving to a post-technocratic model of professional education and the introduction of a formal, structured preceptorship model will enhance the development of new graduates not only in terms of clinical competence but in consolidation of knowledge, reflection and promoting independence.

The issue of supporting newly qualified radiographers was explored by Naylor (2014) as part of a PhD study previously discussed. In the paper by Naylor et al., (2016) two support mechanisms were discussed; peer support and scaffolding. It was found that peer support was valued by all participants

whether formal or informal. Although there is limited literature on peer support during transition it was established that it reduced anxiety with regards to starting work, provided a personal support group, and reduced isolation by providing a sense of belonging. Alongside this some departments offered structured support based initially introduced by Bruner (1956). This is where support is reduced over time as the graduate begins to gain experience, develop their practice and increase in confidence.

Lewsey (2008), used a qualitative, exploratory study to investigate the level and nature of support received by newly qualified operating department practitioners in Scotland during their first four months in post. She also ascertained from what was offered which type of support they found most and least useful at this time. This study was undertaken due to concerns in the profession that a move to HEI delivery of the Diploma in Higher Education course had resulted in less time in practice and that this may give students less time to develop the necessary skills, in turn questioning the need for different support mechanisms to be in place post-qualification to address this.

Using structured interviews with closed responses, 15 participants from one university were interviewed and their responses recorded. The mechanisms of support identified by the participants were; preceptorship/mentorship, access to education co-ordinators/facilitators, orientation programmes, working under direct supervision, formal review of progress and the Flying Start programme. Of these mechanisms, peer support from co-workers was deemed to be the most useful, followed by team leader and other newly qualified practitioners. It emerged that the support offered directly from others was thought to be the most valuable. Formal review seemed not to be well utilised and therefore it can be concluded that limited feedback was received by the newly qualified operating department practitioners at this time. Interestingly 73.3% of the sample were either very or moderately satisfied with the support that had been given.

It should be acknowledged that for a quantitative study, a small sample size was used and taken from only one institution and therefore the generalisability

of the findings is limited. Also, by not investigating the topic using a qualitative approach may have resulted in a lack of meaningful data which could have been explored further by the researcher using additional methods and added insight to the findings.

In her paper, Inch (2013) discussed the role of simulation-based learning using clinical scenarios as a way to offer the opportunity to experience 'real life' simulations. It is thought that this can help practitioners develop behaviours, approaches and techniques that can be transferred into practice. Linking the experience of simulation to Benner's work on novice to expert (2001) Inch presents a model which combines the two, illustrating the value of simulation in developing not only the newly qualified practitioner but also the more experienced ones. Through this approach, the proposed model provides a scaffolding which enables the practitioner to own responsibility for their own learning and development thus underpinning CPD.

The potential for simulated learning as a strategy to prepare students for increasingly pressured work environments is well argued. As clinical learning opportunities continue to decrease due to workload demands, simulation allows the opportunity to experience, learn, practice and receive feedback on a range of situations (Inch, 2013). The confidence the practitioner potentially develops may provide a springboard for a more prepared workforce in the future.

2.1.7 Environment

The study by Black et al., (2009) has already highlighted that the clinical environment and practice community was shown to have a big impact on the novice practitioner and fully contribute to their professional identify formation and role transition. It was noted in particular that instability in the clinical environment had a negative impact on the participants' performance. This is an important issue as the NHS is a constantly changing environment and the increase in workload is underpinning many different ways of working which the graduates are exposed to on a daily basis from the very start of their career.

Fenwick et al., (2012) explored the experiences of newly qualified midwives during transition by interviewing sixteen graduates. In using the metaphor of *'the pond'* to represent the work environment, other metaphors were used to describe the themes identified as part of the analysis. These were the *'life-raft'* to represent midwife-to-midwife relationships, *'swimming'* to represent positive interactions with colleagues and a supportive environment and *'sinking'* to describe the effect of poor relationships with midwives and a difficult working environment (p2054). Participants describe their working environment as very structured, being governed by rules, routines and being very task focussed. The general feeling was that the provision of care was not centred towards the mother and her family but rather on the system. This has direct application to the working environment of a diagnostic radiographer and the study by Strudwick et al., (2011) examines this further concluding that radiographers often choose to concentrate their efforts on being task focussed, managing the time pressures and working with efficiency. They conclude that by concentrating on these aspects of the role it allows radiographers to detach themselves from patients as a way of coping with emotional engagement and allows for self-preservation.

The perception of newly qualified midwives' working environment combined with excessive workloads and little communication and information regarding the hospital systems and processes really challenged the graduates, making transition problematic at times. Varying levels of support were experienced with the majority of students receiving a lack of educational support and it was felt that designated support was provided but *'only on paper'* (Fenwick et al., 2012, p2056).

In the settling in period it appears that the new graduates quickly noticed the hierarchy within the environment, noting the obvious *'pecking order'* (ibid, p2058). It seems that they felt outsiders, almost visiting their workplace which they felt belonged to the experienced midwives. During this time the newly qualified midwives felt under pressure to fit in and prove themselves, often being tasked with difficult cases to purposefully test them out. This toughening up period was a common experience across the participants and not isolated

to this one study. This links directly to Lave and Wenger's concept of Communities of Practice (1991) where it is suggested that the graduates are seen as newcomers and thereby sit on the periphery of an already established group. It is then through a process of watching, learning and developing that they become integrated into the group. The process of this situated learning will be influenced by the culture of the community of practice and professional identity is formed by the interaction that occurs within and between Communities of Practice (CoP). This concept has been explored further by Trayner-Wenger and Trayner-Wenger (2015) who suggest that naming by the CoP it allows us to discard the formal structure of the CoP and thus engage in practice and the informal learning that comes with it. The original work by Lave and Wenger (1991) was developed whilst studying apprenticeships however, as suggested by Trayner-Wenger and Trayner-Wenger (2015) these type of communities exist everywhere and the complex social relationships through which learning takes place is not limited to novices but due to the fact that the CoP is dynamic, learning occurs for everyone.

The building up of positive relationships with their colleagues was paramount to the new graduates at this time symbolised by the metaphor of *'the life-raft'* Fenwick et al., 2012, p2058). The behaviours and interactions of their colleagues had a profound effect on the newly qualified midwives' level of confidence and competence. The provision of a positive and safe learning environment helped the new graduates to engage more fully within their environment and progress more quickly. Midwives who demonstrated care and compassion for the women and their families were highly thought of as were those who shared their knowledge and expertise enabling the new graduate to optimise the positive learning opportunity. Role modelling seems to have played a major part at this time and heavily influenced the participants' personal and professional development.

Mixed messages and poorly delivered feedback was seen to hinder successful transition as was the opportunity to feel comfortable enough to ask questions. There were times when this may have been attributed to workload but overall

this was felt as an excuse as there were times where the participants felt actively ignored and left to flounder.

This study has highlighted some important issues in particular the harsh, sometimes toxic environment that the graduates were exposed to and the affect that this had on their learning and continuous development as a midwife. The limitations of this study cannot be ignored due to the convenience sampling method and the fact that the researcher was in fact a recently qualified midwife. The impact of this is on the findings is of course difficult to ascertain, however, strategies were used to ensure trustworthiness of the data in order to enhance the credibility of the findings. As with many studies of this type, the findings cannot be generalised to the wider population but they well may resonate across the profession and others.

A study undertaken by Gilling and Parkinson (2009), examined the transition from veterinary student to practitioner in New Zealand. Registered veterinarians who graduated between 2001-2003 were sent questionnaires alongside the heads of Human Resources of all veterinary practices. Follow up focus groups and interviews were also conducted. At this time many changes had taken place in the veterinary profession and the purpose of this study was to establish whether or not these changes had impacted on the experience of veterinary practitioners during their first year of practice. Of the respondents, 42% of graduates felt that their technical ability was less than adequate and this was also endorsed by employers. However, it was recognised that the level of skills were as good as could be achieved within the confines of academia and it was generally felt that confidence was more of an issue. Some of the graduates felt that they gained confidence as they settled into their role and that this was again improved on receipt of compliments. Being valued and receiving praise enhanced their transition period. The employers were however ambivalent about providing personal support.

The similarities between radiography and veterinary practice can be regarded as scientific knowledge, technical skills, clinical acumen, communication skills

and the ability to empathise. The pressure on the new graduates to fit in and to be able to increase their knowledge base quickly is mirrored between the professions. Also the level of responsibility given to the practitioners from day one is a concern that is acknowledged across both professions as is the level of support given during this transition period. The first year after graduation is again labelled as the *'make or break'* period (Gilling and Parkinson, 2009, p209). The findings of this study leads me to consider how certain factors influence the transition period and how they directly contribute to the *'make or break'* experience. This needs further exploration in diagnostic radiography and given the similarities between the professions it would be interesting to see if the participants of my study also identify with their transition period in the same way.

Familiarity with their working environment was seen to reduce some of the stress experienced by the newly qualified radiographers in the study by Naylor et al., (2016). All of the purposive sample of eight graduates which were part of this longitudinal study previously discussed were employed in departments where they had previously been placed as a student. This may well have influenced the impact of other factors during the period of transition if the participants already felt comfortable in their own environment.   The environment and culture into which each graduate is introduced will vary considerably and the culture of diagnostic imaging departments has been explored further by Strudwick et al., (2011, 2012) which will be discussed in section 2.3.

2.1.8 Confidence

Roberts and Johnson (2009), discuss the tension that exists between competence and confidence when practitioners are novices. The inextricable link between the two cannot be ignored as a lack of confidence can often be misinterpreted as a lack of competence (ibid). Roberts and Johnson (2009) are not alone in recognising the tension that exists between competence and confidence when practitioners are novices. However, the development of confidence during the transition period is not always easy. Often those who

appear more confident are encouraged to take part in various learning activities and thus the feedback from this further increases their confidence (Roberts, 2007). Spouse (2003), identifies a link between confidence, peer support and coaching which is further reiterated by Currie (2008) who discusses how graduates gain confidence in their ability by the recognition that they have gained and therefore been able to apply new knowledge. The increase in self-belief following these episodes of learning is then externally projected and forms the behaviour of expert practitioners. The impact of personal and professional self-identity on the development of competence and confidence is acknowledged (ibid).

The *'swimming'* metaphor used in the work of Fenwick et al., (2012, p2054), was about the new graduates building confidence. The ability to learn and assess their own learning needs was underpinned by feeling good about oneself which again was largely attributed to a supportive and safe environment. The complex relationship between confidence and competence was highlighted as the participants acknowledged that the more supported they felt the more likely they were to push themselves forward and if there was a positive outcome this increased their confidence, promoting a feeling of competence. On the other hand the *'sinking'* metaphor (p2054) was aligned to the consequences of a harsh working environment where participants felt *'belittled'* and *'intimidated'* (p2060). Feeling unable to question or speak out due to the poor management of relationships by the experienced midwives left the graduates with an increased sense of anxiety and nervousness. This directly impacted on their confidence and ultimately their perceptions of their own competence. The pressurised environment which was also deemed hostile by some of the graduates, undermined their confidence and also reinforced the fear of making mistakes. The cyclical relationship of fear, lack of confidence, increased anxiety and the inability to cope was a significant finding and this left some participants distressed and exhausted.

Developing confidence was highlighted in the study by Black et al., (2010) where it was identified that the confidence of graduates increased over the twelve months alongside evolving independence. In exploring this further with

the participants it was found that an increase in confidence occurred following dealings with a range of people including patients, peers and other staff which had resulted in a successful outcome. This often included some form of positive feedback either informally or formally via appraisals or similar.

Building confidence is also a sub-theme of experience identified in the study by Naylor et al., (2016). The participants found that their confidence grew with experience and that incidents when they had managed on their own had also positively contributed to this growth. Developing autonomy in this way with the appropriate support helped the graduates to successfully navigate through this transition period and underpinned their professional development.

Due to the increased demands on the NHS, employers need graduates to have more advanced skills now more than ever before. The difficulty remains in not only how the students gain this experience in the practice setting but also the necessary knowledge and skill which is expected at the end of their course. Roberts (2007) argues that the attitudes and values that a practitioner has areas equally important as the knowledge and skills they possess. She also discusses the links between confidence and learning and how the students that appear confident have more access to patients. The resulting increase in self-confidence is then recognised by the mentor who then allows the students to partake in more learning episodes and therefore engage in peripheral legitimate activity. The challenge for educators and practitioners alike is how to foster confidence in students and ensure that this is continued into the transition period.

2.1.9 Summary

The phenomenon of role transition has been investigated by a range of differing professions over a range of time and utilising a range of different methodologies. It is acknowledged by all studies that the period of transition from student to practitioner is a challenging and at times a stressful experience. Many of the studies explore the concept of support but there is no firm consensus on type, depth and length of support needed and it has

been seen across the healthcare professions that the support given is both variable and inconsistent.

The period of transition continues to be a complex one and there are many factors which influence this experience some of which have been discussed in-depth such as environment, preparation and confidence.   Although the experiences of newly qualified practitioners have been explored through a variety of methods as seen in the literature review, there does not seem to be a consensus yet as to how the transition period can be best facilitated.

With regard to radiography up until recently research into role transition has been extremely limited. The study by Decker (2009) offered some insight into this phenomenon but as already discussed this study was undertaken using Diploma educated radiographers and the data were collected some years after they had qualified. This may well have impacted on the accuracy of the data collected, however, it does provide a platform for my research and will allow comparisons to be made with their findings.   The other studies by Feusi et al., (2006), Mackay et al., (2008) and by Hutton and Eddy (2012) offer information on preparedness to practise and areas of strength and weakness of the new graduates all of which will usefully underpin this study and contribute to the transition of student to practitioner.   The studies into the culture of the radiography department by Strudwick et al., (2011, 2012) also have some relevance to this project.

During the time scale of this study, new research has come to light and the recent PhD study by Naylor (2014) has been completed. . This study explored the transition from student to practitioner in diagnostic imaging by investigating the expectations and experiences of new graduates. Although similar in focus to my study there are some fundamental differences which allowed me to build on the knowledge that this study produced and also offer new perspectives. Firstly, a focus group formed part of the data collection methods in order to explore expectations with a group of four students prior to graduation. These data were then utilised to form the questions of the semi-structured interview. This may have led the researcher to focus her initial questions on the anxieties

and concerns perceived by the chosen intake rather than the wider body of literature. This could have introduced bias at this stage. Another difference is the methodology chosen and the overall approach. My study aims to look at the influences of being and becoming a radiographer during the transition period and as such will aim to examine these influences in-depth and help to understand the participants' experience during this time. The data collection methods were enhanced by the use of two tools which are used at the three month and twelve month interviews. These are explored further in the methodology section. Finally, the majority of participants in the study by Naylor et al., (2016) were employed in departments which they had previously been placed in as students. It is difficult to ascertain the effect this may have had on the findings but as highlighted in the environment section of the literature review this could have had a significant impact on a range of the experiences. This is recognised by the authors who recommend that a further study is undertaken with participants who are employed in different departments (ibid).

Having discussed the pertinent research available it is highly likely that there are still some unexplored areas. It was therefore the intention of my research to investigate further the nature of being and becoming a radiographer and make possible recommendations as a result of the findings.

This is the first study to explore the transition experience of student radiographers graduating from the host university since the introduction for the degree course in 1993. However, there are currently 30,418 radiographers on the HCPC register and approximately 90% of these are diagnostic radiographers. In order to ensure that the experience of transition from student to practitioner in radiography is explored in detail there needs to be a body of literature akin to other professions such as nursing, occupational therapy and physiotherapy.

2.2   Resilience

As previously stated earlier in this work, the role of the radiographer is constantly changing in order to keep abreast of advancing technology and the increasing demand for imaging services.   Ever increasing targets add to the pressure that health service providers face whilst they strive to find more effective and efficient ways of working. This is exacerbated by an ageing population, increases in long term conditions and a health service struggling to cope with a vast range of complex morbidities. As Brown (2004) suggests this has exerted undue pressure on the radiography profession and as such has directly affected the working environment into which newly qualified radiographers enter. Scholes (2008) in her study argues that the challenges that health care professions now face requires them to be both committed and resilient.

In a study by Verrier and Harvey (2010), the nature of work related stress (WRS) was investigated in a single diagnostic imaging department.   Forty questionnaires were distributed to all staff containing a number of statements to which the respondents could rank across a 5-point Likert scale from never to always. The questionnaire was based on the HSE Indicator Tool for WRS which contains 35 statements relating to seven standards; demands, control, managers' support, peer support, relationships, role and change. There was an 80% response rate. The results demonstrated that the standards were not achieved in any of the seven areas and the specific problem areas were managers' support, relationships, role and change. Work pressures were associated with staff shortages, heavy workloads and volume of patients. Although it is recognised that this was a small scale study undertaken in one department and that it was cross sectional in its approach, it does offer some insight into the working environment of a diagnostic radiographer and the day-to-day pressures that they are having to cope with. These pressures will remain the same for the newly qualified radiographers who may not be so well equipped to deal with the challenges early on in their career. The areas identified as directly related to WRS are common across health and social care professions and as such underpin the need for resilient practitioners.

There are numerous definitions of resilience in the literature, many of which refer to the ability of an individual to recover from a period of stress/adverse event (Stephens, 2013). This implies that there needs to have been a significant event from which a recovery is needed whereas in fact I believe that the development of resilience will allow an individual to cope more effectively with sustained levels of stress and allow them to move forward. Gillespie et al., (2007, p133) offer a more measured definition of resilience as *'an ongoing process of struggling with hardship and not giving up'*. As a life coach, I am particularly drawn to the work by Ungar (2008, p225) who proposes the following definition '*the capacity of individuals to navigate their way to …..resources….., and …. individually and collectively to negotiate them ….'* Not only does this highlight the individual's ability to cope but also focusses on their capacity to seek out and use the available resources. This is particularly relevant to newly qualified practitioners during early transition.

McAllister and McKinnon (2009) also highlight the pressures placed upon health professions such as fast-paced work, interactions with a diverse range of people at different levels, the constant change and also the underpinning desire to care for others. It is this last pressure that separates health and social professions from any other type of career in that the majority of people enter these professions *'because they sincerely want to care for others'* (Skovolt, 2001 cited in McAllister and McKinnon, 2009, p1). In doing so, the emotional effort this can take may sometimes lead to stress-related issues and evidence suggests that health professions suffer more from this type of issue in the workplace in comparison with other professions (Wieclaw et al., 2006). In their literature review, McAllister and McKinnon (2009) suggest that resilience can be learned and propose that through transformative education it can be introduced into an educational framework to prepare undergraduates for the challenges of their professional role.

New and possibly young graduates entering the health professions tend to '*perceive hospitals as harsh and unresponsive institutions*' (McAllister and McKinnon, 2009, p372) and they find this a stressful and uninspiring environment. Gaynor et al., (2006) also discuss the impact of the continuous

change within the healthcare environment and the challenge of chronic conditions causing complex patient pathways. McAllister and McKinnon (2009) go on to suggest that if students are ill-prepared for the emotional labour required in addition to the cognitive knowledge needed then the burden of trying to cope can result in stress and burnout.

McDonald et al., (2013) undertook an instrumental case study to investigate the effects of a work-based personal resilience educational intervention. Fourteen participants (a mix of nurses and midwives) took part in six resilience workshops and a mentoring programme over a six month period. The sessions were a combination of didactic teaching, artistic creativity such as drawing, painting and moving followed by some therapeutic elements e.g. relaxation techniques and massage. Data were collated via three face-to-face interviews; pre-intervention, post-intervention and six months' post intervention. Following thematic analysis, three major themes were identified; personal gains from resilience workshops, professional gains from resilience workshops and personal resilience initiatives. Some of the sub-themes included increased assertiveness at work, improved workplace relationships and communication and understanding of self-care practices. Although this was a small scale project and the participants self-selected to take part it does illustrate that there are demonstrable positive outcomes to running such a programme. The potential of being able to enable health and social care professionals to enhance their resilience in the workplace has far reaching implications for both education and practice.

Medical training in particular has developed a recent drive for teaching resilience in medical education. Passi (2014) discusses the importance of collaborative working to support medical students in developing resilience and the impact this has on standards of care for patients. The need for trainee medics to develop this during their training is argued by Tempski et al., (2012, p343) who describe it as an '*emotional competence.*' The debate within medical education seems to suggest that there is a growing drive to include resilience as a key component in medical education programmes to help fully prepare graduates for demanding workloads and government expectations.

Richez (2014) explores this further from the perspective of supporting nurses in transition. Recognising the stressful nature of nursing, she goes on to acknowledge that newly qualified nurses may be susceptible to the additional stress caused by moving to an unfamiliar environment. In acknowledging that small stressors experienced over longer periods of time can cause distress, she discusses the importance of resilience in enhancing practitioners' ability to overcome the challenges and be able to improve their performance.

Hunter and Warren (2014) appreciate that midwifery is an emotionally demanding profession and recent changes with regards to rising birth rates, more complex pregnancy cases combined with a shortage of midwives places practitioners under increasing amounts of pressure. Those that do stay in the profession need to find ways to cope and ensure that they attend to their own well-being and this is where resilience is key. Combining a number of sources, they define resilience as *'the ability of an individual to respond positively and consistently to adversity, using effective coping strategies'* (p927). This fits in well with the previous definitions given and focusses on the ability to overcome challenges and move forward. In order to explore the understanding and experiences of resilience they recruited twelve midwives to participate in an online discussion group. Eleven midwives took part in the discussions which took place over a period of four weeks. Occasional questions were posed by the researchers to the group and also a vignette of a resilient midwife was also shared to promote discussion. Thematic analysis was undertaken using NVivo and then the themes reviewed by an expert panel refined the findings. The conclusions of this study were commensurate with some of the issues already discussed such as work place adversity, response to and coping with those challenges, level of self-awareness and building resilience.

It can be seen by the discussion that there is a growing body of evidence to suggest that resilience is an important facet of professional practice. It is not only something which current practitioners need to adopt for their own health and wellbeing but also to ensure effective and patient-centred services which can respond quickly to change. As discussed by McAllister and McKinnon (2009), a resilient workforce will reduce attrition of the workforce but also make

it a more appealing career option thus enhancing recruitment. The pressures and stressors that have been discussed are not discriminate and therefore affect all health professions including students and new graduates. It is for this reason that the issue of resilience and its potential effect during the transition from student to practitioner in the first twelve months is of interest and relevance to this study.

2.3 Workplace Culture

The work by Lave and Wenger (1991) introduced the concept of Communities of Practice (CoP) in attempting to understand an environment and its culture. Through their work they proposed that a social learning process occurs when people come together who have a shared interest. This collaboration tends to last for an extended period of time and facilitates the exchange of ideas, assists in the formulations of different ways of working and triggers innovation. In order for a CoP to exist there are three essential components; a domain, a community and practice (Figure 4). The domain is identified by a shared interest and for the purpose of this study that would be diagnostic radiography/diagnostic imaging. The community is the membership of the specific domain who share activities and engage with one another. Again, for the purposes of this study that would be all the staff working within the diagnostic imaging department in particular diagnostic radiographers. In order for the CoP to be formed there needs to be interaction and learning between the members and thus a CoP is not merely an interest group but requires its members to be practitioners. Through this they share resources, stories and problem solving techniques. Being able to look at a work environment through a CoP lens allows us to gain a better understanding of the workplace and its culture and see past its organisational structure.

Figure 4: Elements of a Community of Practice Adapted by Lave and Wenger (1991)

Wenger (1998) further developed this work and suggested that a CoP defines itself along three dimensions (Figure 5). These are; joint enterprise, mutual engagement and shared repertoire. Joint enterprise is a shared understanding and this is continually renegotiated by its members. Mutual engagement is how the CoP functions, it is how the members interact with each other and work together. Finally, the shared repertoire consists of the communal resources that the members have developed over time.

Figure 5: Dimensions of a Community of Practice Wenger (1998)

If you combine the elements of a CoP (Lave and Wenger, 1991) with the dimensions (Wenger, 1998) it can been seen that there is a link between the two models.   Figure 6 illustrates a combined model which is applied to the profession of diagnostic radiography.

Community of Practice		
Domain/Shared Enterprise A shared interest in diagnostic radiography/imaging which is developed by a shared understanding of different procedures and ways of working	**Community/Mutual Engagement** Radiographers working together, building relationships to fulfil their role and provide optimum care	**Practice/Shared Repertoir** Working in practice allows radiographers to develop resources which can be used to underpin and enhance clinical decisions

Figure 6: Adapted CoP from (Lave and Wenger, 1991) and (Wenger, 1998) to illustrate its application in diagnostic radiography

Not only does an awareness of CoPs enhance our understanding of the working environment and culture it also allow us to develop a knowledge of situational learning and legitimate peripheral participation. The work underpinning the concept of CoP was based on work with apprentices and was used to explore social learning.   It is proposed that when newcomers join a CoP they begin on the periphery as observers. At this stage they watch and learn how the group works and functions. This is particularly relevant to this study as all the newly qualified radiographers will begin their transition journey as newcomers. From the position of observer they begin to discover how they can contribute to the group and begin to participate and it is that participation in the CoP that underpins their learning. Learning is therefore not seen as the acquisition of knowledge but more as a process of social participation which allows the newcomer to move towards full participation and into the centre of the CoP.   In doing so the learner then achieves legitimate peripheral participation and becomes an accepted and knowledgeable member of the community.
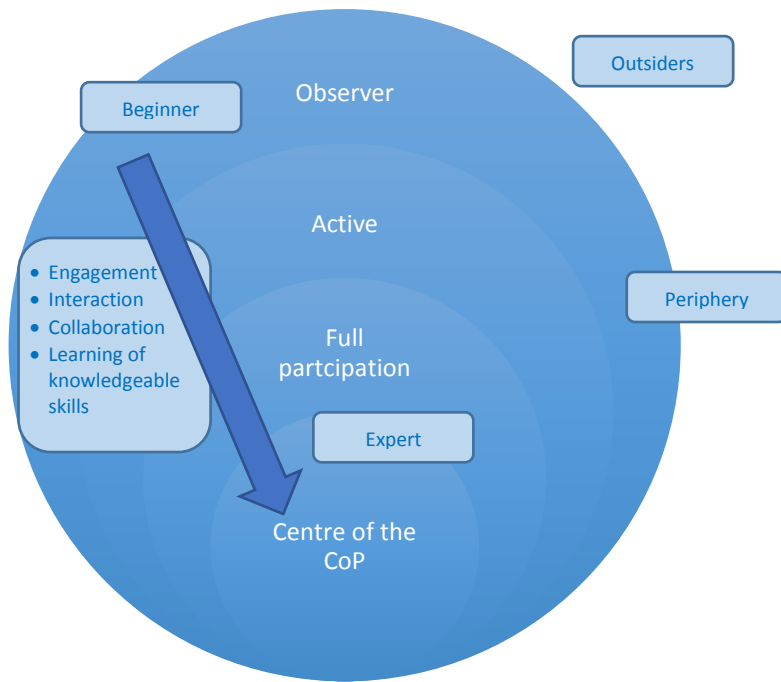
Figure 7: Legitimate Peripheral Participation Adapted from Lave and Wenger (1991)

In moving towards full participation, the newcomers will need to engage and collaborate with other members of the community. This may mean that they need to adopt a similar language, and acquire the values and beliefs of the community in order to align themselves with the other members. There are of course barriers to this journey from observer to full participation and in the current health care environment this can be a range of things such as continuous change, hierarchy and culture. It can also be as a consequence of personal traits, for instance preparation (including previous experience), confidence, self-belief and resilience. There is no doubt that CoPs have some impact on the transition of the newly qualified radiographer and this study will be able to explore this further.

Strudwick (2011, unpublished ProfDoc) undertook an ethnographic study of the culture in a diagnostic imaging department. Participant observation was undertaken for one day a week over a period of three and a half months. This was followed with ten interviews with a cross-section of staff which were purposively sampled. Four overarching themes were identified; relationships with colleagues, relationships with patients, structure and environment and

characterising the role of the diagnostic radiographer. There were also some key themes identified one of which was involvement of patients. It appeared from the data that diagnostic radiographers try not to become emotionally involved with the patients. Diagnostic radiographers are increasingly involved in complex cases and are often one of the first health care practitioners to recognise the patient's condition. In order to protect themselves they use a form of detachment as a coping mechanism. This ties in with some of the discussion in the resilience section that suggests that developing resilience as a practitioner can prepare you for the emotional demands of the role. The use of dark humour was also a key theme and links in with the previous key theme. It was observed that diagnostic radiographers used dark humour in difficult, sometimes stressful situations and also when feeling uncomfortable. The dark humour used would rarely be appreciated or understood by those outside of this working environment and may be judged as derogatory and disrespectful (Dharamsi et al., 2010). It is also suggested that it may be viewed as dehumanising and unprofessional but that this behaviour is a result of the culture in which the professionals work. Strudwick concluded that mocking patients and their adversities was part of the accepted culture in the diagnostic imaging department.

The final key theme that was identified in this study that has relevance to this thesis is blame culture. This seemed to manifest in the way that diagnostic radiographers were ready and willing to take the blame for mistakes and in doing so began to feel guilty for the error afterwards and as such it became a source for wider discussion (Strudwick et al., 2011). It is acknowledged by the authors that this culture of blame may well be reinforced by the wider culture of the NHS and the way in which is it continually criticised by the government and media.

Finally, Strudwick et al., (2012) explored the nature of teamwork in their ethnographic study and suggested that there are two distinct aspects of team work; firstly, atmosphere between colleagues, and secondly, the methods by which they work together. They concluded that in order for effective teamwork to take place that the members of the team all needed to adopt a shared

language which correlates with the concepts discussed around CoPs. They also discussed how a member of the team knows what to do and which part to play and debated whether or not this is something that can be taught or learned or is it simply down to intuition.

The literature discussed in this section offers some insight into the culture of a workplace and how this can affect the practice of a radiographer and more importantly the transition period of a newly qualified radiographer.

2.4   Being and Becoming and Professional Socialisation

The purpose of this thesis was to explore the transition of newly qualified radiographers over their first twelve months in post. By identifying what influences this experience and their journey we can gain an understanding of the process of becoming a radiographer and what it is like to be a radiographer.

Dall'Alaba (2009) and Dall'Alba and Barnacle (2005, 2007) have explored this area extensively and believe that professional education is actually a process of becoming. In her paper, Dall'Alba proposes that *'learning to become a professional involves not only what we know and can do, but also who we are (becoming)'* (Dall'Alaba, 2009,p34). Through her discussion she challenges those curricula that are underpinned by epistemological thinking by solely focussing on the acquisition of skills and application of knowledge. She argues that by ignoring the ontological perspective in a curriculum that graduates are inadequately prepared for the process of transformation into a professional e.g. a radiographer. By using Heidegger's concept of 'being in the world' it is possible to see how we are entrenched and interwoven into our world, we are part of it, not simply a spectator. By performing our role every day, undertaking the necessary duties, using a range of equipment, producing images as radiographers we become absorbed into *'average everydayness'* (ibid, p35). Operating in this way becomes routine and we generally take everything that we do for granted, allowing little place for critique. The possibilities that open up to us as we carry out our role also aligns with Heidegger's concept of being

human. Possibilities allow us to continually learn, thus continually be in a process of becoming and this directs our future.

Learning professional ways of being is not undertaken in isolation but involves interaction with others, and being open to new ways of working. As Dall'Alba (2009, p37) states *'becoming a professional, then, involves transformation of the self through embodying the routines and traditions of the profession in question.'* In reshaping professional education to offer ontological dimensions it can have a major impact on who the graduate becomes, what they know, how they act and in discovering who they are (Thomson, 2004; Dall'Alba and Barnacle, 2005, 2007).

In recent years, the importance of knowledge in HE has seen a decline and this was most noticeable in the Dearing Report (NCIHE, 1997) where there was virtually no mention of knowledge as a major element within the HE curriculum. Barnett (2009) discusses this shift and the surfacing of the 'performative student' (Lyotard, 1984 cited in Barnett, 2009, p430). In this case the focus is on a student with transferable skills, one that can gain information, effectively use resources, problem solve and is self-confident. Knowledge he argues is no longer seen as the be all and end all, the emphasis is on learning how to learn and consequently knowledge no longer holds the power that it once had.

In his exploration of the relationship between knowledge and being, he discusses how this is influenced by the dispositions and qualities of a human being and how they engage with the world. What he suggests is that through a student's course of study concepts of being and becoming should be embedded and in doing so a transformation will take place. This intricate relationship between knowing and becoming will then underpin the student's journey to become a new self. This correlates with the work of Dall'Alba and Barnacle (2005, 2007) and Dall'Alba (2009) which also calls for an ontological focussed curriculum which will better prepare students for their role in an increasingly complex world.

The work by Boychuk Duchscher (2008) focussed on the transition of new nurses' role transition into acute care in Canada. Her PhD formed the last stage of a ten year programme of research on the experience of transition in new graduates. Using a grounded theory approach she used the data gathered to develop a framework of transition. The data were gathered from fourteen graduate nurses from the same education programme. A demographic survey was conducted at the start of the research followed by six face-to-face interviews at one, three, six, nine, twelve and eighteen months. Focus groups for the one and three month interviews were utilised and pre-interview questionnaires required the completion of a *'process-revealing exercise'* (ibid, p442) such as drawings and letter writing. Continuous communication via email was used during the eighteen month period to keep in contact with the participants.

A conceptual framework of transition was developed as a result of this work which consisted of three main stages; doing, being and knowing. This can be found in Appendix V. Boychuk Duchscher (2008) discovered that the first twelve months of transition was a process of becoming. A transformation occurred in the participants who underwent both personal and professional journeys. The journey was not linear but over the period of twelve months the newly qualified nurses *'evolved through the stages of doing, being and knowing'* (ibid, p444). In examining these stages more closely, the doing stage seemed to occur in the first three to four months and was very much driven by the need for the new graduate to undertake their role. This consisted of sub-themes; learning, performing, concealing, adjusting and accommodating. This was a time of high levels of stress and anxiety, lack of formal support, fluctuating confidence and a lack of predictability/structure.

The next stage of being had the following sub-themes; searching, examining, doubting, questioning and revealing. This was thought to last for the next four to five months and was a time when the new graduates began to have increased self-awareness, were feeling professionally comfortable, starting to scrutinise practice and planning their future. During this time the participants also experienced a wealth of emotions such as *'feeling perpetually*

incompetent, inadequate, exhausted, disappointed, devalued, frustrated and powerless' (ibid, p446).

The final stage of knowing occurred at about the nine to twelve month stage and the recovery that has begun in the being stage continued. This stage consisted of; separating, recovering, exploring, critiquing and accepting. The participants acknowledged that they only felt moderately stressed at this stage but the source of their stress had changed from individual factors to much wider issues such as the system in which they were working. Comparing themselves to new starters at this stage helped the graduates realise how far they had come and how much they now knew.

This study can clearly be linked to the work of Dall'Alba and Barnacle (2005, 2007) and Dall'Alba (2009) in that the stage of knowing relates to the epistemological elements of the curriculum in which the undergraduates learn the functional aspects of their professional role. However, as they move to the next stages of Boychuk Duchscher's framework (2008), being and knowing these are underpinned by the ontological aspects of professional ways of working. This can also be transferred to the legitimate peripheral participation model adapted from Lave and Wenger (1991) seen in Figure 7 as you move into towards the centre of the CoP you move through the three stages of doing, being and knowing.

Professional socialisation in nursing has been explored by a number of studies but there is yet to be an agreed definition (Holland, 1999; Howkins and Ewens, 1999 and Mackintosh, 2006). In their concept analysis of professional socialisation in nursing, Dimmohammadi et al., (2013, p27) suggest that professional socialisation is *'the process of internalising and developing a professional identity through the acquisition of knowledge, skills, attitudes, beliefs, values, norms and ethical standards in order to fill a professional role.'* Through their exploration of professional socialisation, they propose that it has four essential stages; learning, interaction, development and adaptation. In this case, the learning stage extends far beyond skills acquisition but also includes learning the attitudes and behaviours expected, the professional

language being used and adopting the professional values and norms. In integrating these aspects it suggested that it is a lifelong process of learning across all three domains; cognitive, psychomotor and affective.

The interactive stage centres on socialisation being a proactive process, no longer seen as being a reactive linear process but one that is constantly changing and evolving. As such, interpersonal relationships and communication play fundamental roles in socialisation. The development stage recognises the role of education in underpinning effective professional socialisation culminating in the creation of a humanistic professional. Finally, Dimmohammadi et al., (2013) discuss the importance of adaptation and how during the first few months following graduation the nurses have to adjust to new roles and responsibilities and acclimatise to the differences between theory and practice.

Mooney (2007) undertook a grounded theory study in the Republic of Ireland to explore professional socialisation in newly qualified nurses. She interviewed twelve nurses across two cohorts who all gained posts in one hospital where they had all trained. In-depth interviews were held with the nurses who were all qualified between six and ten months. Following data analysis a category was identified entitled *'Old Habits Die Hard'* (ibid, p77) which was then divided into two subcategories '*Set in Stone'* and '*Without a Voice.'* The first subcategory '*Set in Stone'* was concerned with the newly qualified nurses having to learn ritualistic practices and routines. They found that staff were resistant to change and there was pressure to conform to ward rules which were often non-patient centred. The other subcategory *'Without a Voice'* centred on the existing hierarchy and the expectations that the junior nurses would cover the night duties and Christmas period. The culture seemed to reward the more experienced with certain perks and there was clear evidence of the existence of a blame culture. Overall, the new graduates seemed to feel powerless and vulnerable in those early months following registration and the imposition of professional socialisation was linked to low self-esteem, lack of assertion and avoidance.

Clouder (2003) undertook a three year longitudinal study to explore professional socialisation in a group of occupational therapy students. Following twelve students throughout their three year degree course, interviews took place approximately every ten weeks. There was also an element of participant observation when the researcher attended an interpersonal skills module in the second year which had been highlighted as having been influential in their development. In her work, Clouder (2003) discussed the role of individual agency within professional socialisation and identified two major ways in which students orchestrate this by *'learning to play the game'* and '*presentation of self'* (p217). Being able to navigate the explicit and implicit rules of the workplace presented a challenge for the students who developed two main strategies *'putting up with things'* and *'not rocking the boat'* (p217). Recognising the existing hierarchical system and the power relationships in the workplace was also vitally important to the students' survival and it seemed that students needed to expend a lot of energy in order to negotiate this.

Students also recognised the need to create the right impression and adopted various behaviours expected of them such as *'looking keen and enthusiastic, avoiding clock watching, being polite and keeping busy'* (ibid, p218). Some students found that the pressure of *'acting a part'* (p219) uncomfortable and often found that they were expected to work above and beyond expectations in order to receive positive feedback and become accepted.

There are also some other interesting concepts discussed as part of this work which outlines three aspects of socialisation; primary which is associated with childhood, secondary which is linked to integration into society and tertiary which is the socialisation into an occupation. This underpins Clouder's argument that professional socialisation is largely a process through which individuals become socially constructed into the environment and are moulded so that they conform to the values, beliefs and norms of that profession. She also states that *'the game' is prescribed by the profession and those who wish to join that profession need to adapt accordingly to gain membership'* (p220). The ability to identify, understand and to *'play the game'* (p217) when newly

qualified can be a stressful time and it is this experience that is rarely captured particularly in radiography.

Sim and Radloff (2009) considered professional socialisation of medical radiation science (MRS) practitioners (radiographers and radiation therapists) in Australia. In their work, they explored three characteristics of professionalism; expansion of professional knowledge, the profile of the MRS profession and the practitioners' willingness to assume increased responsibility. Although the work was undertaken in Australia where there are some differences in the role to that of the UK there are some parallels that can be drawn from this work. A resistance to change in the MRS practitioners was identified alongside a lack of involvement in research and this is something that is also noted in the UK. Also similar is the low profile of the profession and a lack of professional recognition, factors that impact greatly on self-esteem. The authors note that *'as a group we harbour a significant inferiority complex….there is a tendency to de-value our role in the care and treatment of the patient, more so in the diagnostic field than in the therapy field'* (AIR cited in Sim and Radloff, 2009, p205) and this has certainly been my experience since entering the profession in 1991.

The role of the radiographer is governed by protocols and policies and this frequently restricts radiographers' autonomy. As an educator this can often cause tension as the degree course prepares students to critically evaluate their practice but in reality the opportunity to do this is limited, often de-motivating practitioners as they become *'followers'* not *'thinkers'* (Sim cited in Sim and Radloff, 2009, p205). In their work Sim and Radloff (2009), conclude that although MRS practitioners have in the main fulfilled the criteria of a profession the issue of professionalism remains a challenge. They argue that a workplace culture which promotes compliance and breeds apathy and resignation is a barrier to achieving true professional status.

The role of education in professional socialisation is a relatively unexplored area however, it was the focus of a systematic literature review (SLR) by Trede et al., (2012). During their SLR they discussed the intersection of professional

identity between university and work and also the role of the university in professional identity formation. Establishing that both the curriculum and workplace influenced professional identification development, they explored the need for improved communication between the two. There is also an argument for universities to reflect on how they prepare students for the workplace and to question if it is sufficient. In the current employment climate it is essential that students are equipped for a constant shifting professional identity and armed with the skills to manage the continuous changing environment.

It was found in this SLR that universities did not make professional identity development a priority; moreover the drive towards maintaining high professional standards dominated their attention. The learning that takes place in the workplace always overrides the learning at university and there needs to be further research to establish how universities can further contribute to the professional identity development of students. It is suggested that the curriculum needs to be developed so that *'in teaching the knowledge, skills, values and ways of being, lecturers also focus on building in students a sense of being part of or belonging to a community of a certain type of professional'* (ibid, p380). Interprofessional learning could certainly underpin this by introducing the students to differences in professional identity and therefore enabling students to build a picture of the workplace environment and culture.

It can be seen by the studies in this section that being and becoming a professional and professional socialisation are complex processes. The transformation that occurs during this time in the individual is impossible to measure and it will always be a subjective experience. However, we can begin to develop an understanding of the factors that influence this journey and gain an insight into the experiences of newly qualified practitioners and this is explored further in the findings chapters when the participants share their stories.

3.0   METHODOLOGY

3.1   Introduction

This chapter contains a detailed explanation of the chosen methodology and methods utilised for this study. All issues related to the design and management of the research will be explored in-depth and each decision will be justified, with the focus throughout being the research question, aim and objectives.

However, before moving on to the next section in this chapter it is necessary to clarify the phenomenon of interest in this research. From an interpretive phenomenological perspective, phenomenology is based on the principle that reality exists of objects and events (the phenomena) and the way in which they are perceived and understood (Davidsen, 2013). The aim is to study the experience of the phenomenon from a subjective/first person perspective in order to develop our understanding of that experience. In order to do this, the researcher in some way uncovers the world that is experienced by the participants through their '*life world stories'* (Kvale, 2011, p186).

The phenomenon being examined in this study is the 'experience of transition' which is intrinsically linked to the context in which the participant is situated. According to Heidegger (1927) this includes everything that is lived through and performed, including both the conscious and unconscious awareness of that experience. This approach enabled me to access the thoughts, feelings and perceptions of the participants whilst they were in transition. From this, I was able to gain an understanding of the transition period and how this experience facilitated how they each became a diagnostic radiographer in their first year of practice. This ontological approach underpins the philosophy of interpretive phenomenology, and focusses on the link between time and being where being is simply a process of becoming (ibid).

3.2   The position and role of the researcher

In order for me and others to make sense of my research it is essential that I am both aware of and make my philosophical stance on research (and the influence of my role) explicit. A research paradigm is the belief system which guides the researcher and ultimately influences the choice of research question, methodology and subsequent methods to investigate the chosen phenomena (Denzin and Lincoln, 2011). Therefore, as a researcher the use of transparency and reflexivity is vital when considering how I influence the research process and the participants and indeed how the participants influence me (McCabe and Holmes, 2009). Reflexivity is acknowledged as a difficult skill to develop but it is essential in order for the researcher to identify how both subjective and intersubjective elements influence their research (Finlay, 2002). In doing so, Finlay (2003, p5) posits that *'subjectivity in research is transformed from a problem to an opportunity.'* Reflexivity engages researchers in a continuous and dynamic journey, in which researchers develop their self-awareness, thus allowing them to immerse themselves into the research. This enables the investigation of a phenomenon whilst being acutely aware of their own perceptions, experience and interpretations and those of others in the process (Finlay, 2002).

The research paradigm which underpinned this research was influenced by both my belief system and the nature of the research question. The concepts of ontology and epistemology will be explored in more detail so that you the reader will understand my position and the reasons for the paradigms selected as part of the research.

A paradigm is the way in which we view the world and *'it is composed of certain philosophical assumptions that guide and direct thinking and action'* (Mertens, 2010, p7). According to Guba and Lincoln (2005), a paradigm is defined by asking a series of questions which relate to axiology, ontology, epistemology and the methodology.

3.2.1 Axiology

Axiology refers to the values of the researcher and how these influence the research process (Ponterretto, 2005; Denzin and Lincoln, 2011). Positivists reject the notion that values have a place in the research process and that the researcher's values, feeling, expectations or hopes should all be eliminated through the use of rigorous scientific enquiry and by remaining detached from the enquiry (Ponterretto, 2005). The distinction between fact and value and objective and subjective are fundamental to the positivist approach (Crotty, 1998).

In qualitative research, it is recognised and often celebrated that the researcher's values ultimately influence all stages of the research process (Mertens, 2010). Being transparent and reflexive throughout the study is essential if the study is to be credible (ibid). According to Heron (1996), it is important for the researcher to state their personal values at the outset of the study. In doing so this allows the reader to contextualise the methodology, methods, findings and conclusion throughout the research process.

In terms of this research, my values influenced the study from its inception. On reading the minutes of the Heads of Radiography meeting in July 2011, I was perturbed. As an educator and a course leader for an undergraduate diagnostic radiography programme it seemed to me that newly qualified radiographers (some of which may have been former students) were being harshly judged so early in their career. My compassion for others made me question this from their perspective and consider what it might be like for them during the first few months following graduation. The more I read, the more I realised what a stressful time this can potentially be. Deciding to investigate this phenomenon further I began to explore the myriad of qualitative research methodologies and phenomenology as both a philosophical position and as a methodology immediately resonated with some of my core values. I recognised in this approach the emphasis on giving the participant their 'own voice' and a vehicle by which they could share their own lived experience of the transition period. The selection of one-to-one interviews as the method of

data collection is not only commensurate with a phenomenological study but also with my own values and beliefs on the importance of interpersonal interaction with the participant in order to explore this issue in-depth.

3.2.2 Ontology

Ontology is a branch of philosophy which is concerned with the world and the nature of existence (Crotty, 1998). It focusses on the structure of reality and realists believe that a world outside of our consciousness exists (ibid). Therefore, phenomena exist independently of our perceptions or cognitive structures and this reality already exists and is waiting to be discovered. Along the ontological continuum from realism at one extreme lies a multitude of different ontological assumptions. It is at this point, I must acknowledge that my past educational and world experiences once situated me firmly in the realist arena. Being an accomplished mathematician and scientist, I did not feel the need to question the nature of reality. However, over the years and through professional and personal experiences, I have begun to develop a more questioning mind through the cultivation of a more humanistic and holistic approach to my role within healthcare and education, underpinned by my counselling and life coaching experience. As I have continually discovered the subjective nature of experience and perception it has become apparent to me that there is no such thing as a 'true reality' for all. Moreover, that the world we know is in fact created by the engagement and relationship we have with it by experiencing the phenomena within it. Many believe that it is the subjective experience of reality that acknowledges the existence of the world and that through experiencing the world one begins to recognise and appreciate its existence (Crotty, 1998; Walliman, 2011). Therefore, 'truth' is viewed from differing perspectives and acknowledgement is made to multiple realities which are individual and value-bound (Welford et al., 2011). This aligns me within the subjective philosophy of reality and more specifically within the constructivist paradigm, in that reality is multi-faceted and that the goal of the researcher is to understand the multiple meanings for others (Mertens, 2010).

3.2.3 Epistemology

Epistemology refers to the philosophy of knowledge; that is, how do we know what we know? It is way of viewing and understanding the world (Crotty, 1998). Its focus is on exploring the meaning of knowledge, what it means to individuals and who is involved in creating that knowledge (Krauss, 2005; Tuli, 2010). This has caused much debate and divides researchers into different epistemological positions. There are those who believe that knowledge can be sought and gained by scientific explanation, that there are always laws of cause and effect, and from those laws patterns of behaviour can be predicted. This objective approach is commonly known as positivism and tends to link with quantitative methodologies and research methods which produce data that are generalisable to the wider population (Tuli, 2010).

Positivists uphold the belief of one reality and that it is the responsibility of research to uncover that reality (Mertens, 2010). The assumption that there is an objective world which can be represented and measured by the use of scientific methods underpins this paradigm, as those that subscribe to this philosophy believe that methods can be used to establish that there is only one reality (Gephart, 1999). In adopting this approach, positivists separate themselves from the world and study phenomena in an objective and measurable way in pursuit of truth and knowledge. The data collated and their subsequent analysis is thought to be value-free and non-changeable and can thus be used to predict and control the world by proving causal relationships (ibid, 1999). Deductive reasoning is at the heart of this approach where the aim of the research is to test a theory (Nicholls, 2009a). To a large extent, positivism still predominates in health care where there remains the dominance of a medical model and clinical trials, epidemiological surveys, experiments and other quantitative designs which are widespread (ibid).

In contrast, there is the belief by some that knowledge is in fact gained by experience, by the co-construction of knowledge and interpretation of events. This is far removed from positivism and is situated at the other end of the epistemological spectrum. The idea that knowledge can be gained by our

interpretation of the world and this is how meaning exists encompasses interpretivism. In direct contrast to positivism, the interpretivist approach attempts to understand and explain human behaviour and its sense of reality (Crotty, 1998). According to Nicholls (2009a, p530), central to this approach is the attempt to *'understand experience through the eyes of the person experiencing it'*. The focus on the subjective experience of the phenomenon by the individual is at the heart of interpretivism. The search for meanings is aimed at understanding participants' views in their natural context (Gephart, 1999). Therefore, 'truth' is viewed from differing perspectives and acknowledgement is made to multiple realities which are individual and value-bound (Welford et al., 2011). In this case, inductive reasoning is at the heart of the approach where the data are used to develop meanings and not to test a pre-agreed theory. This links with naturalistic inquiry, using qualitative methodologies and methods that seek to understand a phenomenon, and which does not attempt to generalise the findings (Tuli, 2010).

The positivist approach is less successful in studying human behaviour because it believes in the collation of objective knowledge and that facts can be separated from values i.e. it is value-free. Its focus is to explore cause and to be able to use this to develop causal laws and thus predict outcomes (Robson, 2011). This approach as such fails to recognise the complexity of human nature where experience is subjective and facts cannot be separated from values (Cohen et al., 2000). As such, I strongly believe that a patient's lived experience of illness plays a major role in his/her wellbeing and that diagnosis and treatment will not necessarily solve 'the problem' in its entirety (Nicholls, 2009a).

Each individual experience is value bound and informed by our own perceptions (Denzin and Lincoln, 1994; Krauss, 2005). My insatiable interest in people, their experience, their beliefs and values has led me to my chosen research topic, which has been directly influenced by my subjective/relative stance on the nature of reality. It is my experience of counselling and as a life coach which has largely informed this decision. It has however, taken some time and much soul searching to finally balance this with my profession of

diagnostic radiography. Although the acquisition of a radiographic image forms a product which one could argue is 'reality' it is still interpreted by the reporting radiographer or radiologist and thus a subjective opinion is given on what many would see as an objective artefact. This underpins the argument that subjectivity influences everything and that despite the positivists argument, interpretation is present in everything that we do.

3.2.4 Impact of self on the research

It can be seen that the belief I have in the importance of experience and the way that a human makes meaning out of something or from something, encompasses both a subjective/constructivist ontology and an interpretive epistemology. This domain subscribes to the belief that there is a subjective relationship between the 'knower' and the 'known'.

In using the subjective-objective dimension by Burrell and Morgan (1979), it can be seen that my values and beliefs most closely align to the subjective approach to research as illustrated below:

The subjective approach to social science		The objective approach to social science
Nominalism – objects are dependent on the knower for their existence	← Ontology →	Realism – objects have an independent existence
Anti-positivism (interpretivism) – knowledge is subjective, personal and unique	← Epistemology →	Positivism – knowledge is hard, objective and tangible
Voluntarism – human beings are the creator of their environment having free will and control	← Human nature →	Determinism – human beings and their experiences are products of the environment. They are controlled
Idiographic – a research approach designed to understand individual behaviour	← Methodology →	Nomothetic – a research approach defined by procedures and methods to discover general laws

Table 3: The subjective-objective dimension (Burrell and Morgan cited in Cohen et al., 2000, p7)

In applying this subjective-objective dimension (Burrell and Morgan, 1979) to my own research stance, it can be seen that my belief is that objects only exist through their interpretation by others (nominalism) and that all knowledge is subjective, underpinned and influenced by personal experience and therefore unique to each person (anti-positivism). In this study, the phenomenon of transition is explored through interpreting the experience of others and each participant will have his/her own exclusive journey to share. Each journey will be heavily influenced by the environment in which the participants are working and is created by the participants and the radiographers around them (voluntarism). Finally, an idiographic approach to this study has been chosen in order to understand each individual's transition so that this can be shared with the profession.

Although it is acknowledged in qualitative inquiries that researchers will always bring their own pre-conceptions and involvement into their research, reflexivity is essential in order that this is transparent throughout the process (Finlay, 2002). I have several roles which will have influenced this study; the researcher, an educator, a radiographer and a life coach. All of these roles have already in some way influenced the choice of topic for this research as previously discussed, as my interest in people and their experiences underpin the purpose of this study, as does my background in radiography education.

There are also several factors which have undoubtedly had an impact on this research, some of which will be discussed further in conjunction with the ethical considerations of this study. The first one was the expectation I may have had which was that students from the HEI in which the study has taken place leave the university fully prepared for practice; in that I believe that they are sufficiently skilled in order to undertake a band 5 diagnostic radiography post. The second assumption was that little consideration is generally given to the transition period for newly qualified radiographers outside of the skills set required. A review of the healthcare literature has led me to believe that newly qualified practitioners receive little support during this time. These first two assumptions may of course be incorrect, and the findings of the research may well challenge the fundamental beliefs that I currently hold. However,

that is the purpose of this research; to uncover new insights, to challenge pre-conceived ideas and to offer new knowledge that will act as a catalyst for transformation.   For this reason, researchers should always be open to the findings of their research and report them as accurately as possible acknowledging their preconceptions and prejudices throughout.

The third influence for consideration is the changing nature of the relationship between the researcher and the participants. The researcher was no longer a tutor to the participant who was now a qualified practitioner and no longer a student.   I needed to be mindful that the participant may still view me as a teacher. This power relationship could have inhibited the participants from sharing certain information, in case I may be disappointed in them in some way. This needed to be managed carefully as it had implications for the accuracy and authenticity of the data being collected.

Being an insider researcher has both advantages and disadvantages. The advantages are that I already have knowledge of the subject matter, an awareness of the culture of the profession, an established relationship with the participants and I have a good understanding of the profession in which they are entering. Having already addressed some of the disadvantages of being an insider researcher it is notoriously difficult to establish whether or not a researcher's bias can ever be fully known (Freshwater, 2005). However, Mays and Pope (2000), suggest that all personal biases need to be declared at the outset of the research to ensure greater credibility of the findings.

It is for this reason that it is important to be mindful of these biases throughout the research design. The acceptance of an inevitable bias in research underpins the necessity of a reflexive study as a study may only be considered valid and trustworthy if it is free from hidden agenda and that the researcher's bias is transparent throughout (Freshwater, 2005).

The constant call for rigour in qualitative research from those who subscribe to the positivist paradigm has led to much debate. In response, the nature of

trustworthiness is now often referred to in qualitative research as a measure of quality and will be explored in-depth in the methodology section.

3.3   Overview of methodology

In alignment with the epistemological and ontological philosophies underpinning this research, a qualitative study was undertaken. This research aimed to explore a topic about which there is currently little published with regards to radiography and therefore is an inductive and exploratory study which is best suited to a qualitative approach (Ng and White, 2005). Carter and Little (2007) define qualitative research as being reliant on the collation and analysis of textual rather than numerical data.   The fundamental aim of qualitative research is to attempt to understand the meaning of human action by asking open questions rather than aiming to test predetermined hypotheses.

This research did not appear to sit comfortably within a positivist epistemology as this relies on the notion that the relationship between the world and our sense of perception of it is straightforward, impartial and unbiased (Lyons and Coyle, 2007). This research is situated in the epistemological paradigm of interpretivism as it is believed that a positivist approach is unable to address all aspects of a phenomenon. Indeed, the need to explore the experience or meaning of a phenomenon in social and health sciences became an influential factor in the rise of the interpretivist paradigm (Nicholls, 2009a).   The complexity of the world and how it is constructed by individual and social experiences is widely recognised by interpretivists. An interpretive paradigm focuses on how individuals make sense of the social world around them, emphasising the world of lived experience. This fits well with the aim of this research which is to explore the experiences of transition in newly qualified radiographers and how it is to be and become a radiographer and thus a phenomenological methodology was chosen (Robson, 2011).

The focus of the experience of the newly qualified radiographer is congruent with a qualitative methodology which attempts to explore feelings, perceptions

and behaviours of individuals or groups (Cresswell, 2007). It seeks understanding, meaning, belief and opinion about a phenomenon and the research often takes place in the participants' natural environment (Blaxter et al., 2010). The main focus is to describe and interpret the experience of others in order to increase understanding of their experience (Holloway, 1997).

Nicholls (2009b) argues that one research approach is not better than another but that the primary driver for the research approach must be the research question. This is undoubtedly influenced by the underlying interest of the researcher(s) and their theoretical perspective; however it remains that the research approach must be the most appropriate in order to answer the research question. A qualitative approach has been chosen for this study as it is the most suitable way in which to answer the research question and thus fully explore the experience of transition in newly qualified radiographers.

According to Creswell (2007) there are five primary approaches to qualitative research; narrative research/inquiry, phenomenology, grounded theory, ethnography and case study. On closer examination of the research question it is evident that phenomenology is the most appropriate research approach for this study because it sits firmly within the interpretive paradigm and is humanistic in nature (Nicholls, 2009a). The purpose of phenomenology is to *'describe a lived experience of a phenomenon'* (Mapp, 2008, p308) and this is entirely congruent with the purpose of this study. For this research to be meaningful and useful to both educators and practitioners, the phenomenon needs to be explored in such a way that it offers insight and interpretation of the experience. It is for these reasons that a phenomenological approach was selected.

3.4   Phenomenology

Phenomenology is often referred to as philosophy which has been in existence since before the First World War and is defined as the study of structures of experience, or consciousness (Smith, 2016). Historically, before the 17th Century much of what we believed about the world was based on religion and

governed very much by religious authorities at this time. There was a traditional mode of thinking which was based on a system of beliefs theorised by theology. This is commonly referred to as the pre-modern era of research. This period became superseded by what became known as the modern age (also known as positivism) which rejected previous thinking, labelling supernaturalism as ignorance and superstition. It was argued at this time that everything is based on concrete reasoning and is scientifically based. Researchers became focussed on searching for the truth and very much believed in the principle of cause and effect. However, this approach became challenged as researchers began to question if reality could truly be independent of experience. There came a movement which suggested that social events cannot be predicted with the same accuracy as physical events and rejected the reliability and application of objective knowledge to all situations. The onset of the post-modern period began and along with it the birth of qualitative research.

Phenomenology as a branch of qualitative research sits firmly in the subjective paradigm of ontology and in the interpretivist paradigm of epistemology, the founders believing that not everything can be explained by a scientific method and that there is no such thing as an objective truth (Wiercinksi, 2009). Based within the humanistic paradigm and embedded in qualitative research (Denscombe, 2003), its purpose is to describe *'how things are experienced first-hand by those involved'* (ibid, p97). Its focus is on human experience and the subjective experience of a phenomenon, the way things appear to us through our experience of them, often referred to as a *'lived experience'* (Kafle, 2011, p182). It has therefore been chosen as the suitable methodology for this study since it aims to focus on *'people's perceptions of the world in which they live and what it means to them'* (Langdridge, 2007, p11) and in the case of this study this will be their world of diagnostic radiography. Although described as a movement by Spiegelberg (1982), this approach allows the experience to speak for itself, providing a greater meaning of the phenomena.

There are two main phenomenological philosophical stances; Husserlian (transcendental/descriptive) and Heideggerian (interpretive/hermeneutic).

Whilst it is also recognised that there are a range of significant contributions to these two schools of thought e.g. Merleau-Ponty (1962), van Manen (1977) and Gadamer (1982), they all tend to fall into either the descriptive or interpretive domain.

3.4.1 Descriptive Phenomenology

The work of Brentano (1838-1917) focused on what is known as descriptive phenomenology and considered the concept of intentionality. *'Intentionality is the principle that every mental act is related to some object and implies that all perceptions have meaning'* (Dowling, 2007, p132). This principle was further developed by Husserl (1931) who introduced the concept of phenomenological reduction. This purist approach to phenomenology centres on simply describing the experience with use of bracketing to allow the true essence of the lived experience to be captured without contamination. In fact, although Husserl (1931) identified a shortfall in empirical research in being able to study human experience in a meaningful way, he was still heavily influenced by his grounding in scientific research. His development of transcendental phenomenology, attempted to redress this tension and to preserve some form of objectivity to his research, thus assuring academic credibility (McConnell-Henry et al., 2009a). He continued to be driven by his positivist background and his primary focus remained epistemological, in the pursuit of knowledge.

In this form of phenomenology, the researcher is required to describe the experience before it has been reflected upon, presenting the phenomenon free from interpretation or prejudice. Husserl (1931), believed that this was the only way to acquire the essential components of the phenomenon. In asking the researcher to apply such an objective approach to the presentation of the data, it can be argued that it aligns to the positivist paradigm and according to some, adds academic rigour to the methodology (Paley, 2002). There are some that argue that this approach has been misunderstood (Finlay, 2002) however, it is my belief that this approach remains underpinned by the desire for objectivity, credibility and reliability. The requirement of this approach for

the researcher to in some way suspend their personal beliefs about the topic that they are researching presents this approach with its largest challenge (Robinson, 2000). My belief is that this is not entirely feasible because unless all unconscious thoughts become conscious ones, they will still be influencing the researcher to some extent during the process. During the study, it maybe that the researcher is unaware of these influences and therefore be unable to bracket appropriately thus not achieving the level of objectivity that Husserl aspired to and only partial reduction may be achieved. The lack of recognition that Husserl had of the influence of the unconscious part of the mind and the belief that only consciousness attributed to the real truth is a fundamental weakness to this approach. It is for these reasons that this approach was not adopted either as a philosophy or a methodology as it is not congruent with the researcher's beliefs and will not allow the depth of data to be collated and interpreted.

3.4.2 Interpretive Phenomenology

In contrast to transcendental phenomenology, is the school of interpretive phenomenology. The birth of interpretive phenomenology is largely attributed to the work of Heidegger (1962), previously an assistant and protégé of Husserl who was supported and guided by Husserl for a brief period of time. Whilst still appreciating the underpinning philosophy of his teacher and the importance of description, Heidegger moved the discipline of phenomenology into a new era, that of interpretive/hermeneutic phenomenology. Ontologically, Heidegger's focus was to discover the meaning of being, and what it means to exist; or existence.

The practice of hermeneutics is to interpret and understand texts and historically originated as a method for studying theological scriptures (McConnell-Henry et al., 2009b). Heidegger used hermeneutics as a basis to study human activities in detail, the aim being to describe and interpret phenomena. This approach allows the discovery of the ontological experience of the participant (McConnell-Henry et al., 2009a). Focussing on the meaning of being, Heidegger believed that the only way the researcher could fully

explore the lived experience was to have some prior knowledge of the topic in order to ensure that pertinent questions were asked. Underpinning this philosophy was the focus on discovering the *'subjective, humanistic meaning of an experience'* (McConnell-Henry et al., 2009b, p4) and to this end, *'enter the world of the person and interpret the meaning they assign to the experience'* (ibid). In opposition to the concept of intentionality, Heidegger coined the concept of *Dasein*. *Dasein* is essentially what it 'means to be' or as he termed it *'being in the world'* (McConnell-Henry et al., 2009b, p9).

The purpose of phenomenology in this case is not only to describe the experience but also to discover the meaning of being in the experience/context. The acknowledgement that all human beings are completely immersed in their world and that context has a major influence on their experience of the world and thus their existence is fundamental to Heidegger's philosophy.

The principle that the researcher is as much a part of the research as the participants is also central to this approach, making reflexivity essential. Heidegger argued that it is impossible to undertake research free of the judgement or influence of the researcher. This belief has been challenged by many researchers as they feel that this introduces the nature of researcher bias into the study. It is therefore imperative that the researcher makes their underpinning philosophy known at the outset in order that the reader is informed and that transparency is assured.

The work of Hans-Georg Gadamer (1900-2002) and van Manen have also been influential to this study. Although Gadamer was said to have been profoundly influenced by both Husserl and Heidegger, his beliefs were much more aligned to those of Heidegger as were van Manen's. Gadamer argued that the key to human existence is understanding and that conversations (speech) are the way in which we as humans gain understanding. Thus conversation is the mechanism through which understanding can be achieved (Gadamer, 2013). According to Gadamer, the use of language in the conversations plays an essential part and influences our understanding of

'being in the world' (McConnell-Henry et al., 2009b, p9).   It is the process of conversation that brings about a common understanding of a phenomenon and in doing so increases self-awareness. Furthermore, he argues that language can never be free from bias because it is continually influenced by the culture and value system in which it is placed (ibid). In my interviews I was mindful of this and tried to create an environment where the participants felt comfortable to share their feelings and experiences.   Establishing a relationship with the participants which *'ensures an atmosphere of trust, acceptance and mutual respect'* was essential to the successful facilitation of the interviews (Taylor, 2005, p42).   Thus the interviews became more of a conversation which used a common language underpinning a shared understanding between the participant and the researcher.   This is often referred to as the *'fusion of horizons'* and was fundamental to the approach taken in this thesis (ibid). Gadamer believes that an individual's '*horizon'* is what they can currently see or understand. During an interaction, we learn to look beyond this in order to see it in more detail and through discussion and exchange of ideas and experiences we are moved to a new horizon which is formed by a combination of the old and the new understanding.   Therefore, we need to recognise that the present cannot be formed without the past and they co-exist and fuse to form our understanding of a certain phenomenon (ibid).

Both van Manen and Gadamer agreed with Heidegger and acknowledged that in reaching an understanding of a particular phenomenon, researchers must develop their self-awareness and demonstrate a level of reflexivity.   They argue that being open to prior assumptions and prejudices is an essential part of interpretive phenomenology and it is this that grounds our understanding and experience (van Manen, 1998; Gadamer, 2013). Both therefore reject the notion of phenomenological reduction and bracketing, claiming that is only through our pre-understanding of the world that we can reach an increased understanding (Moran, 2000). This supports my subjectivist stance; the reason why earlier in the chapter I set out my position as a researcher at the outset.

The research question will attempt to explore the experience of transition from student to practitioner in diagnostic radiography and in particular focuses on being and becoming a radiographer. An interpretive phenomenology is fully commensurate with not only the purpose of this research but also the ontological and epistemological stance of the researcher and was therefore chosen as the preferred methodology.

3.5   Research Design

This research was a longitudinal, qualitative prospective study in that data were collected from a group of individuals at regular intervals over a specified period of time (Cohen et al., 2000). In this case the data were collated from the participants during their first twelve months in a band five diagnostic radiography post. It has been recognised in several studies that the period of transition from student to practitioner can be a challenging time (Maben and Macleod Clark, 1998; Aldermann, 1999; Charnley, 1999; Martin and Wilson, 2011).   Although there is no specific time period associated with transition, studies indicate that the first twelve months is the most stressful and when most learning occurs for the novice practitioner (ibid).   It is for this reason that data collection was undertaken over a twelve month period to ensure that all meaningful data related to the phenomenon was collated.

The participants remained the same for the duration of the study (consent dependent), often referred to as a cohort study (Cohen et al., 2000; Gravetter and Forzano, 2011). The ongoing collation of data from the participants whilst they are experiencing the transition from student to radiographer defines this as a prospective study. Kumar (2005), posits that a longitudinal prospective study allows the researcher to collate the data on the same individuals at timed intervals in order to examine any change or identify any relationship between variables. Although this approach ensured that the data collated were current and relevant to the study, it is a time consuming and often expensive approach. However, it is acknowledged that it did depend on the participants having to recall retrospective information that within the period of twelve

months and as such provided relevant and exact data in terms of recall. It is recognised that the advantage of collating real time data may be disadvantaged by sample mortality in that this approach requires a certain level of commitment from the participants and an interest in the research will need to be maintained (Cohen et al., 2000). This was a challenge that needed further consideration as it influenced the recruitment and selection of the participants. This will be discussed in more depth further on in this section. The other strength of the prospective approach is that because it is based in the future, it attempts to establish the likely occurrence of a phenomenon, problem or situation (Kumar, 2005). This allowed me to explore current feelings and experiences related to transition as they happened. The researcher can also to some extent plan and control the data collection, ensuring the relevance and appropriateness of the data (Friedmann, 2004).

3.6   Recruitment and Selection of Participants

The sampling strategy utilised took into account the potential participant dropout rate as sample attrition rates are a commonly associated problem with longitudinal studies (Robson, 2011). In order to address this, the participants were well informed with regard to the purpose of the study and the level of commitment that was required from them as participants was emphasised. It was important that they understood the advantages to both them, their colleagues and their profession in taking part in the study. One of the advantages I considered for the participants taking part lies in the support network received via the possible therapeutic nature of the interviews. Although it is recognised that this is not a supervision session akin to those used in nursing and midwifery, it could be said that being given time to reflect on their experiences in a safe environment away from practice may have allowed them to consider a different perspective and help them to develop strategies for coping in their new role more effectively. Having the time to talk about their experiences may have also reduced anxiety and stress levels thus helping them to develop more resilience. However, measures were put in place as discussed later in the chapter in case the opposite occurred and that talking through the experiences made them become more fretful. Taking part

also gave them opportunities for continuing professional development (CPD) which they can evidence as part of their CPD portfolios in line with the standards required by the HCPC (2013). Finally, it will have given them the opportunity to be involved in a piece of primary research which will in the future shape their profession in some way.

It was essential that the adopted sampling strategy for this study ensured that all participants had the knowledge and experience of the transition period. Cohen et al. (2000), outline four key factors for consideration; the sample size; the representativeness and parameters of the sample; access to the sample and the sample strategy to be used. According to Cresswell (2007) there is a narrow range of qualitative sampling strategies that can be used in qualitative research. However, only a few of them are directly applicable to phenomenological studies. Due to the in-depth exploration of the individual experience, Smith & Osborn (2008) recommend using small sample sizes. On further examination of the strategies a combination of purposive and criterion sampling was adopted for this study. The combination of these sampling methods were utilised to recruit and then select between 6-10 participants. This approach allowed the retrieval of rich and meaningful data allowing the researcher to take an insider's perspective due to the prior knowledge and experience of radiography and knowing the participants (Pringle et al., 2011).

Purposive sampling is considered by some researchers as being less credible than other forms of sampling due to the findings not being generalisable to the wider population. However, this has less impact on this study due the fact that phenomenological studies do not aim to generalise their findings but anticipate that the readers in some way will resonate with the outcomes. This sampling strategy allowed ease of access to potential participants as recommended by Gravetter and Forzano (2011) and in a phenomenological study where there is a small number of participants, it enabled the researcher to select relevant people to take part in the study who have a good knowledge of the phenomenon being investigated. This allowed the researcher to explore the topic in-depth and gain a good insight into the experience of role transition as discussed by Denscombe (2003) and Nicholls (2009c). Each participant also

had to meet the criteria set out in the inclusion criteria and thus a combination of the two strategies was used.

Following all ethical approval policies, I undertook a short training session with the diagnostic radiography practice educators at each placement site. The practice educators were chosen as independent information givers as the students were now out on placement. The training session provided an overview of the study and empowered them with enough knowledge of the study so that they could assist in the recruitment of participants. Each practice educator was provided with a PowerPoint presentation which outlined the purpose of the study which they presented to their group of students. At the end of the session they gave each student an information sheet which outlined the aim of the research for them to take away and read and then decide whether or not to participate in the study (Appendix VI). Any students interested in taking part in the study were then asked to email a named teaching colleague from the School of Nursing and Midwifery (the gatekeeper) to express their intention to take part in the study. The gatekeeper kept each radiography student's details confidential until such a time that all assessment had been undertaken and the students' marks had been ratified. At this point the students then became recent graduates. During this period of time, the nursing lecturer only informed me of the level of interest to allow for further methods of encouragement to be used including follow up emails to the year group and announcements on the Blackboard Learning System. The Blackboard Learning System is the virtual learning environment and course management system currently used by the university and for the purpose of this study it offered an ideal platform with which to directly communicate with the 3rd year diagnostic radiography students. The announcement function allowed me to post up an invitation to participate in the study followed by two reminders. The generic way in which this announcement system functions meant that there was no coercion merely an open invitation with a reminder for interested parties to contact the gatekeeper if wishing to be considered for the study.

Once all the assessment process had been finalised, the details of all potential participants were forwarded to me by the gatekeeper. The following inclusion and exclusion criteria were then applied:

Inclusion criteria	Exclusion criteria
Students who graduated with a BSc (Hons) Diagnostic Radiography degree from the HEI in June 2013 Students who gained employment in a NHS Hospital Trust that was not their placement site during their degree course	Students who gained employment in a NHS Hospital Trust for a period of less than 1 year

Table 4: Participant inclusion and exclusion criteria

There were 10 potential participants following the application of both the inclusion and exclusion criteria, which met the target number. Once these were finalised, the researcher contacted them to make arrangements regarding the study. Out of the 10 potential participants, 9 responded to the initial e-mail and committed to take part in the research.

3.7   Research Methods

Three research methods were considered as part of this study; focus groups, participant observation and interviews. Focus groups are commonly utilised in qualitative research where the researcher elicits the thoughts of the participants about a particular issue/topic through the form of a group interview (Cohen et al., 2000). They usually consist of a group of 8-12 participants that are brought together by the researcher and last 1-2 hours. They can be either structured or semi-structured and are thought to be most useful when interaction between the participants is thought to yield meaningful data (Cresswell, 2007). Focus groups are considered most useful when exploring new areas of research to gain a broad picture of how particular groups perceive an issues/topic (Denscombe, 2010). They are certainly less time consuming and more cost effective than both participant observation and one-to–one interviews (Holloway and Wheeler, 2015) but have certain

disadvantages in relation to this study. Firstly, the purpose of the study is to discover the personal lived experience of each participant and it is unlikely that this will be achieved by using this approach as each experience will be very individual. Secondly, the group dynamics may prove a disadvantage in that a participant may feel reluctant to contribute to the discussion, particularly if their experience has been very different to the others in the group (Bowling and Ebrahim, 2005). Often, the conversation can be dominated by stronger personalities and others may be compliant, therefore biasing the results (Holloway and Wheeler, 2015). It is for these reasons that focus groups are rarely used as part of a phenomenological study and were not chosen for use in this research.

Participant observation is often associated with naturalistic, qualitative inquiry (Finlay, 2011). It involves the researcher entering the field and undertaking the research on site. This allows the researcher to make observations in order to develop an insight into and understanding of the phenomena. This approach is commonly used as part of ethnographic studies where the interaction as part of a group is an important part of the study. Although participant observation is acknowledged as an effective way to collate data in a practice-based profession (Kennedy, 1999), it must be the most appropriate way to answer the research question. In using this method, I would have been able to observe the behaviour and decision-making skills of the newly qualified radiographers (ibid). However, I would have gleaned very limited information about their feelings and perceptions during their transition using this method. Logistically, it would have also been problematic as I have identified the twelve months as being a crucial time for the newly qualified practitioner and the feasibility of entering the field for this length of time to observe more than one participant would have been unmanageable. Access to the field is also a challenge and as I did not want the employing Trust to beware of the study due to the potential of the 'Hawthorne effect' in that the hospital Trust may have altered their standard practice of managing newly qualified radiographers in response to my ongoing study (Adair, 1984). Overall, it would be impossible to collect any meaningful data of their experience using observation and

despite other arguments it is for this reason in particular that participant observation was not chosen as the research method for this study.

Two of out the three potential methods have been discounted therefore leaving interviews as the chosen research method for this study. The following section discusses the justification for this choice and outlines the purpose and management of the interviews in detail.

3.7.1 Interviews

In line with other phenomenological studies, the data were collected in the form of interviews. According to Taylor (2005), interviews are the most common form of data collection for qualitative research and allow the researcher insight into the participants' understanding and experiences of the phenomenon. This form of data collection allows the exploration of complex and subtle phenomena and provides insight into opinions, feeling and experiences (Denscombe, 2003). Broadly speaking, there are three types of interviews; structured, semi-structured and unstructured (Bell, 2010). Smith & Osborne (2008), suggest that many phenomenological studies have used semi-structured interviews and these formed part of the data collection method due to their flexibility and some element of researcher control. This allowed me to use open ended questions to explore the phenomenon in detail but also offered the flexibility to probe the participant if further understanding or clarification was needed as recommended by Denscombe (2003). This is a distinct advantage in that complex issues often need further exploration by the interviewer (Bowling, 2002).

Three interviews were undertaken with each participant; at three months, six months and twelve months post qualification. These time intervals have been chosen for the following reasons:

- The first three months as a new practitioner has been pinpointed as a crucial time as they are required to *'hit the floor running'* and to adapt quickly to a new, dynamic working environment (Decker, 2009, p77). It

is therefore essential that this initial experience and the associated feelings were captured at this time.

- A study by Smith and Pilling (2007) which examined the effectiveness of an allied health programme in supporting the transition from student to professional found that participation was at its maximum at between the first four to six months. There was an obvious drop-off after the six month period which seems to indicate a change in the novice at this point. It is for this reason that an interview was undertaken at six months to explore any changes in experience and associated feelings.

- The twelve month interview was chosen for two reasons. The first was to enable the practitioners to reflect on their experience over the whole of their first year as a newly qualified radiographer and thus identify positive and challenging experiences and feelings. The second reason was to use this interview as a way of looking forward and to bring closure to the relationship between the participant, the research and the researcher.

Each interview was audio recorded, allowing a permanent record of the interview to be kept for the length of the study, enabling the researcher to revisit the data as many times as necessary in order to analyse the data (Denscombe, 2003). The questions used at the three month interview can be found in Appendix VII and an example interview schedule for a six month interview can be found in Appendix VIII. The twelve month interviews were theme board led and therefore there is no schedule available.

3.7.1.1   Three month interviews

The three month interviews were undertaken with the nine participants between the 12th October 2013 and the 9th January 2014. The large time span was due to the wide range of start dates for each participant in their first post and each date was set at three months from this date. All interviews were

conducted face-to-face and at either the participant's home or at an agreed meeting place near to the HEI. The length of the interview varied from 35-65 minutes with some participants needing more prompting than others.

Prior to these interviews, I undertook two practice interviews with radiography students entering their 2nd year. Some of the questions used were similar to those outlined in Appendix VII as the purpose of the interview was to ask them to reflect on their practice placement experience during their 1st year. This allowed me to practice my questioning and probing techniques such as gaining feedback on my non-verbal body language including eye contact and to trial the technology with regards to the digital audio recorder. It proved to be a valuable exercise and also gave me an insight into how much time to allow for responses, to become comfortable with pauses and an overall indication of how long each interview may take.

The interview began with an open question which allowed the participant to talk freely about their experience to date. Following this, the Peaks and Troughs graph (discussed in section 3.8.2) was used to explore their experience in more detail by looking at their feelings and what it is that contributed to those feelings whether negative or positive. This allowed me to probe in more depth regarding some of the issues that were raised and I was also able to interlink this with some of the semi-structured interview questions in Appendix VII.

On reflection, I feel that some of the interviews went better than others and this often depended on how open the participant was and how much they had to say. Those participants that needed more probing were at times challenging as they gave short answers with little elaboration and when listening back over the interviews and on reading the transcripts there are times when my questions may have been leading to help them provide fuller details. However, my confidence grew throughout the study and I felt more able to trust in the process as the interviews progressed.

3.7.1.2 Six month interviews

The six month interviews were undertaken with the nine participants between the 18th January 2014 and the 17th March 2014. Again, the large time span was due to the wide range of start dates for each participant in their first post and each date was set at six months from this date. Eight of the interviews were conducted face-to-face and one via Skype due to participant work commitments. The use of the Skype interview allowed more flexibility in terms of timing of the interview and allowed the participant to still be interviewed in the comfort of their own home (Lo Lacono et al., 2016). It was still possible to build up a rapport with the participant as with the other interviews as it was in essence still a face-to-face interview. This may not have been the case if telephone interview had been utilised (Deakin and Wakefield, 2013). Generally, the interviews were shorter than the three month interviews with the length varying from 35-65 minutes.

In preparation for these interviews some initial analysis of the three month interviews was undertaken from which some themes were identified. Not all the themes identified were common across all participants so the initial analysis was used to formulate some questions for the semi-structured interview and these were done on an individual basis. This allowed me to explore some of the individual issues in more depth and to also use the six month interview to check out my interpretation of the meaning of the participant's responses in the three month interview.

I feel that overall these interviews went better than the three month interviews. I felt much more confident at probing the participants and also staying with the silences that often occur in this type of data collection. I was also pleased to be able to share my interpretations with each participant and found that they were able to validate the meanings that I had made from their responses at the three month interview stage.

3.7.1.3 Twelve month interviews

The twelve month interviews were undertaken with the nine participants between the 27th July 2014 and the 10th December 2014. The large time span was again due to the wide range of start dates for each participant in their first post but also had to be negotiated around working hours and these were much more problematic to arrange than previous sets of interviews for that reason. All interviews were conducted face-to face with the length varying from 23-56 minutes.

In preparation for these interviews both the three month and six month interviews had been read and some initial analysis undertaken. This provided me with some previous knowledge and understanding that I could use when listening to the participants explaining their theme board allowing me to explore any issues with them further when necessary.

The quality of the theme boards presented was variable and some participants had provided an extensive range of images. When talking through their boards each participant took time to reflect over the last twelve months, often revisiting and reinforcing feelings and experiences previously discussed. It also gave each graduate the opportunity to focus the interview and also look to the future. As previously discussed this was the final interview and therefore the last time I was to meet in this format with each participant. I remember feeling rather sad at the end of each interview as the feeling of closure dawned upon me. It was also a time to thank each participant for taking part in my study and for the time that they had given up. I was fortunate to retain all nine participants for the duration of the study which I feel is a real strength of this research and I am extremely grateful to the participants for their continued commitment and support.

3.7.2 Associated data collection methods

In order to maximise the effectiveness of the interviews as the primary data collection method, two associated data collection tools were used at two

different time intervals in order to complement and inform the semi-structured interviews.

There is much evidence to suggest that people learn in a variety of ways. Various inventories have been formulated in an attempt to understand how these learning styles affect the way in which both children and adults experience and interpret a learning situation (Fleming and Mills, 1992). It is for this reason that two associated data collection tools were utilised as part of this research. Using VARK (Fleming, 1987) which identifies four different learning styles; visual, auditory (aural), read (write) and kinaesthetic, the purpose of the two additional data collection tools was to ensure inclusivity to a range of learners and thus participants. It was hoped that by utilising these additional data collection tools that there would not be sole reliance on the verbal interview and the participants would be encouraged to use visual methods to aid their reflection. This allowed the participants to process and reflect on their experiences using both the visual and kinaesthetic learning styles in addition to the auditory domain and will in turn increase the quality of data collected.

The two associated data collection tools used were:

- Peaks and Troughs graph (Appendix IX). This was adapted from the graph developed by Bourner et al. (undated cited on http://www.jimsimpsonconsultancy.co.uk). This was used by the participants to record their experiences and feelings in the first three months in post. The information recorded was utilised to guide the questions for the initial interview at the three month time interval.

- A theme board (Bligh, 1992). Participants were asked to complete a theme board to bring to the final interview at the twelve month stage. It was anticipated that this would be a representation of their journey during the first twelve months in post and again formed a basis for the themes discussed at this interview.

3.7.2.1 Peaks and Troughs Graph

The Peaks and Troughs graph was used as a way of encouraging the participants to reflect on their experiences over a specific time period. It is attributed to the work of Bourner et al. (undated) who utilised this tool primarily as a self-assessment exercise as part of the process of personal development planning (http://www.jimsimpsonconsultancy.co.uk). The purpose of this graph was to enable the participant to plot the experience of certain events on a graph and indicate the feelings associated with that experience. The participants of this study were asked to complete a Peaks and Troughs graph every day for each week during their first three months in post (Appendix IX). It was anticipated that this would capture the early experiences and the associated feelings during this time. The first three months has been identified as a stressful time for those in transition from student to practitioner (Gerrish, 2000; Tryssenaar and Perkins, 2001; Mooney, 2007; Boychuk Duchscher, 2008; Decker, 2009; Black et al., 2019 and Fenwick et al., 2012) and it is therefore essential that this raw data is collated as near to the events as possible in a way that is both simple to complete but also fully inclusive. The participant was asked to bring the graphs with them to first interview in order that the contents can be used as part of the interview to explore their experiences in more depth.

This approach seemed to work well in that it captured some of the feelings early on that may well have been forgotten. At times I had to be careful that it did not result in the interview becoming too mechanistic and focussing on the minutiae. However, overall I think that it worked well in helping the participants to reflect on their early experiences and then analyse how they were feeling at that time.

3.7.2.2 Theme Boards

The use of imagery is a powerful way to encourage the reflection and evaluation of past events. However, the use of image work in qualitative research has been relatively underutilised particularly in health sciences until

the last six years or so where it seems to have developed some interest (Edgar, 1999; Leavy, 2009). According to Leavy (2009), the nature of qualitative research is that meaning is derived from an iterative process and there is a close relationship between interpretation and analysis. Using a visual/arts method allowed the researcher to encourage the participants to explore their experiences and feelings in a holistic way and represent them as a theme board at the end of their first year.

A theme board is used to capture experience, ideas, and moods thus enabling the person constructing the board to in some way crystallise these (Bligh, 1992). It is thought to be a powerful tool that can be used to convey messages behind the images and can be effectively utilised as a permanent record of a journey on which to reflect but also a visual reminder of future goals and aspirations (ibid). In this way it was hoped that this method would access data that may be missed by a traditional qualitative interview as by referring to the theme board during the final interview the images should trigger memories of and feelings about experiences that may otherwise be forgotten (Leavy, 2009). The process of creating the theme board itself should also encourage the participants to give further consideration to issues than they would have done initially (Bligh, 1992). The subsequent interpretation of the images on the theme board by the participants during the final interview therefore played a significant part in the data collection process. A copy of the guidance provided to each participant can be found in Appendix X.

3.8   Issues of Rigour

Trustworthiness is not inherent in research but relies on a sound methodology and rigorous data analysis, ensuring that its findings represent the participants' experiences as closely as possible (Murphy and Yielder, 2010). Murphy and Yielder (2010) and Rolfe (2006) also suggest that trustworthiness of a study is to some extent in the eyes of the beholder e.g. the reader but undoubtedly influenced by their experiences of the phenomenon and professional knowledge.

Lincoln and Guba (1985) divide 'trustworthiness' into four aspects; credibility, transferability, dependability and confirmability. The meaning and the way in which these four aspects were addressed as part of this study is illustrated in the table below and has been adapted from Krefting (1991).

Aspect	Meaning	How it was addressed
Credibility	The ability of the researcher to represent the experiences of the participants.	Effective use of the data from the Peaks and Troughs graph and the theme board to allow good design of the interview questions Considered description and interpretation of the human experience that would be recognised by others sharing that experience Checking interpretation of the interview transcripts with the participants in the following interview
Transferability	The transferability of the findings into contexts outside the study.	Presentation of the data in a detailed way to allow others to make comparisons to their own practice - use of detailed thematic analysis.
Dependability	Variation in experience so an audit trail is necessary to track how this was collated.	Dense description of the methodology, including data collection, analysis and interpretation. This allows an audit trail of the decision making process.
Confirmability	The degree to which the findings may be collaborated or confirmed by others taking subjectivity or bias into consideration. Increasing the worth of the findings by decreasing the distance between the researcher and the participants.	A longitudinal study with each participant being interviewed three times. Developing a good rapport between the researcher and the participants with the interviews being enhanced with the use of two additional data collection tools.

Table 5: The four aspects of trustworthiness (Adapted from Krefting, 1991)

It is anticipated that by using the framework above it is evident that I have addressed the four aspects of trustworthiness. In the design of my study I have paid attention to the methodological issues and data collection tools in order to ensure that this study is rigorous. The use of transparency and

reflexivity throughout enables you as the reader to contextualise my decision-making and understand how and why each choice has been made. If you, as the reader judge that this research has been well managed and is systematic, that you find my interpretations plausible and the findings resonate with you then I am satisfied that I have demonstrated rigour in this study in line with Finlay (2006) and Finlay and Evans (2009).

3.9   Data analysis and interpretation

The analysis of qualitative data presents researchers with a challenging task, especially those that are relatively inexperienced in this area.   Nine participants took part in the study and therefore there were twenty seven interviews to transcribe and analyse. This was a vast amount of data and therefore a systematic approach to data analysis was necessary.

Transcribing the data was a very time consuming process and in reality it took far longer than the length of the actual collection of the data as proposed by Denscombe (2003). Gilham (2005 p123-4), sets out some basic rules for transcribing; *'do not let the tapes accumulate; transcribe as soon as possible after the interview; ideally transcribe the day after the interview; be realistic about the time the transcription will take; don't spend more than an hour at a time on transcription, clearly identify tapes and transcripts'.* Initially, I intended to transcribe each interview myself, however, this proved to be far too onerous and therefore a transcriber was employed, with a confidentiality agreement put in place. Once the initial transcript was completed, it was checked against the audio recording for accuracy. This was the first step in enabling me to familiarise myself with the data. In a sense this was a process of interpretation and required excellent listening skills to ensure that nothing was missed (Gilham, 2005).   It also allowed me to begin to develop a sense of understanding of the meaning of what had been said (Kvale, 1996).

Once the process of transcription had taken place, data analysis followed in the form of thematic analysis. Thematic analysis was utilised to ensure that there was a thorough examination of each individual experience,

commonalities and relationships, including the identification of differences across the participants (Gibson and Brown, 2009). Although it is recognised that this is a more structured approach than is often used in phenomenological studies it is a somewhat flexible method (Braun and Clarke, 2006). The purpose of thematic analysis is to identify, analyse and seek patterns (known as themes) within data sets. It allows an in-depth interpretation of the data and also the detailed examination of relationships alongside a particular phenomenon (ibid). Thematic analysis is an inductive process which enables the researcher to discover meaning and understanding of a phenomenon through the data. Driven by the data, the researcher may then offer an insight or theoretical understanding of the phenomenon through careful data analysis (Nicholls, 2009b).

It was essential during the data analysis stage that my epistemological and ontological position, values and beliefs and role within the research were acknowledged. This is because any interpretation and analysis of the data would have been heavily influenced by these. It is essential that the process of data analysis was clearly explained and that the framework and methods used were transparent.   For the purpose of this research the process of thematic analysis was undertaken using the framework devised by Braun and Clarke (2006) (see Table 6).

Phase	Description of the process
1. Familiarising yourself with the data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating the data relevant to each code.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes	Checking if the themes work in relation to the coded extracts (level 1) and the entire data (level 2), generating a 'thematic map' of the analysis.
5. Defining and naming themes	On-going analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Table 6: Phases of thematic analysis (Braun and Clarke, 2006, p87)

Using this framework, each interview was analysed and themes identified. The themes were then compared across a range of data sets to allow comparisons to be made and from this a thematic map was be developed. This allowed an in-depth analysis of each individual experience and also allowed common themes to be drawn from the data, allowing insight into the phenomenon being explored.

Although it is recognised that thematic analysis is a straightforward process there are often vast quantities of data to be analysed and there are several pitfalls that need to be avoided. In order to ensure that the process is optimal a 15-point checklist formulated by Braun and Clarke (2006) was used as a guide to ensure that a methodical approach was followed during the data analysis. This can be found in Appendix XI.

3.9.1 Analysis of the interviews

The data analysis began following the three month interviews of which there were nine, lasting between 37 minutes and 1 hour 2 minutes. Each interview was listened to in its entirety before transcription to allow me space and time

to reflect on the interview. Once transcribed, the tape was again listened to and the transcription checked for accuracy. These two processes allowed me to familiarise myself with the data and I began to note down some initial thoughts and ideas. These were then compared to the notes that I made immediately following the interviews which I used to record my overriding feeling and impressions once the interview had finished.

The transcript was then read again and on second reading I began to identify interesting or important properties within the data. I made note of these by writing notes in the text and in the margin and underlined direct quotations for possible use relating to each code. I did this for each of the transcripts on an individual basis and began to notice some commonalities within and across each transcript from which the themes began to develop.

An example of initial coding link to the overarching theme can be seen below with key phrases highlighted in yellow:

Interview transcript	Initial codes	Theme
James: 'Well I would say it's been an absolute whirlwind of ups and downs and err it's been very exciting but erm you certainly are sort of thrown in at the deep end and err from my experience I mean within a couple of weeks, within my first day it was literally like right this is the kit, use it, go and X-ray'	Reality hits	Being supported
Gareth: '… I was really pleased with the amount of support I got. But, I found myself out of my depth on many occasions. And I still find myself out of my depth on many occasions'	Reality hits Support from colleagues	
Adam: 'The induction programme at X and Y is really elongated. Like erm, I started off in generals, then we went to theatre. And we had a good five three week blocks in each area. So, it's a really thorough training period and I'm still in my induction period three months in'	Structured support	
Charlotte: "….but I think the way the department I work in works, everyone is really supportive. Err which is good, but at times, people forget that you're newly qualified erm, so I think sometimes you get a bit lost and they think you've been doing it for years, and they kind of let you get on with it. And you stand there like 'I don't know what I'm doing!. I need someone to help me!' and no one's there to help you"	Reality hits Support from colleagues	

Harry: 'Yeah, because they've been hiring people, they have been short of staff, so they have been taking quite a few people when I started, which was a big bonus actually because there was a couple of us new, and we just sort of stuck together.	Peer support	
Adam: 'We all sort of chip in and help each other'	Peer support	

Table 7: An example of the initial coding linked to the theme being supported

The next stage was to produce a thematic map (Appendix XII) which allowed me to see how the codes and themes were related allowing me to have an overview of the data and identify any significant themes at this time. The transcripts were then re-read whilst referring to the mind map to ensure that it captured all the essential information. There is a copy of the three, six and twelve interview transcripts with participant Ben, accompanied by his theme board in Appendix XIII.

This process was followed again for the six and twelve month interviews. The six month interviews lasted between 30 minutes and 1 hour 5 minutes and the twelve month interviews lasted between 27 minutes and 56 minutes. Once all the coding was completed and the main themes and sub-themes identified a final version was developed and can be found in the next chapter. It became evident during the process that there would evitably be some overlap between the themes due to the holistic experience of transition. This will be acknowledged throughout the discussion of the findings.

3.10 Ethical considerations

Research ethics refers to a set of guidelines which underpin the decisions and actions of the researcher (Fouka and Mantzorou, 2011). It is recognised that almost all types of research involve human subjects to some degree or another

and therefore will generate some form of risk. Therefore, it is the responsibility of researchers to introduce safeguards in their research design to minimise risks wherever possible and to conduct a morally acceptable piece of research.

The history of medical ethics can be traced back to ancient Greece, however, it is the events of the Second World War (WWII) which had the most notable impact on the ethical principles of research. It was discovered at the end of WWII that experiments had been carried out by Japanese, American and German researchers on prisoners (of war) (Robson, 2011). It was the medical experiments undertaken in Nazi concentration camps which caused most outrage and in 1946 many were tried for crimes against humanity in Nuremberg. The most well-known American research experiment was that of the Tuskegee study which examined the condition of syphilis using African-Americans who were denied treatment and were also misled about the nature and purpose of the research (Tzamaloukas et al., 2008).

Following the Nuremberg trial, the Nuremberg Code (US, 1949) was produced which consists of ten moral commandments relating to research. These were used by the judges during the trial and were adopted as best practice. The code focuses on informed consent, the right to withdraw from a piece of research, protection from harm (physical and mental) and also emphasised the risk-benefit balance (Fouka and Mantzorou, 2011). In 1964, the World Health Organisation (WHO) produced the Declaration of Helsinki (updated in 2008) which provides ethical principles upon which research should be based. Its primary focus is the protection of participant interest but also details the importance of undertaking research with acceptable scientific standards (Ellis, 2010).

In addition, the professional body the Society and College of Radiographers (SCoR) recommends that radiographers should continually undertake research in order to inform evidence based practice within the profession. Their code of conduct states that the interests and confidentiality of

participants must be protected and there should be no misuse or distortion of clinical findings (SCoR, 2008).

In this section, two aspects of research ethics will be discussed. Firstly, the ethical issues that needed consideration in order to underpin this research, illustrating how the methodology has been developed and designed in order to meet these. Secondly, an outline of the ethical processes undertaken in order to gain the appropriate ethical approval from the organisations involved.

3.10.1 Ethical issues

In order to address the ethical issues in this research, reference to the research ethics wheel (REW) by Hammick (1996) has been made in order that reasoned decisions regarding the management of this study have been made (Appendix XIIIV). The REW divides ethical issues into four main areas; principles, duty, outcomes and practicalities and each of these areas will be discussed in relation to this study whilst recognising that there is some overlap between each section.

3.10.1.1 Principles of the research

It is essential that the research has a clear purpose and a justifiable rationale. The outcome of the research needs to be valuable, underpin change and improvement in some way and have relevance within the researcher's profession(s). A clear aim and objectives with a well-designed methodology that is rigorous and trustworthy is required. This has been outlined in the introduction and the methodology has been explained and justified throughout.

Equal respect requires the researcher to treat all participants in the same way. This began at the recruitment stage by ensuring that all potential recruits were given the same information regarding the study. The selection process was fair and transparent, using clear inclusion/exclusion criteria and a detailed sampling strategy as necessary. This was outlined in recruitment and selection of participants section 3.5. Once the participants were recruited, the

process of gaining informed consent must be consistent and the subsequent treatment of each participant must be fair and equal. Attention was also paid to those who did not wish to participate in the study and also those who were excluded in some way. They were all treated with respect and without penalty i.e. that if a student opted not to take part in the study there would be no consequences to this decision and their training would continue as normal.

The researcher must ensure that the participants are given the freedom to make their own decisions. Therefore as part of the information sheet and the consent form it was made clear to all participants that they can withdraw from the study at any time and this will in no way affect their relationship with the researcher or their existing job. Written consent was gained prior to each interview to ensure that the participant was happy to remain in the study. A copy of the consent form can be found in Appendix XV. In terms of the recruitment of participants, the power relationship between the researcher as course leader and the potential participants as students was carefully managed. In order to ensure that coercion was limited in the recruitment of research participants a nursing lecturer as 'gate keeper' was utilised as recommended by Walliman (2011). This was to ensure that students did not feel pressurised in any way to participate in the study and would only do so of their own free will. This also had implications for the management of the relationship within the interviewees as I had to ensure that I was sensitive to the issues of power discussed by Holloway (2005).

In their study, Richards and Emslie (2000) identified the impact that the status of the interviewer had on the information that the participant gave in response to the interview questions, and what they were willing to share as part of the interview. It was found that participants were less likely to share certain opinions and views with the researcher they perceived to be of a higher status. This has obvious implications on the quality of the data collected in this way. Taylor (2005) discussed the nature of power and authority when interviewing her students. She acknowledged that the notion of the tutor being expert can often pressurise a student into giving what they feel is a right or wrong answer. In this case, I needed to be explicit in my role as a researcher and emphasise

that I was no longer their 'tutor'. In doing this I utilised both my counselling skills and my experience as a life coach to build a rapport with the participants. I hope that by making them feel comfortable it gave them the licence to be honest and open and able to share their experiences to a level that provided valuable data. There was also the need for me to be reflexive throughout the process, demonstrating an awareness of self in the relationship (Holloway, 2005).

A critical review of the tape recordings of the interview was crucial to enable me to reflect on my part in the research process. Taylor (2005), recommends that the interviewer should ask the following questions when reviewing the tape recordings:

- Was silence allowed?
- Were cues picked up?
- Were probes used?
- Were the participants given time and opportunity to develop ideas and take the interview in their own directions?
- How directive was I?

(Taylor, 2005, p43)

I considered these questions whilst reviewing the tape recordings and the transcripts, to ensure that a reflective, critical and consistent approach to the data collection was undertaken.

3.10.1.2 Duty of the researcher

Veracity and consent inevitably overlap with issues of autonomy. In order to guarantee that informed consent was obtained from each participant, I ensured that the full facts regarding the research were shared openly with the participants. Informed consent was gained prior to each interview using the consent form (Appendix XV) which has been designed using guidelines from the University of Brighton and the National Research Ethics Service (NRES). It was vitally important that all information given to the participants contained

all facts regarding the research, that there were no omissions and that the information was understandable to the audience. There was also the opportunity for the participant to ask further questions for clarification prior to giving their full consent.

Confidentiality and anonymity were particularly important issues in this research as the number of participants was small. However, it was my responsibility that all details regarding the participants were kept confidential, and when the results are shared that anonymity is maintained. Pseudonyms were chosen for each participant as I felt that the reader would feel closer to the data if they could identify with the participant by name. I chose each pseudonym following the first interview by looking at the participant and selecting a name I thought suited them. This was important so that the participants felt able to share information regarding their experience of transition without fear of retribution by the NHS Trust or their colleagues where they are currently working.

The assurance of confidentiality and anonymity was clearly stated in the participant information sheet and was not only a concern regarding the protection of the individuals but also to ensure that the data collected was accurate. It was essential during the interviews that all participants trusted me in order to respond to the questions openly and honestly. Again, I used my counselling and coaching skills to build a relationship with the participant which fostered trust. Tillmann-Healy (2003) recommends developing an 'ethic' of friendship as an interviewer and this includes attending to and alleviating concerns, the use of active listening and responding with compassion to any issues that are raised during the interview and build a rapport with the participant.

All data collected were securely stored in a locked safe at my home. All electronic data were stored on a password locked memory stick and backed-up using a secure cloud storage system. All interview tapes and transcripts were coded so that the participants cannot be identified in any way. Each participant was allocated a pseudonym and therefore this protected their

identity from the transcriber and the researcher's supervisors. Transcripts and tapes will be kept for the period of time determined by the ethics committee and will then be destroyed or wiped clean. Principles of data protection and anonymity will be followed according to the Data Protection Act (1998) and the Human Rights Act (2000).

Following agreement, the majority of interviews were face-to-face and occurred in the participant's home with the exception of one Skype interview due to participant work commitments. This ensured that the participant's work colleagues or employers were not aware of the interview process and therefore will not be able to identify the provider of the data once it is shared. Another important risk to consider was that of dealing with sensitive information. It is acknowledged by Allmark et al. (2009) that interviews may often cover issues that are sensitive and the emotions that may surface during the interview may need careful management. Given that the period of transition has been identified as a stressful time for some, it may have been that during the interview process that the participant became distressed. This may be due to several reasons such as the experiences they are having; confidence issues and lack of support. It therefore seemed prudent as part of the risk management strategy to provide access to the HEI Student Support as an Alumni where counselling can be offered. This mechanism made sure that each participant had access to the support as necessary therefore carrying out the research in a safe and moral way.

3.10.1.3 Outcomes of the research

The choice of non-participation was carefully managed as the hierarchical relationship that currently existed during the recruitment period may have unknowingly coerced students to volunteer for the study as they wanted to be seen to be helpful and to co-operate without fully considering the commitment required (Allmark et al., 2009). In order to minimise this a gatekeeper was used to effectively manage this process.

In order to undertake a valuable study and to protect the use of participants it was essential that the outcomes of this research were considered to be meaningful and achievable. The research question, aims and objectives were therefore closely scrutinised during the ethical approval processes and it was considered that the study would produce worthwhile and useful results.

The scrutiny by a wide range of peers and experts should result in a credible piece of research which will add value not only to the profession of radiography but across the healthcare sector as a whole. My ability to undertake the study was underpinned by professional experience and the knowledge gained from undertaking a Professional Doctorate at the University of Brighton. During each stage of the Doctorate there have been challenges to consider regarding the methodological and ethical basis of the research and this has assisted me in developing a critical and reflexive approach to the study.

3.10.1.4 Practicalities of the research

As an educator and practitioner I am bound by professional codes of practice. In addition, this research required ethical approval by both the University of Brighton, and the HEI where the students had studied (Host University). The recruitment of the participants was undertaken through the University and subsequent contact with each participant was made through the University Alumni system or their personal email account. No contact was made through the hospital Trust and all interviews were undertaken in the participant's home or via Skype and in their own time. This in itself protected the participant from any repercussions that may present as a result of the findings of the research and it allows complete anonymity. It ensured that each NHS Trust did not implement specialist support for each new graduate as a result of knowing about the research taking place in the hope of influencing the findings. This is known as the 'Hawthorne effect' and is commonly associated with empirical research, in particular longitudinal, prospective studies (Cohen et al., 2000). It was anticipated that by gaining ethical approval by the universities only that it helped to reduce the 'Hawthorne effect' where possible and thus the

participants felt able to discuss their experiences openly and honestly without fear of reprisal.

This project was resource intensive as 27 individual interviews were undertaken. Consideration was given to the time to undertake each interview, travel, cost and also the transcribing process which realistically turned about to be far more than first estimated.

3.10.2 Process of Ethical Approval

The following flowchart outlines the ethical approval processes in order for this research to proceed.

Stage 1	Submission to the Faculty of Health and Social Sciences Research Ethics and Governance Committee (FREGC) at the University of Brighton	13th March 2013

↓

Stage 1a	Initial decision from the Faculty of Health and Social Sciences Research Ethics and Governance Committee (FREGC) at the University of Brighton Minor revisions needed.	7th April 2013

↓

Stage 1b	Re-submission to the Faculty of Health and Social Sciences Research Ethics and Governance Committee (FREGC) at the University of Brighton. Minor revisions addressed.	12th April 2013

↓

Stage 1c	Approval received form the Faculty of Health and Social Sciences Research Ethics and Governance Committee (FREGC) at the University of Brighton.	20 April 2013

↓

Stage 2	Submission to the Ethics Committee of the relevant Schools at the Host University	20 April 2013

↓

Stage 2	Approval from the Ethics Committee of the relevant Schools at the Host University	26 April 2013

Figure 8: Flowchart illustrating the process of ethical approval

3.11 Summary

In this chapter I began by outlining my role and position as a researcher, establishing that I subscribe to a subjective ontology and interpretivist epistemology. In the interests of transparency and reflexivity as a research this is essential in order for you the reader to understand how this has influenced my approach to the research process.

Given my epistemological and ontological position and taking into account the research question being asked, a qualitative approach was taken. On further consideration and following a rationalised discussion, interpretive phenomenology was chosen as the methodology. This was then followed by a detailed section explaining and justifying the selection of participants, the research method (interviews), associated data collection tools, method of data analysis and the ethical considerations and process.

The next chapter will introduce the overall findings under six main themes and this will be followed by three chapters which will present and discuss the findings from the three, six and twelve month interviews.

4.0   OVERVIEW OF FINDINGS

The following three chapters will present and discuss the findings from the three, six and twelve month interviews. It was discovered during the process of data analysis that each interview represented a stage in the journey of transition for each participant. The three month interviews were full of new experiences, the six month interviews were used to check out my interpretation of some of the themes in the three month interview and offered some new insights and finally the twelve month interview offered the opportunity for reflection and looking forward. It therefore became impossible to analyse each data set in isolation and after many hours of reflection and reading through the transcripts, it began to make sense to discuss the experience of transition from a longitudinal perspective. It is hoped that this will allow me to build a sense of, and to develop an understanding of, the journey of each participant.

Prior to introducing the main themes and sub-themes which emerged from the data, there is some background information given about each participant in order for the reader to establish some context surrounding each one. The choice of pseudonym was previously explained in the methodology chapter and also the need to ensure participant confidentiality. As diagnostic radiography is such a small profession I am mindful that I do not want any of the participants to be identified, therefore an age range is given for each one, alongside the size of hospital NHS Trust in which they were employed (using bed size) and the number of other new starters in their department. This information is presented below in Table 8.

Pseudonym	Age on graduation (in range)	Approximate number of new starters	Size of hospital (number of beds)
Ben	25-30	3-4	600-620
Adam	20-24	15-16	150-1300
Charlotte	20-24	3-4	600-620
James	20-24	3-4	390-400
Gareth	35-40	12-15	1200-1250
Harry	20-24	3-4	390-400
Ruby	20-24	2-3	300-310
Jane	20-24	3-4	800-810
Rebecca	20-24	1	1900-1950

Table 8: An overview of the context of each participant

The themes and sub-themes identified during the data analysis process are shown in Figure 9. As the findings are presented it will become evident that some themes and sub-themes feature more strongly than others at differing times over the twelve month period. Although the themes and sub-themes are presented in the format below this is for the benefit of the reader. It must be acknowledged however that some overlap did occur and this will be explored during the following chapters.
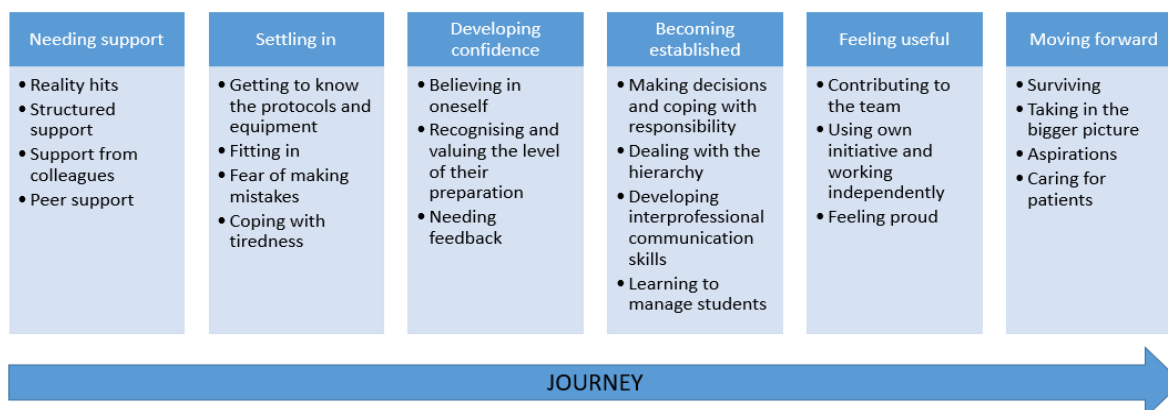
Figure 9: Themes and sub-themes identified across the transition journey

In keeping with an interpretive phenomenological approach, I will attempt to discuss the experience of the individuals in a holistic way so as not to get too involved in the minutiae of each sub-theme, but to pay attention to the lived experience of each newly qualified radiographer where possible. Each of the participants has been given a pseudonym and these will be used throughout

to allow the reader to fully engage with the participant and their experience. In order to tell the story of each participant there are at times some lengthy but pertinent quotations used to underpin the themes being discussed. A summary of each participant journey can be found in Appendix XVI.

Each chapter will cover two themes which were closely linked with the time period when they were most prevalent. The findings, analysis and discussion will be linked throughout and followed by the conclusions chapter which will link the implications of this thesis to the profession of radiography. This approach was chosen after many months of reading and re-reading the interview transcripts and on reflection I decided to join the findings, analysis and discussion together as it seemed to present a more holistic view of each experience and allows the reader to gain an in-depth understanding of the transition period.

5.0   NEEDING SUPPORT AND SETTLING IN

Needing support	Settling in	Developing confidence	Becoming established	Feeling useful	Moving forward
• Reality hits • Structured support • Support from colleagues • Peer support	• Getting to know the protocols and equipment • Fitting in • Fear of making mistakes • Coping with tiredness	• Believing in oneself • Recognising and valuing the level of their preparation • Needing feedback	• Making decisions and coping with responsibility • Dealing with the hierarchy • Developing interprofessional communication skills • Learning to manage students	• Contributing to the team • Using own initiative and working independently • Feeling proud	• Surviving • Taking in the bigger picture • Aspirations • Caring for patients

JOURNEY

Figure 10: Themes: Needing support and settling in

These themes appeared early on in the transition period and were discussed at length by the majority of the candidates at the three and six month interviews.

5.1   Needing Support

This theme featured strongly in the three month interviews and was reflected on in many of the theme boards at the twelve month stage. It consists of four sub-themes; reality hits, structured support, support from colleagues and peer support all of which will be woven throughout the discussion using pertinent quotations to encompass the main theme 'needing support'.

5.1.1   Reality Hits

The opening question of the three month interview asked the participants to describe this initial period and it was evident by the responses that the graduates had found this period of time to be challenging. Many of the descriptions correlated with the emotions described in the existing literature.

The majority of the responses contained a range of analogies which attempted to describe the array of emotions that had been experienced during this time.

'… You can leave university and you can do the job. But, then once you are qualified, you need to incorporate everything you've learnt, and learn all these new protocols and just become the radiographer. It's just sort of – what's the best way to put it – it's like they train us up like a little bird, then they push us off the edge of the cliff and say, "GO!" That's a bit what it's like. It's a bit of a strange analogy, but that's the best way to put it.'

(Adam, 3 months)

Adam seemed to be feeling overwhelmed by the amount he still has to learn in his new environment and appears to be saying here that there is an expectation that now he is qualified he should be able to perform to the required level. The analogy of the bird standing at the edge of the cliff infers the need for the courage to jump and hope that he has the skills to fly (in this case perform as expected in his role) without the safety net previously provided during his degree programme. This use of an analogy correlates with the work of Fenwick et al. (2012, p2054) who described the work environment of newly qualified midwives as *'a pond'* and referred to the challenged faced by them as learning *'to swim'* and not *'to sink'*. Both of these analogies give a real sense of the need to fight for survival in these early days and the rawness of the emotional feelings that go with this.

At the six month interview, Adam acknowledged this time as *'terrifying'* and when asked if that was still how he was feeling he explained how it had changed over time.

'…It's sort of gone from terrifying to sort of, erm – yeah, it was terrifying to start with, but now it's just, it just is what it is really, it's not, there's' no stress involved; it's just, you turn up and you have to believe in what you are doing and know that you are doing the right thing, and as long as you sort of stick by that, you are always alright, I find.'

(Adam, 6 months)

Believing in himself has played a crucial part in Adam developing confidence in his own abilities and in overcoming those initial emotions when faced with

the reality of the role. He is able to pinpoint the change to when he finished his induction and the fact that the completion of this gave him the feedback that he was competent and in his own words *'I must be good to go now.'* The approval of others has been a significant step in Adam developing his confidence at this time.

By the time we spoke again at the twelve month interview, Adam had moved on and did not mention much about those early days. In fact, he used a picture of a boat sailing serenely on the water to represent his overriding feelings on his first year.
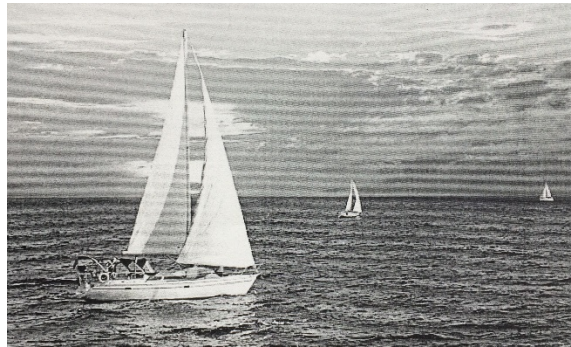
'….leads me on to the picture of the boat it's been quite plain sailing there's been relatively no drama it's been straightforward I've enjoyed doing it and it's just sort of I've got to this point through working hard but I feel like I've got there quite naturally….'
(Adam, 12 months)

This demonstrates how quickly the trauma of those first months is forgotten in the larger scheme of things. This is one of the reasons it was so important to capture those early experiences at the three month interview by utilising the Peaks and Troughs graph (Appendix IX). If this interview had been left any later then the intensity of these earlier emotions well may have been lost.

This experience of being *'thrown in at the deep end'* at the beginning was also shared by James:

*'Well I would say it's been an absolute whirlwind of ups and downs
and it's been very exciting but […] you certainly are sort of thrown
in at the deep end […] from my experience I mean within a couple
of weeks, within my first day it was literally like right this is the kit,
use it, go and X-ray…'*

(James, 3 months)

James is quick to share the fact that he had many ups and downs during this time and his use of a *'whirlwind'* suggests that it has been a rapid learning curve which has left him feeling windswept, maybe even exhausted but also excited, exhilarated. The emotion of excitement was also identified in the study by Naylor (2014) whose findings suggested that the period of transition for newly qualified radiographers was stressful but also exciting. This study was similar to this in that it explored the transition of diagnostic radiography graduates using a longitudinal approach both pre- and post-employment. Although it was suggested in this study that the period of transition was stressful, the participants did not seem to experience the reality shock as first proposed by Kramer (1974). In fact their overriding emotion was one of excitement whereas in this study the majority of the participants found the first three months to be a very stressful time.

In a high pressured environment, James was having to manage the expectations of others and again this has been picked up in other studies. Decker (2009), explored the experiences of newly qualified radiographers between 1950 -1985 and found that the expectation to *'get on with it'* (p74) was a common trend experienced across the decades. This seems to be what James has described at his three month interview. Although the participants in the study by Decker (2009) experienced a range of emotions when starting work such as *'scary, terrifying, daunting and strange'* (ibid, p74), overall none of them described it as stressful. This may have been due to the time period that had passed from qualification to the data collection stage and potentially the difference in training i.e. 1950-1985 in which the majority students undertook hospital based training and stayed in the same hospital for the duration of their course and their first post. The work by Mooney (2007), exploring the role transition in nursing also found that newly qualified nurses

felt that high and sometimes unreasonable expectations had been placed upon them and this again mirrors James' experience.

In the study undertaken by Tryssenaar and Perkins (2001), which explored the transition period of new PTs and OTs four consecutive stages were identified; transition, euphoria and angst, reality of practice and adaptation. Throughout these four stages there were six recurrent themes identified of which great expectations was one. On closer examination it was felt that there was a gap between the expectations and realism of practicing as a newly qualified practitioner and this is what James is also experiencing. In their study, they concluded that support certainly enhanced the participants' ability to cope in the early months.

The fact that he felt that he was thrown in *'at the deep end'* seems to describe a feeling of having to sink or swim and again the expectation that he should be able to come straight in and get on with the role. Although James was still experiencing *'lots of ups and downs'* at the six month interview he was able to reflect on his progression since starting.

> *'….you don't really realise how much you learn each week until you look back and look at how naïve you were before, erm, and sometimes you think you're ready for things and then you realise that you're not and you kind of progress, and you kind of learn quite gradually...'*
>
> (James, 6 months)

Here, James has recognised that he sometimes over estimated his abilities and has started to come to terms with being more patient with his learning and future opportunities as well as managing his own expectations. At the twelve month interview, James referred to early days as a *'baptism of fire'* and in a similar way to Adam he chose not to dwell on those early feelings although he did acknowledge that he felt that he had been on *'quite a journey'* which was still *'full of ups and downs.'*

Gareth also concurred with these early emotional feelings as he seems to have also felt the same pressure as James in relation to what was expected of him during the initial three months.

> *'I think it's been interesting to see how another hospital, the structure of another hospital, another department, radiology department, works. I was really pleased with the amount of support I got. But, I found myself out of depth on many occasions. And I still find myself out of depth on many occasions.'*

> (Gareth, 3 months)

He spoke about being *'out of his depth on many occasions'* which creates an image of drowning, being out of control and potentially invokes a sense of panic. This again is commensurate with the findings of the study by Fenwick et al. (2012) which explored the transition of newly qualified midwives and tied in with the metaphors used whereby the participants' experience was described as having to *'sink'* or *'swim'* (p 2054). These metaphors give a sense of panic to the situation. When questioned further it appeared that much of this was attributed to a new environment and having to learn the procedures and processes alongside that. What most challenged him during this time was dealing with complex patients and their needs and he lacked confidence in his ability to be able to handle these situations appropriately. Despite his positive comments regarding the support he received, it still did not seem to alleviate his anxiety at this time.

I unpacked these feelings with Gareth further during the next interview and he spoke about the fact that he thought he had put too much pressure on himself and this had contributed to his anxiety in the early weeks.

> *'I've grown to take […], be less a kid-gloves with the whole radiography thing, I'm much more, not blasé, but I'm like, kind of just mellowed., I think, and just become more human, and that's a good thing. It helps if you are more-you, if you are not trying to be someone else. I did think I was trying to be someone else maybe.'*

> (Gareth, 6 months)

Being able to relax more in the role has clearly been beneficial to Gareth and has allowed him to find himself as a radiographer. He is no longer measuring himself up against others which is something that appears to be heightened in students and less experienced staff. There is a perception that there is some cross comparison of ability which occurs and this puts additional pressure on the practitioners but as they gain experience and become more comfortable in their role, the anxiety about comparisons to others then reduces and becomes less important or valuable.

At her twelve month interview, Jane used two images to represent her feelings in those early weeks. The first was of a young child, about 5-6 years old. He is walking on the path towards the front door of the school holding his lunch bag in his left hand with a rucksack on his back. Jane went on to explain why she chose this image:

'I thought that represented how I felt to begin with quite well - first day at school….. as a third year obviously you've got the second and first years below you know more than them so you're a student at the top of the pile almost and on that first day you're right back at the bottom again and everything seems really scary and daunting and that was probably the biggest one of the biggest feelings I had when I started.'

(Jane, 12 months)

This quote by Jane is really interesting as it relates to a pecking order. Having been at the top of the student pecking order as a third year being *'right back at the bottom again'* is not a comfortable place for her to be and it seems to conjure up thoughts of how much she needs to achieve. This was picked up by the midwifery graduates in the study by Fenwick et al. (2012) and relates

to hierarchy. In their study the newcomers quickly noticed the '*obvious pecking'* order that existed and this added to their anxiety (ibid, p2058).

Later on in the interview, Jane referred to a picture which was a silhouette of a rabbit in front of a bright set of lights.

'I said in our first one (interview) rabbit in the headlights…and I don't think I could explain it any better than that when you first start it is. As a student you're a rabbit underground like we just said you don't really pay any attention to the stuff going on but once you've qualified you put your head up and there's everything else like it blinds you and it's like oh my God and it's that initial shock. After a year the lights and everything else dim down a bit and it's not so bad ..'

(Jane, 12 months)

A powerful image which provides a thought-provoking analogy which clearly illustrates how Jane was feeling at this time. The blinding light seems to represent everything that Jane needs to now learn and the realisation of this is so intense that it almost *'blinds'* her. I think what Jane is trying to say here is that the longer you are exposed to the light, the less daunting it becomes and as your learning increases the less intense the situation feels. The blinding light is a clear metaphor here for the sudden realisation of the steep learning curve associated with the transition period of newly qualified radiographers also found in the work by Decker (2009).

On her theme board, Rebecca used two images to try and sum up how she felt in her first few weeks as a newly qualified radiographer.

'I'm so…scared the spider because I hate spiders um… obviously when you first begin it's quite a terrifying step from being a student into to qualified radiographer a lot of […] stress and it's all new and you have to make all the decisions […] kind of felt a bit clueless. You know being somewhere different to where you trained […] I felt a bit lost which indicates the maze there…'

(Rebecca, 12 months)

Many of the other participants described this first three months with phrases such as *'absolutely terrifying'*, *'absolutely petrifying'*, *'quite a roller-coaster*, '*a big learning curve'*, and *'stressful.'* This range of intense emotions were felt by almost all of the participants at this early stage highlighting the first three months as a very challenging but frightening time. These findings correlate with that of Decker (2009) whose participants used similar words to describe their emotional experience of transition. The strength of emotions experienced at this time was also felt by newly qualified veterinary practitioners during their transition period. Gilling and Parkinson (2009, p209) labelled this time the *'make or break'* period. There are some similarities between veterinary science and diagnostic radiography in that both require scientific knowledge, technical skills, effective communication skills and the ability to empathise. There was also the same pressure to fit in and increase their knowledge base.

The emotional experience of transition is heighted during the first three months in particular as the participants' experience what is known as 'reality shock' (Kramer, 1974). Their feelings at this time seem to hit hard and it questions whether there is a need to prepare students for the experience of role transition itself and help them to cope with their emotions at this time. In her work on exploring the transition of newly qualified nurses, Boychuk Duchscher (2007), argues strongly for the need to prepare students for the experience of transition. The gap between expectations and realism identified by Tryssenaar and Perkins (2007) in their study of newly qualified OTs and PTs

also suggests further preparation for this period and proposes that ongoing support may well reduce the emotions experienced at this time.

The expectation that the new graduates should just *'get on with it' (*Decker, 2009, p76*)* placed additional pressure on them in an unfamiliar environment*.* This was evidenced by James, *'it was literally like right this is the kit, use it, go and X-ray'* and that is how he was introduced to the department and quickly got on with it. This has certainly been the experience of many newly qualified practitioners where a number of studies have identified that there is a general expectation that they should hit the ground running (Tryssenaar and Perkins, 2001; Mooney, 2007; Black et al., 2009 and Fenwick et al., 2012).

In the study by Naylor (2014), there was little evidence to suggest that the newly qualified radiographers experienced reality shock (Kramer, 1974). There may have been several reasons why there is a difference between the findings of this study and the one undertaken by Naylor (2014). Firstly, all of the participants of this study entered a completely new diagnostic imaging department upon graduation whereas in the study by Naylor (2014), the students had all gained employment in a hospital in which they had been placed as a student. Secondly, all the participants of this study stay at the same hospital for the duration of their three year degree programme and are therefore unaccustomed to changing their working environment and will have become socialised into the culture of that particular department (Strudwick, 2011). Also during their programme all students will have been supernumerary which was highlighted by Mooney (2007) suggesting that this causes tension when trying to effectively prepare students for graduation. This may well be exacerbated by the university's current structure which provides practice educator support at each placement site. This is highlighted by Adam's quotation early in the chapter when he says '*they train us up like a little bird, then they push us off the edge of the cliff and say, "GO!"* Although the practice educator model is highly valued by both staff and the students it may bring in to question that as the students' progress are they protected from the reality of the role and therefore underprepared?

The intensity of emotions reduced throughout the twelve months to the extent that some participants did not discuss this phase at all in their final interview. This can be explored further by referring to the work of Lave and Wenger (1991) on Communities of Practice (CoP). In the first few months the students will have very much been regarded as first *'outsiders'* and then *'beginners'* (Figure 6, p57). As they begin to *'learn the ropes'* and begin to participate they move towards the centre of the CoP thus becoming an accepted member of the community. The change in their status is acknowledged at the six month interviews when they are beginning to feel more settled and less stressed and James in particular reflected on his progress at this six month interview. By the time I interviewed them again at twelve months all the participants reflected on those early days using similar emotions and some powerful images to capture how they had felt at that time. However, it was clear that they had left that phase of their transition behind and their source of stress now came from other places.

5.1.2 Structured Support

In 2005, the DoH introduced preceptorship into the NHS for all newly qualified professionals, however, the participants in this study experienced varying levels of structured support during their first year. In her review of support for newly qualified OTs, Morley (2006) discussed how preceptorship would enhance the experience of new graduates. During this time of adjustment she feels that preceptorship would give a range of vital support including the opportunity to receive feedback on performance thereby promoting reflection on practice. In exploring the experience of newly qualified nurses, Gerrish (2000) found that the participants who had been allocated a preceptor rated it a positive experience and the provision of constructive feedback had been invaluable to their development.

It is clear that being supported was an important aspect of the transition period for James, particularly when struggling with learning new ways of working. Throughout his interview he spoke about the lack of support he had received as a new graduate and how he had been disappointed by this. He had found

it difficult to find his way at times and felt that there was no one to turn to for support and that the only way forward was to just get on with it.

> *'For me that was fine because that's what I was used to… and I enjoy kind of working on my own but I think it's a bit of a struggle sometimes when you're getting used to new protocols and there's not as much support as you sometimes think there would be.'*
>
> (James, 3 months)

James revisited how he had felt during this time during his twelve month interview:

> *'….As a newly qualified you don't exactly get supervised throughout the year […] there's no kind of regular time to talk things through like that so you kind of have to bury it and get on with it….'*
>
> (James, 12 months)

What James seems to be saying here is that it would be useful to have the opportunity to regularly reflect on his practice with an experienced member of the team. He feels that because he has not had the chance to do this that he has just had to keep on going and coping which may have resulted in him missing valuable learning opportunities.

The concept model proposed by Black et al. (2010), was discussed in the literature review and was produced as a result of their study of the experience of newly qualified OTs and PTs. It focussed on four key concepts related to the transition period; clinical environment and practice community, learning through experience, growing confidence and professional identity formation and role transition. It can be seen here, that James has been given very little support with one of these concepts in particular, that of learning by experience. An opportunity to reflect with a more experienced practitioner as part of a preceptorship scheme would have ensured that James not only learned from his experiences but was also given the appropriate support to underpin his professional development.

The work of Dall'Alba (2009) on professional ways of being and becoming, challenges the epistemological aspect of education and in this case the transition period. If we were to consider the ontological aspect of transition then being and becoming encompasses the transformation into a professional. This therefore involves not only the element of performance but more importantly the possibilities to learn and grow which is enhanced by reflection, interaction with others and being open to new ways of working. This is also discussed by Barnett (2009) who recognises the need for students to develop transferable skills. He argues that learning to learn is an essential graduate skill, proposing that knowledge no longer holds the power it once did.

As the interviews progressed it became apparent that the participants' experience of any formal support mechanisms was indeed very different. Gareth continued to acknowledge the excellent support he felt that he had been given and went on to explain the preceptorship that had been put in place for him at his hospital.

> *'So we started, and the introduction was really good… we were given all of our information for our preceptorship, […] it's a six-month preceptorship which was clearly laid out, which included all the normal tick-lists, plus an audit as part of it and that was really daunting at the start to get so much information, and so much to fill out…. but it was okay.'*
>
> (Gareth, 3 months)

Gareth acknowledged that he felt completely overwhelmed by the amount of information he was given. Although it was well laid out and organised there seemed to be a lot required of him as part of this preceptorship and by his own admission he found the expectations of this very daunting. It seemed that much of the preceptorship focused on paper-based exercises and was task-focussed. He was however, given support over the first six months and he undoubtedly viewed this a positive thing.

In complete contrast Ruby appeared to have received no structured support.

'No, no reviews, no nothing. I've been told I'm getting a three month review, whatever… which had not been discussed, I don't even think they know how long I've been here now…. They don't ask me how I'm getting on, there's an Excel sheet that you've got to tick when you're competent in something, so you just say 'yes' to all these different features of all the different machines, and that's all they're interested in me doing and as soon as that's all ticked off, they're happy.'

(Ruby, 3 months)

Ruby felt that she needed support, especially to help her fit into to a new department. It seems as though the department were happy just as long as she did her job and kept imaging patients.

When discussing her experience there seems to be a sense of disappointment and in some instances disbelief from Ruby. She was not really sure what to expect in terms of support and felt as though the department had little idea of how long she had been working there and how well she was performing. As with some of the other participants, she has been required to prove certain competencies but this is simply a tick box activity. Ruby does not appear to have had any formal or informal feedback on how she is getting on and her assumption is that as long as the competencies she has been given are met then that is all that is needed. This seems to have Ruby feeling much more like a number in the workplace rather than a person. Again, there has been a focus on task-based activities and little on individualised support and personal development. This has left Ruby feeling despondent and disillusioned in these early months, feeling of little value.

Ruby revisited this at her twelve month interview:

'I kind of didn't feel that I had the appropriate support from work management just sort of telling me not helping you, you know not really any help there at all…but really just a bit of reassurance a bit more guidance would've just helped me to actually you know sort of fit into the department and feel reassured that what I was doing was right because at the time I just thought you know I don't if what I'm doing is right I'm just going with the flow and I'm just X-raying patients…'

(Ruby, 12 months)

Later on as we were talking, Ruby referred to this early period as feeling like *'a ticking time bomb'*. She explained how this feeling changed during the twelve months to *'a ticking time bomb on her shoulder'* at six months to about nine months when the ticking time bomb disappeared. At the nine months' time period is when Ruby felt that she had finally settled in to the department and was now confident in her knowledge and abilities.

The time period of nine months correlates with the stage of knowing in the study by Boychuk Duchscher (2008). The concept framework of transition produced from her work on newly qualified nurses in Canada identified that the stage of knowing followed doing and being and was when the participants had begun to appreciate how far they had come.

Adam, like Gareth was also given an induction period albeit for a shorter length of time at three months. However, this differed in the respect that it was not a preceptorship and more akin to Ruby's experience where it was focussed on training and competencies in specific areas. Adam was pleased with the in-depth training he received although does mention the length of time that it took.

> *'…as time has gone on I've been trained in loads of different areas. The induction programme at ……… is really elongated. Like I, started off in generals', then we went to theatres. And we had a good five, three week blocks in each area. So, it's a really thorough training period and I'm still in my induction period, even three months in.'*

> (Adam, 3 months)

Later in his interview, Adam talked again about how elongated he felt this process was and at times he had found this irritating as he felt sometimes that it had held him back from working in certain places undertaking specific procedures and had also restricted his working hours. His frustration was evident as he felt at times he could have made quicker progress but was restricted by the requirements of the induction period. Interestingly, though

this is again focused solely on the epistemological aspects of the role and fails to consider the wider aspects of being and becoming.

Only two of the participants were given a structured support programme during their first twelve months.   When both Gareth and Adam spoke about this support it was evident that both programmes were very much task-focussed and structured towards getting them competent in certain areas of the diagnostic imaging department so that they could contribute to the department as soon as possible.   Being very competence-led they were both at times daunted by the amount of work needed and often found it onerous.

Preceptorship has been discussed by many healthcare professions as a way of supporting newly qualified practitioners and is defined *as 'a foundation period [of preceptorship] for practitioners at the start of their careers which will help them begin the journey from novice to expert'* (DOH, 2008, p72).   Some years ago, preceptorship was proposed by the Society of Radiographers (SoR) as a way of supporting newly qualified radiographers during this transition period however, the uptake in departments was variable. Those that provided preceptorship often used the model provided by the SoR (Appendix I) which is predominantly product driven instead of process driven and rather mechanistic in approach. The focus is on twelve aspects which the preceptee needs to complete.   It does not appear to address other common issues related to transition such as professionalisation, developing confidence and the importance of reflective practice. From listening to Gareth and Adam's perception of the programmes they were offered it seems as though they both lacked elements of personal and professional development and this would correlate with the SoR model which appears to be limited in terms of professional development and is heavily linked to outcomes.   This epistemological approach to the role ignores the process of transformation into the role of a diagnostic radiographer. As Dall'Alba (2009), Dall'Alba and Barnacle (2007, 2009) and Barnett (2009) argue, there is an intricate relationship between knowing and becoming which underpins the students' journey to becoming a new self. Preceptorship schemes need to ensure that

there is an ontological aspect to the programme in order to facilitate the process of 'becoming a radiographer.'

Following the introduction of Agenda for Change (DoH, 2004), the pay, terms and conditions of all NHS employees were radically changed. The original inclusion of Annex T: Development of professional roles offered all band five practitioners the opportunity to progress to a band six within twelve months whilst following a programme of preceptorship. At this point many diagnostic imaging departments were offering preceptorship schemes based on the one proposed by the SoR. However, when Annex T was removed from the new contract many preceptorship schemes in radiography disappeared. This has led to the majority of the participants receiving little or no support at this time. Some of the participants did not feel valued and were left feeling more like a number than a person within the workplace, as they have moved from the supportive environment of the university to one where they are now expected to ensure patient throughput is maintained.

At the twelve month interviews, the level of formal support had become less important to the participants as they had grown in confidence and were starting to widen their perspectives and look forward to their future. They had become established in their roles and were now well versed in supporting and teaching others.

5.1.3 Support from colleagues

The importance of support from colleagues was highlighted by participants in the interviews and Jane illustrated how she used her colleagues' support to substitute for mentor support and a more formal support mechanism such as preceptorship.

> *'As far as I'm aware, we are the first like year that don't (have preceptorship), we still get assigned mentors so there was somebody that you could go to […] and I've met with mine quite a few times, we've worked together a bit. So, she's kind of kept an eye on me and that but because there wasn't an obligation to meet and talk about stuff, you didn't always, if you didn't have the time,*

you didn't worry about it. Which, may have caused issues, but because all of the staff there are so supportive, I didn't ever feel like I needed to go and see her specifically because there was plenty of people at the time which I could talk to.'

<div align="right">(Jane, 3 months)</div>

The lack of formal support for Jane meant that often other things took priority over her meeting regularly with her mentor and as a consequence Jane sought support from other members of the team. This seemed to work well for her as by her own admission she had no particular issues in which she felt she needed additional support. She felt able to talk to others if needed and it is clear that Jane felt very much supported by her colleagues; however, this may not have been the case for other newly qualified radiographers. She was evidently disappointed that a preceptorship scheme was no longer offered by her department and although she managed to compensate for this in her own way it did mean that she received very little in the way of consistent, formal feedback on her performance at this time.

At six months, Jane goes on to explore the tension between knowing whether or not other staff are supporting you or if they are in fact just watching and waiting for you to prove yourself.

'They didn't know me from Adam, they didn't know if I was any good, you know. So, I felt like they were constantly watching me just to make sure that I wasn't going to do anything dreadfully awful. And now, gradually, I feel that they don't watch me anymore, because they know that I know what I'm doing, which is a really nice feeling.'

<div align="right">(Jane, 6 months)</div>

Jane felt under pressure to perform and wanted in her own word to *'make a good impression.'* This often appeared to create a stressful environment for her. However, she now seems relieved that she is no longer under a constant watchful eye and that she has had the seal of approval by her colleagues and this has made her feel good in her role.

Jane explored this further during her final interview referring to herself as a *'foreigner'* and during her three month interview, Rebecca also refers to herself as a *'newbie.'* By labelling themselves in this way it suggests that they are both feeling on the periphery of the group. This fits nicely with the term *'outsider'* described in the CoP by Lave and Wenger (1991). When newcomers join a CoP they usually begin as outsiders. As they begin to slowly join the group they then become observers and watch and learn how the group functions. The feeling of being on the periphery is what both Jane and Rebecca are describing here by the use of labels and can be an uncomfortable experience. As they both begin to become more active in the group by engaging and interacting with others, they begin their transition towards the centre of the CoP where eventually they will achieve full legitimate participation.

Jane feels that the support she has now from other staff is stronger as she has been accepted into the department. This again ties in directly with the CoP (ibid) as at her final interview Jane has now achieved legitimate peripheral participation and as such has become an accepted and knowledgeable member of the community.

Although James acknowledged during his first interview that at times there were members of the team that were supportive, overall there was a sense that he had not felt fully supported during this time. He seemed to have come to some acceptance of, almost resigned to the way things were and this is highlighted in the following excerpt:

> *'When you haven't had much support from your colleagues, but I suppose you get that anywhere but it's been interesting getting used to it. As a student, you obviously always have someone with you and you've got a fall back, but as a radiographer sometimes you're just left on your own and that's it.'*
>
> (James, 3 months)

Here, James has struggled to get used to the lack of support and admits that he just had to get on with it as there was no choice. He clearly highlights the

difference between being a student and now being a qualified radiographer in that there is usually someone that you can turn to who is also responsible for your work as a student. However, he was acutely aware that this safety net as such was no longer there and he had very much felt that he had been left on his own to get on with it. This seemed to be the culture of the department and James has resigned himself to the situation. The expectation of getting on with it was also found in the study by Decker (2009) which also explored the experience of newly qualified radiographers.

The lack of support from his colleagues was again picked up in James' six month interview where he discussed the culture of the department where he was working in more detail:

> *'I think there's a bit of a culture where the newly-qualifieds are expected to pick up a lot of the difficult shifts and stuff like that, expected to stay late when others will kind of not pull their weight as such, sometimes – which has been difficult.'*
>
> (James, 6 months)

Although this is also related to hierarchy, James is feeling under pressure by his colleagues to work above and beyond what is expected in order to prove himself. This correlates with the findings of Fenwick et al. (2012, p2056) who found that newly qualified midwives quickly experienced the *'pecking order'* within their profession and were put to the test early on by experienced practitioners.   The work by Mooney (2007), also discovered that newly qualified nurses felt under pressure to conform to the ward rules and to cover the Christmas and night duties. This hierarchical culture seemed to leave the new graduates feeling powerless and vulnerable which seems to echo James' sentiments at this time.

James has a young family and the undertaking of extra duties has impinged on being able to spend quality time with his children. When asked if he felt able to address this with any of his colleagues, his response was:

'It's difficult […] to deal with it with them, they are your kind of seniors, more senior staff, so you kind of think, to take them up on it would be detrimental to your progression in a way, so there's a certain amount of having to put up with it and shut up – which is difficult.'

(James, 6 months)

It seems that James felt that he was in a no-win situation and that if he wanted to get on in the department and be given opportunities then he has no choice but to put work first. This is a hard decision for James to have to make and it is disappointing that in a healthcare environment staff often do very little to help, support and look after each other. In their work on resilience, McAllister and McKinnon (2009) suggest that new graduates tend to *'perceive hospitals as harsh and unresponsive institutions'* (p372) and if they are not prepared for this then stress and burnout may occur.

Charlotte when talking about her experience at three months acknowledges that her colleagues have been very supportive but often forget that she is newly qualified.

'...at times, people forget that you're newly qualified, so I think sometimes you get a bit lost and they think you've been doing it for years, and they kind of let you get on with it. And you stand there like "I don't know what I'm doing! I need someone to help me!", and no one's there to help you. […] I think overall it's been a positive experience. But scary!'

(Charlotte, 3 months)

However, as she talks further she describes feeling lost and isolated when left to her own devices. Her description leads you to think that she is shouting out silently in her head and feeling panicked by not knowing what to do. She suddenly comes to the realisation that there is no one there to help her, no back up and this scared her. She does however, appear to cope whatever her reservations or self-doubt were.

When speaking to Charlotte at her second interview, these initial feelings had subsided and her confidence had grown. She had begun to see the bigger

picture and realised that she is not totally on her own and support is always there should she need it. This seems to have really made a difference to how Charlotte feels about her role and she has started to relax and enjoy the role far more.

> *'So you kind of, […] you know that there is someone there if you need them, so it's not like you are always by yourself, you've got nothing to support you. […] and the department I'm in is really supportive anyway.'*
>
> (Charlotte, 6 months)

Because students are supernumerary and still being supervised until graduation it seems that this causes difficulty when first newly qualified. This was discussed by Mooney (2007) who debated the tensions that exist between students' supernumerary status and if this effectively prepares them for graduation.

In his initial interview, Gareth was full of praise for the support he had been given which is illustrated in the following quotation:

> *'I've been supported really well. So I've got a mentor, he's really great. We have meetings with our superintendent […] every other week. We get emails […], saying "well done guys, job done" and getting kind of weekly updates of what is happening. We always get praised when praise is due, which is great, in the emails […] It's good, they're used to the new graduates kind of coming through quite a lot. They've put lots in place to make people feel comfortable, I think.'*
>
> (Gareth, 3 months)

The department where Gareth was working recruited several new graduates. They seemed very well prepared and organised in giving each one a good level of support. The emails sent from the Superintendent seemed to lift Gareth and it was a very thoughtful and personal approach to use.   This department has put a lot of work into thinking about how best to support newly qualified staff and how to help them fit in to a new environment.

Gareth really seemed to appreciate the initial level of support that he had been given, however, by the time we spoke at the six month interview this had significantly decreased. He seemed very relaxed by that and by his own admission feels that he no longer needs it as much as when he first started.

> *'It's slightly died off now, so I think with the, the initial kind of help that you're given has waned somewhat, […] but I think, equally, I don't need kind of pats on the back and you know, fanfares or whatever, you know. I think […] all in all I want to just do my job and I don't really need all of the support so much, at this point.*

(Gareth, 6 months)

It seems that Gareth has reached a place where he is less reliant on others' feedback and is able to take satisfaction from being able to undertake his role to the best of his ability.

The graduates all seemed to feel under pressure to perform and this appeared to be heightened in those that received less support. At times they were unsure of the expectations and motives of their colleagues and whether or not they were being supported appropriately.

At the twelve month interviews, the emphasis had very much changed from needing support from others to one of feeling part of and contributing to the team. At this time many of the participants were already supporting new members of staff and supervising and teaching others.

5.1.4 Peer Support

Peer support was the strongest of the sub-themes in this section and it was valued by almost all of the participants, particularly those who had received less support from their colleagues and little in the way of formal support.

> *'I think for me the best part of the team has been the two people I started with, Harry and Sophie (pseudonyms) who are really good pair of newly qualified – they both work hard, and they're both going through the same thing as I am. We've been really good at*

supporting each other and when we've all had a bad day we've all looked out for each other, so, it's been really good to have that before, as were all in the same situation.'

<div align="right">(James, 3 months)</div>

James spoke about peer support at numerous times throughout his interview and it was clear how important this type of support had been to him. The fact that his two peers had been going through similar experiences was in some way reassuring and seemed to help him cope. Not only did he feel that they had more of an understanding of how things were for him they were also able to empathise and support him when things had not gone so well. This small support network definitely helped James manage in the early days and was seen by him as invaluable thus making them the most important members of the team for him.

Even at six months, peer support was still vital to James. He explains that he has often dealt with difficult and upsetting situations by discussing them with his peers.

'I think the way I've dealt with (difficult situations) has been talking to my colleagues about it, particularly my peers who qualified at the same time, like Harry and Sophie (pseudonyms). They've been really good, for me to help me kind of deal with those situations, because we've all going through the same thing together.'

<div align="right">(James, 6 months)</div>

Here, James is describing his mechanism to reflect on practice. Reflection on practice has been discussed by many authors but more recently Finlay (2008) has critically examined reflective practice from a range of perspectives. She describes reflective practice *'as the bedrock of professional education'* (ibid, p2). By using his peers to underpin his own self-developed model of reflection, James has attempted to try and make sense of his workplace and his experiences. Reflective practice is an integral part of being a professional and in developing his own ways to reflect will underpin James' learning and help him to foster new ways of working in the future (Steele, 1998).

Again, James reiterates that he feels that radiographers that have been qualified for some time are unable to support him as they are more distant from the experiences he is going through. Having others who are going through similar events has helped him to cope as he has been able to share his feelings with them and feels secure in doing so.

Already moving on to another department, James acknowledged the value of the peer support he had received and how much he would miss it during his final interview:

> *'…they've all been really good and I will be sad when I move onto the next job that I'll miss them and […] I just think it's a really good team to start off with because a lot of them have been newly qualified and stuff so a lot of people have been through similar situations.'*

(James, 12 months)

It would be interesting to see if James builds up a similar network of peer support in his new department or whether he feels that he no longer needs it.

Adam's experience of peer support was also very positive although there were several more peers involved, in fact there were sixteen other new starters.

> *'Seventeen new starters. We all sort of chip in and help each other and it's like we're one group and we all help each other out. It's sort of, if we get a bit stuck, we just pull someone in the room and ask, and we learn from each other. We've had opportunities during our induction period to work together. Like pair up with another new starter, which has been really really helpful.'*

(Adam, 3 months)

There seems to be an openness to learning from and sharing of information with each other in this group. Adam has particularly enjoyed it when he has been paired up with another new starter as this has allowed them to work together and help each other out. It has created a safe environment in which to learn, ask questions and try out new ideas. Even though Adam has received

little in the way of formal support in terms of mentorship, the department has organised the work rota in order to facilitate and encourage peer support at this time and this has worked well from Adam's perspective. This has been a positive experience for Adam and was well thought out by the department.

For Adam, the peer support encountered early on in his transition had become less important at the six month interview as he has now immersed himself into the wider team. The socialisation aspect has certainly helped him feel part of the team and recognises that for him *'everything gets easier when you make friends.'* This was also the same for Harry who whilst still acknowledging the value of peer support felt that as time progressed it became less important. This was because he has started to make friends with other colleagues thus setting up his own support mechanisms for the future. It is evident that both Adam and Harry are beginning to feel part of the CoP (Lave and Wenger, 1991).

Charlotte also recognised the benefit of starting with other newly qualified radiographers during her first interview.

> *'…it's nice to start work with people that have just qualified as well. Obviously, because I knew them and I could kind of go to them for advice as well…. but you kind of rebound off each other, you kind of ask each other questions […] it feels like you're not doing it alone – like someone is with you and in the same boat as you. […] I think that's nice, because you both have different, kind of experiences, and you can both, kind of, learn with each other instead of doing the same what they've done, and you kind of laugh about it a bit more. So, your mistakes, you kind of can share it with someone and say, "Well, that was ridiculous. Why did I do that?" and they won't judge you because they will make stupid mistakes as well.'*

(Charlotte, 3 months)

The sharing of information and the exchange of ideas has been particularly helpful for Charlotte as it was for Adam. Again, it seems that it has been important to be with others who are having a similar experience and in Charlotte's case this has been to share both good experiences and also mistakes in a safe environment without judgement. Not being the only one going through new experiences has helped to make it much less stressful for

her and helped her feel less lonely. Again, this is a good example of building a self-developed model of reflection.

Peer support was used as part of the Allied Health Program introduced in Australia (Smith and Pilling, 2007). The programme received very positive feedback and the Allied Health Professions attending reported that it supported them well during transition. This may be an ideal way to offer peer support to those newly qualified practitioners across an organisation when they are not many new starters in one department. Peer support for newly qualified staff is not widely discussed in the literature. However, there is a body of evidence on the use of peer assisted learning (PAL) regarding students and clinical practice which can be directly related to the use of peer support. In their exploration of PAL in clinical education, Henning et al. (2008) reviewed over 40 articles on the use of PAL in nursing, PT, OT, medicine, athletic training and higher education. Through their work they established that there are a range of strategies being used in PAL such as; peer teaching and learning, peer assessment and feedback, peer mentoring and peer leadership. Whatever the strategy being used it is clear that PAL has significant benefits including; the reduction of anxiety, opportunities to share ideas and practice techniques, increased self-awareness through in-depth reflection, improved organisational skills, enhanced personal growth, and increased self-awareness.

Naylor (2014), identified two main support mechanisms in her study; scaffolding and peer support. Peer support was valued by all participants and was thought to reduce anxiety, provided personal support and helped to provide a sense of belonging. In her study, it was also stated by the participants that knowing that others would also be new to the department helped to reduce their anxiety. In line with James, one participant also described a mini-support group where all members shared their challenges and insecurities. The empathy and understanding received from peers far outweighed that given by experienced staff. However, a combination of both peer support and support from experienced practitioners is most desirable to

ensure that it is not *'simply the blind leading the bind'* (Kelly and Ahern, 2007, p915).

The findings of this thesis would seem to corroborate the need for peer support and the value placed upon it by the participants. This is an important topic as there is still limited literature on the effectiveness of peer support in practice available.

The newly qualified radiographers have displayed a range of emotions to describe their first few months. Although courage and resilience is needed, support is such an integral part of their early experiences. As they begin to develop their skills, the graduates will look for reassurance and guidance. This may come in the form of formal support which is structured and allows them to practice and refine their skills. The support may come from older, more experienced, accomplished radiographers who may be willing to mentor or share their practice, give encouraging words and provide feedback. Or, it may come from other novice radiographers (newly qualified radiographers) who are willing to share their experiences, will empathise or just provide a listening ear. Whatever form the support takes, it is apparent that all the participants needed supporting during these early stages and for the majority peer support was the most valued.

In summary, needing support has played an essential role in the first three months of transition for the participants. Each experience has been unique and illustrates the diversity of support provided in diagnostic imaging departments across the country. The exact nature of support in these early days will be discussed further in the conclusions chapter. There are some complex issues that need to be developed further in order to inform the profession to ensure that newly qualified radiographers are effectively supported in their new posts upon graduation.

5.2 Settling In

This theme also strongly featured in the early stages of the transition journey which justifies its inclusion in the chapter. It contains four sub-themes; getting to know the protocols and equipment; fitting in; fear of making mistakes and coping with tiredness. These will be discussed using quotations from the participants where necessary bringing together the main theme of settling in.

5.2.1 Getting to know the protocols and equipment

Each diagnostic imaging department has a set of protocols which detail the type of radiographic projections that should be taken to answer the clinical question on the imaging request. This may vary according to the type of patient, the referring clinician or the patient's condition. At each hospital the set protocols may differ and the type of X-ray equipment that the radiographer will need to operate to undertake the imaging will also vary.

The need to learn new protocols and use unfamiliar equipment seems to have caused stress to some participants particularly in the early weeks. Ben reflected on his decision to move to a new department once qualified and how the experience of learning in a completely new environment had been unnerving for him.

> *'Stressful, I'd say. To start with […] the first couple of weeks I was thinking, 'what have I done?' Why have I changed for a place, where I'd spent three years learning, gone somewhere that's just completely different in so many new aspects.' So, it was a bit daunting in that respect…but I'm slowly sort of getting used to it now and I have less days when I come home and think, 'what have I done?', and I have more days where I actually really enjoy my job again…'*
>
> (Ben, 3 months)

Ben talked about having days where he questioned his decision to move and admitted that he had days when he had no idea why he made that choice. In his placement during the three years of his radiography course, Ben had

become very familiar with the protocols and equipment. Now, he is back to re-learning them and he has found this very stressful.

This seems to have hindered his enjoyment of the job early on in his transition because he freely admits that it was a difficult and uncomfortable time. Many days he went home disillusioned and overwhelmed about the amount he had to learn. However, once he started to become more familiar with the new protocols and equipment he began to have more days when he had enjoyed his new role.

Exploring this further in his second interview, Ben goes on to describe the stress he felt at the time:

> *'The stress was that bad for me, I just, I couldn't get myself into a routine, and I like routine. Even though I had more of a routine as a qualified radiographer, because I knew that I had to go to work, it just felt all over the place. I couldn't, I couldn't get myself into a routine.'*
>
> (Ben, 6 months)

He followed this up by explaining how important it is for him to know what is expected of him and having an established routine is clearly important. The lack of clarity in the protocols is something he seemed to be struggling with and this may not be unusual for someone new in post as several other participants were also feeling hindered by this at this time. Clearer guidance and support may well have helped to alleviate the stress and anxiety that Ben was feeling at this time. He feels that consistency in radiographic technique across the department would certainly benefit a range of people including the patient.

"Surely the radiologists can't like that, surely they want some two set views that they can report on…….. and I'm just sort of like, well, what do you want me to do, because I will do any one you want, just tell me which one you prefer…but I think the department definitely needs a bit of help in terms of, I think we should just work to a stricter protocol because it's easier for the patient, easier for the A&E doctor or the A&E nurse and definitely easier for the radiologist'

(Ben, 6 months)

Diagnostic radiography has moved to a much more protocol-driven profession since the introduction of IR(ME)R (2000). The legal responsibilities of the radiographer with regard to radiation dose can often restrict autonomous decision-making. Newly qualified radiographers like Ben are often over-reliant on the local protocols, however, during this interview Ben acknowledges that this approach gives him greater autonomy and professional choice as to which projection to undertake to answer the clinical question. As he has become more confident and settled in his role he recognises the value of this to his professional development and the profession as a whole.

The work by Sim and Radloff (2008) found that there were three characteristics of professionalism; expansion of professional knowledge, the profile of the profession and practitioners' willingness to assume increased responsibility. Recognising the ways in which radiographers are governed by protocols and polices, Sim (2005, cited in Sim and Radloff, 2008) proposed that it can result in practitioners becoming *'followers'* not *'thinkers'* (p205). The restriction of autonomous practice has the potential to undermine the professionalism of the role (Skar, 2009) and this is something that needs to be continuously monitored and opposed.

When we spoke at the twelve month interview, Ben was no longer stressed by the unfamiliarity of protocols and equipment as he now knew these well. For him the source of his stress had changed to what he refers to as 'the system' and this will be discussed later on in chapter seven under the theme of moving forward.

At her initial interview, Charlotte found the change from DDR which is a relatively new technology and processes images very quickly to working with CR which is much older and slower when processing images a real challenge.

> *'I trained on DDR, all DDR, and suddenly I've had to go to CR and that was a massive kind of barrier for me to start with – I was so worried about it. … most of them are really accepting, so they said – if you don't, if you can't get it on one cassette, don't worry, do it on two, it's not a massive problem.'*
>
> (Charlotte, 3 months)

For Charlotte, the thought of working with CR turned out to be much worse than the reality. Although the need to think more carefully about positioning patients when using a CR system caused her some concern and she made a few mistakes, she learned how to adapt to the different equipment and recognised that she had in the end picked it up quite quickly. She realised that by using trial and error she was able to develop her skills and confidence. This is an important piece of learning for Charlotte as practitioners are not always fully prepared or conversant with what is being asked. There are many times they have to bring their past experience, knowledge and skills together and apply them in the current but unfamiliar environment. This expansion of Charlotte's professional knowledge correlates with the characteristics identified by Sim and Radloff (2008) in their work on professionalism.

Gareth certainly found the amount of re-learning that he had to do almost overwhelming. He outlined the amount of different systems, processes, protocols and equipment that he encountered. In this quotation he also states the structure of the department as being different and yet another thing to learn. The only thing that stayed the same for Gareth and provided him some consistency in this early transition period was the radiographic technique that he used and for him this provided a safe haven.

> *'Things like, issues that you're getting yourself into, different protocols, you have to relearn. I had to relearn the whole back-office computer system, so CRIS, completely new kind of equipment, GE equipment. All the equipment was different, all the background, back office equipment was different and the protocols*

were different. And the structure of the department was different so […] what I knew in my previous hospital, no longer applied apart from the actual radiographic technique.'

<div align="right">(Gareth, 3 months)</div>

At this twelve month interview, Gareth reflected on these early days when he felt out of his depth:

'I think it was just the transition from kind of being at one hospital for three years and knowing exactly how that hospital works and all of the […] all of the imaging equipment etc. I knew and then going to another hospital where all the imaging equipment was different and the protocols and the way it works was different so it was in the initial three or four months of trying to kind of get my head round all the new back office work systems all the protocols […] probably was the most daunting thing…'

<div align="right">(Gareth, 12 months)</div>

There is a marked difference in the way that the participants in this study focussed heavily on learning the protocols and new equipment compared to those in the study by Naylor (2014). This is likely to be due to the fact that all the newly qualified radiographers in this study were placed at the same NHS Trust hospital for the duration of their course. Therefore their exposure to different working practices has been limited during their three year course. This combined with the fact that they all took posts in hospitals where they had never been before did seem to make the transition in the early months more challenging for them. Whereas in the study by Naylor (2014), the participants were all employed as band five radiographers in hospitals where they has previously been placed as a student. Therefore their previous knowledge of protocols and equipment allowed them to be confident in their practice at an earlier stage. It is likely that these participants would have reached legitimate participation more quickly due to their previous knowledge and experience of the department in which they were now working.

During his six month interview, Adam goes some way to explaining how he has developed in this time and this is illustrated in the following quote:

'I always thought I knew I was doing the right thing and you have to sort of go with your gut instinct as well, sometimes if you're not sure, just, if you spot a fracture, do the extra view to the fracture, and just things like that. But, maybe in the first couple of months, you would have been a bit like, don't know if that's the right thing to do, but now, you're more used to the protocols and everything that comes with it, and you're like 'Yeah, I can do that', and it's giving yourself practice to do it as well, and they encourage you to do it, especially in xxxxxx, as well, which is nice.'

(Adam, 6 months)

Initially, Adam relied on his gut instinct and having the confidence to do this enabled him to progress quickly. By becoming familiar with the protocols he now has the knowledge and competence to undertake extra radiographic projections if needed and to make decisions himself. The department in which he is working seems to encourage him to be an autonomous practitioner and he is clearly enjoying the opportunities that this is giving him.

At times, radiographers need to image patients who are for some reason unable to adopt the desired position for the X-ray examination. This is when they need to have an awareness of protocols and also be able to adapt their technique by working effectively with the equipment.

'…..you do a lot of adapting technique obviously in radiography but you don't think, I don't think about it anymore I used to really over think it and that's like a real overriding problem now I don't think actually think about adapting it at all, I just know how to do it .. and I'm much more confident with my patients…'

(Adam, 12 months)

Adam has developed his confidence in this over the twelve months as a newly qualified radiographer and as a result he feels that the gives the patients a much better experience. This is a good example of the intrinsic link that exists between confidence and competence which has a direct impact on both personal and professional self-identity (Currie, 2008).

Generally, the participants were feeling much more confident about working with the protocols and equipment at the six month interviews and this is summed up nicely by Rebecca:

'Yeah, I don't worry so much anymore. Yeah, it's strange. Obviously, I still you know, think twice about what I'm doing, but it's not, it's not always you know, in the back of my head like, 'Did I do the right thing?' I kind of just, I think I have better instincts now about what I'm doing, 'cause I'm used to how the A&E works and how the doctors work.'

(Rebecca, 6 months)

The levels of stress experienced by these participants in the early months correlated well with the findings of Boychuk Duchscher (2008, p1015) which identified the early stage of *'doing'* in the transition period led to high levels of stress and anxiety. The quantity of learning in order to perform in their role appeared overwhelming at times leading to a combination of uncomfortable feelings. At this time, the participants are very much focussing on the skills required for their role which Dall'Alba (2009) suggests will take them to a place of *'average everydayness'* (ibid, p35). In being able to undertake the necessary duties required in their role, the participants are 'becoming' a radiographer. The learning that has taken place to get them to this stage has occurred because the newly qualified radiographers have become open to new ways of working. The transformation that has taken place due to this has contributed to the process of becoming and is directly linked to professional socialisation.

5.2.2 Fitting in

The process of fitting in to their new department was an important factor for the newly qualified radiographers. Several mentioned the need to fit in and feel comfortable within their working environment at various times throughout their interviews. Some also seemed to feel under pressure to prove themselves during this early stage as if they needed to earn their right to be a radiographer.

Harry found it very frustrating when more experienced radiographers came into the X-ray room when he was with a patient and took over from him during

the examination. In the quotation below he explains how this had made him feel:

> *'Well there's a couple of radiographers where I work that, when I'm undertaking a procedure, they'll come in, and sort of take over. And I think they do it with everybody, but especially new qualified. It's just sort of takes me back to being a student, and it's quite irritating to me. […] I have had words, but I just kind of start to sit back now and let them take over and just go and do something else […]……..I would say that it makes me feel like a student again […] and they're just, just frustrating really.'*
>
> <div align="right">(Harry, 3 months)</div>

When this happens to Harry it makes him feel like a student again and although he has tried to address this with the staff concerned it has been a continuing problem. Throughout his interview, Harry comes over and also openly admits that he is inherently a laid back person and dislikes confrontation. In this example, you can see that he has in some way resigned himself to the situation and rather than deal with it he has chosen to let the staff carry on taking over from him and moves onto something else. He does not feel listened to by the staff and even though he is confident that often his solution to a problem would have worked better, he lets the situation continue. The lack of recognition that Harry is receiving from his colleagues despite his education and experience has left him feeling despondent and under-valued.

This is a strong message for Harry to receive at such an early stage of his career and may have initially affected his integration into the group. As seen in the work by Lave and Wenger (1991) in order for the beginner to move towards the centre of the CoP and gain full '*legitimate participation'* they need to progress from observer to active participant. At the moment this seems to be being blocked by particular members of staff. This may be due to the culture of the environment which protects the community when newcomers (outsiders) join until they align themselves with the expected values and beliefs of the community to which they are entering.

However, since his first interview, Harry has noticed a significant change in the way that his colleagues are now treating him.

> *'I actually feel nothing like a student anymore […] people are asking my advice, I'm giving it them, and they are listening to me and I just find that incredible really, after six months, and they are asking me for advice and taking it on board.'*
>
> (Harry, 6 months)

As he was talking to me he seemed really pleased that others were asking for his advice and that he was being listened to. He seemed genuinely proud of what he has achieved during this time. This had changed even more when we spoke at his final interview and he discussed his role as a super user and core trainer for the new DDR equipment. His knowledge and expertise in this area has finally been recognised and in his own words '*I seem to be the go to person about it at the moment.*' This is a significant change in the way Harry felt at his first interview and he has evidently navigated his way towards the centre of the CoP to achieve full legitimate participation.

Ben goes on to describe a different working environment and how for him in a small but busy department he is trying to grasp what his role is. In contrast to James, Ben doesn't feel pressure is put purely on the newly qualified radiographers to do all the work but he has identified another issue entirely, that of competition.

> *'Whereas down in department it was a bit more […] it's busy, there are lots of radiographers and it's a really small area, and it's difficult to know what your job is. It's difficult to know whether to stand out of the room and get the next card and do the next patient, or whether to go in the room and help, and make yourself useful as a team member… That was difficult and I still find that difficult now. […] I kind of – I like the idea of it being more team orientated, but it seems to be, I don't know whether it's just competition between colleagues. But, people definitely compete to see who can get in there and do the most X-rays'*
>
> (Ben, 3 months)

The difficulty that Ben describes is the tension between entering into the competitive nature of the department and working as part of a team. It is clear that Ben places huge importance on team working and he is struggling to understand the ethos of radiographers competing against each other to see who can do the most imaging examinations in a day instead of working together for the benefit of the patient. There seems to be a game being played by the radiographers which centres on 'one-up-manship' rather than collaborative team working. It is not clear where the driver for this behaviour has come from and why the radiographers feel the need to behave in this way.

Exploring this further with Ben at his second interview he spoke about how he had found himself drawn into this competitive environment and how this had started to make him feel. Consequently he sought advice from a couple of experienced radiographers.

> *'… but I kind of got bogged down by the people kind of influencing me, and I just got to a point where I thought, 'Well I can't do this anymore, I can't keep making myself feel like this'. I spoke to a couple of people in the department who really are quite experienced, and they were really useful. They told me to just take it back to the basic thing of doing your job, being there for the patient […] and that's kind of what I've done really – just stripped it right back, I'm not worried now about, 'Do I look good because I've X-rayed sixty patients in a day', I don't really mind if I do thirty, if thirty of those patients would recommend me being their radiographer again, then I've done a better job than doing sixty quickly. And that's kind of the attitude that I'm putting into practice now, and I'm feeling a lot better about it.*

(Ben, 6 months)

It is interesting that Ben sought the advice of more experienced radiographers about this situation who encouraged him not to enter into the competitive environment he was surrounded by. Again, it brings in to question why this behaviour and way of working is being adopted in the first place. The patient has always featured strongly in Ben's interviews and here he has had to work through this issue in order to re-focus his priorities. He is once again putting the patient at the forefront of his care despite the environment in which he is

working and that has resulted in him feeling much more settled and happier at work.

At twelve months, Ben acknowledges how important the team are to him and there are several pictures on his theme board to emphasise this.

'… I love the team atmosphere that's why I picked that image I love the team atmosphere because I think that makes your whole working life better. You spend so much time at work you should want to come and be social with your colleagues and we should feel like you're wanted as part of a team…'

(Ben, 6 months)

However, when Ben doesn't feel like this and there are things impacting on how the team functions together then this becomes a source of stress and unhappiness for him, making his work life much less enjoyable. He goes on to explain how other radiographers can become difficult *'it's other people that drag me down.'* It has been a turbulent time in the department where Ben is working and it seems as though he feels that this has negatively impacted on the team spirit and ultimately affected the way in which he settled in to the department.

Adam has intrinsically linked getting to know people he is working with to the ability to fit in.

'… I think the more you get to know the people you work with, the easier it is to fit in to that team. The more you sort of put yourself out there, the easier it is to feel a part of the team and then, when you feel part of the team, you feel more comfortable in your job role

more automatically, which is what I find. So, the more you sort of put yourself out there to help other people, the more they put themselves out there to help you.'

<div align="right">

(Adam, 3 months)

</div>

Adam has identified here that learning in his new role is not all about the acquisition of skills but heavily involves interacting with others as highlighted by Dall'Alba (2009). As Adam gets to know his colleagues it helps him to become part of the new world he is entering. By performing his role, undertaking certain duties he is doing the same as others and therefore becomes interwoven into the social environment as proposed by Dall'Alba (2009). This is an essential part of professional socialisation.

In their study of the transition of newly qualified nurses, Dimmohammani et al. (2013) identified interaction as one of the four stages of professional socialisation. In this stage, professional socialisation is not seen as a passive process but requires the newly qualified practitioners to be proactive. This proactive approach also resonates with the need to be responsive and the skills needed for contemporary practice   Effective communication and the ability to manage interpersonal relationships was found to be a key part of the socialisation process and this is what Adam has found to his benefit. One could argue that Adam has been very astute in the way that he has managed his transition in that he has chosen to *'play the game'* as identified by Clouder (2003, p217). In her study she explored the role of individual agency in professional socialisation and learning to *'play the game'* (ibid) was a key finding. From the data it appears that Adam has learned to orchestrate this effectively.

During their twelve month interviews, both Adam and Gareth mention the age range of the radiographers working in their department and how this may have affected the way in which they fitted in to the department. They are both in departments with a much younger group of radiographers compared to the departments where they undertook their clinical placements.

'...It's dynamic, it's very welcoming […] I didn't feel like I was the only starter there was 15 starters twelve fifteen starters on that my year so we had a lot of new people.'

(Gareth, 6 months)

'It's an environment where I can, it's allowed me to become the radiographer I want to become which is quite nice…. they were all like early thirties some late twenties and now I'm obviously mid-twenties so like everyone here's my age so it's made it much easier…'

(Adam, 12 months)

What is important here is that Adam has become the radiographer he wanted to be. He feels that the young work environment has allowed him to do this. His efforts to fit in to the team have not gone unrewarded and he seems to have achieved full legitimate participation very quickly (Lave and Wenger, 1991).

Although Adam is now feeling settled in his final interview, he referred to a picture on his theme board of a girl sitting on a bench all alone. He went on to speak about how isolating the job can be, especially early on and this is a view also shared by Ben and Ruby.

'…this one down here the girl sitting on the bench um sometimes this job can I find can be a bit lonely sometimes and […] can feel a bit isolated especially that's more like when I first started to be perfectly honest I felt obviously I came to XXX on my own […] I had to go about do everything on my own the first few months six seven months I was very lonely.'

(Adam, 12 months)

Adam and Ruby both moved away from home to new areas. Not only did they have the pressure of all that was expected of them in their new role at work but they also had entered into an unfamiliar environment at home. Their support networks were no longer readily available adding another dimension to their experience of loneliness and isolation.

For Rebecca, settling in to her new department was the most difficult thing for her and heavily influenced by her confidence.

'Just, you know, the initial settling into the department was probably like the hardest thing, like not knowing anyone, you know, being the newbie, because I was the only new person who started for a while, so that was probably quite hard. And just erm, the confidence and just getting in there and, you know settling in was probably the hardest thing...'

(Rebecca, 3 months)

Rebecca was the only new member of staff to have started for a while and therefore there was no peer support for her to rely on. She refers to herself as being a '*newbie*' and how she needed to get to know everyone when she started. Having the confidence to put yourself forward and get on with it has been really hard for her and has taken a great deal of courage and resilience. The way in which Rebecca has labelled herself here is explored further in the next chapter.

5.2.3 Fear of making mistakes

As a diagnostic radiographer you are required to work across several specialities which may include being located in other areas of the hospital e.g. Emergency Department (ED), theatres and wards. The pressure for diagnostic imaging departments to provide a 24/7 service has resulted in departments across the country implementing various shift systems and extending their services according to demand. This has resulted in radiographers now working a variety of shifts, some of which may be with one or two other radiographers, some of which may be alone. The changing working practice of imaging departments has had a consequence not only on

the workload of the diagnostic imaging departments but also the working hours of a diagnostic radiographer (CoR, 2016).

For many of the participants adapting to the workload pressures and the working hours has been somewhat of a shock and manifested itself in a constant fear of making mistakes.

> *'In this instance, it's because there was just two of us. I had all the inpatients and all the GP patients. So, there were just two for either area. So you're constantly, and on this day, there were so many inpatients and we only have limited space for them to wait before, you know, they go up to the ward. So, it was just building up like crazy, crazy amounts. It was just so busy and I think just 'cause you're rushing so much and still being quite new and still having to really think about what I am doing, it's hard to rush because you don't want to rush and get anything wrong.*
>
> (Rebecca, 3 months)

Here, Rebecca describes the strain that she and a colleague were under one day due to the amount of patients attending for their X-ray examinations. Still being relatively new to the post, she recalls feeling rushed to image the patients quickly and how this meant that she had a lack of time to think about what she needed to do. The build-up of patients was difficult to cope with and she felt constantly under pressure. She is conscious that she still needs to think carefully about what she needs to do and that results in her needing to take her time.

Later on in her interview, she re-iterates how the workload becomes stressful as she is continually trying to keep up with and compare herself to other more experienced radiographers who are faster than her. The pressure that Rebecca feels under is exacerbated by her fear of not wanting to make a mistake and the never ending, demanding workload.

> *'And I think that's why it's so stressful, because I'm still, you know, trying to take my time with things to not make any mistakes, so that's probably why I was so stressed because just I was…because they were working at a faster speed so I had to kind of keep up with the*

> *workload as well, because it was just, it was manic. So, that is what, yeah, It was just very busy.'*
>
> <div align="right">(Rebecca, 3 months)</div>

Even during the six month interview, Rebecca is still feeling nervous due to the ever demanding workload.

> *'I think I'm still quite wary of, of what I'm doing. I'm still like, I still feel nervous like when it gets to that sort of stage of busy-ness, I still get quite scared. The fact that I can't rush myself because I'm scared that something will go wrong.'*
>
> <div align="right">(Rebecca, 6 months)</div>

Much of the concern surrounding the level of responsibility is tied to the fear of making mistakes which has already been highlighted by Rebecca. However, this was also felt by Ben who tries to explain exactly how much pressure radiographers can find themselves under due to excessive demand of services on a regular basis.

> *'Not to where it kind of feels like you are the last line of defence and there is nothing behind you. You've just got to kind of dig your heels and work, which I don't mind, and I actually enjoy working hard, but it was just continuous all day, and then I kind of felt like, 'cause it was so, just full-on, I felt like it was more at risk of making mistakes…'*
>
> <div align="right">(Ben, 3 months)</div>

I explored this further with Ben during his second interview and he explained:

> *'I was always on the edge…. I was on the edge of working to my maximum ability and making mistake, and I don't like being that close to the edge. So, and that again comes down to just being more confident with my own ability and not really caring about the pressure that's put on us. Because there is a lot of pressure put on us as band five radiographers, to just kind of work and get through the work.'*
>
> <div align="right">(Ben, 6 months)</div>

Ben has had to learn to cope with the pressure and the fear of making a mistake. This has been hard to do in such a busy environment where there

are such high expectations of band five radiographers. Trusting in his own ability and not letting himself be panicked by the amount of patients waiting have been essential strategies for him to develop. It is difficult to consider how students could be better prepared for the pressured workload as they already spend 60% of their time in practice. However, perhaps the sharing of stories amongst the radiography profession may help students consider this further in the future.

The need to create the right impression and the expectations of *'acting a part'* was significant at this time and correlates with the findings of the study by Clouder (2003, p218). In her work she discusses the fact that her participants found that they were often expected to work above and beyond expectations and often the pressure is exacerbated by staff shortages.

At their twelve month interviews neither Rebecca nor Ben mentioned the fear of making mistakes at all. The source of their anxieties had clearly changed and these will be discussed under the theme of moving forward later on in chapter seven.

Ruby describes how she was feeling at her first interview when we spoke again at her six month interview.

> *'I think last time I spoke to you I felt like a ticking time bomb and if I made a mistake […], and I just was just sort of waiting….. just constantly like, 'What have you forgotten? What have you forgotten? What have you forgotten? Have you pressed the button yet? Don't press it! Don't press it!' And staring at stuff and just constantly feel like, this is not grounded in yet, and didn't quite feel like… when I started work, and I was left, I was thrown into it by myself pretty quickly…. And I just constantly felt like, 'I'm going to make a mistake. I'm going to make a mistake.'*
>
> (Ruby, 6 months)

The use of a *'ticking time bomb'* is a strong analogy to illustrate how she was feeling in those early days. The fear of making a mistake seemed to cause an internal panic which led Ruby to question her own abilities. As discussed previously, Ruby was given very little support in her transition and the

department where she worked was very short-staffed. This has no doubt impacted on her emotional reactions at this time.

At her final interview, Ruby illustrated this feeling by using this image:

Ruby, 12 months

By the time I spoke with Charlotte at her six month interview she had certainly begun to rationalise her fear of making mistakes which like Ruby was a powerful emotion in the early days of her transition.

> *"I think it's more accepting that you are going to make mistakes and that everyone makes mistakes, but minimising them and, I dunno, just learning from them. Like, if you never made mistakes you're never going to learn from it, so then that experience is probably better if you do and then you know that you are not going to do it wrong in the future, and if you do do it in the future, you know how to put it right. So… it's just building like a back-catalogue of knowledge up, I suppose.'*
>
> (Charlotte, 6 months)

Here, Charlotte is talking about how she has learnt to cope with making a mistake and use it as a learning experience rather than agonise over it and let it become destructive. She has come to recognise the value of learning from your mistakes in order to improve your practice in the future and this shows a level of professional growth and development.

Reflecting on this again at her twelve month interview, Charlotte illustrated how she had developed strategies to accept making mistakes:

'….once you've given yourself permission to the mistakes then you're, it's much easier to learn from them whereas if you don't, if you don't give that permission to yourself then you're just caught up in the whole 'I've made a mistake and you're much more likely to make it again…'

(Charlotte, 12 months)

Certainly at the three month interviews the fear of making mistakes was a significant concern to the majority of the participants. Many mentioned concerns of being 'struck off' which seemed to be a realistic and constant fear for them. The anxiety and fear of making mistakes which is experienced by the participants is likely to be underpinned by the blame culture which exists in the NHS. Fear was identified in the Berwick Report (DoH, 2013) as a barrier to both safety and quality improvement in the NHS. The Care Quality Commission are urging NHS hospital Trusts to eradicate this culture and to provide an environment where staff will feel safe to be open and honest about concerns in order to allow transparency to become the stimulus for change (Gwande, 2015).

In his literature review, Fitzgerald (2001) discussed errors in radiology and how traditional medical culture has led to the belief that mistakes should not occur. He goes on to link this to the blame culture in the NHS and how mistakes can lead to feelings of personal and professional failure. This undoubtedly makes staff anxious about errors and this is evident by the anxiety expressed by the newly qualified radiographers during the first three months in this study.

In the study by Strudwick et al. (2011) which examined the culture of a single diagnostic imaging department, blame culture was identified as a key theme in the data. Through observations it was found that many of the behaviours in the department were influenced by the blame culture in the NHS. Radiographers appeared to be constantly on the defensive, worrying and feeling guilty about making mistakes, a behaviour that Strudwick et al. felt was learned. The blame culture present in the NHS is exacerbated by the constant

critical media attention and the continuous scrutiny by a range of quality control measures.

5.2.4 Coping with tiredness

Ben really struggled with the tiredness to start with in his new post and explains how difficult it was to adapt to the increase of working from four days a week as a student to five days a week as qualified radiographer. As stated, he felt that this almost doubled his workload.

> *'Yeah, the first month or so, I was coming home and thinking like, 'weekends are just pointless', I'm not, I'm not even recovering by Saturday, and then Sunday I'm thinking 'I've got to go back to work' and that was really tough, because as I get more tired, I get really stressed out. Because I worry about things like that. And then it's kind of the rollercoaster, not a rollercoaster, like a snowball effect, you get tired, you get stressed, and then I get more stressed because I'm stressed and it's, it's a really hard thing to get yourself out of which just comes back to really making the most of my rest days… but adding that fifth day on, just makes it just so different. It's almost like doubling your workload even though it's just a day …'*

(Ben, 3 months)

In fact, Ben describes having to use nearly all of his weekend to rest and yet he still felt tired on the Monday. This seemed to go on for a few weeks and built up leaving him little time to recover. The excessive tiredness resulting from the increased working hours and the workload led to him feeling stressed. Initially, he found this difficult to adjust to and was regularly going to bed when he got in from work in order to cope, just as he did in his early days as a student. As time progressed, Ben began to adjust and he found that he was able to begin to achieve more of a work-life balance and started to regain some of his own time back. Later on in his interview he acknowledged how important it is to have some 'downtime' and to find a way to unwind outside of work.

Ben acknowledged during his second interview that much of his tiredness in the early days was attributed to mental fatigue and that he finds this particularly

difficult to cope with. As he has become more familiar with the environment and has started to feel more settled this has improved and he now relishes the shift work pattern that he has started.

> *'I love the shifts, I love working nights, I'd say, not just because I'm on my own but I just like the whole staying up thing and I don't sleep much anyway, just makes you feel like you're doing something, I guess. But yeah, I love the shifts, I like the diversity.'*
>
> (Ben, 6 months)

On meeting Ben again at his final interview, he refers to a picture of a person sleeping which he has included on his theme board. Coping with the shift system is something that Ben has had to get used to in his first year:

> *'…there's a couple of people sleeping I quite like…I think it's normal for anybody to feel tired in their job from time to time. I think with the shift pattern it's something I have to get used to or have got used to over the last year or so like learning when I need to sleep.'*
>
> (Ben, 12 months)

Adam was also shocked by his level of tiredness:

> *Yep, it really does hit you. I worked from the start of August right through till the end of October, without a holiday. And by the time I was on holiday, I think I slept for like two or three day's solid. Like, it's just so tiring because I think, I mean, I was tired as a student, because you're constantly learning new things, but now you've moved on from learning from about like how to do an X-ray and learning about anatomy – to actually, how do I go about doing this?' ….so it's just that, the tiredness comes from, I think, having to constantly be thinking about what it is you are doing and learning how to be a radiographer..'*
>
> (Adam, 6 months)

Adam describes the amount of new things he had to learn and how this contributed to his tiredness just as it did when he was a student. Conscious that the type of learning is different due to his responsibility as a radiographer he recognises that it is attributed to *'learning how to be a radiographer'* and this is the main source of his tiredness. I think what Adam is alluding to here is the bringing together many of the elements that underpin the role of the radiographer and learning to piece these altogether in the first few months was both physically and mentally demanding. Working for three months without a break was a long stretch for Adam and not something he was accustomed to and by the time he did have a holiday, he realised how much of an impact the working hours had had on his life.

Rebecca selected a picture of a bed for her theme board. Moving to a large trauma hospital, she has noticed the increase in demand for services compared to her placement site as a student.

'I get tired all the time we work crazy hours like my think my average of my last working time directive was 47.5 hours a week and that's what I'm working on average so yeah it's I kind of cope, but yes I'm tired all the time. It does get you down a little bit and I think as a student we kind of worked the four days it was kind of nice having that day off all the time and now it's going from four days to five days maybe six days three of them might be a twelve hour shift, yeah so obviously that's a massive change from when I was a student as well.'

(Rebecca, 12 months)

Settling in to the new environment has presented its challenges to the participants. The unfamiliar surroundings of a new department and hospital can seem so overwhelming that it is difficult to know where to start and which

route to take. The protocols almost provide the radiographer with a map, a plan of where to navigate and the equipment provides the means by which you can undertake your role. Once the basics have been mastered the newly qualified radiographer needs to continue to practice and this may need the negotiation of different environments, having the courage to try out new things and be prepared to make mistakes. The excessive tiredness is a result of the amount of new learning that takes place when grasping different skills in a new environment. As the participants have now started their on-call shifts or a 24/7 shift working pattern many of them are expected to work between 50-60 hours per week and therefore tiredness is still a main issue for the participants even at twelve months.

The environment is ever-changing and the newly qualified radiographer continues to see and image an endless stream of patients. Perseverance and resilience to reach the end of the never ending and challenging elements results in the newly qualified radiographer comparing themselves to those who are more experienced and in this case lack of speed seems to have put them under pressure and made them fearful of making mistakes. The need for the graduates to adapt and cope with change is essential for their professional survival and will be discussed in more depth in the conclusions chapter.

It can been seen in this first findings and discussion chapter that the first three months is an exceptionally challenging and emotional time for new graduates. There are a wide range of challenges to face and overcome and the need for support, patience and kindness cannot be underestimated at this time. Listening to the participants in the first interviews was sometimes a very difficult and uncomfortable experience for me. As a health care professional, educator, life coach and mum it was hard to sit and hear about the harshness of the environment that they were exposed to and I had to fight the urge to find some way of protecting them. It became apparent that in order to survive in the early months, it was essential that the graduates developed their resilience. This was highlighted in Scholes (2008), who suggested that all health care professionals need to be resilient in order to cope with the challenges and demands placed upon them. The findings of this study

resonates with this and links to the work of Verrier and Harvey (2010) which found that the work pressures experienced by radiographers were due to staff shortages, heavy workloads and volume of patients. These issues have all been experienced by the participants in this study, the difference being that they are newly qualified practitioners and as yet have not had the time and experience to build up the resources to cope with this. Coupled with this is the tiredness, the unfamiliar environment and in some cases moving away from home which can all adversely affect the way in which they cope on a day-to-day basis. By the time they have been working between six to nine months, the participants have begun the develop ways to deal with the pressure and have been able to seek out and use available resources to help them cope (Ungar, 2008).

6.0   DEVELOPING CONFIDENCE AND BECOMING ESTABLISHED

Needing support	Settling in	Developing confidence	Becoming established	Feeling useful	Moving forward
• Reality hits • Structured support • Support from colleagues • Peer support	• Getting to know the protocols and equipment • Fitting in • Fear of making mistakes • Coping with tiredness	• Believing in oneself • Recognising and valuing the level of their preparation • Needing feedback	• Making decisions and coping with responsibility • Dealing with the hierarchy • Developing interprofessional communication skills • Learning to manage students	• Contributing to the team • Using own initiative and working independently • Feeling proud	• Surviving • Taking in the bigger picture • Aspirations • Caring for patients

JOURNEY

Figure 11: Themes: Developing confidence and becoming established

These themes developed during the three and six month interviews as the participants began to settle into their new environment.

6.1   Developing confidence

The theme developing confidence spanned over the first two interviews as the participants began to find their feet. Believing in oneself, recognising and valuing the level of their preparation and needing feedback are all part of this main theme developing confidence. This played a major part in many of the participants' experiences and it must be acknowledged that at times it is less tangible than some of the other themes. However, the quotations below go some way in explaining how the newly qualified graduates began to develop their confidence over the twelve months.

6.1.1   Believing in oneself

Charlotte explains the elation of graduating and how quickly this is followed by self-doubt when walking into a diagnostic imaging department as a band five radiographer for the first time.

'Yeah, I think you, I think you're so confident when you qualify; you're like, "Yes! I've qualified, I've done it!" and then you walk into department and you're like, "Oh God, I can't remember anything I did, like a few months ago at uni". And, I dunno, it's just being qualified you think you should know it all when you don't, and you're never gonna know it all. And I think that realisation...'

(Charlotte, 3 months)

What Charlotte appears to be describing here links to the work of Tryssenaar and Perkins (2001) in which they identified four stages of transition in OTs and PTs. The second stage is euphoria and angst which seems to be exactly what Charlotte is experiencing, the euphoria of graduating quickly followed by the angst of remembering everything. The four stages identified as a result of this work are often referred to throughout OT and PT publications. This work also concluded that further work needs to be undertaken with students about the transition period including helping them to develop appropriate coping strategies.

On talking to Charlotte about her confidence in her second interview she has begun to appreciate what she has to offer others in the way of knowledge and experience

'…but I think I've grown […] and I don't know, when you're in department and you look at other people, people who have been there longer than you and they're asking questions that you know, and you're like, 'okay, so you've got a lot more experience than me yet you don't, you haven't had the experiences that I've had', you kind of realise that everyone had different experiences, so you're kind of like, 'okay', you start believing in yourself a lot more.'

(Charlotte, 6 months)

Charlotte feels that having trained in a different hospital she has much to offer and by sharing her experiences with others this has helped her to develop more self-belief in her abilities.

During her final interview, Charlotte adds to this:

'I think I'm a lot more confident than when I started […] and I've found myself kind of ... I dunno like I suppose there's not always a right or a wrong way to do things and I think when you first start off you're kind of like I can't kind of experiment and stuff like that and find what's the best… I have to do it this way and I think now I'm starting to say oh okay well maybe if I can't do it one way I can do it another way'

<div align="right">(Charlotte, 12 months)</div>

Charlotte then goes on to acknowledge the importance of sharing stories and the comfort that can bring when you are feeling vulnerable and still learning.

'I think […] at the start when you do make mistakes […] you kind of when you're not struck off you kind of realise you're like okay and then you kind of talk to other people and they're like 'oh yeah I've done that and I've done that much worse' and you kind of hear their stories as well ...'

<div align="right">(Charlotte, 12 months)</div>

This clearly links to the work of Strudwick et al. (2013) which explored the notion of diagnostic radiographers sharing stories. It was observed that radiographers tend to share stories and experiences with their colleagues in a variety of situations. Although it identified the competitive nature that story telling may encourage, it was overall felt to be a positive exercise by supporting and reassuring others and helped to create amongst other things a sense of belonging which in turn formed a CoP.

For Adam believing in himself was the most important quality to have and Ben feels very similar in that:

'I just think that having confidence in my own ability is, that's kinda the biggest learning curve from last time I spoke to you and now – is that I've got more confidence in my own ability.'

<div align="right">(Ben, 6 months)</div>

With Harry his confidence noticeably improved in the first three months. As previously discussed he struggled with radiographers taking over from him whilst he was undertaking X-ray examinations and this undermined his

confidence. His frustration at being treated in this way was exacerbated by the fact that he actually felt well prepared for the role.

> *I think I was well prepared, it was just knowing myself that I was prepared, I think that was the big thing. […] Getting my own confidence to say "Yeah, actually I know what I'm doing" and letting other radiographers who have been there for a while know that I know what I am doing as well because, like I said, they will try and take over. […] that has changed over the last few months, yeah. It was predominantly in the first month and a little bit beyond there, but the past few weeks have been fine […] a trust thing, a confidence thing […], like I said, just knowing my own abilities and believing in myself.'*
>
> (Harry, 3 months)

Harry acknowledges how his confidence began to develop at around the two month period and at this point he started to believe in himself and trust his own judgement. The trust he began to have in his abilities became apparent during the interview and perhaps this was beginning to be acknowledged by his colleagues as he noticed that radiographers had begun to take over from him less and less. For Harry it became important that he was able to display self-belief and confidence to others so that they let him consolidate his experience without interfering, this in turn helped him to further develop his confidence as a professional. Becoming a super user and core trainer has helped immensely with Harry's self-belief and he is relishing these roles.

Ruby spoke about a couple of incidents in her six month interview that had led her to doubt herself when challenged by doctors. On both occasions she relented and did what she was asked to do even though she felt that it was not the right thing to do and this left her feeling uneasy. On reflection she was annoyed with herself that she had conceded and stated *'I should have trusted myself….I just shouldn't have trusted him, he's not a radiographer.'* This has been a steep learning curve for Ruby and by her own admission her self-belief is improving, giving her the confidence to make her own decisions and stand by them.

This was also found in the study by Henwood et al. (2016) under the theme 'identity'. Some of the participants in this study also experienced a lack of confidence when faced by certain doctors who questioned their decisions but again this improved with experience as illustrated by Ruby below:

'I think I've found quite a logical way of working within radiology and I also find that [...] you get a request card you're not quite convinced by it - you know it's justified and I've found logical ways of thinking through what's wrong with the patient and thinking why on earth would they need this? They've not given me a reason why but [...] I look through what's wrong with the patient, I can find a logical reason as to why we're doing it and then sort of discuss what's appropriate and perhaps discuss it with a doctor [...] and there are people that you know I've managed to convince.'

(Ruby, 12 months)

It is evident during her final interview that Ruby is much more confident in her own abilities. She gave examples of where she has challenged referrals for X-ray examinations and as a result has begun to trust her own judgement.

Jane discussed her ability to handle pressure at her twelve month interview and how over the first year she has developed in confidence.

'…having the confidence to fight my corner has helped a lot when doctors are coming round to pressure you that their patient's nearly breaching and you've got all the other patients that need X-raying it's about having the confidence to stand up for yourself…'

(Jane, 12 months)

The findings in this study correlate with the existing literature on building confidence. In this section, it can be seen that as the graduates progress, their confidence increases alongside evolving independence. This correlates with the findings of Black et al., (2010) that also found in their study of novice physical therapists that confidence increased alongside independence and this was reinforced by positive interactions with peers, other professionals, patients and employers. Anxiety at this time is often caused by the tension that exists between competence and confidence (Roberts and Johnson, 2009). As Roberts (2007) identified, often those that appear more confident

are given more opportunities, learn more and the feedback from this further increases their confidence. This was also explored by Clouder (2003, p218) in her study exploring professional socialisation of OT students in which she proposed that students felt under pressure to *'act a part'* in the socialisation process.

Overall, believing in oneself was not explicitly mentioned by most of the participants at the twelve month interview stage. However, recognition and approval from others seem to have played a major part in the development of confidence in the new graduates. The way in which they now talk about their role and share certain experiences seems to exude confidence. Many of them have already begun to make plans for the future and have also been given development opportunities.

6.1.2   Recognising and valuing the level of their preparation

Being able to recognise and value their level of education seemed to play a fundamental part in the newly qualified radiographers developing their confidence. Below, Ben illustrates how he came to recognise the level of both his academic and practice education:

> *'I appreciate how well I've been trained. Especially here, and both academic and placement wise. I definitely appreciate that, and that surprised me, because you don't really know how well you have been trained until you can kind of see someone else who has been trained somewhere else.   And I feel I went into that job fully equipped to be able to do my job properly, as a newly qualified radiographer there's still things that I'm not so confident at doing, but the basic things that are expected of me, I feel that I have been trained superbly to be able to do that.'*
>
> (Ben, 3 months)

It is often difficult to measure how well prepared you have been until you are actually qualified and have something or someone to measure it against. Having done this, Ben seems surprised at how well educated he was but what is so positive here is that he feels that he was fully prepared for the role of a band five radiographer and he found this very reassuring. He still recognises

that there are areas in which he is less confident but is fully prepared to develop these further.

This is an interesting point as it indicates that Ben felt fully prepared in terms of his radiographic ability and this may well be due to the amount of time spent in clinical practice during the course. It could also be due to the fact that students are supported by practice educators based in the departments and that they also have the consistency of one learning environment over the three year course. However, this does not seem to fully prepare the students for the transition experience as highlighted in the previous chapter. The graduates' ability to transfer and apply their knowledge to a new situation appears to be compromised in the early months of transition due to a lack of experience in dealing with change. This correlates with the work of Boychuk Duchscher (2008) who suggests that preparedness for practice should not be solely focussed on skills and competencies but also prepare the graduates for the experience of role transition itself.

Adam underwent a similar experience in that as he started to undertake more procedures, the more he realised he knew and the more he appreciated how well prepared he had been. In fact he has already been teaching other new starters different techniques that they had not come across before. Having others ask him questions has helped him to develop his confidence and he now has a real appreciation of his educational experience.

> '….the more you get going, the more you realise everything you've been taught when you were a student and how actually after like a month, I was showing other students how to do something. Like, they didn't, they had never done before, that I had already learnt while I was still training [ ]… it's sort of made me think, 'actually people do come and speak to me about things', which makes you feel quite good and makes you appreciate that where you trained, has actually trained you really, really well.'
>
> (Adam, 6 months)

At the six month interview it was clear that the participants had made significant progress. None referred to this particular theme as most now concentrated on what they had learned since their transition period had begun.

On reflection at her twelve month interview, Charlotte spoke about her preparation for the role in-depth. Although she appreciated the education that she had received she recognised that however much you undertake as a student it is almost impossible to fully prepare for being qualified.

> *'….I don't think you can be prepared for it I think you have to go and do it yourself cos as a student you're always going to have someone look over your shoulder and to a degree you do rely on that whereas as a qualified you're put, you're by yourself sometimes and you can't physically turn round and ask someone you have to work it out yourself and I think so that you I don't think that you can be prepared'*
>
> (Charlotte, 12 months)

In her work, Mooney (2007) discussed the tension that exists between students being supernumerary and effective preparation for practice. I think this is what Charlotte has recognised here, that however much you try to prepare as a student you always have a safety net in the form of a supervising radiographer.

Rebecca also discussed her preparation and is quick to recognise the value of her education:

> *'….what helped me throughout the year […] is that I had good training at SSS I felt like I was well prepared although I was scared because of the equipment and different protocols and what not. I did feel I had … had good knowledge and I was trained well so I was prepared for what was coming although it was scary and daunting.'*
>
> (Rebecca, 12 months)

Again, very little was said by the other participants with regard to this sub-theme during the twelve month interview.

6.1.3 Needing feedback

As a student all the participants would have completed a practice assessment document which contained competencies and written feedback on their placement.   In addition, they would have been given daily and weekly feedback both verbally and in writing.   The participants were used to receiving copious amounts of feedback on their performance on a regular basis right up to the point of graduation.

Ben in particular found the sudden lack of feedback difficult to cope with, almost unnerving and in the following quotation he explains the impact that it had on him:

> *'First of all, because, like I say, I was in clinics, I was really nervous because I was thinking - because you're used to, as a student, getting feedback on everything that you do, aren't you, either way? You do an X-ray, the person that's supervising says 'Yeah, that's really nice', or they'll say, 'I think this is acceptable'.   And I'll say, "Shall I send it through", and they'll say, "Yes that's a really nice X-ray, send it through" or, "No, it's not, you kind of just need to do another one".   And it's that feedback all the time, and then you go into this as a new qualified and there's no feedback, none at all, not a daily station report, not looking at your images, nothing.   So, the only feedback that I could see that I would get, was if I would send patients back to clinic and they weren't happy with my X-rays.'*

(Ben, 3 months)

Ben almost seems bereft and lost without the feedback on his images and there has been no one for him to check through or talk through his images. Adjusting to no feedback has been hard for Ben and he found it very strange. Although up to graduation he would have been primarily responsible for assessing his own images there was always a safeguard present in the form of a supervising radiographer.   The only way that Ben could be sure that he was producing images that were acceptable was by relying on the fact that the patients were not being sent back from the clinic to be re-imaged.   This indicated to him that the staff must have been satisfied with the images that he was producing.   This default feedback position is not a good way for Ben

to assess his progress and does not provide him with any form of developmental opportunities.

This fits in with the finding of the study by Decker (2009) which identified a general expectation amongst radiography staff for students to simply *'get on with it'* (ibid, p74). This study was based on Diploma educated radiographers who underwent a very different training model than the degree students. It is therefore possible that expectations of newly qualified radiographers have remained the same over the years when in reality the educational model and the practice environment are very different.

At six months, Ben had moved on from this position entirely and was far more confident about his abilities stating that:

> *'Like I say, it's nice to be reassured from time to time, but I don't feel like I need the feedback, because I'm just confident in what I'm doing.'*
>
> (Ben, 6 months)

Rebecca seemed confident in her new role early on and was fortunate to receive some initial, albeit informal feedback on her performance. It seemed that being allowed to work on her own and having the opportunity to develop her own way of working with the occasional word of encouragement from other staff worked well for her. Being in control of how she was working added to her confidence and made her question her ability far less than if she was directly having to compare her practice to others.

> *'I think when you're left on your own and you're in control of it, you have to just get on with it. I think as a student, you're always like nervous if you were doing it differently to how the radiographer does it. I think, you know, now I have my own ways of doing things, I just get on with it [ ] I think being just being on my own and having to get on with it has helped, and the initial boost of you know, people saying, you know, "you've got it", kind of thing, you know what you are doing.'*
>
> (Rebecca, 3 months)

Rebecca mentioned feedback again in her second interview and how she received it almost by default.

> *'I think that, if people weren't happy, that's when you know, people start to talk to you. But, if they kind of like, you know, leave you alone like and don't really like say anything, you kind of know that you're doing okay.'*
>
> (Rebecca, 6 months)

Feedback or lack of feedback was mentioned by nearly all the participants and Gareth in particular highlighted how important it is to receive feedback on your performance in a timely manner.

> *'So, it was a success, and it was hard work and it was a good day because I'd successfully, you know, been imaging for a very good surgeon and he'd thanked me, and I'd done a really good job. And I was the one who put their hand up to do it, so… I was happy …..It's (feedback) incredibly important, it's incredibly important […] in everything you do, I think […] you should be thanked if you've done a good job……yeah; I do – especially from the surgeons.'*
>
> (Gareth, 3 months)

In this instance Gareth was so pleased to have been thanked by the surgeon that he goes on to explain that this should be done for everyone, especially in the theatre environment which can be a stressful situation. From Gareth's perspective taking time out to thank people for a good job done is an important thing to do and when he received this type of praise it made him feel happy.

Both James and Adam mentioned the lack of feedback during their six month interviews but at the final interviews this was not mentioned at all by any participant. However, Charlotte and Ben spoke about their cannulation training and through discussion it appeared that they had both interpreted being given this opportunity as positive feedback from the department.

This sub-theme links closely to those of structured support and support from colleagues. An effective structured support system such as a preceptorship scheme would ensure timely feedback was given to the new graduates. In the

study by Black et al., (2010), it was identified that regular performance appraisal meetings in which feedback was given increased the confidence of the graduate.

An evaluation of the NHS Flying Start programme (Banks et al., 2011) highlighted that newly qualified AHPs waited between four to nine weeks to be allocated a mentor. Due to small sample numbers of radiographers (2.7%) it was inconclusive as to how useful the mentors had been. However, overall the programme was well evaluated and considered a positive support for new graduates in providing feedback and developing confidence and clinical skills. Nesbit (2008) recommended moving to a post-technocratic model of professional education and introducing a structured preceptorship to support newly qualified therapy radiographers. She felt that this would enhance the development of these practitioners by using feedback to promote reflection, to help develop skills, to consolidate knowledge and ultimately promote independence.

Finally, in the study by Fenwick et al., (2012) which explored the transition of new graduates in midwifery it was established that the provision of a positive and safe learning environment promoted engagement and progress more quickly. It was felt that mixed messages or poorly delivered feedback hindered successful transition. It may be worth considering in this study what effect receiving no feedback has had on the participants and if this is the same as being given mixed messages or poorly delivered feedback.

6.2   Becoming established

A large part of making the transition from student to practitioner is developing your own way of working and establishing yourself as a professional in your role. As such this theme spanned across the twelve months varying in intensity. It is made up of four sub-themes; making decisions and coping with responsibility, dealing with the hierarchy, developing interprofessional communication skills and learning to manage students.

6.2.1 Making decisions and coping with responsibility

Although much of diagnostic radiography is guided by protocols, there is still a level of autonomy in the role whereby a diagnostic radiographer needs to decide on which radiographic projection is the most appropriate to answer the clinical question. Once the image is produced the radiographer then has to decide if the resultant image answers the clinical question and if the projection is acceptable to send on for viewing by the referrer and then reporting. Intertwined with this is the radiographer's responsibility under IR(ME)R (2000) to ensure that every X-ray examination requested is adequately justified by the referrer before performing the procedure. Although students experience this on a daily basis during their placement experience as part of their degree, the responsibility of making these decisions as a registered practitioner had a substantial impact on them in the first three months.

> *'I think 'cause I'm, I'm in charge of like what, of what I do, you know, I need to make sure if you know, if an X-ray is good enough, if I have to, you know, repeat it […],I have to get it flagged up, you know if I can see anything. I think just that in general just really scary because I was, everything that I did I was making sure, you know, I was doing it properly.*

(Rebecca, 3 months)

Rebecca describes here the period of adjustment from having her images checked by a supervising radiographer to now having to check and approve them herself. She admits to finding this responsibility scary and because it is now ultimately her responsibility she wanted to thoroughly check everything and that took more time.

The burden of responsibility was a theme identified in the work of Decker (2009, p73) which found that the sudden responsibility of accepting their *'own films'* caused a great deal of anxiety. This was also mirrored in the study by Tryssenaar and Perkins (2001) which identified a phase in the transition of OTs and PTs known as euphoria and angst. In this case, the angst part relates to the sudden realisation of what is to come in terms of learning curve and coping with the levels of responsibility.

During her second interview, Rebecca states:

'I don't worry so much anymore. Yeah, it's strange. Obviously, I still you know, think twice about what I'm doing, but it's not, it's not always you know, in the back of my head like, 'Did I do the right thing?'… I kind of just, I think I have better instincts now about what I'm doing...'

(Rebecca, 6 months)

She goes on to explain that she no longer thinks about the responsibility so much. Although it is still there in the back of her mind, it does not appear to feature as strongly as it did in the early days when we spoke. Getting to know how the department works and fitting in with the staff has helped considerably and allowed her to make informed decisions using what she describes as *'better instincts.'*

At her twelve month interview, Rebecca goes on to discuss her development further:

'……so with my confidence came assertion and this is um ... yeah it's just ... as a student I was quiet, shy and quite I kind of held back views and stuff. Now I've been qualified I feel that I can say no I can you know query requests that come through that are a bit dodgy […] and obviously that does improve with my confidence'

(Rebecca, 12 months)

This was nicely illustrated by Rebecca's choice of an image of a cat looking at its reflection in the mirror and seeing a lion.

Jane also found coping with the new found responsibility scary:

'Feeling that, it's just you now. There's no, you're always supervised as a student, so… although you've still got people there now that you can ask, you're qualified so there's that feeling of responsibility that wasn't there before necessarily. That's quite scary; it's quite a big responsibility.

(Jane, 3 months)

Jane also describes the feeling of accountability now that she no longer has a supervisor and the strength of feeling is not one that she has experienced before. She goes onto discuss the onus that she feels when being solely in charge of a patient and their care.

On speaking to Jane about this again at her six month interview she had also begun to effectively manage the responsibility of making decisions.

'It's still there, but I find it – I find it, because I can cope with it a lot easier and I'm used to it now, I don't notice it so much. The only times it really sort of, comes out a bit more is when you've got a difficult patient and you're looking at your image and you think, 'Oh, is that acceptable or is that not? Is it worth repeating? You think, this is on me – I've got to make this decision, because there's nobody else here. It's the middle of the night, nobody else here. That can be quite a challenge to actually bite the bullet and make that decision as to whether you're gonna do it again or not.'

(Jane, 6 months)

Jane notices the pressure of decision making much less now, particularly with straightforward patients. However, there are still times with more complex cases where she has to have the confidence in her ability to know that she is making the right decision at the time. This not only involves courage but also self-belief. In order to build up her knowledge and confidence Jane has utilised her experience of working with a wide range of staff whenever possible and also talks about how the shift work has helped her to develop strategies to cope.

During her final interview, Jane explains how she is now beginning to enjoy the responsibility.

> *"…I do quite enjoy the challenge of being on my own having the responsibility now whereas before that scared me slightly that it was me I was the radiographer and people were asking me questions and expecting me to know what to do whereas now I quite enjoy that the responsibility and the pressure'*

(Jane, 12 months)
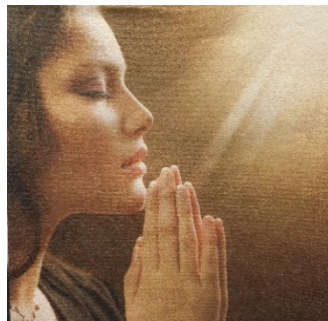
Reflecting on how she felt in those early days at her final interview, Jane used the image above to try and explain how she felt waiting for her images to process.

When Adam talks about how he feels about the level of responsibility he now has, it is clear that he is enjoying that aspect of the role.

> *'…you do feel a high level of responsibility at night when you're sitting there, behind the desk at three in the morning, on your own, everyone else of off around the hospital, and they say, 'Would you do this?', or 'Adam, can you get these images transferred over from XXXX?' and you're like, 'Oh yeah, I know how to do that now'. So it's things like that – when people come to you with tasks at three in the morning because it's a much smaller team throughout the whole A&E, you have to be able to do the things that other people ask you to do. So, it's a much greater sense of responsibility.*

(Adam, 6 months)

When Adam is describing his role within the wider team whilst working shifts he is animated and it is clear that the sense of responsibility he feels during a

night shift gives him a real sense of achievement and an increase in job satisfaction.

As Gareth acknowledges there is no easy transition into the responsibility of the role once qualified. As soon as you begin your post the ultimate responsibility for your images lies with you despite the support you may be given. However, the support he has been given does seem to have helped Gareth to cope with that level of responsibility. When I followed this up with Gareth during his second interview, he simply stated that '*nothing fazes me too much anymore*' (Gareth, 6 months). This is very encouraging and is a testament to the support he has been given during this transition period.

In the main, the participants seemed to have developed the confidence to deal with the responsibility of approving an image(s) by evaluating whether or not it has answered the clinical question. Getting to this stage has been a significant step for the newly qualified radiographers and highlights their progression during the first six months.

Interestingly, the responsibility of checking images did not appear to be a concern amongst the participants in the study by Naylor et al., (2016). In fact there was an indication that the decision-making process had been well practised as a student and therefore the graduates in general had felt confident in taking on the responsibility. This may be due to differences in the degree courses at the two HEIs used as part of the two studies and the practice experience provided to the students. It seems that the students whose experience spanned across different sites felt more prepared for the level of responsibility and making decisions in the early months.

At the twelve month stage, few mentioned the responsibility of making decisions which indicates that they seem to have absorbed this into their everyday role. Other things appear to have taken priority as they have begun to see the wider picture of working as a radiographer in the NHS.

6.2.2 Dealing with the hierarchy

In a large organisation such as the NHS there is inevitably a well-established hierarchy across the organisation as a whole and in each individual department. Gareth is quick to question the logic of such a hierarchy and how it is used to keep people in line, to keep them in their place. What he readily describes as *'a ridiculous hierarchy'* is already apparent in his workplace and he questions the necessity for its existence in radiography.

> *'I think you spend three years being knocked back and then you, have to kind of pull up and put these big boots on and stamp stamp stamp on other people's heads as they're coming up. It's a ridiculous hierarchy, which doesn't need to be, doesn't need to even, doesn't need to exist in radiography.'*
>
> (Gareth, 3 months)

This is a powerful statement by Gareth using the image of stamping to keep people down.   Here he seems to be describing what he sees as a very top-down, controlling department which can be a very destructive environment in which to progress and implement change.

In their study of the transition period of newly qualified midwives, Fenwick et al., (2012, p2057) also noted how quickly the graduates picked up on the *'pecking order'* in their workplace. They also felt under pressure to fit in and again were given specific tasks to test them out.

In other participants' experiences, the hierarchy is still apparent but in more subtle ways. The way in which newly qualified radiographers are expected to undertake certain duties and to take on extra work was mentioned previously and is again highlighted by James and Harry. Their experiences highlight the already established hierarchy that exists in their diagnostic imaging departments.

"I think there's a bit of a culture sometimes where people think that the newly qualifieds will pick up the work because they should, because they are newly qualified and they need the experience...'

<div align="right">(James, 3 months)</div>

During his three month interview, Harry described an incident to me whereby a menial task had been given to a newly qualified radiographer which was completely unrelated to radiography. The newly qualified radiographer felt under pressure to carry out the task and there was no comeback from this incident and no questions were asked by other colleagues.

'....there was a surprise once but it wasn't for me. It was what a colleague told one of the starters to do, it was to go and clean the fridge in the staff-room. I was in theatre when that kicked off, and I came down and I heard and I couldn't really believe that he had been forced to clean the fridge'

<div align="right">(Harry, 3 months)</div>

Both these examples highlight the aforementioned subtlety of the hierarchical system within these departments where more experienced staff use their 'rank' to exert pressure on the newly qualified staff to undertake additional duties or other tasks. James reiterated this at his six month interview, confirming that this is still the case and how as a new person to the department it is difficult to challenge this type of behaviour as you do not want to be seen as awkward or make yourself unpopular. His fear of how this may affect his progression should he speak out was apparent.

Harry is also struggling with the hierarchy at his six month interview and again feels that he does not want to challenge more senior staff.

'...She's been there much longer than I have, she's well I suppose, let's be honest, I don't want to annoy her, she's slightly more senior.... I'm just not somebody who likes to shake the boat.'

<div align="right">(Harry, 6 months)</div>

Jane goes on to discuss how she has started to become much more aware of the underlying hierarchy in her department:

…with certain radiographers, you notice it straight away. Erm, but as you are there longer, you sort of notice the subtle hierarchy going on, and I'm friends with a lot of the radiographers now, so like they talk and you pick things up and that, as to what they think of certain members of staff, and then you notice it yourself and think, 'Yeah actually – they do sort of come a little bit above you'. But, with some of them, it is a definite, as soon as you're in that situation, you think, 'right, they're at the top and I'm just gonna – at least for the moment, until I know what's going on – fit in with what they're saying. Because they're obviously in charge'.

(Jane, 3 months)

Adam highlights that one of the advantages of working in a smaller team whilst on shifts is that there tends to be less hierarchy as the team members all pull together regardless of their position in the organisation. By the time that the twelve month interviews occurred hierarchy was not mentioned by any participant. It maybe that the newly qualified radiographers are beginning to feel part of the team and that this has become less noticeable to them as they become immersed into the culture of the workplace.

The presence of hierarchy in the workplace is one of the barriers to beginners moving towards the centre of the CoP and gaining full legitimate participation (Lave and Wenger, 1991). Certainly the way in which hierarchy can affect teamwork will have a direct impact on the way in which care is delivered. The culture of the workplace needs to underpin the team work aspects which were identified by Strudwick et al. (2012) such as atmosphere between colleagues and the methods in which they work together.

Mooney (2007, p844) also discussed the impact of hierarchy in her study. The participants felt under pressure to conform to certain rules within the work place and felt that staff were resistant to change. She also identified a theme *'without a voice'* which directly mirrors the experience of my participants whereby the junior nurses were expected to pick up the night and Christmas duties. In both studies the graduates felt powerless and vulnerable and this would have directly affected their socialisation into the professional group.

6.2.3 Developing interprofessional communication skills

Whilst practising as students, the participants were to a certain extent protected by their supervisors and although they communicate with other professionals this would have been minimal and carried out under guidance. It is therefore encouraging that Adam has found it much easier to question doctors since he graduated. It is almost as if qualifying has given him the confidence he needed to engage with them on a professional level and he is now assured enough to ask them questions and use the opportunity to increase his learning.

> *'But I'm still learning all the time though, there's still things I'm asking. And now I'm qualified, I find it much easier to ask doctors questions as well.'*
>
> (Adam, 3 months)

This correlates with the findings of the work by Decker (2009) who concluded that students who graduate from the radiography degree programme are much more confident in terms of professional communication compared to those who undertook a diploma qualification.

Jane talks about the need for effective communication in theatre to enable her to undertake her role successfully.

> *'I knew the C-arm enough, I knew the theatre staff enough and they had explained what I would have to do to get me through and it was fine. But, luckily that day I was with a consultant that was really nice so I just explained that I was newly qualified and hadn't done many spinal cases and it was all okay, and know I'm confident with spinal stuff and I've been up with surgeons that aren't quite so friendly. And it's been all right because now I know what I'm doing…..'*
>
> (Jane, 3 months)

The way in which she openly engaged with the surgeon encouraged proficient teamwork and demonstrated a good level of professional maturity and confidence.   When she first went up to theatre she was lacking in confidence and therefore it was important for her to have an approachable surgeon in

order for her to feel comfortable and be able to ask questions to ensure the procedure could go to plan. However, as she has gained in confidence this has become less important as she knows what she needs to do and is now less intimidated by the surgeons and more able to undertake her role even in stressful situations.

Working in the operating theatre is often an area of radiography that newly qualified radiographers find difficult and this was an initial finding in the study by Naylor et al. (2016). It was also identified in a range of studies discussed in the literature review that an area of concern regarding preparedness for practice in newly qualified radiographers was in fact the readiness to carry out imaging procedures (Nisbet, 2008; Mackay et al., 2008; Decker, 2009; Higgins et al., 2010; Whitehead et al., 2013 and Avis et al., 2013).

This certainly does not appear to be the case in this study, in fact several of the participants have actively chosen to work in theatre, firstly to escape the pressures of the main department but also because it is the one place at this time that they were given instant feedback on their performance.

Jane has continued to develop her interprofessional communication skills and at her six month interview she discusses her need to be able to negotiate with A&E staff whilst working night shifts.

> *'Someone got on top of me because they were just putting on request after request after request and no matter how fast I went, it wasn't happening, at all. So, I just rung the A&E coordinator and said, 'Look, I'm snowed under, but a lot of what's on there now is extremities, so I should be able to reel them off a bit quicker', you know…… And I felt a lot more confident to say, actually I'm doing my best, but it's not my fault that they're waiting a long time, it's the sheer workload, rather than how quickly I'm working. Whereas the first time, I was just like, 'I'm not going quickly enough', whereas now I'm like, 'I am, but I can't physically work any quicker.'*
>
> (Jane, 6 months)

Jane has developed the confidence now to evaluate the situation and then to discuss the possible options with other staff to achieve the best outcome

without blaming herself first. The importance of being able to engage effectively with other professionals has a positive impact on patient outcomes but is sometimes challenging (Foronda et al., 2016). In their literature review, Foronda et al., 2016 identified several barriers that exist including confidence, experience, and hierarchy. They also suggest that health professionals are educated very differently in terms of communication skills and this can often lead to misunderstandings and frustrations resulting in a lack of collaboration at times (ibid).

The need for effective interprofessional communication appears to have increased since the participants started their shifts and on-call duties. Liaising with other health professionals is discussed by Jane at her final interview.

> '…I'm not on my own anyway and there's always people around even if they can't help you with the radiography side of it they can always come and give you a hand usually so you know it's just getting used to actually asking people that aren't radiographers to help you which is a bit scary you know talking to someone who's just a completely different profession I can't do their job they can't do my job but working at a multidiscplinary thing and working together ... it's weird how it all starts to … what people have been telling me for three years… starts to actually make sense'
>
> (Jane, 12 months)

Charlotte has also noticed how her relationships with other professionals within the hospital has developed during her first year.

> '... like the other night […] some of the requests because we've got new doctors coming through were quite dodgy and it's quite difficult to justify doing them, so you just pop round to A&E and have a chat with one of the doctors and stuff and it's a lot more like oh you're criticising me it's not like that kind of thing […] it's just quite nice really ...'
>
> (Charlotte, 12 months)

In the study by Black et al., (2010) it was found that the novice PTs' confidence in communication had increased during the period of six to nine months. This

included talking to patients, carers and colleagues and the ability to listen to and interpret information given to them.

Being part of the wider team is an important aspect to James as he describes how he becomes part of whatever team he is working with. The quotation below illustrates how James entered a new CoP by ensuring that he was an active member straight away.

> *'…one of my mentors at YYY is an ex RAF radiographer and he kind of told me to help the team in any way you can whenever you can so whenever I'm not doing something with the Image Intensifier in theatre I'm trying help PatSlide the patient or whatever, or doing whatever I can to be useful and I think people appreciate that and they've been really good in their feedback and kind about that and doing little things in a team can make you part of that team.'*
>
> (James, 12 months)

The confidence that the graduates demonstrated in interprofessional communication could be as a result of the Interprofessional Learning Programme (IPL) that they undertake as part of their degree course. They are introduced to a range of health and social care professionals early on in their educational journey and undertake three modules together over the three years. The aim of the IPL modules is to explore the role of interprofessional communication, team working and increasing an awareness of others' roles. In the case of the graduates in this study this seems to have had a positive impact in their transition period.

Although the majority of participants discussed how their interprofessional communication skills have improved there were still some frustrations regarding a lack of understanding of their role amongst other professions.

"…I don't think there's much sympathy for how much pressure there is sometimes like when you're in A&E doing trauma calls … you've got consultants running into your bay when you're trying to take an X-ray and stuff and just mulling about when you're trying to do things and then they come in a second later and expect the X-ray to be there and I don't think there's much of an understanding of the radiographer's perspective in a hospital a lot of the time.'

(James, 12 months)

Although Ruby also feels confident at dealing with other health care professionals she has not always experienced a positive attitude in return. Below, she describes the attitude of some nurses towards her when she has undertaken mobile X-ray images on the wards.

'I was up in ITU, and I'd been round two bed-spaces, and the nurses just haven't helped me at all, whatsoever, and just not acknowledging my presence and they may help or they may not – I mean I was trying to get into these really small cubicles and bring the machine in, and trying to hold the door open as well when they could easily just hold it for me……….. And I don't think half of them understand, the ITU units have usually got an attitude towards radiographers because all they ever see is us come up, put a board in, do a chest X-ray and go. None of them ever see us do anything complicated or difficult, and I think they've generally got this idea that we're all pretty dumb and easy jobs and stuff like that – and they have no idea what we do.'

(Ruby, 6 months)

Ruby was clearly frustrated not only because of the lack of help she received but also because she feels that there is a lack of awareness of the role of the diagnostic radiographer.

Adam used an image of a man punching his fist through the screen of a laptop to illustrate his frustration.
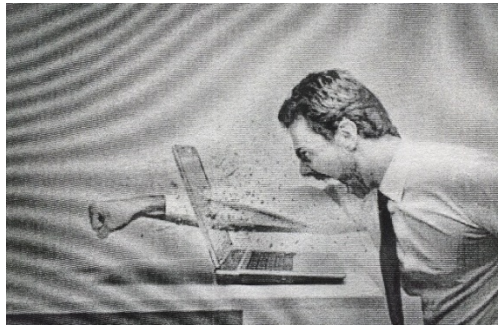
'…it is very frustrating especially when as I say again on a night shift when you're responsible you've got other people asking your opinions and you've got doctors coming round asking for your opinion, you've got the ward on the phone giving you a hard time and you've got radiologists saying where's the CT scan why isn't it done…… everyone expects you to drop everything and do it for them…'

(Adam, 12 months)

It is evident from these examples that there is still a lack of awareness of the radiographer's role and the willingness for professionals to work together for the benefit of the patient. Further work still needs to be undertaken in the form of IPL to break down these barriers and to encourage a more cohesive workforce.

6.2.4 Learning to manage students

Many newly qualified radiographers are taken by surprise at how quickly they are expected to supervise and teach students and the participants in this study were no exception. By the time the three month interviews were undertaken they had all had experience of working with students. It is a big responsibility for the new qualified radiographers to take on and Charlotte outlines her initial concerns in the following quotation:

'… well, at first, I just felt awful about it, because I didn't feel like I had the confidence in myself to be doing what I was doing unsupported, let alone support someone else to do it. Erm, but then, I dunno, I think it was the student, that I think made me feel like I could do it, because, we were in outpatients and she was very

much like me as a student and that kind of gave me confidence. I kind of thought, "Okay", and she's a really good student as well, so I thought, "Oh well, if I was like her, and I felt the way she did when I was training, then I must be able to do this. And I can support her in doing this". And she kind of came to me and asked me questions – and that was the first student that had come to me and asked me questions and my opinion and I helped her. And, she was really grateful for that and you could see she was really grateful for that. And then I thought, "I can do this, and I can support someone else. I may not know it all, and I may have to say at times 'I'm sorry I don't know that answer, you may need to ask someone more senior than me', but then I can learn from that as well, because I will know the information.'

(Charlotte, 3 months)

Feeling as though she was already lacking in confidence in her own abilities, Charlotte felt unable to also support a student. However, on working with the student and seeing something of herself in them it gave her the confidence to support her in her learning. This confidence was further increased by the fact that the student came to her to ask questions and the subsequent feedback she received from the successful interaction further enhanced her self-belief. Realising that she did not have to know all the answers but can point the student in the right direction somehow reduced the pressure that she had put on herself and she realised that this could in fact provide a valuable learning opportunity for her.

Ruby's experience when working with students was completely different and she was very reluctant to let the students do anything whilst working with her due to a lack of trust in her own abilities.

' I don't really let them do anything yet, because I hardly trust myself, let alone trust, put my trust in them, so I generally don't let them do anything, and I just apologise to them all the time, like "I'm sorry, I'm just going to have to do it all.'

(Ruby, 3 months)

Ruby highlights here that she is still learning herself and coming to terms with her new role. Therefore, she clearly felt ill-prepared to cope with the additional responsibility of a student and felt unable to effectively support or teach them

in her current role. At the six month interview, Ruby admitted that she was still struggling:

'It's hard to put your trust in someone else. If they were a third year, I've not had many third years; I think I would let them do a lot more. But, when they are first and second, they only come for a week – if we had permanent students, then I could.'

<div align="right">(Ruby, 6 months)</div>

One of the things that has impacted on Ruby's confidence to manage students is that they come from a range of different Higher Education Institutions and for short non-recurring placements. She has therefore been unsure of their knowledge and thus feels less able to let them do very much even under her supervision. This has also been a challenge for Adam.

'……they are all from different, they are from three or four different sites…… you just don't know what level they are and they vary so widely across the range, of their ability level, that it's really stressful;, really really stressful training students in XXXXX. I love it when you get a good one, that's proactive and willing to learn, but the ones, some of them are really stressful – they really make the day stressful for you. They are my biggest stress.'

<div align="right">(Adam, 6 months)</div>

When we spoke again at his twelve month interview, Adam still acknowledged the problems with students with regard to managing them.

'…so I had to have a whole chat with her and then somebody from her cohort as well did the same thing about three weeks later with me and I was like right this isn't good they're third year students they need to be … they need to know what they can and can't do so I had to speak to the clinical tutor about it and just have a chat with them'

<div align="right">(Adam, 12 months)</div>

James has also had to develop in this area:

'I've had to learn a bit of patience and […] I've tried to stop myself as much as I can, 'radiographer-tweaking', where the collimation is just a millimetre away from where I want it to be and I had to go and

touch it, so I've tried to take a step back with some of that and you know, learn to let go with some of it – but it's difficult when you know that your name is going on the X-ray to go off to the doctor at the end of the day, it has to be right, and it has to be right for the patient as well.'

(James, 6 months)

Here James is feeling the responsibility of not only his work but that of others. In trying to ensure that the correct images are obtained he is zealous in his checking of students' work. This extra accountability puts him under extra pressure and he is really trying to hold back and let the students have a go.

The additional stress of having to supervise and teach students as well as coping with a high pressured work environment can be difficult to cope with as Harry goes on to explain:

'I did snap at one student… was he a first year? Yeah, he was a first year, it was something really simple that he kept getting wrong and I felt really bad …… he didn't get it straight away, I should have been more patient – but it was a simple thing…..It was a really busy day and it just slowed things down a little bit and it got to me, and it shouldn't have really.'

(Harry, 6 months)

Harry openly admits that he felt under pressure and lost patience with a student during a particularly busy period. The workload does not always allow radiographers the luxury of time to teach and let students practice, particularly when they are inexperienced themselves. Harry did feel guilty after this incident and found the student and apologised for his behaviour.

Henwood et al. (2016) also found that the newly qualified radiographers were concerned about the levels of responsibility when supervising students. However, over time the participants began to enjoy this aspect of their role and found that it increased their job satisfaction.

Working with students was a real positive for Rebecca and it was evident to see how much she had enjoyed it. At her second interview, she is still enjoying

the experience and is now undertaking assessments. As she has become more involved with students she has started to come across some challenging ones.

> *'I've had a few challenging ones that I really have to keep an eye on, and you have to kind of tell them that they're, you know, not doing things right. And I find that quite hard to do because you don't want to come across horrible, but you need to teach them'*

(Rebecca, 6 months)

Rebecca has clearly found giving constructive feedback to students uncomfortable and has yet to receive any formal training from her department to undertake this.

This is again something identified by Henwood et al., (2016) in that assessing students was found to be a challenge as was being able to give them constructive feedback. Although the participants do cover aspects of this in a third year module entitled Preparation for Practice in which they undertake a peer review it may be that further preparation and support as suggested by Henwood et al. (2016) is still needed.

The majority of the participants do enjoy working with students despite the stress that it may cause at times. During these early months some have spoken about their need to develop patience and trust. Some of the newly qualified staff also spoke about how working with the students provided opportunities for them to continue learning and how they found this stimulating. Further support to explore this and to be able to reflect on their experiences in the form of a structured preceptorship scheme would help in the professional development of the participants.

As the newly qualified radiographer continues to develop they become more aware of other radiographers around them, some equals, some more dominant and some faster learners. As they reach this stage it becomes important for them to learn to keep certain boundaries whilst they try to

understand and navigate their way through the hierarchy that exists not only in the diagnostic imaging department but across the hospital. There seems to be a certain pressure and expectation for the newly qualified radiographer to 'keep in line' in these early months.

Part of this navigation process is underpinned by the newly qualified radiographers' ability to communicate with others both uni (intra) and interprofessionally. By having the confidence to interact with others, ask questions and clarify information, the new graduate will become much more aware of how not only to plan their future but also how to make it most productive and enjoyable.

7.0   FEELING USEFUL AND MOVING FORWARD
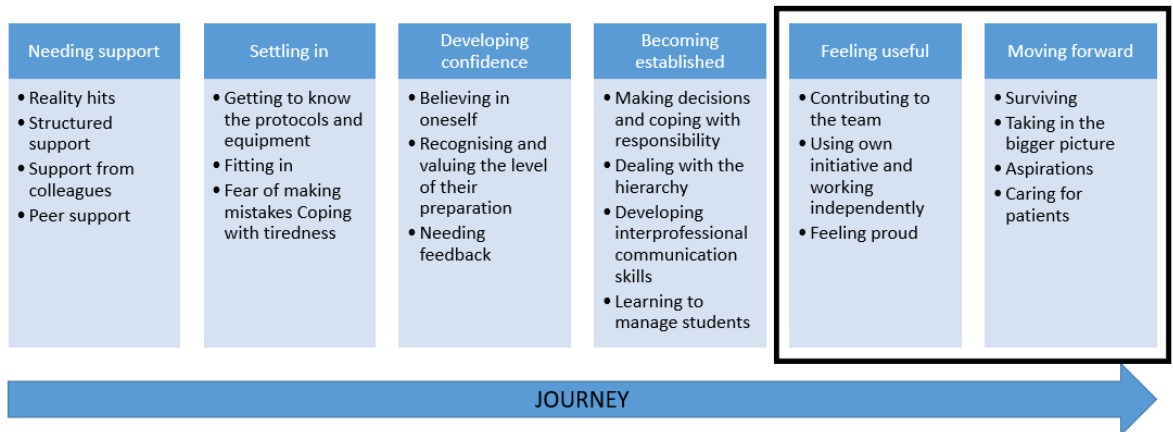
Figure 12: Themes: Feeling useful and moving forward

These themes featured most strongly at the six and twelve month interviews as the participants began to develop in their professional roles and started to consider and plan their future.

7.1   Feeling useful

This theme varied in intensity throughout the twelve month period and also across the participants. Some were anxious early on about feeling useful whilst others reflected upon this at a later date. Feeling useful was shown to be an important theme for the newly qualified radiographers and comprises of the following sub-themes; contributing to the team; using own initiative and working independently and feeling proud.

7.1.1 Contributing to the team

For Jane, there was a real sense during her three month interview of how important it was for her to feel useful. She spoke about the importance of being able to contribute in some way as part of the team and how despondent she felt when she had not been able to do so.

'That's been, I think, pretty much all the really low points have been linked to that (contributing). You don't actually feel like you've helped at all, you've just got in the way.'

(Jane, 3 months)

All Jane's low points in the first three months were linked to days where she had felt unable to fully contribute to the department. The feeling of helplessness described by Jane impacted heavily on her enjoyment of the role and left her feeling dejected and unfulfilled. This has significant implications for diagnostic imaging departments and the retention of staff in a time of radiography shortages.

By the time we spoke again at her six month interview, Jane linked the feeling of being useful to fitting in.

'It's all part of that fitting in and feeling like you're actually being useful and people see you as a radiographer that's part of the team, rather than somebody that does something in the background.'

(Jane, 6 months)

It is evident that Jane is feeling much more part of the team and less like a 'spare part' as she described it. This had a really positive impact on her experience and made her feel worthwhile. This mirrors the findings of the study by Black et al., (2010) which followed the transition of PTs. They found that professional identity formation and role transition was deeply affected by growing respect from patients and colleagues. They noted that the novice PTs progressed during the transition period when they began to recognise the value of their role.

By the time we spoke again at her final interview, Jane reflected back to earlier days:

> *'…it was busy and you weren't working very fast and you had to keep asking questions because you weren't sure what to do. I thought, what's the point of me being there I was probably more a hindrance than I was a help?'*
>
> (Jane, 12 months)

Now, however, she feels that she fully contributes to the team *'it's just feeling like you're worth what you're getting not necessarily what you're getting paid for but it's the easiest way to put it … you're actually worth what they're paying you for ..'* Again, this feeling of contributing has aided Jane's integration into the team and strongly influenced the formation of her professional identity. She is no longer an observer on the periphery of the CoP but has made significant steps towards the centre and achieving full legitimate participation (Lave and Wenger, 1991).

By the time the participants had been qualified for six months, the majority had completed their induction (if applicable) and had started working shifts/on-calls.

Rebecca had certainly found this a challenging time:

> *'You all have to work with each other, you know – tell each other […] where you're going – where you're heading and work together with beds and trolleys and yeah – it's really, it's good to have a good team on. Yeah, it's important.'*
>
> (Rebecca, 6 months)

Despite the challenges, it is evident by listening to her talking that Rebecca now feels that she is an active and useful member of the team. This has been underpinned by a supportive learning environment which has promoted a sense of worth in Rebecca. This correlates with the work of Roxburgh et al., (2010) who evaluated the Flying Start Preceptorship NHS programme in Scotland. It illustrates just how important a supportive workplace is and how this should never be underestimated in helping employees reach their full potential.

Charlotte has also experienced this shift in feeling useful and now feels that she has started to contribute to the team much more in the last three months.

> '....then to be able to do shifts, […] and then when you've got that, then you can, everything comes together. […] and you just kind of work more without questioning everything, and you know what you are doing a bit more.'
>
> (Charlotte, 6 months)

Adam is also feeling much more part of the team:

> '....you're all much more part of a team. And […] right I'm going to off and do this, not, yes, you are telling people what you are going to do, but you're feeling much more confident and comfortable with doing it because you're in that small team… So, I'm going to go and do that, and you can stay, can you stay and whip through these?', so it's much more working within a smaller team, which in turn help to gain respect with the people that you are working with.'
>
> (Adam, 6 months)

Negotiating and taking responsibility for the workload in smaller teams whilst out of hours has helped Adam feel that he is contributing to the team and a worthwhile member of that team. He also feels that in doing so he is gaining respect from his colleagues as an integrated member of the team.

Gareth has certainly proved himself as a valuable team member:

> '....and all of a sudden, because I was a spare part, essentially, I was doing CPR, I was doing it for 25 minutes as well while everything was going bonkers […] and that was quite a thing actually, that was quite a thing. But, I think the, I think I got lots of support […] from […] the little cardiac team down there. Again, I think it was much more teamwork, not even with the radiographers, but with the whole cardiac team, and they all said, you know, well a couple of them said, and the senior down there, 'you know are you alright, do you want something?'
>
> (Gareth, 6 months)

In reacting to this emergency, Gareth played a major part in saving this patient. His experience of working within the interprofessional cardiac team was a positive one and he came away having been offered support following his active contribution.

Being able to contribute to the team has been vitally important to the participants. It has given them a feeling of self-worth and a feeling of being valued in the workplace. For many, it has taken six months to reach this point and much of this is has come from within themselves. For me, this research raises questions as to why the newly qualified radiographers have not been given feedback earlier to expedite this process and to facilitate the process of becoming.

Not only is the importance of teamwork and integrating into the team highlighted by the CoP (Lave and Wenger, 1991), but a study by Rafferly et al. (2001) explored the relationship between teamwork, autonomy and improved patient care. In their survey of 10,022 staff nurses across 32 hospitals they sought to investigate five dimensions of the role of the staff nurse; autonomy, use of resources, relationships, emotional exhaustion and decision-making. Their findings suggest that teamwork is associated with a range of positive attributes such as job satisfaction, plans to remain in post and lower levels of burnout. This is an important observation as it illustrates the importance of newly qualified practitioners in becoming part of an established team. The benefits are not only to the individual as seen by the participants' experience in this study but also to the organisation and wider profession.

7.1.2 Using own initiative and working independently

Gareth has really enjoyed being able to use his own initiative, being allowed and encouraged to run his own section of the department at an early stage in his career. The responsibility he was given obviously gave him a real sense of achievement and being able to work as an autonomous practitioner added

to his job satisfaction and this was evident in the way that he spoke about this experience in his interview.

> *'I've enjoyed it immensely. I've enjoyed […], running a little ship, you know. Your little part of the department, I enjoy that. I enjoy problem solving. I don't know if I should be doing that at this present, at this moment, but there aren't enough band sixes to do that so, you end up doing it. But, I don't mind.'*
>
> (Gareth, 3 months)

Being able to lead a small team gave Gareth a sense of purpose. And although he acknowledges that it is early on in his career to take on this level of responsibility Gareth rose to the challenge and his level of enjoyment and pride was obvious.

In addition to contributing to the team, working independently has also had to come quickly for all the newly qualified radiographers in this study. James points out he has been expected to work on his own from very early on, mainly due to staff shortages.

> *Oh yeah regularly, and independent and obviously I work on my own in theatres and […] since week three I've been working independent in theatres, mobiles and in ITU and resus. Then in department, there are often times where there isn't that much staffing, so I can be on my own for the whole morning, or whatever, so there is a lot of independence. That's had to come quite quickly.'*
>
> (James, 3 months)

There were several areas where James had been expected to work independently and where there has been a shortage of staff this has left him with minimal support to call on if any.

The way in which the graduates in this study have coped with the pressure to work independently and use their own initiative is encouraging. The willingness to assume increased responsibility is one of the three characteristics of professionalism outlined in the work by Sim and Radloff (2008) who explored the issues of being a profession and professionalisation in medical radiation science in Australia. It also challenges the concern raised

by Mooney (2007) in her study exploring the role transition of newly qualified nurses in which she raised the issue of supernumerary status. Through her work she highlighted the tension that often exists between students being supernumerary and how this can help them effectively prepare for graduation and their professional role. However, in the case of this research this does not seem to have affected the graduates' ability to work independently from an early stage in their career.

There are a range of specialities where a diagnostic radiographer will be required to work on their own early on into their career and the operating theatre is one. The majority of participants have been surprised about how much they have enjoyed the independence of this work and Ben evidences this:

> *'I've surprised myself with theatre, I thought I would be really nervous going up there, but I actually feel, for the first few weeks, I've actually felt more comfortable in theatre than I have, than I did in main department. Just because I knew that was my job, I knew what I was supposed to do – it was in front of me and I did it and I can take pride in that.'*
>
> (Ben, 3 months)

Ben found theatre a comforting environment away from the mayhem of the main department. During his interview, Ben spoke about his need to be in control and his preference for a structured approach to his job. This goes some way to explain why he enjoyed theatre so much early on in his post as he was able to plan his workload and approach and was fully clear of what was expected of him. The resultant image also gave him immediate feedback on his performance which is something that he struggled to get when working within other areas of the diagnostic imaging department. This was re-iterated in his six month interview where his preference was still to work in theatre rather than in the main department.

The newly qualified radiographers' enjoyment of working in the operating theatre so early on in their transition was a surprising finding in this study. It

is in direct contrast with the findings of the study by Feusi et al. (2006) which explored whether or not new radiography graduates were prepared for certain aspects of radiography. In their study it was found that the newly qualified radiographers lacked readiness to carry out imaging in theatre. This was also discovered by Naylor (2014) in her PhD study in which the participants identified specific areas of radiography in which they felt they had had a lack of experience prior to graduation. Imaging in the operating theatre was also identified as one of the key areas. In this study however, it is evident that the participants have found working in the operating theatre to be an enjoyable and comfortable experience and they have appreciated the immediate feedback on their performance that it provides.

Ruby was fortunate to have four weeks to settle in to her department before staff shortages affected the department. The next four weeks she was working completely independently with a great deal of multi-tasking and very little support.

When we met up again at her six month interview, things were pretty much the same for Ruby and the department was still very short staffed. She had started her shifts and was often working in isolation.

> *'….all of December I'd done a lot of shift work so I'd been left completely on my tod for sort of twelve hours at a time and … I'd done a lot of work over Christmas and prioritising a lot of the work myself and I think it was, once I got to January and I'd done every shift and I'd done them all a couple of times, I finally felt yeah, so January I finally felt, 'I can do this!'*
>
> (Ruby, 6 months)

Working in this way had enabled Ruby to develop her decision-making skills and she felt confident in her role as a radiographer when we spoke at her final interview and this underpinned her ability to work independently.

> *'….I notice a difference between me and you know there's a few people there's […] three people that started at the same time as me or after me and lots of them I think even people who have worked there 10 years they quite often come up to me and ask me what I*

*think […] which is I think fairly significant and also like ... I think I'm
I've found quite a logical way of working within radiology.'*

(Ruby, 12 months)

At twelve months, it was clear that Jane had also grown into her professional
role:

*'… you always get those situations in radiography because there's
always stuff that takes you back, you've not seen before. Things
happen which you weren't expecting to happen and it all goes
downhill very quickly and you kind of have to think right what am I
going to do and then when it's all sorted out you think, there we go
what was all the fuss about sort of thing you know?'*

(Jane, 12 months)

The need for radiographers to work independently is an early expectation
placed upon the graduates and the ability to be able to do this is paramount if
a 24/7 service is to be fully realised. Many of the participants achieved this at
around the six to nine month period. The confidence to work autonomously
also contributes to the ability to work independently. Again, this was
highlighted in the study by Rafferty et al. (2001) where it was found in their
survey of staff nurses that autonomy and teamwork were extrinsically linked
but the association between the two was synergistic and not conflictive.
According to the Bath People and Performance Model (Purcell et al., 2004)
there are several key influences which affect individual performance in
addition to the three key factors of ability, motivation and opportunity
(Appendix XVII). The most pertinent ones in terms of this research are job
challenge/autonomy, team working, involvement (including communication),
satisfaction (pay), training and development, performance appraisal and
career opportunities. From this model it can be concluded that job
performance is indeed a complex area and that to attribute a poor performance
to simply a lack of skills is unjustified.

In her study, Naylor (2014) found that many of her participants felt less
prepared to work out of hours due to the limited exposure they had had to this
during their degree programme.   This was also an issue identified by Brown

(2004) in that graduates were identified as being ill-prepared to undertake on-call duties when no colleagues were present to offer support. This, however, does not appear to be the case in this study and may be as a consequence of certain designs in the undergraduate programme from which these students graduated. During the course, students spend 60% of their time in practice and undertake 30 practice hours per week. This is a mixture of shifts and as they progress through the course they are expected to undertake weekend duties, 2-10 and 5-12 shifts to widen their experience. This exposes the students to different working environments and different patient types outside of the standard 8.30-17.30 Monday to Friday. In their final year, they finish attending university at Christmas and then spend a period of 21 consecutive weeks in practice. This uninterrupted placement time allows them time to consolidate their skills and knowledge and also work on any areas of weakness they might identify in their practice at this time. They are also required to undertake a minimum of two on-call duties, although in reality many students do far more than this in order to fully prepare for their first post.

During the final interview the participants did not talk much about independence. It could be that as they are now working shifts/on-call duties it has become such an ingrained part of their role that they no longer give it the thought that they once did. I would suggest that at this time the graduates have now absorbed this aspect of their role into what Dall'Alba (2009, p35) defines as *'average everydayness.'* As the newly qualified radiographers are becoming radiographers, these experiences and the subsequent learning transforms them into being a professional.

7.1.3 Feeling proud

Several of the participants discussed this during their final interview and as such it featured strongly as a sub-theme in this section.

Rebecca used the image of a peacock on her theme board at the twelve month interview to represent how she was feeling at this time:

'this is representing like proud, proud of myself for what I've achieved.'

(Rebecca, 12 months)

This was also an emotion felt by Ruby:

'I walk past people who've sat at a desk all day and I just sort of feel proud to say that I've been doing more than that today and yeah I love the job itself I love my job so much.'

(Ruby, 12 months)

She goes on to add that *'I feel proud, proud to be where I am.'*

James is feeling proud to have made a contribution to his department over the last year:

' I look back on my time at […] I feel really pleased that I look at it now and think it's a lot better radiology department than it was a year ago and to have been a bit of a part of that is a real privilege.'

(James, 12 months)

For Ben, it is important for him to have achieved something in his day in order for him to feel proud of his job and that sense of achievement adds to his job satisfaction.

'…I've enjoyed my job I've done what I trained to do and I'm proud of that so I think that's what it comes down to being proud of the job that I've done that day.'

(Ben, 12 months)

Ruby, James and Ben are acknowledging their professional identity and self-concept through the pride that they are feeling about their role and achievements. According to a systematic literature review undertaken by ten Hoeve et al. (2013) which explores the concept of public image, self-concept and professional identity in nursing there are several factors that influence professional identity and self-concept. This includes public image, work environment, work values, education and culture. A supportive work environment therefore has a major impact on how newly qualified radiographers develop their professional identity and self-concept with personal values also seen as an important influence as illustrated by the Iceberg Model (Knight, 2002). This shows the link between the behaviours of an individual (seen as performance) to the beliefs, values, purpose, capabilities and internal thoughts and feelings of that person (Appendix XVIII). Again, this highlights the complex processes which happen inside an individual which directly relates to their performance. The importance of this model is that the link between performance and self-belief is acknowledged and therefore cannot be undervalued.

Much of what is being experienced during this time is influenced by how useful the participants feel in their role and also as part of the team. It is important for them to be able to work independently, to use their own initiative and to be trusted and valued as a team member. They have become less focused purely on their learning and the task in front of them but have begun to consider the wider context and this in itself shows the development of a professional.

As they have processed what they have achieved, the radiographer they have become and the profession they now belong to seems to have become deeply important to them. This can be linked to job satisfaction and in the study by Hutton and Eddy (2012) which explored the factors that influence job satisfaction in band five/six therapy radiographers, the transition period was key as was the development of new roles. As the NHS becomes more pressured then it will become even more vital to retain staff and ensuring job satisfaction in key to this. Professional socialisation plays an important role and as individuals become socially adapted to the environment, they move

towards the centre of the CoP adopting the values, beliefs and norms of that profession (Clouder, 2003).   Once this has been navigated it gives the practitioner a sense of achievement and belonging which will directly influence their enjoyment and satisfaction of the role they are undertaking.

7.2   Moving forward

This theme was heavily weighted towards the latter part of the transition and featured strongly in the twelve month interviews with some mention early on. Some of the early stressors mentioned by participants had now been replaced by some of the sub-themes presented here.   The final theme is composed of four sub-themes; surviving, taking in the bigger picture, aspirations and caring for patients.

7.2.1 Surviving

During the final interviews, the participants reflected on their twelve months as a band five radiographer. At this time, many spoke about the challenges of surviving during this period of time, particularly in the early days.

Ruby spoke about the sheer determination she needed to get through at times by referring to two images on her theme board, a baby chick trying to fly and a baby climbing up the stairs.
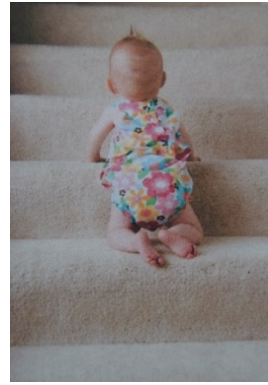
'I think these two are more just demonstrating determination you know like I will fly I and I will go up those stairs…. I have needed a lot of it because I think I have been in the situation where I've never turned round to myself and I'm going to give up I'm going go back to ZZZZ I'm going to get another job. I've never, I've never had that as a consideration you know. I could never do it […] but to get to get through it I think I have needed quite a lot of determination […] you know there's a lot of times when you ask for help and you just don't get it and you've got to be determined…'

(Ruby, 12 months)

Ruby discusses here about the determination she felt she needed to in order survive those first twelve months as a novice practitioner. The more I listened to the way in which Ruby was describing how she felt, the more it sounded as though what she referring to was in fact resilience. The work pressures that Ruby has had to deal with during this time were also highlighted by the work of Verrier and Harvey (2010) who explored the nature of work related stress in one diagnostic imaging department. Reflecting on her year, Ruby has had to cope with a lack of support, staff shortages, heavy workloads, building and developing new relationships, volume of patients and dealing with emotional situations. Developing resilience has helped Ruby not only to cope with these challenges but also to have the capacity to navigate and identify appropriate resources to help (Ungar, 2008).

Resilience is becoming a much debated topic within health and social care and Scholes (2008) argues that the challenges now faced by health care professions requires them to be committed and resilient. To date this has

remained unexplored in the context of diagnostic radiography but it is evident throughout this study that at times participants have been required to dig deep to utilise the available resources to enable them to cope in the early days of transition. Richez (2014) explored resilience from the perspective of supporting nurses in transition and recognised that additional stress may be caused by moving to an unfamiliar environment and this is relevant to all the participants of this study. The ability to overcome challenges and improve performance is a key feature of resilience (ibid).

The continually changing workplace of the NHS also impacts on the experience of transition. Not only are the graduates becoming and being radiographers, the constant demands and challenges of the system within which they work often makes this difficult to achieve.   People entering the healthcare professions often do so because they want to care for others, however, the emotional effort required on top of coping with all the other challenges can often lead to stress related issues and burnout (Skovolt, 2001; Wieclaw et al. 2006).

Ruby also spoke about the need to survive challenging situations with patients, where the outcome is not always a positive one. The need to develop coping strategies to deal with difficult and emotive situations is often overlooked.

> *'…think the connection you get obviously when things just don't go so well […] it's not nice, you know we do see a lot of horrendous things you know like in the last month we've had two kids come in who have been drowned.'*
>
> (Ruby, 12 months)

What Ruby is referring to here is a concept known as emotional labour often required by health professionals when dealing with patients and their relatives. This has been explored across the professions in nursing and midwifery (Mann, 2005; Theodosius, 2008).

In their study of midwives, Hunter and Warren (2014) recognise that it is an emotionally demanding profession which is placing practitioners under an

increasing amount of pressure. In exploring resilience amongst midwifery they found that developing the ability to overcome challenges and move forward was paramount.

Ruby was the only participant to mention the emotional aspect of her role and this may well be due to the hospital in which she works and the nature of the patients that she deals with. The emotional effort that is required by Ruby is largely unexplored in diagnostic radiography but recognised in the work by McAllister and McKinnon (2009) as an isolated pressure of health and social care professionals as the majority of people who enter these professions want to look after and care for others.

Part of the challenge of surviving for some participants was how to deal with the monotony and pressure of the role.

> *'…it that's what I was going to be doing the, the realisation I'm just going to come in to monotony of it I think that's what I hit I hit a wall..'*
>
> (Ben, 12 months)

Ben goes on to explain:

> *'…I just want to have the days where I can do something that's going to make me engage my brain and feel like I'm learning again not even learning just something where I have to actually stretch my brain rather than just the monotony of the same old thing all the time I don't, maybe I'm unrealistic...'*
>
> (Ben, 12 months)

Using an image of cars queuing for miles at the toll for the Dartford tunnel he illustrates the feeling of pressure:

'…I think that's just kind of how my work is sometimes I feel it's like a conveyer belt one car through one car through one car through and I don't like that…'

(Ben, 12 months)

These feelings were also shared by Adam and Jane are illustrated by the following quotations.

'I find radiography can be a little bit boring….I do love my job I wouldn't do anything else but there are times when you do feel a little bit bored like you feel like you do the same thing over and over and over again… I think it's just monotony and pressure are the two over riding things just the same things over and over and over and over'

(Adam, 12 months)

'…like when it's busy and you've got stacks of other patients to do you don't want to have to repeat an image because it's going to take you however many minutes to do that and put you even further back and you stand there and you just pray it's like please let it be on or you know lateral or whatever so I can get the patient out and do the next one which is awful because it does become slight kind of a conveyer belt'

(Jane, 12 months)

The monotony of job role which extrinsically links to boredom is investigated in the work of Schufeli and Selana (2014) who examined the relationship between burnout, boredom and engagement in the workplace. According to their work, boredom *'is conceived to be a state of low arousal and dissatisfaction due to an unchallenging work situation'* (p298) and is usually

linked to monotonous and repetitive work (O'Hanlon, 1981). In developing this further they ascertain that work and time pressures, long work hours and frequent contact with clients/customers combined with conflicting work roles, an inability to fulfil a role due to inadequate information, being exposed to emotionally challenging situations and a poor work life balance will all result in burnout.

Monotonous and repetitive work is an antecedent to boredom (Schufeli and Selana, 2014) and the consequences of this can be job dissatisfaction, high sickness absence, high staff turnover and poor performance. In order to counter this and ensure work engagement they suggest that workload is challenging, responsibility is encouraged, feedback on performance is given and there are development opportunities. This will result in a committed workforce with a low turnover of staff, low sickness absence, effective job performance and the provision of a quality service.

Similar antecedents were found in the work of Martin et al. (2006) who undertook an interpretive phenomenological study to explore the experiences of boredom in ten participants. The participants were recruited via a local newspaper advertisement, the job centre, residential homes and workplaces and were aged 18-81. The experiences of being bored were similar to those already discussed but there were some more personal traits mentioned such as; frustration, fatigue, feeling meaningless and depression. One of the most successful approaches to counteract the onset of boredom at work was making plans and setting goals for the future.

The use of the phrase *'conveyor belt'* by Jane and Ben is also interesting as it is one that has been used widely in recent years by the media when focusing on the NHS. From Jane's perspective the endless stream of patients puts her under increased pressure and de-humanises the experience of imaging patients. The Chairman of the National Institute of Health and Care Excellence, Professor Haslam has been reported as saying that the *'NHS is becoming a conveyor belt for patients.'* It seems that wider opinion is that treatment is no longer tailored to meet the needs of each patient but that

meeting the set targets is the priority (NICE: NHS Becoming 'Conveyor Belt', 2014).

At their twelve month interviews Ben, Adam and Jane all discussed the volume of work and the impact that this has had on how they feel about their role. Some of the quotations above illustrate the monotony of the role and how this has in some cases started to lead to feelings of boredom. This was again picked up by the study by Hutton and Eddy (2012) when exploring job satisfaction amongst band five/six therapy radiographers. They found that some of the graduates felt that there was a mismatch between expectations and reality as the repetitive nature of the role became apparent. The pressures placed on the new graduates due to the workload has led them to feel despondent as their main focus is on patient throughput rather than on the quality of care given to individual patients. For those that have entered radiography because they wanted to care for others and make a difference, the restriction of being able to do this because of the nature of the workplace could result in a stressful and uninspiring environment (McAllister and McKinnon, 2009). The emotional labour required to work and cope in this environment requires the new graduates to be resilient practitioners.   In medical education this has been recognised and recent initiatives have introduced resilience into the curriculum in order to prepare graduates to deal with stressors in the workplace. These may be large or most likely small stressors experienced over long periods of time which if not well managed will result in distress or burnout (Richez, 2014).

As McAllister and McKinnon (2009) discuss in their work, resilience is an important skill to develop for these reasons. In order to reduce attrition in the NHS workforce then potential careers need to be appealing to the public, improvements must be made to recruitment and a resilient workforce is essential.

7.2.2 The bigger picture

As the participants move through their journey of transition they begin to notice things outside of their control. James picked up the culture of his department early on in the interviews and at six months he made this comment:

> *'I think too many people have the attitude that they just think, 'it's not going to change' and no one will put in the effort because no one ever thinks it's going to change. It's frustrating, but I think there is a lot of that attitude in the NHS and I experienced it when I was probably training a bit as well, where the effort required to make things better just isn't worth it for some people and it's not the case for me so I find it quite frustrating.'*
>
> (James, 6 months)

This apathy in the workplace is something that Harry also noticed:

> *'It's just that whole thing about seeing the hospital go forward, it just seems like, from what I have heard from other people that have been there a couple of years as well, nothing ever changes.'*
>
> (Harry, 6 months)

The apathy that both James and Harry describe is related to the issue of passive behaviour exhibited by the radiography profession. It is still evident today that radiographers lack the assertiveness needed to have their voice heard and to move the profession forward (Yielder and Davis, 2009; Strudwick et al., 2011).

Adam also started to notice what he refers to as the 'politics' of his workplace.

> *'I've noticed as well, that six months down the line, people start to talk to you about who doesn't pull their weight, which is quite, not the nicest part of the job'*
>
> (Adam, 6 months)

At the twelve month interviews, several of the newly qualified radiographers made comments regarding wider issues within the workplace which they had

picked up on. Jane in particular notes how she has changed from being a student.

> *'I was there to learn I wasn't there I didn't work there it didn't really affect me what was happening to the employees….but I think it is a big part of the job because it's your job and what they change is going to affect how you work whether you can do your job properly. Or whether it's going to be detrimental to your job even excluding the wages and the shifts that you're working what they change means you can't do your job properly that is a huge part of the job you need to actually pay attention and start doing something about it .. which is what I'm doing having you know having my say…'*
>
> (Jane, 12 months)

The graduates have entered the profession at a pivotal moment with regard to changes to the work pattern of radiographers. Charlotte explains how unsettling this has been:

> *'…you don't know what's coming in the future and as well it's affected our rota now because they had to rota us to fit with the band sixes because our rota didn't come out at the same time so it meant that we've had a really short rota which also means you can't plan anything for, we're waiting for the next one… I think as a student there was a rally protest when we were students so I kind of knew about it but you don't think about these things… the new rota change would mean changes in pay and things like that and enhancement…'*
>
> (Charlotte, 12 months)

Ben sums up how he has been feeling with the use of an image of a dilapidated boat on his theme board during his final interview.

'I've kind of stuck that one in the middle cos it just feels […] that's kind of what it all feels like it's obviously been a nice boat at some point but it's kind of just not been cared for and everything feels like it's just, just needs a little bit more […] care from the system rather than me. It's not it's not very much me - it's about where I work and how I'm expected to work… it's quite symbolic really because I say this boat at one point was a really nice boat and it was a really nice you could go and sit on it on the lake and you feel you have a lovely time. Now you'd sit on it and you'd be thinking is it going sink it's not going to sink and you're looking for somebody to make a decision do we fix the boat or do we not fix the boat or do we get a new boat […] that's what it feels like to me it just it needs somebody to come and grab the department my department specifically by the horns and say right the boat's a right off, get rid of it and do it again. We'll get a new boat or let's put some care into this and make this boat work but for the moment it just sits there and nobody's actually making that decision.'

(Ben, 12 months)

It is clear to see that the participants are becoming much more affected and frustrated by the culture of their workplace the longer they have been qualified and as an educator and a diagnostic radiographer I find this deeply worrying and disappointing.

The effects that politics has on the NHS and the subsequent changes in policies, priorities, setting of new targets and changes to work patterns is something that needs to be recognised. The impact that this has on how valued the staff feel within the NHS is of utmost importance and concern. Anecdotal evidence suggests that UCAS applications for radiography courses nationally have fallen by 25% due to the changes in funding and this is

mirrored across all other health-related courses. With this fall in applications, the NHS must ensure that staff retention remains a priority. The preparation of students to work within this environment of constant change and challenge, and being able to deal with both political influences and professional issues may well be something that needs further consideration.

7.2.3 Aspirations

There was a variation of aspirations across the participants. James was the first to speak about his plan for the future as early on as his three month interview. His ambition for the future was clear to see.

> *'… and then you're working away at a job and you think in, constantly about the next, moving up to the next thing and I'm always kind of looking forward, where there is an opportunity to develop…'*

(James, 3 months)

When we met again at six months, James had already applied for a band six post:

> *'There's been some knockbacks, like I went for a […], the angios job and […], I didn't realise that there was quite so many more experienced radiographers going for it but […], and in the end I got offered an angios post for three months away. And at the time I felt really disappointed and crushed by it, I thought oh I really wanted to do that.'*

(James, 6 months)

At his final interview, James has already applied for another post and was moving back to the hospital where he was placed as a student.

Many of the participants spoke about their future plans at their six month interviews. Ruby and Gareth were considering moving to other hospitals whilst others were looking at progressing where they were. Rebecca and Charlotte both seemed content to stay as they were and consolidate their experience.

Adam had already expanded his teaching role as well as being interviewed for a band six post:

> *'I'm going to be mentoring two or three of the students for extra time at the weekend – I'm going to take them up into the X-ray rooms and practice imaging on a dummy, things like that for a couple of hours in the morning, a bit of practice work. Going to the university and give a lecture, just things like that...'*
>
> (Adam, 6 months)

Following on from this at his final interview Adam states that for him *'progression is really like key.'*

At his six month interview, Gareth is already considering his future:

> *'I think I've got more of an idea about where I want to go, […] and it's probably going into neurology, and it's probably going more into, going into […] kind of brain, brain CT, kind of being able to do head reporting, and I think that's - and I've thought of all the ways of getting to band seven and I think that's the way I want to go'.*
>
> (Gareth, 6 months)

However, during his final interview, he seems to be having second thoughts about staying in the profession altogether.

> *'I would be happy to do another year and then take a few years out reassess whether I want to do radiography continually and then maybe come back to it. There's always the opening of coming back to it…. I think because we see a few openings in this area where we are now ... where we can where we can make a business and at my age I think I would be better to do it now than later and I can still have if it all goes to pot I can always go back into radiography.'*
>
> (Gareth, 12 months)

Finally, Ben uses a picture of a hare to explain how he is feeling at the twelve month interview.

'I just feel like I'm in a like a no man's land probably the best way of describing it. I don't know what my direction is I'm kind of lost… sometimes I just feel like running away. I love hares anyway, sometimes I feel like just .. when a hare gets out of its burrow it'll get up and it'll do this stretch thing over their legs. They stretch their bodies out and then they run to get rid of their energy to stretch their muscles and I kind of feel like that that's kind of how I feel I'm in a burrow at the moment and at some point I'm going to get up I'm going to stretch and I'm going to run for whatever I don't know but whether it's to a different place to work […] and hopefully be happier and get some more job satisfaction.'

(Ben, 12 months)

From the six month period onwards most of the participants were considering their future career direction. James and Adam had already applied for band six posts without success and Ruby, Gareth and James were considering whether or not to move hospitals. For some, this was an attempt to overcome the boredom and monotony they felt and to improve their job satisfaction, for others it was a move towards their career ambitions. In a study commissioned by Health Education England (2015), the high turnover of band five nurses and midwives in the Birmingham and Solihull region was examined. It was found that there was a generational difference in the nurses and midwives which spanned four generations. These differences were related to values, perceptions, expectations and motivations in the workforce and it was established that these are highly relevant in terms of engagement and opportunities.

Given the age range of these particular participants I think that this clearly relates to the findings of this study and would benefit from further investigation. This new type of graduate (from Generation Z) has very different needs and expectations to that of previous generations as seen by how quickly their stress levels at three months have turned into feelings of monotony and boredom at between nine to twelve months. James at the three month interview had already begun to apply for band six posts and by the twelve month interviews many others had followed suit. As a profession, radiography needs to work more closely with this generation and provide effective career planning at an early stage to minimise boredom and to stimulate and motivate radiographers in their role. It is suggested that graduates from Generation X will benefit from a structured career pathway that that is flexible and meets their needs (HEE, 2015). It is also important to consider the future needs of Generation Alpha and how as a profession we can not only attract people into the profession but also retain them, otherwise the NHS will find that graduates such as Gareth and following generations will begin to consider other career options.

7.2.4 Caring for patients

The final sub-theme is caring for patients and it is something that only started to appear at the six month interviews.

Rebecca had moved to a hospital which is accessed by many patients who speak English as a second language or not at all. She found this very challenging at times.

> *'…and I find that I don't – I'm not as caring. I know it's really bad on me, but because they can't understand you as much, you just don't want to care as much because you can't talk to them and you can't have sort of – you can't engage, engage with them in that kind of level. Yeah, I find that quite challenging, those patients.'*

<div align="right">(Rebecca, 6 months)</div>

Rebecca is finding it difficult at this time to demonstrate her care for this group of patients. The language barrier has hindered her in connecting with her patients and as such she feels as though she has not engaged with them as well as she would like and has failed to show compassion. This has certainly provided a challenge for Rebecca in ensuring that she works within the guidelines and polices set by the government to ascertain that compassionate care in the NHS is delivered to all (DoH, 2012).

Ruby is one of the newly qualified radiographers who really values her relationships with patients and this is reflected throughout all her interviews culminating in her twelve month interview with this quote:

> *'…the fact that you X-ray the same patients over and over and over again you get to know them which I just think's lovely. It's something I've never experienced before and just assumed I never would and it's something I'd excepted and now I've found out oh God I can experience this you know, it's shown a side of the job which is really just so many patients I've gotten to know and I love getting to know them.'*
>
> (Ruby, 12 months)

Adam also talks about caring for the patient in his final interview.

> *'… if you put the effort into the patient the patient will put the effort into you and they'll appreciate what you're doing for them and you'll find you get a better outcome. At the end of it you've got a good diagnostic X-ray, you've spoken to the patient, the patient goes away happy you go away happy everyone's happy and that's good'*
>
> (Adam, 12 months)

The reflections of Rebecca, Ruby and Adam illustrate that they have moved beyond the technical aspects of their role and are now focused on the quality of care they are providing their patients. From the patients' perspective this would include the consideration of other issues such as environment, how they were treated (including respect and dignity) and whether or not they felt cared for (DoH, 2012). Ruby in particular is relishing this aspect of her job, especially

when she sees her patients numerous times and is able to provide continuity of care.

This theme covers some of the less tangible aspects of the role and illustrates how the newly qualified radiographers are becoming much more aware of external factors and how they have an influence on their professional role and the public perception of it. It is evident that during the reflections on how they have survived their first year a great deal of determination and resilience was needed. It was also interesting to see how quickly some of the participants had started to plan their career with some already having applied for band six posts or moved hospitals.

7.3   Final thoughts

7.3.1 The reality of practice

It was evident in all but one of the participants of this study that the emotional experience of transition was high. Reality shock was experienced in the first three months of graduation in line with the seminal work of Kramer (1974) and subsequent studies. During the three month interviews, the participants described their early experiences using a range of metaphors to describe their emotional feelings at the time. These were also captured at the twelve month interviews where a range of images were selected to represent some of these feelings. It was clear to me at this time that is was a stressful time for the graduates and some of their experiences and how they were feeling was difficult to sit and listen to. Not only were the participants dealing with their emotional reactions to transition during this time but they were also coming to terms with expectations and reality and all that this encompassed. The need to *'hit the ground running'* is something which has been found across the literature exploring the experience of transition across the healthcare professions. In fact this was also identified in the studies directly related to diagnostic radiography undertaken by Decker (2009) and Naylor (2014). However, the distinction between this study and the previously mentioned studies is that none of the participants in the work by Decker (2009) and Naylor

(2014) described their experience of transition as stressful and none appeared to experience reality shock (Kramer, 1974).

One of the aspects that sets this research apart from others in radiography is the fact that all the participants gained employment in departments where they had not previously worked as a student. They were all exposed to new, unfamiliar work environments. This seems to have been the contributing factor to their levels of stress in the first three months and highlights the need for the effective preparation of students for the experience of transition. This needs to begin during their undergraduate degree programme at the HEI and continue post-graduation, linking directly to practice. Although it was found that some departments did provide induction programmes or preceptorship schemes, these were very much task focused in line with the proposed SoR preceptorship scheme which is centred on the newly qualified radiographer completing a range of twelve activities. There does not seem to be any consideration given to the emotional experience of transition and therefore the ontological aspect of this experience has been completely overlooked.

During the early stages of transition there needs to be both intrinsic and extrinsic strategies to help the new graduates cope with the stress experienced at this time. From the stories shared it would appear that in some departments little or no structured support was given and the graduates were left to *'sink or swim'* (Fenwick et al., 2012). Some found their managers supportive, some not and the same was also said of new colleagues. Many spoke about the value of peer support and how this was for some the main source of support. The lack of personalised support and feedback was something that many of the participants found difficult to deal with. As students they were used to regular support and continuous feedback through their degree course and all of a sudden it was gone and this came as somewhat of a shock. In the previous chapters I discussed what has been found in the literature about the effect that receiving either mixed messages in feedback or poorly delivered feedback had on professional development and it would be interesting to establish if receiving no feedback has a similar effect and is something that could be explored further.

With regard to extrinsic strategies to deal with the stressful period of transition, some participants developed their own way of compensating for the deficit in structured support e.g. peer support, seeking out experienced members of the team for advice. At the twelve month interviews, several reflected on the determination needed to survive the early months and their intrinsic strategy was the development of personal resilience. The capacity to develop resilience has become essential, not only for the newly qualified healthcare practitioner but also for those established in their roles as highlighted by the work of Scholes (2008).

The capacity to develop resilience in the workplace would certainly help the newly qualified radiographers cope with the harsh and busy environments they now face, emphasised by M[c]Alister and M[c]Kinnon (2009). The pressured and constantly changing conditions challenges even the most experienced practitioners and ensuring a supportive work environment where resilience is valued, encouraged and developed could well reduce staff attrition in the NHS. Attrition is going to be a major priority for the NHS over the next few years as the impact of a full Brexit is unknown and anecdotal evidence from UCAS estimates that applications to healthcare courses have decreased by approximately 25% as a result of the cuts to the NHS funding of these courses. Attracting and retaining staff is going to be essential for the continuing future of the NHS in the coming years. One of the barriers to developing resilience raised frequently over the twelve month period was the extreme levels of tiredness that the graduates were experiencing. This was due to the emotional reaction to transition but also amount of hours and the shifts they were now working. This may be something that needs to be taken into account when supporting the new qualified radiographers to develop their level of resilience.

At the three month interviews, all of the participants had completed the Peaks and Troughs graph for each week during this time period. As previously discussed, these underpinned the initial discussion at the first interviews and enabled the participants to recall some of their earlier experiences which may otherwise have been forgotten. The feedback from the graduates was that they found this to be a very useful and valuable exercise as it had encouraged

them to reflect on their experience and highlight the positive and negative aspects of their transition. In fact, many of them continued to use this tool until the six month interview. For me, this was an interesting but unexpected finding. Having been an advocate for reflective practice for many years and often teaching this to undergraduate students, my experience is that many fail to see the value of reflection during their course, but at the three month interviews I listened to the new graduates talk about how valuable the process of reflection had been to their development, particularly in the early stages. In fact, many also spoke about how the interviews themselves had been a useful support and development mechanism in that it gave them an opportunity to discuss their progress and feelings in a safe and supportive environment. This highlights the need for newly qualified staff to be given the opportunity to discuss their progress with someone and to be able to reflect on their feelings and experiences of transition.

The needs of the new graduates during transition strongly suggests the need for a preceptorship programme in radiography. In 2010, the DoH introduced a Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals (DoH, 2010) and this could certainly be built on by the radiography profession. Using a range of stakeholders to include representatives from practice, HEIs, patients, students and new graduates I would recommend the development of a coaching based model of preceptorship. This could begin as part of the undergraduate course in the HEI and transfer with the newly qualified radiographer into their practice setting. This approach would ensure that both the ontological and epistemological aspects of transition are addressed and the use of a coaching model will help to develop autonomous practitioners equipped with the skills for contemporary practice who are given the space and time to reflect and are goal and solution focused.

7.3.2 Adapting to change

The new graduates struggled at first to adapt to their new and unfamiliar surroundings. They all took up employment as band five radiographers in a diagnostic imaging department where they had not previously worked, even as a student. This is a major difference to the study by Naylor (2014) in which some of her participants had already been students in their new workplace. Fitting in to a well-established team and culture and becoming part of that presented challenges for the newly qualified radiographers. This process of becoming part of the team can be further understood by referring to the CoP model (Lave and Wenger, 1991). An awareness of how CoPs' function enhances our understanding of the working environment and culture and the process of professional socialisation. It would therefore be useful for students to have an understanding of CoPs and how as newcomers you can move from the periphery as an observer to the centre of the CoP and achieve full legitimate participation.

There are several factors that can help the graduates navigate their way to the centre such as engagement and collaboration with other members of the community (i.e. radiographers) as well as learning the necessary skills needed to undertake the role of the radiographer within the CoP. They will also need to immerse themselves in the culture of the CoP which requires adopting the same language, beliefs and values of that community. In their interviews, many of the participants spoke about the expectations of others in the community (e.g. radiographers) and the existence of hierarchy within radiography. The issue of hierarchy was also something experienced by newly qualified radiographers in the work of Fenwick et al. (2012). It was found that they felt like outsiders and felt under constant pressure to prove themselves to the community. Both the expectations of the members of the community and the existence of hierarchy can be barriers to the graduates achieving full legitimate participation.

In light of this it would also be prudent for not only students to have a knowledge and understanding of CoPs and how they work but also

established practitioners. This may well encourage them to consider how the culture of the department and staff expectations may well adversely affect the initial progress of newly qualified radiographers and their ability to fit in and build up their confidence.

Several participants also spoke about their communication with other healthcare professionals, and their experience of interprofessional learning (IPL) appears to have effectively prepared them for this aspect of their role. This was also found by Decker (1992) in her study which suggested that today's radiography graduates are much more confident in terms of interprofessional communication than their predecessors. The strong presence of IPL in the undergraduate curriculum of these newly qualified radiographers seems to have produced practitioners that are confident in dealing with a range of professionals and one of the most notable findings of this thesis was their willingness and preference to work in the operating theatre. This indicates that they found it much easier and more comfortable to navigate their way into a CoP composed of a range of healthcare professionals than the one in the diagnostic imaging department. There are two major influences here that may have made this environment more preferable; the structured approach away from the mayhem of the department and the opportunity to receive immediate feedback on their performance. Whatever the reasons may be not only are the graduates adaptable to changing roles but are also confident when negotiating with other healthcare professionals.

In these chapters, the findings from the three, six and twelve month interviews have been presented under six main themes; needing support; settling in; developing confidence; becoming established; feeling useful and moving forward. There are some important influential factors to the experience of transition and although there are many shared experiences, each individual story is unique and offers insight into the early stages of the transition period from student to qualified radiographer. In the conclusions chapter, I will discuss what these findings mean for the profession of radiography and the potential impact of this research on both the profession and education.

8.0   CONCLUSION

8.1   Introduction

This chapter will present a summary of the findings of this thesis and place them in the context of the profession of diagnostic radiography.   The implications of these findings will be related to both the practice and campus-based settings in order to enhance the experience of students and graduates.

I will also take the opportunity in this chapter to reflect on my journey as a researcher whilst undertaking this doctorate and how this has developed me both personally and professionally. The strengths and limitations of the study will also be identified and their influence on the findings discussed. Finally, this chapter will close with my plans for dissemination of this work and my closing remarks.

8.2   Summary of key themes

8.2.1 Needing support

This theme consisted of four sub-themes; reality hits, structured support; support from colleagues and peer support.

The majority of the newly qualified radiographers experienced reality shock which was underpinned by a lack of structured support across most of the diagnostic imaging departments. The structured support that was offered was task-focussed and concentrated on the graduates achieving certain competencies.

Despite guidance from the DoH (2010), support across departments varied and evidences that preceptorship has not been readily adopted by the radiography profession. This has implications for the new starters in that they are not given any personalised, formal support in the early few months. This initially delays their progress and a lack of feedback affects their confidence.

Given that at least three of the participants changed their workplace at around the twelve month period indicates that a lack of formalised support affects retention. In the current climate, retention of staff is vitally important and preceptorship may be the key to this.

Some of the graduates found their colleagues supportive whilst some did not. Again, this not only has an impact on retention but also how quickly the newly qualified graduate progresses and becomes part of the CoP. By sharing some of the stories from this thesis it may prompt staff and departments to reflect on the way that they treat newly qualified radiographers and encourage them to foster a more nurturing, caring and positive environment in which the graduates can thrive and become part of.

Finally, the main support mechanism used by the graduates was peer support and this substituted the lack of any other form of support. This worked well in one department where new starters were paired up. This good practice needs to be shared and built upon. This provides good opportunity for HEIs to work with practice to develop the use of peer support further with the use of buddying and PAL, all of which could start at an undergraduate level.

8.2.2 Settling in

There were four sub-themes which influenced the graduate's ability to settle in. These were getting to know the protocols and equipment; fitting in; fear of making mistakes and coping with tiredness.

The major source of stress in the early days was caused by the graduates having to adapt to a new environment. This challenged the participants as they had to learn new departmental protocols and become used to working with a range of different equipment. Their lack of confidence at this time was highlighted by their reliance on protocols and some struggled with the opportunity to be autonomous in their practice.

The environments that the graduates entered were all very different and provided a range of challenges with regards to fitting in. The desire to fit in was apparent at the three month interview and there were a range of influences on the professional socialisation process. Again, a knowledge of CoPs would help to more effectively help prepare the graduates for this experience and help them to adopt strategies to assist with this process.

Many of the newly qualified radiographers had an overwhelming fear of being struck off due to making mistakes. The strength of this fear seemed disproportionate to the reality of this actually happening and was certainly underpinned by the responsibility they now felt and which some found to be overwhelming. This angst was possibly heightened by the high levels of tiredness which was caused by the amount of learning required at this time, workload pressures and also the changes to their working pattern which included five days instead of four, a range of shifts and weekend working.

There is clearly some further work to be done to help students prepare for coping with responsibility and mistakes. It would also be useful to speak to them about the expected level of tiredness and coping with change. Again, this would be a good opportunity for alumni to be involved as they could share their stories to add authenticity to the topics.

8.2.3 Developing confidence

This theme included; believing in oneself; recognising and valuing the level of their preparation and needing feedback and spanned across the first six months.

All the participants felt fully prepared for the role of a band five radiographer and were very positive about their educational and practice experience. They felt that compared to some of their peers that they were very knowledgeable and some had already been teaching other new newly qualified radiographers alternative radiographic techniques and this also helped to develop their confidence. This was a positive finding.

As the graduates progressed in the first few months their confidence increased and the more independent they became. Being given the approval and having the recognition of others seemed to play a major part in the development of the graduates' confidence. Having been used to continuous feedback throughout the course, many of the participants struggled with the sudden lack of feedback and this experience had made it difficult for the majority of the graduates to assess their progress and offered them little in the way of developmental opportunities.

The lack of feedback given to the graduates has slowed progress and the development of confidence. If a coaching-based preceptorship scheme was introduced this would ensure that feedback is given on a regular basis and the graduate would have the opportunity to reflect on their practice and evaluate their progress. This model would help enhance confidence and also allow the graduates to progress more quickly.

8.2.4 Becoming established

This theme was noticeable across the twelve months and included; making decisions and coping with responsibility, dealing with the hierarchy, developing interprofessional communication skills and learning to manage students.

As discussed earlier, the majority of participants struggled to adjust from having their images checked by a supervising radiographer to now having to make the decision to accept them themselves and the burden of that responsibility. There are lessons to be learned in how to prepare students for this in the final days of their degree course which will be discussed with the PEs and Trusts.

The graduates, in line with other studies quickly noticed the hierarchy within the department which was both covert and overt in its manifestation. At times this left the graduates feeling powerless and vulnerable. This highlights the culture of the imaging department and how this directly affects the graduates' progress. Again, an understanding of the CoPs would be useful for both

graduates and staff to help them ensure that the environment in which they are working offers a positive learning experience.

In the majority of cases the inclusion of IPL in the curriculum seems to have well prepared the participants to communicate effectively with a range of healthcare professionals. This is a very positive finding and highlights the need for IPL to be part of all undergraduate health and social care curricula.

There was a mixed reaction to the responsibility of supervising and teaching students so early on in their career and by the three month interview nearly all the participants had been actively undertaking this. Although the participants currently receive some preparation as part of their undergraduate degree for this responsibility this needs some improvement and there is work to be undertaken to better support this role in practice.

8.2.5 Feeling useful

The intensity of this theme varied across the twelve month period and consisted of contributing to the team; using own initiative and working independently and feeling proud.

It was extremely important to the participants that they were able to contribute to the team as soon as possible. The sense of validation and acceptance from their colleagues gave them a feeling of self-worth. This combined with being valued as part of the team, was how they measured feeling useful. For the majority of participants this did not happen until at least the six month period and this could be as a result of the lack of feedback received by the newly qualified radiographers.

After the initial shock, the way in which the graduates in this study coped with the expectation to work independently and use their own initiative was encouraging e.g. in the operating theatre, shifts, on-calls. The majority of participants were surprised about how much they enjoyed their independence at times and as they developed their own way of working and decision-making

skills they developed into professionals. This transformation directly contributed to the development of their professional identity and self-concept and led them to feel proud of their role.

8.2.6 Moving forward

This theme became apparent in the latter part of the transition period and included; surviving, taking in the bigger picture, aspirations and caring for patients.

Surviving was a key feature and for some participants required an enormous amount of personal resilience. The development of resilience is something that we have been working on as a course team and have recently introduced some workshops into the undergraduate programme. It was disappointing to hear that some many of the newly qualified radiographers were already becoming bored and were struggling with the monotony of the role and this is something that the profession needs to address in terms of attracting students and keeping staff in the profession once qualified. This could be addressed by a coaching-based preceptorship scheme followed by a structured career pathway to facilitate the graduates in managing their future and setting realistic goals to achieve.

As students, the participants admitted that they really did not pay much attention to the wider professional issues and the social, economic and political drivers for change within the NHS. Although much of this is discussed in a third year module, it seems as though this is not valued as important. Again, preparing students to work within an environment of constant change and challenge, political influences and dealing with professional issues needs to be addressed.

Some of the graduates shared their ambitions very early on and were already looking for promotion. Again, a coaching-based preceptorship scheme followed by a structured career pathway to facilitate the graduates in setting realistic goals for their future may help these graduates. However, other newly

qualified radiographers seemed settled and were happy to stay as they were, consolidating their knowledge and experience.

The final sub-theme was caring for patients and this was barely mentioned which I found disappointing. However, the graduates found so many other things to worry about and discuss in the early days of transition the patient did not feature strongly in their thoughts. Diagnostic radiography is technologically focussed, however with more and more patients now presenting with complex needs there is a requirement for radiographers to adopt a Values Based Practice approach in their role (Hadwen et al., 2016). There is currently some work being undertaken by the profession to introduce this approach across all Trusts.

8.3 Implications for the diagnostic radiography profession and original contributions to knowledge

The purpose of a PhD is to ensure that the findings make a contribution to existing bodies of knowledge. This study has identified the following areas for consideration:

- Eight of the nine participants experienced what has become known as transition shock (Kramer, 1979) due to a lack of structured and personalised support. This may be due to the fact that all the newly qualified radiographers in this study had only been placed in one department during their degree programme and had entered new diagnostic imaging departments. As discussed below, the participants felt well prepared for their first post which would indicate that this reality shock was mainly due to the unfamiliar work environment and their lack of experience at dealing with changes to this. Therefore, a review of the pattern of practice based education in the current programme is required to address the issue of students only being placed in one department. In the future, students will be exposed to at least one other department during their degree course.

- The speed at which the graduates developed feelings of boredom and spoke at length about the monotony of their role as early as nine to twelve months post-qualification surprised me. It led me to investigate this further and I came across a study by HEE which examined the needs of early career nurses and midwives in the workplace (HEE, 2015).

The NHS workforce now spans four generations; Baby Boomers, Generation X, Y and Z and this is the first time in its history that the NHS has had to meet such a diverse range of needs. The differences between the generations were identified as values, perceptions, expectations and motivations in the workforce and it was established that these are highly relevant in terms of engagement and opportunities (ibid). The implications of these generational differences are multi-faceted and require further deliberation with regards to meeting educational needs and the recruitment and retention of the future NHS workforce.

The speed at which the newly qualified radiographers became bored and identified the monotony in their role is a strong indicator of this new type of graduate (from Generation Z). It is evident that their needs and expectations are very different to that of previous generations and goes someway to explain why their stress levels at three months quickly turned into feelings of monotony and boredom at between nine to twelve months.

Taking into consideration, the lack of formalised support during the early days of transition which led to the stressful feelings and given the uniqueness of the Generation Z workforce, it would be a prudent time to consider how best to support these practitioners. Taking into account the needs and expectations of this generation and the current climate of the NHS I propose that the diagnostic radiography profession should consider developing a coaching based model of preceptorship.

The development of a coaching based model of preceptorship would be in conjunction with the professional body, HEIs and Trusts. Although in its infancy in my mind, the purpose of this approach would be to teach all preceptors some fundamental coaching skills to allow them to utilise a coaching approach in their role. This could be undertaken in the HEI over a two day course which would cover skills such as; listening, asking powerful questions, creating accountability, affirming, acknowledging and challenging. It would also include the introduction to some basic coaching tools and the TGROW model (Whitmore, 1998). Once the preceptors are equipped with these skills, the preceptorship scheme will facilitate the graduates to develop an increased self-awareness, identify where they are now and where they would like to be (including the steps of how to get there), foster accountability and reflect on practice to find solutions. This would not only offer initial support to graduates during transition but also to provide a supportive, stimulating and structured career pathway for graduates of Generation Z to help increase retention within the workforce.

Little research has been focussed toward the generation gap and this will have a significant impact on the future of not only radiography but all other healthcare professions.

- Peer support was heavily utilised by the newly qualified radiographers and in some cases was the only support they received. Adam's experience illustrated that there is already a Trust framework that has been developed to facilitate the use of peer support which could be shared as an example of good practice. Other diagnostic imaging departments should adopt a similar scheme to support new starters.

In considering the use of peer support further, HEIs should work with students and alumni to explore ways in which they could draw on peer support as a newly qualified radiographer. This should be introduced as part of the undergraduate curriculum and taken forward in to the

Trusts. The strategies developed would then ensure that the graduates made optimum use of the support available in the Trust. The framework used by Adams's department could be developed by liaising with local Trusts and establishing a buddying scheme where new starters are paired up on the rota. In addition, buddying would form part of a peer support network and facilitate the development of collaborative relationships which are supportive and non-competitive. This model is suggested by Morton-Cooper and Palmer (2000) and has formed part of the approach taken by NHS Scotland to provide personal and professional support for effective practitioners.

It would also be timely to enhance the peer learning experience by implementing peer assisted learning (PAL). A systematic literature review undertaken by Secomb (2008) found that PAL is primarily a positive experience which increases students' confidence and enhances learning. It was found to be an effective intervention for students on clinical placement and can help to overcome workload pressures whilst ensuing that students can continue to develop their knowledge and skills. PAL is predominantly utilised at undergraduate level, however, the findings of this thesis would suggest that this is an opportunity for the profession to utilise strategies such as buddying and PAL to develop a framework of peer support for newly qualified radiographers. A pilot scheme could be developed between the HEI and one of its partner sites and then rolled out across the regions. Current students and alumni would work with academic and practice staff to take this forward.

This is a significant finding and its original contribution to the profession at this time could have a significant impact of the future support of graduates and staff retention.

- The inclusion of interprofessional education in the undergraduate curriculum has produced practitioners that are confident in communicating with a range of health care professionals.

As a result of the Bristol Royal Infirmary Inquiry (DoH, 2001) and the Laming Inquiry in to the case of Victoria Climbé (Laming, 2003), interprofessional learning was embraced by the HEI in 2003 following the DoH subsequent recommendations. There are three modules delivered across levels four, five and six as part of all undergraduate health and social care degree courses at the HEI. Although it is a logistical challenge to deliver and not always popular with the students at the time, it has been found that there is often a recognition and appreciation of its purpose following graduation. The majority of the graduates have benefited from the experience and have a good knowledge of other professionals and are able to confidently liaise with them as part of their role. The significance of the way in which IPL has effectively prepared the newly qualified radiographers for their role needs to be emphasised to the undergraduates in some way. The work by Healey et al. (2014) discusses how HEIs can work with students as partners and the use of alumni in the delivery of IPL would build on this. By sharing their stories and experience with the students it would provide authenticity in practice which would promote the importance of IPL and assist in contextualising it in preparation for graduation. Links could also be made to the Sustainable Transformation Plans (Alderwick et al., 2016) to enable students to see the necessity of working together in the future in order to provide a non-competitive, collaborative approach to meet the changing needs of the population by providing more co-ordinated services to patients within current financial constraints.

There has been little written about the value of IPL in radiography education and this finding emphasises that IPL is an essential element to undergraduate health and social care programmes and is of significant importance for the future challenges of the NHS. The focus on IPL needs to be not only in the educational setting but also in the practice setting. The Interprofessional Education Guidelines (2016) produced by the Centre for the Advancement of Interprofessional Education (CAIPE) debates the complexities of delivering IPL,

particularly in practice. Often in practice, students are expected to identify their own IPL opportunities and according to CAIPE this is often inappropriate. What is suggested is that students are given well planned placements which give them the opportunity to actively contribute to an interprofessional team. The provision of every student to be given one placement in an interprofessional team during their course is considered best practice and ensures that they have the opportunity to reflect on their professional relationships, performance and develop effective team working skills (Barr et al., 2016). It is therefore vital that IPL is part of all undergraduate health and social care programmes' curricula and that the benefits of this are shared.

- All the participants felt well prepared for their first post and this may be as a result of the students spending 60% of their time in practice for the duration of their course, culminating with a block of twenty one weeks after Christmas in their final year. This seems to have given them time to consolidate their practice up until graduation.

One of the most notable findings of this thesis was the willingness and preference of the new graduates to work in the operating theatre. This finding is in direct contrast with other studies that found that graduates felt ill-prepared to do so (Naylor, 2014; Feusi et al., 2006). This clearly shows the graduates were able to practice autonomously at an early stage in their career. It also evidences their ability to reflect-in-practice (Schon, 1987) as they were able to adjust their techniques whilst undertaking imaging during the operation. The leadership skills demonstrated by the graduates putting themselves forward and being confident enough to actively seeking out opportunities to become a part of other interprofessional teams is very encouraging. Whilst reflecting on this finding I was taken back to one of the early quotes in my first findings and discussion chapters by Adam in which he used the analogy of a bird standing at the edge of the cliff. For me, this sums up the courage and confidence that is demonstrated by the newly qualified radiographers. Again, this could be due to the length of time in practice

and specifically the long placement time prior to graduation. However, it was also a preferred area due to the graduates receiving immediate feedback on their performance, something that was omitted in other parts of the diagnostic imaging department and an aspect that the graduates struggled with. This original finding warrants further investigation to explore the reasons why this group of graduates were willing and capable to work in the operating theatres and this shared with other HEIs to ensure other radiography students are also well prepared for this autonomous aspect of their practice.

- The working environment requires resilient practitioners and HEIs should look at ways in which they can help students build the capacity to be resilient. As previously discussed resilience is an important aspect of professional practice and it is something that needs to be cultivated within the profession. Having the adaptability to respond quickly to change whilst maintaining health and wellbeing is essential to all healthcare practitioners in the current climate. As a consequence, resilience workshops have been introduced into level four of the diagnostic undergraduate programme and have recently been evaluated. It is the intention that this is expanded into levels five and six and becomes an integral strand throughout the curriculum. The challenge in delivering resilience as part of the curriculum will be similar to that of IPL in that undergraduates do not always understand the importance of these type of topics. It was acknowledged by the participants in this study that as students they paid little attention to professional issues and the wider economic, political and social influences on healthcare. Helping students to build up the capacity to develop a resilient outlook will ultimately prepare them for working in an environment of constant change and challenge. Relating back to the work of Healy et al. (2014), there will be opportunities to work with alumni across different professions who would be willing to come and talk to the students and share their experiences of working in the NHS, dealing with change and coping with the work pressures. This is an exciting prospect and would certainly add value to the curriculum as

well as become an original and meaningful way to develop resilient practitioners.

- Although some graduates enjoyed the responsibility of teaching, assessing and supervising students there was an expectation for this to be undertaken very early on in their career. Some aspects of teaching, learning and assessing others are currently embedded into the undergraduate programme of these graduates, however this needs to be developed further as the time frame in which the graduates are expected to support students was for most within two weeks of starting their band five post. As the mix of learners diversifies in departments due to the introduction of apprentices and the demand for capacity increases, learners will need to develop new ways of working and graduates need to be much better prepared for teaching, supervision and assessment roles. This needs to be enhanced in the existing curriculum and the use of alumni to contribute to this part of the curriculum and the sharing of useful strategies, examples of incidents to deal with would all add authenticity to this topic and facilitate the students' understanding of the importance of this preparation.

- The existence of CoPs within the workplace is evident throughout my findings and goes some way to explain how the graduates navigate their way into the culture of their new environment and become part of the community. The findings of this study suggest that this is a major cause of anxiety in the first few months and therefore it would seem prudent that a knowledge of this process and of CoPs should be developed with the students at an undergraduate level to help them prepare for the experience of transition. This would also have benefits for the undergraduate students who have to fit into their practice placement environment and a knowledge and understanding of what happens may help to better support them. During the interviews, it became apparent that the graduates received mixed levels of support from their colleagues and radiographers' expectations were high. The

effect of radiographers' behaviour and how it impacts on how quickly the graduates achieve full legitimate participation also needs to be considered as there are various ways that this can be blocked. If the radiography profession developed an understanding of how CoPs function it may be that positive behaviours and strategies could be developed and encouraged to ensure a less stressful and quicker transition. The principle of CoPs would fit well into the two day course for preceptors as part of their coaching skills training and as such be included in the content of the course as suggested on page 245.

8.4   Revisiting the research question and aim

The research question and aim for this study are stated below:

Research question:
What is the transition experience of graduates as they become diagnostic radiographers?

Aim
To explore the experiences of newly qualified practitioners graduating from one HEI during their first year in post as radiographers in a range of diagnostic imaging departments in the NHS

Reflecting back on the research question and aim, I feel that they were both realistic and achievable. I considered my research question at length and it accurately reflects what my intentions were when starting this thesis. I outlined the trigger for my study in my rationale and my reason for wanting to explore the transition experience of graduates in diagnostic radiography was driven by a desire to find out exactly what it is like in the first twelve months following graduation as they become a radiographer and what influences that experience. Due to the focus of this research being on each personal experience as it is happening (being lived), I wanted to be able to describe and interpret the experiences of the newly qualified radiographers and therefore an interpretive phenomenological approach was the methodology of choice

and as the research journey began it became clear once the data were being collected that this had been the correct choice. My aim as a phenomenologist was to use the data gathered to describe and interpret the experience of each participant in order to gain an in-depth understanding of what it was like for each participant to be a newly qualified radiographer in a new (to the graduates) NHS Trust diagnostic imaging department. I aimed to achieve this by undertaking three interviews with each participant at three, six and twelve months which are deemed crucial points as previously discussed in the methodology. The three month interviews really seemed to capture those early raw experiences and this was helped by the use of the Peaks and Troughs graph. This enabled the participants to give specific examples of when things had gone well and not so well. They all found this a useful exercise and many carried it on to the six month period. I think it helped them to gain a balanced view of their weekly and also to reflect on their strengths and weaknesses. As an educator and a reflective practitioner it has made me consider where I may be able to use this with the current undergraduate radiography students and I intend to introduce this into the undergraduate diagnostic radiography programme next year or to give it to graduates as a tool to use in their early days. As a fairly novice researcher with limited experience of interviewing there were times when I could have probed for more information and occasions when my questions were leading. However, as I gained in confidence this improved and was a key learning point for me as a researcher to take forward.

The three months interviews were relatively hard to listen to at times due to the nature of the experiences but I think they were the ones from which gleaned the most information. I was pleased with the way in which I then used the initial interpretations from these to open the six month interviews. This allowed me to check my understanding with the participants and then gave us a point to move forward from to see if there had been any changes. If I were to undertake a similar study I think I would use this approach again as I felt that it helped to forge our relationship as researcher and participant. The twelve month interviews were based solely around the graduates' individual theme boards. Having only used this method once before in a workshop

environment, it was a risk as the information collated would only be as good as the theme board produced. Although the participants had been given a handout to explain the principles it was still a relatively new concept for them to grasp and an artistic approach to use in a predominantly technically focussed profession. There were a couple of participants who made the minimal effort, however, most produced some excellent theme boards which really helped to deepen their level of reflection on their first twelve months. I am pleased I employed this method as I felt that the images added a richness to the data. In fact when I presented some of my findings at the Achieving Excellence in Radiography Education and Research Conference 2016, the images made the most impact on the audience. I have since adopted theme boarding workshops into much of my teaching practice, particularly at post-graduate level.

I am confident that the findings from this thesis and subsequent discussion have provided nine stories of nine journeys of transition from student to diagnostic radiographer. By analysing these stories further and identifying common themes it has been possible to identify some of the factors that influence the transition experience which was my original intention. Three in-depth findings and discussion chapters have linked the findings of this study to existing literature in order to not only understand the transition experience of these participants but also to identify any lessons that can be learned which may help to inform the transition period of others in the future. There are some clear implications for the future and also some areas that would benefit from further research. To this end, I feel that the research question and aim were fulfilled.

8.5   Reflections on my research journey

Reflexivity is an essential part of the qualitative research process (Berger, 2015). According to Hertz (1997) *'to be reflexive is to have an ongoing conversation about the experience while simultaneously living in the moment'* (cited in Finlay, 2002, p533). In this section, I hope to demonstrate my ongoing

reflexivity throughout the process by evaluating how I have changed during this journey.

At the beginning of this thesis, I spoke about my position and role as a researcher and the roles that I have which will have influenced this study. I will discuss each of these and how I think I have transformed throughout this process.

8.5.1 My role as a researcher

I started my journey as a researcher when enrolling onto the Professional Doctorate. In establishing my role and position as a researcher I had to consider philosophical questions that I had never considered before. My past educational and life experience had once situated me firmly in the realist arena and being an accomplished mathematician and scientist, I had never felt the need to question the nature of reality. However, as my interest in human behaviour and subjective experience intensified I found myself moving along the continuum to a subjective ontology and an interpretivist epistemology. I have stayed true to this throughout this study and if anything my beliefs have grown stronger as my passion for qualitative research has deepened and I would see this as my future in research. There are many hurdles to overcome whilst undertaking a PhD which require patience, good organisational skills and perseverance. I would like to think that I have developed in all of these areas.

There were a couple of significant moments for me throughout the process; the first one was the recruitment of the participants. Initially, I was unsure how many students would be interested but I was fortunate enough to recruit nine participants. I took this as a sign that I had not only explained my research clearly but also they could see the value of the study, this was a really positive message for me. The second was the completion of the interviews; I felt an overwhelming sense of relief. However, undertaking the interviews was also a steep learning curve as my experience in interviewing was minimal prior to undertaking this study. On reviewing the transcriptions I identified times

where I stuck rigidly to my questions which resulted in the participants repeating information and there were also times where my questions could be construed as leading. I feel this improved as I gained more experience, however, I had pre-empted this which is why I decided to reflect my initial interpretations back to each participant at the start of the second interview to ensure that my understanding was congruent with what they had shared. This worked well and I seemed to have interpreted their feelings appropriately.

Developing some expertise in phenomenology, interviewing, ethical processes and qualitative data has allowed me to share this knowledge with not only colleagues but in both my teaching and supervision of undergraduate and postgraduate students.

In terms of challenges, although I piloted the interviews beforehand I think on hindsight I would have benefited from further practice, although my technique definitely improved along the way. The data analysis also took far longer than I expected and was very demanding. These issues were due to my own naivety and as novice researcher not unique, however, they did provide valuable learning opportunities.

This doctorate is the start of a journey into research. It has provided me with a set of research skills which I can build on as I begin to move forward. Research in radiography is still relatively embryonic in comparison with other health care professions and I intend to play an integral part in developing this. I am passionate about my research and genuinely excited about my findings and am very much looking forward to sharing them with the profession and wider audience. I have already begun to network with other like-minded researchers in radiography and I hope that in the future we will be able to work together on some research projects.

8.5.2 My role as an educator

My interest in this topic stemmed from my role as an educator and a firm belief that graduates from the degree course in diagnostic radiography at my HEI

are fully prepared to practice. However, I did not know that for sure and I wanted to know what their experience is really like in the first year following graduation and what aids or hinders their performance. Listening to some of the interviews was an uncomfortable experience and I have revisited the following excerpt from my diary on many occasions '*How can healthcare professionals be so unsupportive and uncaring. Where is the compassion amongst colleagues and for those new to everything?*'

Through the experience of listening to the stories of the participants, I began to reflect on my role as an educator and how I was with students. Sometimes with competing priorities, the students who should be central to everything that we do as educators become our last thought.   I felt myself becoming more empathetic towards students and taking time to see things from their perspective, this was a definite shift in my practice and not one that I had previously realised needed to happen.

I do feel that I am a much more compassionate educator as a result of this experience and I am much more focused on student wellbeing and working with students as partners. Keeping strong links with practice is an important part of this and I feel there is work to be done in partnerships with Trusts to support staff to embrace change and also support others new to their departments by providing a caring and compassionate environment in which they can flourish. I am confident that a knowledge and understanding of CoPs would underpin this.

Not only did I continue to make progress in my research but this was also having a profound influence on my practice as an educator and began to underpin much of my teaching. My teaching style has become much more facilitative and I enjoy debating challenging topics with the students which previously I may have shied away from. Offering a different perspective to that of the positivist paradigm in which radiography is so entrenched is both essential and also satisfying.

8.5.3 My role as a practitioner

Undertaking this study gave me a unique opportunity to scrutinise my own profession and to analyse it in-depth. I have been fortunate enough to be able to share the journey of nine ex-students as they entered their first year as radiographers and I feel privileged to have been given this opportunity. The insight I have gained through this study has allowed me to develop a greater knowledge of what is expected of newly qualified radiographers and the working environments that they enter. Some of my findings did not always show the profession in a positive light and this was difficult to accept at times. It was disappointing to find that there was a general lack of support for the graduates and that preceptorship is not readily adopted by the profession. There seemed to be a harshness to the environment that the newly qualified radiographers entered and expectations were high. This may be due to work pressures or a general apathy within the profession but it needs to be tackled if we are going to attract people into the professional and then retain them. I have come away feeling that there is much to be done within the profession that could improve the working lives of not just the new graduates but all radiographers to ensure that we continue to move forward and take control.

I am positive that the dissemination of my findings will make a definite contribution to the future of the radiography profession and increase awareness of a range of issues amongst diagnostic radiographers. The findings from my research will enable students, graduates, educators, radiographers to develop an understanding of the transition from graduate to radiographer.

8.5.3 Summary

In summary, I have developed so many skills; a knowledge of qualitative research, an in-depth understanding of phenomenology, the ability to interview and being able to analyse qualitative data. In my role as an educator I have become much more student-centred, more supportive, more patient and more compassionate. I work alongside the students as partners and encourage

their input wherever I can. I have realised how harsh the NHS environment can be for staff and how as a profession we pay little attention to caring and supporting our colleagues and how at times we become apathetic to change instead of taking control and driving it forward.

It has overall been an enjoyable, rewarding but sometimes difficult journey but there is no doubt in my mind that I have grown not only as a person but also as a professional during the completion of this thesis.

8.6 Strengths and limitations of my thesis

In this section, I will explore some of the strengths and limitations of this thesis and the impact that these may have had on the findings. As mentioned previously, reflexivity plays a vital part in undertaking qualitative research (Berger, 2015). Recognising factors that can influence or bias the research is as essential part of the process and deepen the quality of the findings ensuring that there is credibility and rigour throughout (Green and Thorogood, 2009).

8.6.1 Strengths

I have identified the perceived strengths of this study:

- The selection of the participants. All the participants of this study took up band five posts in NHS departments that were new to the graduates. This ensured that they were all exposed to unfamiliar environments and that there was no previous experience of working within the department that could have influenced their experience and thus the findings of this study.

- The use of innovative data collection tools. The use of the Peaks and Troughs graph at the three months interviews helped the participants to recall events during this time that may well have been forgotten. It also seemed to help them put things into perspective and often they

realised that things were going much better than they thought. Many of the participants continued to use these up until the six month interviews as they found completing them helped them to identify strengths and weaknesses and reflect on their experience. I intend to introduce this tool to those students prior to graduation.

The use of the theme boards really enhanced the twelve month interviews and were the focus of the final interview. They were prepared beforehand and the participants then reflected on the images they had chosen to explain what they represented. The images chosen often gave a much more powerful message than words could have and it has helped me to share their stories in a unique way. This is a method that I now regularly adopt in my teaching and will be sharing it with my profession.

- The retention of the participants. I was fortunate and overwhelmed that all nine participants stayed with the study to the end. This illustrated to me that they felt that they study was worthwhile and also allowed me to follow the complete journey of each participant without having to consider any implications that attrition may have caused to the findings.

- Interviewer relationship with participants. I had known the students for the duration of their course and had been either a personal tutor or research supervisor to some. I utilised my skills as a life coach to form a positive relationship as researcher with them which I hope allowed them to be honest and open about their feelings and experiences during the interviews.

- The findings of this study have direct implications for practice across HEIs and Trusts. These have been discussed in section 8.3 and have the potential to make some positive changes to the transition experience of graduate diagnostic radiographers in the future.

8.6.2 Limitations

On reflecting on the development and completion of this thesis, I also identified the following perceived limitations:

- The findings are non-generalisable. As with all qualitative studies, the findings cannot be generalised but can be seen as potentially transferable. The thesis tells a story in which there are lessons which may resonate with students, radiographers and educators, underpin change and inform practice.

- My previous relationship with the graduates. Although I feel that my close relationship with the students was a strength of the study, it could also have been perceived as a limitation. It is difficult to establish if they held back information because they didn't want me to know how they were feeling. They may not have wanted to say anything negative about their preparation which related to the course, or how they were feeling about the profession. I think this is unlikely but feel that I must raise this as a possible influence on the findings.

8.7 Strategies for dissemination and considerations for future research

Throughout my doctoral journey I have been active in disseminating aspects of my study along the way. This has been in the form of seven conference presentations, three conference posters and one paper. These are listed in Appendix XIV. An essential part of the process has not only been to share my knowledge and thoughts with others but also to engage in conversations that would help me to continuously reflect on and develop my research.

I have also recently been approached to speak about the findings of my research at the next Society and College of Radiographers Association of Radiography Educator's study day in October 2017. This will be an excellent

opportunity to present my full findings to a professional audience of radiographers and to recommend some of my ideas to the profession. I have also been in contact with the Professional Officer for Education and Accreditation at the Society and College of Radiographers to arrange a meeting to discuss my proposed preceptorship scheme and how this can be taken forward.

My future plans include publishing a series of papers from this thesis to inform the radiography profession across practice and academia. This will cover not only the findings but also the use of innovative methods such as the Peaks and Troughs graph and theme boards and the use of phenomenology in radiography research. Target journals will be Radiography, Qualitative Research, a range of educational journals and the Journal of Practice-based Learning in Health and Social Care.

There are also several areas which I would like to investigate further. Firstly the impact of Generation Z on the radiography workforce and how best they can be prepared for graduation, supported through transition and helped to plan future careers. This is something that I would like to discuss further when I meet with Professional Officer for Education and Accreditation at the Society and College of Radiographers as this could be combined with the work on preceptorship.

Another interest which has developed for me during this thesis is the area of resilience and having already been involved in developing some initial workshops at an undergraduate level I would like to take this forward through further research. I have already undertaken a small evaluation of the workshops but would like to work with student support at the HEI to develop some interprofessional workshops which would be delivered over a period of three years. This would allow us to undertake a longitudinal qualitative study to explore students' development of resilience and identify positive and negative influences on this development.

I am also interested in the concept of peer support for newly qualified radiographers and how this could be studied further to see how this could be enhanced in the HEIs and in practice. The College of Radiographers Industry Partnership Scheme supports radiography research by inviting applications for research grants. It funds projects related to any aspect of the science and practice of radiography up to £10,000. I would like to apply for funding in partnership with a local Trust to set up a pilot scheme to facilitate peer support for newly qualified radiographers. This would be a small scale study with a qualitative evaluation, potentially using interpretive phenomenology to explore the experience of such a scheme.

Lastly, one of the surprising findings of my research was the willingness and capability of graduates to work in the operating theatre. This warrants further investigation to explore what influences this as there may be something to be learnt from the preparation of these students which could be introduced into other radiography programmes. This may take the form of a larger piece of work which could be undertaken nationally and involve both qualitative and quantitative data. This project will need further thought and planning before deciding on the best approach.

8.8   Closing Remarks

There are many uncertainties facing the UK over the next few years. The social, economic and political consequences of Brexit are still unclear and the NHS is coping with increasing demands every day. The surge of transformation across health and social care as well as education bring with it the need for resilience, flexibility and the ability to cope with continuous change. The cut in funding for healthcare courses starting in September 2017 has already had a substantial impact on the number of undergraduate applications and the introduction of apprenticeships brings unfamiliar territory. With fewer people wanting to enter the healthcare professions and the unknown consequences that Brexit will have on EU staff within the NHS we have to focus on retaining existing staff.

The findings of this thesis have suggested that there are improvements to be made in supporting newly qualified radiographers which is mirrored across other health professions. In addition to this the people entering the profession from Generation Z have a different set of needs not encountered before that also need consideration. Combined with this is the potential new breed of students entering healthcare programmes within Higher Education that are now paying for their degree course.

There is much to learn and much to be done in order to deal with these challenges. However, the implications of this thesis suggest some positive ways to move forward and provide the opportunity to start some important conversations and to steer radiography forward to an exciting future.

As Mahatma Gandhi said:

'*You must be the change you want to see in the world'* (undated).

(http://www.positivityblog.com/gandhis-top-10-fundamentals-for-changing-the-world/)

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APPENDIX I:

The Society and College of Radiographer's Preceptorship Scheme

An updated version:

APPENDIX II:

An Outline of the HEI's Student Attendance Pattern

BSc (Hons) Diagnostic Radiography Year Calendar 2012-13				
Wk.	Week Bgn.	BSc Radiography 2012 intake	BSc Radiography 2011 intake	BSc Radiography 2010 intake
	27-Aug-12			1
1	03-Sep-12		Reading week	2
2	10-Sep-12	Induction	1	1
3	17-Sep-12	1	2	2
4	24-Sep-12	2	3	3
5	01-Oct-12	3	4	4
6	08-Oct-12	4	5	5
7	15-Oct-12	5	6	6
8	22-Oct-12	6	7	7
9	29-Oct-12	7	8	8
10	05-Nov-12	8	1	9
11	12-Nov-12	1	2	3
12	19-Nov-12	2	3	4
13	26-Nov-12	3	4	5
14	03-Dec-12	4	5	6
15	10-Dec-12	5	6	Reading week
16	17-Dec-12	6	7	Assessment wk
17	24-Dec-12			
18	31-Dec-12			
19	07-Jan-13	7	Assessment wk	10
20	14-Jan-13	8	1	11
21	21-Jan-13	9	2	12
22	28-Jan-13	10	3	13
23	04-Feb-13	Reading wk	4	14
24	11-Feb-13	Assessment wk	5	15
25	18-Feb-13	1	6	16
26	25-Feb-13	2	7	17
27	04-Mar-13	3	8	18
28	11-Mar-13	4	8	19
29	18-Mar-13	5	9	1
30	25-Mar-13	6	10	2
31	01-Apr-13			
32	08-Apr-13			
33	15-Apr-13	IPL Mon & Tue 11	IPL Weds 11	IPL Thur & Fri 3
34	22-Apr-13	IPL Mon & Tue 12	IPL Weds 12	IPL Thur & Fri 4
35	29-Apr-13	IPL Mon & Tue 13	IPL Weds 13	IPL Thur & Fri 5
36	06-May-13	14	14	Reading wk
37	13-May-13	15	15	Assessment wk
38	20-May-13	16	Reading week	20
39	27-May-13	17	Assessment wk	21
40	03-Jun-13	18	16	Electives
41	10-Jun-13	19	17	Electives
42	17-Jun-13	20	18	Electives
43	24-Jun-13	Reading wk	19	End
44	01-Jul-13	Assessment wk		
45	08-Jul-13			
46	15-Jul-13			
47	22-Jul-13			
48	29-Jul-13			
49	05-Aug-13			
50	12-Aug-13			
51	19-Aug-13			
52	26-Aug-13		Level 6 1	Resit Ass wk
1	02-Sep-13	Level 5 1	2	
2	09-Sep-13	2	3	
3	16-Sep-13	3		

APPENDIX III:

Population, Exposure and Outcome Tool (PEO)

Using PICO and PEO frameworks

The PICO and PEO formats are used widely in nursing and health research to help you formulate an answerable question and to identify the key concepts within your question. Don't worry if your research question does not exactly fit one of these formats. You may find that some elements apply while others do not. It is all part of the process of helping you to develop your question.

PICO is mainly used for quantitative research whereas PEO lends itself more to qualitative research. The elements are described below and can used as required. Not all elements will apply (e.g. the comparison element in PICO) and you should just use those that relate to your question.

There are a number of other formats that can be used e.g. FINER (Feasilbility, Interesting, Novel, Ethical, Relevant) and SPIDER (Sample, Phenomena of interest, Design, Evaluation, Research Type) for mixed methods research.

Developing Your Search Strings

You should then choose appropriate search terms to describe the key concepts and arrange them into a coherent search strategy

Very Important Tip! You may not need a search string for each PEO or PICO element. It does not matter if your database search strings do not follow the same structure as your PEO or PICO statements. If you try to force your search strings to match those of your PICO or PEO elements then you may get poor or inconsistent results.

Population - This element may require more than one string e.g. dementia patients in an acute setting will require a search string for dementia and another for the acute setting e.g.

S1	Acute N1 care OR acute N1 setting OR hospital*
S2	Dementia OR alzheimer* OR cognitive N1 impair* OR memory N1 loss

Intervention or exposure -This element is usually the most tangible and easiest to define and where you should start your search. If you get too many results it is often helpful to redo this search string as words in title to limit and focus the search results.

Outcomes - Outcomes are often difficult to define (e.g. improving patient care) and a search string may sometimes not be required in order avoid over specificity.

PEO format – for qualitative research

P	Population Patient Problem	Who are the users - patients, family, practitioners or community being affected? What are the symptoms, condition, health status, age, gender, ethnicity? What is the setting e.g. acute care, community, mental health?
E	Exposure	Exposure to a condition or illness, a risk factor (e.g. smoking), screening, rehabilitation, service etc.
O	Outcomes or themes	Experiences, attitudes, feelings, improvement in condition, mobility, responsiveness to treatment, care, quality of life or daily living. .

PEO example

Research topic: What are the attitudes of health professionals towards caring for older patients with dementia in an acute setting?

P	Population and their problems	Health professionals working in an acute setting
E	Exposure	Caring for older patients with dementia
O	Outcomes or themes	Attitudes of heath professionals' towards older dementia patients

However, the **search strings** might look like this:

S1	Acute N1 care OR acute N1 setting OR hospital* OR inpatient* OR ward*
S2	Nurs* OR professional* OR practitioner* OR staff OR personnel
S3	Dementia OR alzheimer*
S4	Attitude* OR opinion* OR perception* OR perspective* OR belief*
S5	S1 AND S2 AND S3 AND S4 AND S5

PICO format – for quantitative research

P	Population, Patient/ Problem	As above
I	Intervention	Phamacological (e.g. a drug) or non-pharmacological (e.g. therapy, screening, surgery, service or test).
C	Comparison	Is there a control scenario or comparison element e.g. different treatment options, a new drug vs a placebo or existing treatment? Or no comparison?
0	Outcome	What is to be achieved, changed or measured e.g. mortality rates, a patient's condition or satisfaction, reduction in referrals or length of stay.

PICO example

Research topic: How useful are compression garments in treating patients with leg ulcers?

P	Population, Patient, Problem	Patients with leg ulcers
I	Intervention	Compression garments
C	Comparison	Not applicable
O	Outcome	Usefulness of pressure garments in the treatment of leg ulcers

However, the **search strings** might look like this

S1	Compress* OR pressure OR support*
S2	Garment* OR stocking* OR hosiery
S3	Leg N1 ulcer* OR venous N1 ulcer*
S4	S1 AND S2 AND S3

Making your final selection of articles

The database cannot make your final selection of articles; you may end up with anything between 10 and 100 results depending on your topic. Your inclusion and exclusion criteria will be based on your PEO and PICO statements.

Bettany-Saltikov, J. (2012) *How to do a systematic literature review in nursing: a step-by-step guide.* Maidenhead: McGraw-Hill/Open University Press.

APPENDIX IV:

The Conceptual Model of Preceptorship

Preliminary conceptual model representing the learning and development of the novice physical therapists during the first year of practice
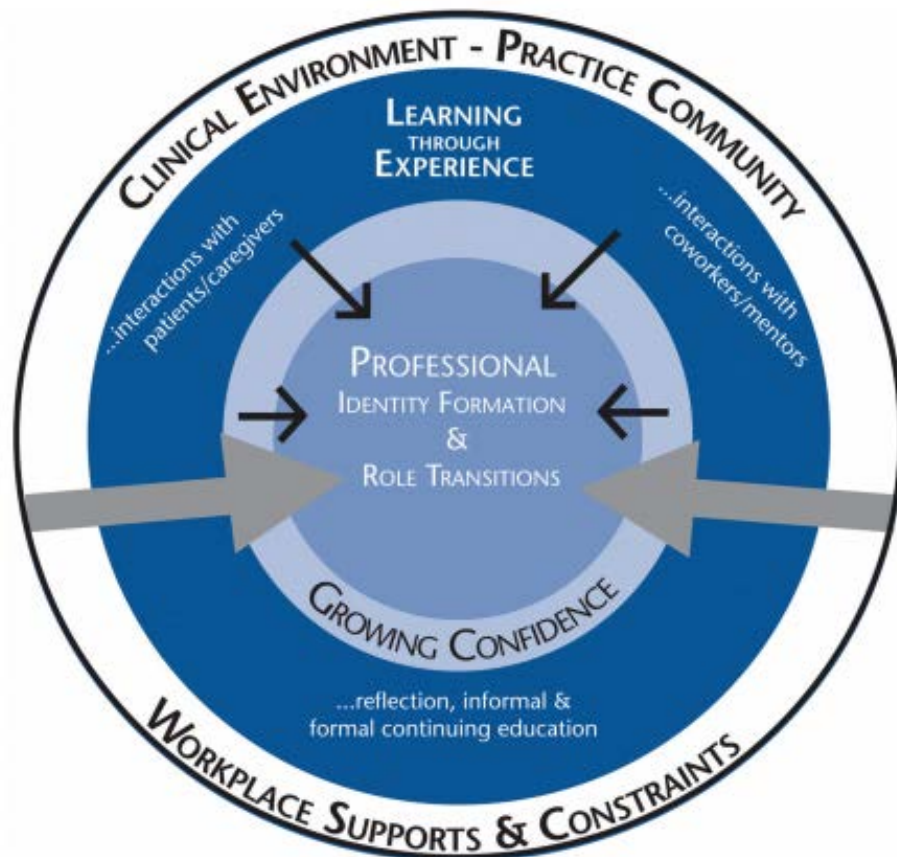
(Black et al., 2010, p1763)

APPENDIX V:

Conceptual Model of Transition
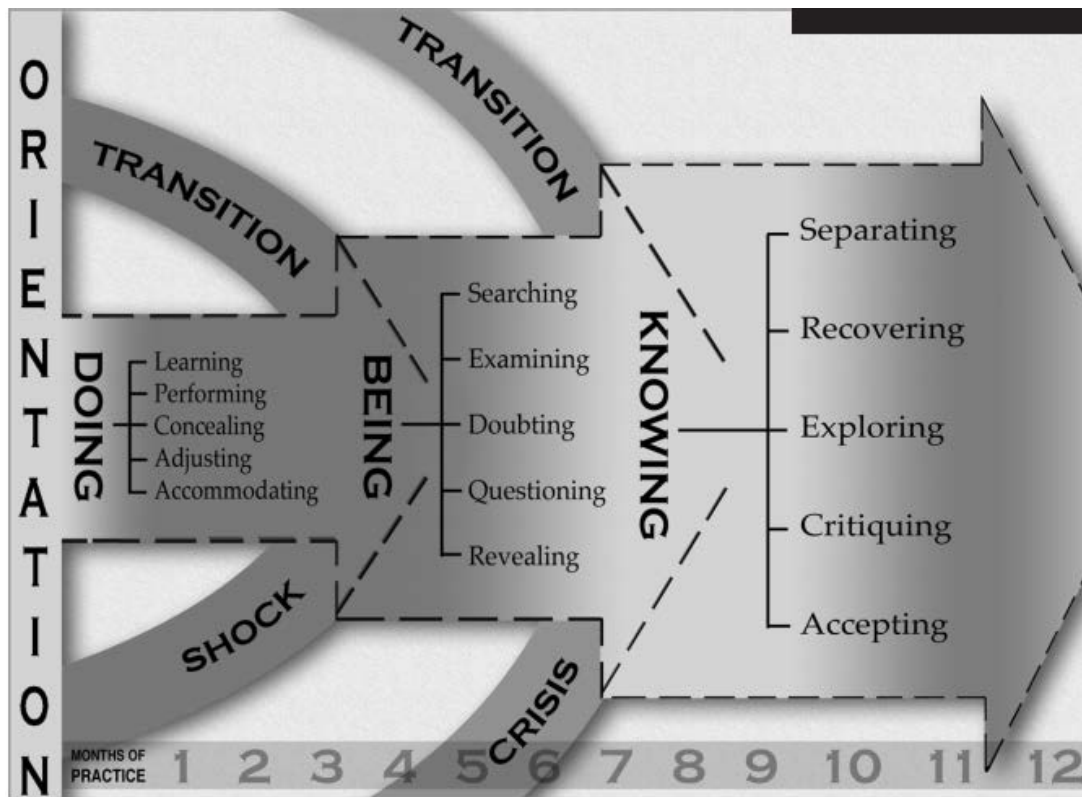
(Boychuk Duscher, 2008, p443)

APPENDIX VI:

Participant Information Sheet

I would like to invite you to take part in my research study. Before you decide it is important for you to understand why the research is being done and what it would involve for you. Please read through this information sheet and contact the gatekeeper for the research at the end of the sheet if you would like to be contacted for further information about this study.

What is the purpose of the study?

The purpose of the study is to explore the experience of newly qualified practitioners graduating from one HEI during their first post as a radiographer in a range of diagnostic imaging departments in the National Health Service (NHS). I am interested in finding out about your experience of transition from student to practitioner in diagnostic radiography.

Why have I been invited to participate?

This study is being undertaken as part of a Professional Doctorate in Health and Social Care at the University and will form the thesis which completes the programme of study.

You are been asked to take part in this study because you will soon be graduating from XXX and taking up employment as a diagnostic radiographer. I am interested in finding out about your experiences during this time of transition from student to practitioner, particularly in the first twelve months. As a new graduate it offers you a unique opportunity to have your say about what it is like for you working in the NHS in the first few months as a band 5 radiographer.

Do I have to take part?

Your decision to participate in this research is entirely voluntary. You may choose to withdraw your consent at any time in the process without giving any reason. Your decision to withdraw consent will have no bearing on any future relationship you may have with XXX.

What will happen to me if I take part?

The gatekeeper will outline the purpose study to you and also go through this information sheet. If you agree to take part in this study you will be asked to complete an 'Informed Consent' form. You may wish to complete this form following your talk

by the gatekeeper, alternatively you might want to go away and think about whether or not you wish to take part. This is perfectly understandable and you can e-mail the gatekeeper at a later date to inform her of your decision. She will be happy to talk through the process further with you and you will have the opportunity to ask any questions you may have about the research before agreeing to take part. The 'Informed Consent' form can be signed when you feel you have enough information to make your decision.

This study is longitudinal and will follow you as you spend the first year as a band 5 radiographer in the NHS. In order to capture as much of your experience as possible, there are various stages to the study. In your first three months you will be asked to fill out a Peaks and Troughs graph for each week, the aim of which is to ensure that those early experiences are not forgotten. These graphs will be used during the interview to help guide the discussion and may provide a useful aide memoir of your experiences.

There will be another interview at six months which will continue to explore your experience and build on some of the themes explored at your initial interview. During your first year you will be asked to complete a theme board which you can bring to your final interview at twelve months. At this interview your theme board will be used as a trigger to the discussion and represent your reflections of your first year in practice.

Once you have signed the Informed Consent form, specific guidance will be given to aid with the completion of the Peaks and Troughs graph and also how to develop a theme board. This will be undertaken via a workshop.

All interviews will take place at a mutually convenient time outside of your workplace and work hours. The interviews will take place at an agreed location, either at a neutral venue or if preferred in your own home. Each interview will last no longer than one hour and will be tape-recorded so that information can be transcribed at a later date. Any information that is taped or written down will be kept confidentially in a locked safe. It will later be stored within a password encrypted file on a home computer until the research is completed.

Once the interviews are complete, the researcher may wish to contact you for clarification of certain points. At the end of the interview, the researcher will check with you if it is acceptable to contact you if necessary and will agree a preferred

method of contact with you e.g. telephone, e-mail etc. If you wish to see a copy of the research findings you are asked to indicate this on the consent form.

Will my taking part in the study be kept confidential?

The personal data you provide the researcher will be used for the purposes of this study only, and will not be shared with any third party within the University of Brighton, the NHS or XXX. All personal data will be kept either a locked safe, or within a password encrypted file to maintain confidentiality. No personal data will be used directly within the research although some direct quotes may be used where appropriate. All data gathered as part of this research will be coded so that the identity of any individual is protected. In the unlikely event you disclose anything which could be construed as criminal in nature or breaches the HCPC professional code of conduct, it may be necessary to breach confidentiality in the interest of public safety.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do her best to answer your questions. Her contact details are available at the end of this information sheet.

What will happen to the findings of the research study?

The research findings will initially be shared with the researcher's supervisors and form a part of the Doctorate Thesis. Following analysis of the findings there will be wider dissemination via national and international conferences. It is also anticipated that papers will be submitted to peer reviewed journals

Who has reviewed the study?

This research has been approved by the Faculty Research Ethics and Governance Committee (FREGC) at the University of Brighton and the XXX Ethics Panel. Should you have any concerns about the ethics of this research, please feel free to contact the Chair of FREGC at the University of Brighton.

Contacts:

APPENDIX VII:

Three Month Interview Schedule

So, how are you today?

Describe your experience over the last 3 months in your new post – *use the Peaks and Troughs graph to explore further*

Other trigger questions:

How do you feel you have settled in during this time?

To what extent has the role been what you expected? Have there been any surprises?

How have you been supported during your first 3 months?

Reflecting back, what are your overriding feelings when you think about the last 3 months?

What have you learnt during your first 3 months?

How have you coped over the last 3 months (re: challenges and expectations)

APPENDIX VIII:

Six Month Interview Schedule - example

Each one was tailored to each participant.

So, it's been six months since you started your role and three months since we last spoke.

So, how are you today? How have you been getting on?

Revisit understanding from last time – check out and expand. Lots of teasing out here of previous material

Do you feel the same?

What has changed and how?

What is different now?

What have you learnt during your first 6 months?

How have you coped over the last 3 months (re: challenges and expectations)

APPENDIX IX:

Peaks and Trough Graph

This graph has been designed so that you can use it to capture your early experiences, thoughts and feelings as a Band 5 radiographer.

Please complete one graph for each week as I will use this information to help prepare for our first interview at the 3 month time period. I would recommend that you fill it in on a daily basis as it will allow you to keep a more accurate record of your experience.

An example is given below to illustrate how you may wish to complete the graph.

	Mon	Tues	Weds	Thurs	Fri	Sat	Sun
Write your comments here to qualify your feelings	Worked with a really supportive team today.. Produced lots of really good images.	In an unfamiliar area today. Struggled with knowing what to do and how to contribute.	Same area as yesterday, still struggling a bit. Met some new people today .	I had a terrible day today and felt completely out of my depth. I could feel myself feeling more and more	Fantastic day in out patients today. I seemed to keep up with the others and produced some good images. The	This was a mixed week for me . On reflection I think I did pretty well. Still feel a bit upset about my experience	Just looked at my rota and am looking forward to next week. I have 2 days in ED!

(Adapted from Bourner et al. undated)

Week 1

Name:

Date:

Peaks and Troughs Graph

Please complete the following graph, being as honest and truthful as possible. You will need to send this to me on the agreed date before we have our first interview.

	Mon	Tues	Weds	Thurs	Fri	Sat	Sun
Write your comments here to qualify your feelings							

Positive

Feelings

Negative
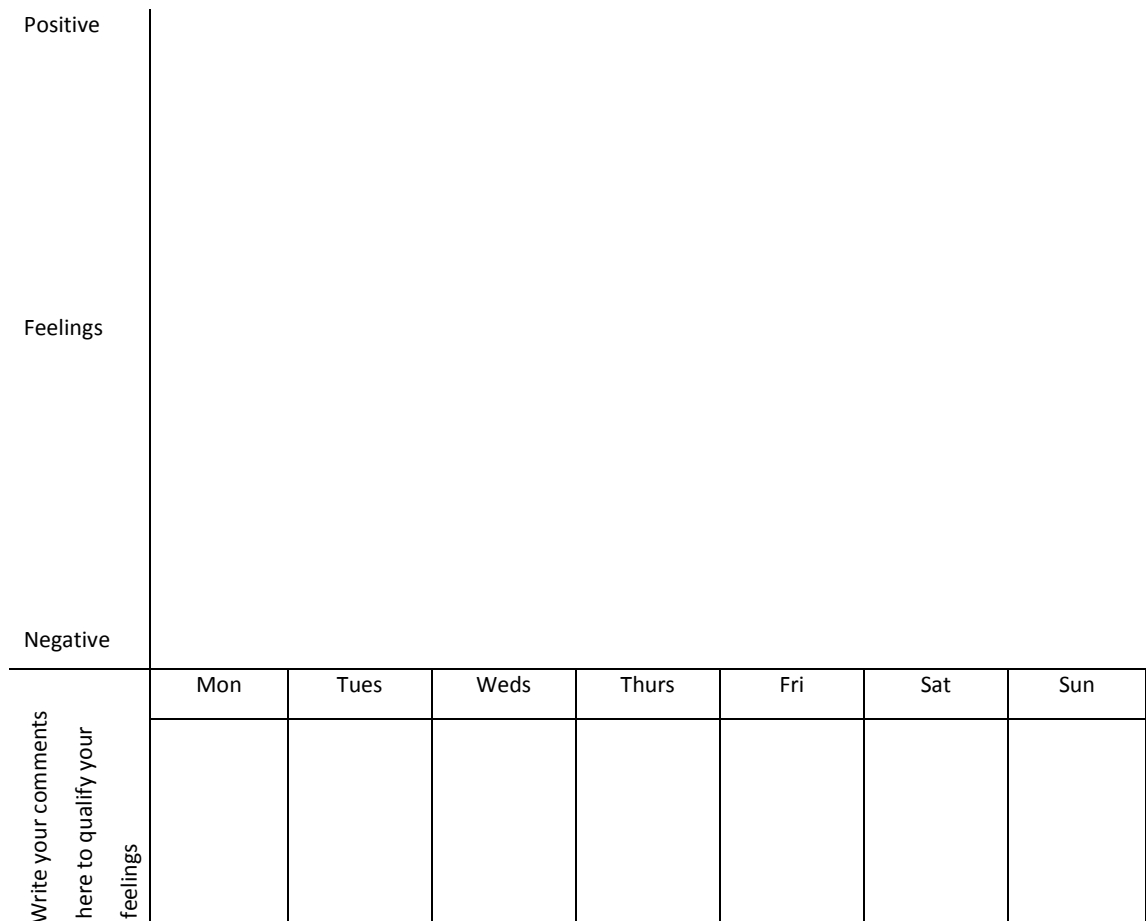
APPENDIX X:

Theme board Guidance for Participants

Using theme boarding to reflect on your experience of transition from student to practitioner

Aim:

To use theme boarding as a technique to explore your experience during your first year as a radiographer

What is theme boarding?

In *"Tell me a story – a way to Knowledge"* Dan Remenyi (2005) posits that story telling is a fundamental way of understanding our environment and relationships in it. The use of imagery is a powerful way to encourage the reflection and evaluation of past events. However, the use of image work in qualitative research has been relatively under-utilised particularly in health sciences until the last six years or so where it seems to have begun to develop interest (Edgar, 1999; Leavy, 2009).

A theme board is used to capture experience, ideas, and moods thus enabling the person constructing the board to in some way crystalise these (Bligh, 1992). It is thought to be a powerful tool that can be used to convey messages behind the images and can be effectively utilised as a permanent record of a journey on which to reflect but also a visual reminder of future goals and aspirations (ibid). In this way it is hoped that this method will access memories of and feelings about experiences that may otherwise be forgotten (Leavy, 2009).

Using a theme board technique to explore experiences of transition from student to practitioner

This activity is based on a qualitative research approach that uses art-like representation (e.g. sculpture, photographs, drawing, collage, drama etc.) 'to elicit, challenge, and shift sense-making frameworks,' (Barry, 1996 p411). It will provide the starting point for your personal stories of transition from student to practitioner.

Using the theme board method will allow you to explore your experiences, feeling and perceptions of transition in a holistic way. For some of you this may be the first time that you have used this method and you may be unsure of how to start. To help you get started, think about the highs and lows and the things that have influenced your experience as you have made the transition over the past 12 months from student to radiographer. Using magazines, newspapers, internet images etc. find images that reflect your thoughts and feelings. Use these to create a theme board that will help outsiders to understand and interpret your perceptions. Useful images are those that dynamically 'suggest', rather than passively 'stand for'. Remember this is your own piece of reflective work so it doesn't matter what it looks like, it's the story it tells that counts!

At the 12 month interview you will need to bring your theme board with you and will we use it to aid your reflection over the past year and underpin the discussion. I hope that the process of creating the theme board itself should deepen your level of reflection and the subsequent interpretation of the images on the theme board in the final interview will provide some meaningful data and play a significant part in your learning experience.

Reflecting on your own theme board

As you contemplate your own theme board ask yourself the following questions (adapted from Barry 1996):

What do I like about this creation?
What are the most obvious things about this creation?
How would I describe my theme board to someone unable to see it?
What are three things people wouldn't know about me from this theme board?
What title would I give my theme board?

What is the message of my theme board?

What feeling does this creation give me?

What secrets does my theme board hold?

What changes would I make to my theme board?

If my theme board (or what it represents) could talk, what might it say?

With whom might I share my creation?

With whom would I definitely not share it?

Examples of theme boards

These theme boards are examples from a workshop undertaken with students asked to reflect on their first year of clinical practice:

Useful Reading

Barry D (1996) Artful Inquiry: A symbolic constructivist approach to social science research. *Qualitative Inquiry* 2(4): 411-438

Bligh J (1992) Using a theme board to enhance small group discussion. *Postgraduate Education for General Practice* 3: 183-187.

Bohnsack R (2008) The interpretation of pictures and the documentary method. *Forum: Qualitative Social Research* , Vol.9, No.3, Art. 26, September. http://www.qualitative-research.net/fqs/

Bourdieu P (1971) Intellectual field and creative project in Young MFD *Knowledge and Control: new directions in the sociology of education* (1971), British Sociological Association.

Deutscher M, Jeffrey P, Siu N The Memory Collage: A Mosaic of Perspectives and Emotions http://hct.ece.ubc.ca/research/memory/DeutscherJeffreySiu.pdf

Edgar IR (1999) The Imagework Method in Health and Social Science Research. *Qualitative Health Research*, Vol. 9, No. 2, 198-211 (1999)

Keller C, Fleury J, Perez A, Ainsworth B, Vaughn L (2008) Using visual methods to uncover context. *Advancing Qualitative Methods,* 18(3): 428-436.

Kolb B (2008) Involving, sharing, analysing – Potential of the participatory photo interview. *Forum: Qualitative Social Research* , Vol.9, No.2, Art. 12, September. http://www.qualitative-research.net/fqs/

Leavy P (2009). Method meets art: Art-based research practice. New York: The Guildford Press.

Parsell, Gibbs T, Bligh J (1998) Three visual techniques to enhance interprofessional learning *Postgraduate Medical Journal,* 1998, Vol 74, 387-390

Remenyi D (2005) "Tell me a story – A way to Knowledge". *The Electronic Journal of Business Research Methodology,* 3(2): 133-140.   www.ejbrm.com
Shank RC (1990) *Tell me a story: Narrative and Intelligence.*   Evanston, Iillinois, Northwestern University Press, page 57.

Sandars J, Murray C, Pellow A (2008) Twelve tips for using digital storytelling to promote reflective learning by medical students. *Medical Teacher,* 30: 774-777.

Todres L (2008) Being With That: The relevance of embodied understanding for practice. *Qualitative Health Research*, 18(11): 1566-1573.

Vaughn K (2005) Pieced together: Collage as an artist's method for interdisciplinary research. *International Journal of Qualitative Methods,* 4(1): 27-52. http://creativecommons.org/licenses/by/2.0

APPENDIX XI:

A 15-Point Checklist of Criteria for Good Thematic Analysis

Process	No.	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for all each theme have been collated.
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent, and distinctive.
Analysis	7	Data have been analysed - interpreted, made sense of - rather than just paraphrased or described.
	8	Analysis and data match each other - the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organised story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you show you have done - i.e., described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as *active* in the research process; themes do not just 'emerge'.

(Braun and Clark, 2006, p96)

APPENDIX XII:

Thematic Map

Transition experience at 3 months

Being supported
- Peers (other NQ's radiographers)
- Colleagues
- In at the deep end
- Structured support

Developing confidence
- Recognising and valuing the level of their preparation
- Believing in oneself
- Making decisions and coping with responsibility making

Adapting to the environment
- Fitting in
- Workload and working hours
- Protocols and equipment

Establishing oneself as a professional
- Interprofessional communication
- Hierarchy
- Feedback
- Managing students

Being useful
- Using initiative
- Contributing to the team
- Working independently

APPENDIX XIII:

Three, Six and Twelve Month Interview Transcripts (including theme board) – Ben

Three Month Interview Transcription
Participant 4: Ben (Pseudonym)
Date: 24/10/2013

JHL: So, the 24ᵗʰ October [...]. What I thought we'd start off with before we look at your peaks and troughs graph is just, I just wondered whether you could just describe how it's been over the last three months, so…?

Ben: Stressful, I'd say. To start with, it was like [...], I dunno, the first couple of weeks I was kinda thinking, 'what have I done?', 'why have I changed for a place, where I'd kinda spent three years learning, gone someone that's just completely different in so many new aspects?', so it was a bit daunting in that respect. [...], but I'm slowly sort of getting used to it now and I have less days when I come home and think, 'what have I done?', and I have more days where I actually really enjoy my job again, so…

JHL: Mmm

Ben: Kind of getting used to that. [...]…

JHL: So what sort of things have made it… stressful?

Ben: Stressful? [...], I don't know, it's that weird feeling when you was a student, if I had to go to an area that I didn't get much time in, I'd feel really nervous, and it almost like I'd be so nervous that I didn't want to go into work. [...], but, because every time I go in, or at the start, every time I went in, I was in a new area, new people, meeting everyone is very daunting, I'm not a particularly confident person when I go into a group of people that already exist. So, I kind of have to just wait for that to come to me. So, it was a bit nervy in that sense, and when I get nervous, I get stressed. And one leads onto another, I guess. No it's, but as I say, as time's going on it's getting better and better, cause I'm getting used to it – it's just the, the fact that it is not familiar to me, was stressful, I think.

JHL: And it was more about the people or the protocols and everything, the hospital…?

Ben: Protocols were just so different. XXXXXX was really controlled and everything within the protocol, YYYYYY there's a little bit more leeway either way, and that is, getting used to that. Cause, not only am I working within the protocols, it's also on me now, so if I was at XXXXXX I would have just, I would have already known

those protocols and stuck to them. But, because I was learning them from new again, and they're a little bit more open to [...], what's the word, open to interpretation in some respects.

JHL: Yes

Ben: There was more for me to actually have to concentrate on, as opposed to just working to those strict guidelines. The people were the only saving grace I think, the department is fantastic for people that are there. [...], everybody, everybody chips in, everybody is really nice. [...], I haven't met anybody that's kind of made me feel unwelcome. So, the people were they were the positive, and kind of getting used to the policies and protocols was the negative because, I dunno, at XXXXXX all the protocols were there, if you wanted them, easy to get to, always printed out, or they were put up on the wall if they were an important protocol. Whereas YYYYYYY, there's kind of nothing on the walls, all the protocols are on like an online database, which are really hard to find. [...], I couldn't log in to them to start with because I was getting all my log ins, so it wasn't easy to kind of sit down and say, "That's what I'm supposed to do", [...], and I don't think it helped that I started in [...] clinic work, so, it's consultant based requests. And you kind of just do exactly what they say, so there isn't much for you to actually think about and I was trying to get my head around that. But, cause they seem a lot busier, clinic wise, at YYYYYY rather than XXXXXX did. [...], yeah – XXXXXX was just one room for clinics, YYYYYY is three rooms, and it's really busy all day, so it's quite a lot of the work, so getting used to just getting the request card and just kind of almost doing what the consultant's asked, without having to justify it too much. [...], kinda getting used to that is difficult, cause I didn't know where I stood, with wanting to know, 'am I doing it right?' or 'am I doing it wrong?', but if the consultant's asked for it, you're doing it right I guess, but it's kind of the attitude, which I've found a bit, yeah, I've found that a bit weird. Because, XXXXXX like it say, is so, 'this is what you do' black and white? YYYYYY'S a little bit more, either side of it, I think. I've found that quite, really stressful the first two weeks, I'm kind of settling down into it now.

JHL: When you said, the protocols are open to interpretation, so is it the decision making you've found… what is it about that that you have found stressful?

Ben: Yeah, well they do different views and things like that, that I didn't do at XXXXXX [...] say so, do you want me to do a for example of a shoulder? They do PA Y views for pretty much all shoulders, as a second view, whereas, I was used to doing an axial for all second views, provided the patients wasn't in A&E. [...], but I would say to them, "so, is that what you do? A PA Y view?" "Well, we kind of just do

what's on the card", "so, that is what the protocol is, to do a PA Y view?." "Well, you can do an axial is you want to", and it's kind of 'why?', I want to know what I've got to do, and not, 'you can do this' and 'you can do that'. So, that was really daunting, because I was trying to get used to being a newly qualified as well, and then to have so much like leeway, I think, that, I found that quite tough [...]…

JHL: And is that because it comes with responsibility, or…?
Ben: Yeah… yes, so. First of all, because, like I say, I was in clinics, I was really nervous because I was thinking - because you're used to, as a student, getting feedback on everything that you do, aren't you, either way. You do an X-ray, the person that's supervising says 'Yeah, that's really nice', or they'll say, 'I think this is acceptable'. And I'll say, "Shall I send it through", and they'll say, "Yes that's a really nice X-ray, send it through" or, "No, it's not, you kind of just need to do another one." And it's that feedback all the time, and then you go into this as a new qualified and there's no feedback, none at all, not a daily station report, not looking at your images, nothing. So, the only feedback that I could see that I would get, was if I would send patients back to clinic and they weren't happy with my X-rays. So, as time went on, I was kind of thinking, 'Well, I'm four days in and I've had nobody come back to me so far so, I'm obviously doing something right'. And it's kind of just trying to remember your training and stick to it and be confident with that. But, it was tough and I felt nervous - the first day I came home and I was like, "I'm gonna go in tomorrow and I'll be struck off. Three years is just straight down the pan", but no… it was really nervy for the first couple of days getting used to that, clicking send was like, 'mmmmm?', hovering over it, 'I don't know what to do!' [...], but then again, coming back to the people, it's really good because I could just say, "Sorry I'm not used to what you do here, is this acceptable?" And they were really open to say, "Yeah". So, a real team attitude towards it, which helps massively, I think. As opposed to just, "Well do you think you need to repeat it? I'm not going to put my name to your work", and they weren't like that, so… yeah. But, that was stressful, that was the most stressful bit was sending images. If, I'd been in A&E, I think, or even a GP service, I would have been a lot worse because it takes a long time to come back to you, and it's going to come back to you via management and not, because obviously, you might send a patients home or not done the right view and they've been recalled. And that seems a lot worse in some respects than the consultant just saying, "Could you just do another view for me?". I dunno, that helped a little bit, but not much, I'm still nervous. It's just translated into stress so, coming back to the whole three-month thing, quite stressful.

JHL: And how have you managed that, do you think?

Ben: I dunno, just time really, just taking my time. And I kind of tried to apply the same attitude that I had as student, if I was unsure, I just said that I'm unsure. Even if it made me look a bit stupid. And most of the time, if I asked, it was because I wasn't really sure whether I should send them, it was just needing that bit of feedback, to say, to know that I am doing the right thing. [...], dealing with it is just, really just applying the same thing as I did as student, and just keep trying to gather as much experience as I can, as quickly as I can. So, when people said to me the first year of a newly qualified, 'you're gonna learn more than you did in three years as a student', I've probably learnt more in three months than I have in the whole of my third year, because it's just such a different job now. [...], and dealing with the stress, I've kind of just when I've finished, I come home and just try to forget about it. Take my dog for a walk and just chill out. Like, when you go to interviews and people say to you, "What do you do in your spare time?", and you think, 'Well, it's just one of those stupid questions they ask you', but you really do, I've really found I have really had to have something away from work, to just get rid of the stress [...], so that I can go back the next day ready to go again, and not already too stressed out, I guess. So definitely walking the dog, playing cricket in the summer which helped, going to the gym, that kind of thing. It's more important to me now than it's ever been, cause I need to get rid of my stress, and I do it that way, I guess. Yeah…

JHL: Interesting, that's good. Let's have a look at some of these things that have affected you most then.

Ben: [...], I've tried to be a positive person, even when days at work are bad and I don't think I've ever gone right down to negative, although in truth I've probably had days that were down there. But, instead of admitting that, I've kind of tried to pick the positive a little bit. [...]…

JHL: So, being thrown in at the deep end is obviously something that you've found uncomfortable, looking at this.

Ben: I think, to be honest, I don't know whether it's the deep end, or whether it's just my perception of what happened. [...], it's just so daunting going into a new place. You're not just worrying about your ability to do your job; you're worrying about your ability to fit in as well. And I'm quite confident with being able to do that, in my own way. But, you still kind of got it in the back of your mind, 'Am I making a

right idiot out of myself?', but that's how I kind of perceived it. [...], yeah…it felt like the deep end but in hindsight, now it wasn't really. But that's – hindsight's a wonderful thing, isn't it?

JHL: Oh it is. And that's how you feel at the time, isn't it? So… and obviously the team that you, you've said a bit about the team already they are making quite a difference to… to your positive days.
Ben: Yeah… That's the silver lining to almost every situation. There's been days where I've kind of found the team a little bit more [...] a bit easier to get on with. And there's been days where it's been worse, but it's never gone below a point where I think 'this isn't good', it's always good, but some are just better than others I guess. I just get on with people, I think that's just life in general, I don't think that's the job. Some people you get on better with than others don't you, I guess?

JHL: Yes, and I know tiredness is one thing that you'd spoken to me about before the interview, but obviously it comes up here as well – so, have you been surprised by how tired you've been?
Ben: Yeah, the first month or so, I was coming home and thinking like, 'weekends are just pointless, I'm not, I'm not even recovering by Saturday, and then Sunday I'm thinking 'I've got to go back to work' and that was really tough, because as I get more tired, I get really stressed out. Because I worry about things like that. And then it's kind of the rollercoaster, not a rollercoaster, like a snowball effect, you get tired, you get stressed, and then I get more stressed because I'm stressed and it's, it's a really hard thing to get yourself out of which just comes back to really making the most of my rest days, cause, I mean even going from 4 days as a student, I found that completely fine, I never had a problem with feeling tired. Even if I did nights, I could, or lates or whatever, I felt completely happy to adapt, but adding that fifth day on, just makes it just so different. It's almost like doubling your workload even though it's just a day, and I found that, getting used to the first few weeks… because I'd been on a preceptorship programme, so I was only doing Monday to Friday for the first, I think it was the first twelve weeks, and now I've gone onto the rota, the general rota, and I'm doing lates and nights. And I feel better now because I'm on that, because I get a little bit more variety in my week. But working Monday to Friday, and in some areas it's just so busy, all the time, you come home and you just think, 'Oh, I've got to go to bed', and then you wake up and you think, 'well, all I'm doing is going to work', it kind of defeats the point. I want to work hard, and I want to have a career, but I've got to have a little bit of balance in my life, and that's

now settling in, and I've used my evenings more to kind of have that work/home balance. But, the tiredness in the first few weeks… I was just getting in and going back to bed, it was like being a student again, that first week student. Just… yeah, it was a bit of a culture shock I think, more than anything. But then, I think that's partly my fault, in a sense, well not my fault, it's just the way it's panned out. I did three years of a degree, went straight into this degree. I've never really worked full time, Monday to Friday or shift work, nothing. So, it was a culture shock to me even more, because I haven't been and done full time work before. So… I think it would be different if I was a mature student that had worked full time, come to this, and then gone to work back full time. It would have been a shock again, but not as much as it is for me, because I had to change my whole life, I think, instead of having the fifth day off, I'd go to the gym, play golf, go for a bike ride, do something that I wanted to do. When now, I guess the Saturday and Sunday and it's already, you're already doing things and I don't have any time for me, so, I've kind of picked up things like I say, stress relieving things and that's helped me not feel so tired now…. I guess. Because it's not really, I wouldn't say it was physically, being physically tired so much, it's like mentally and it just drains you because you're concentrating so hard all the time, working so hard to try and get used to everything, so… yeah.

JHL: So, also the thing… oh, you had a disagreement here with the orthopaedic surgeon? You've put positive for that, actually!

Ben: It was positive, even though at the time it was, it was a really horrible situation; I've never been in a situation where I've had to see a consultant on my own. I mean I've been to see the radiologists on my own, but I've never been in the situation where I've been sent around on my own, it's about my patient and he was quite, I dunno, volatile I would say. He was really stressed out and you could tell he was stressed out before I'd even got there, and then when I'd told him what had happened, he kind of expressed how annoyed he was, not at me but at the situation, [...]. Basically a patient had been dropped off from a care home by transport, didn't have anything on her, no ID, nothing – no purse; she had dementia, so she couldn't tell me who she was. So, I basically said, 'I can't X-ray', so I sat her in the waiting room, went round and spoke to the consultant and said "I can't X-ray the patient because I can't ID her". And he sort of agreed with me and said, "Well, what can we do?", "Well, I found out the care home she is at, that's the number. Would you like me to phone, or would you like to sort it". And he sort of said, "Well, can't you just X-ray her", and I said, "No I can't just X-ray her, because I can't tell

you it's her. I can't X-ray someone that I don't know who it is" and then he sort of started f-ing and blinding a bit, not at me, but at the situation [...], but the patient came back round with a carer and I got the X-rays done, and it was a really good experience because I kind of trusted in my training. Trusted in what I knew was correct and at the end of it, he came and saw me and said, "Thanks for doing that, it was really good". So, it was kind of a positive because I knew I'd done the right thing. And the right outcome had eventually got to the right outcome for the patient, the consultant and for me, so I felt quite good that I had come to a problem, the problem was solved, excellent. So, it was positive for me.

JHL: Good. New equipment, how have you felt with the new equipment?
Ben: Well, the old equipment?
JHL: Yes well – different equipment!
Ben: [...], I dunno. I worked with CR at XXXXXX so it wasn't so much of a problem, they use all of the same post processing software, so that isn't too bad, I found it quite easy just to settle into that. [...], in terms of workflow, it makes it really stressful, especially in the clinics, you have got so many patients come round just so slow, cause you're used to DR in every department, it's just really slow. [...], but that'll all change and hopefully I've had that experience of it changing it might pay dividends for me, I guess. But, yeah it was a shock when I walked in, "what is this?", it was like being back at XXXXXX when I first started and the old machines in, I dunno what room it was in [...], in GP, in outpatients, it was room 3 I think, that really old machine it had all the funny old dials on it, and I walked in and I thought, 'Oh no!", but it will change I think, there eventually. I think they've spent so much money on getting the stuff to fit the rota that eventually hopefully, it will be able to kit the place out with better equipment.

JHL: Okay. And like you say, like it's busy so it does make a huge difference.
Ben: Yeah, but it seems to be a lot going on at YYYYYY all the time so they are trying to improve things all the time, which is quite nice, and you can see it in front of you, you can see that they are working hard to make it better [...], which kind of keeps you optimistic I guess. Whether it's false optimism or… but yeah it does feel like somewhere that's gonna eventually, be somewhere really nice to work in every respect [...], the rotas really good, the equipment will hopefully be good at some point… [...] yeah. I can't really complain about it, you've got to do it, haven't you, what's in front of you, you've got to make the most of it so it's not been a problem at all.

JHL: So, what about your least favourite day? The only saving grace was the fact that it was a pay day...

Ben: It was a … it's strange, they don't organise theatres very well. You've got a senior radiographer at XXXXXX and it's, everything's organised. You know, you could go into the diary on a Monday and see what theatre you are going to be doing on a Friday, it's that well organised - but the theatres don't organise themselves and their, their list changes from the morning to the afternoon [...] so we can't plan. So, you kind of staff the department for what could happen and then you get theatres, every theatre phoned up, all the theatres were booked out and all the C- arms, then it leaves one person down in the department on their own, slogging away and there's just no end to it. [...], you kind of feel a bit isolated so a lot of the time you think, 'well actually it might be better to go up to theatre because I don't want to be…..', I love theatre, that's been one of my highlights. I thought I would worry about theatre but I haven't. I've really enjoyed going to theatre. But I think that day it was just one of those days, I think, if you, when you went to speak to every person in the department that day, they would probably say the same thing, 'the only thing that was good about it was the fact that it was a payday!' Cause it was just horrendous in every sense. There were people calling in sick, so we were moving staff around, there was sort of bare minimums in inpatients, there was me and one other person trying to cover inpatients and ward patients and A&E. Everybody else was in theatre, and it just went on and on all day and it was just a busy day on top of it. It just made it really horrible, but I come home, use my weekend to recover so it was fine….

JHL: So, that pressure of work surprised you, is it more than you expected? Or have you experienced that before?

Ben: I've experienced that before, but not to that extent. Not to where it kind of feels like you are the last line of defence and there is nothing behind you. You've just got to kind of dig your heels and work, which I don't mind, and I actually enjoy working hard, [...], but it, it was just continuous all day, and then I kind of felt like, cause it was so, just full-on, I felt like I was more at risk of making mistakes, and when you come home and feeling, like, 'Did I make mistakes?", and because it was so busy you don't really remember if you had made a mistake or, you can't recall a mistake, but you kind of worry that you will come in on Monday and someone will say, 'you did this, why did you do that kind of thing?', and it's just because you are so, it's so full on you can't really have the time to be calm and collected in your

work. I think that was probably it, but I think the more times that happens and I think it will happen, especially on my nights and stuff the better I will become at coping with it. No bad experience is never a wasted experience; I have that kind of attitude. And in a really strange way, I put it down as a negative, but if I was trying to pull a positive from it, I did come away from that and think, 'I can cope, I can cope if it's like that, I can cope with that', and if I coped with it and that's the first time I've really experienced that kind of pressure, and I coped with it, I can only get better at dealing with that, so that's a positive, it didn't feel like it at the time, but if I'm trying to pull the positive.

JHL: How do you feel you would cope better then?
Ben: Umm…
JHL: Because you obviously coped with it. What was it about the experience that would make you want to cope better?
Ben: Just being a little bit more calm in what I was doing, they weren't easy patients, everything seemed to be chest, abdo, and hip query fracture neck of femur. It was all the kind of examinations that you think, I'd really like to have about twenty minutes just to do this properly, but you didn't have that time. And I kind of just think…

(Dictaphone cut out)

JHL: That will start again, that's fine. I'll just put, make sure I put the number on there. So you were saying, sorry, I just got you to say a little bit more about that day… it's really that was it so busy but you were worried that you'd…
Ben: Yeah, because, as I student, I have always tried to have methodical approach [...], a little, probably a little OCD in some things. And I do it, and it feels really strange if I don't stick to how I like to work. But because it was so busy and there was so much pressure on, instead of say, PI in there, I'd stick it to one side, and then do it once I'd done four or five patients, because it just meant that I could get more work done [...]. But then I think I probably forgot something that I, 'Did I want to make an extra note on that form and scan that it? 'Did I want to make a note on CRIS about something that had happened in that examination?' And by the time I've done the fifth patient and I've gone back to PI them all, I've forgot to do it, or I didn't do it. I mean it's not information that was essential, but it could have been useful. And it's just because I've stepped out of that methodical approach, because of the pressure, I guess. [...], and to deal with that I had to kind of just want to, kind

have the same methodical approach, but if I need to be able to streamline that a bit, and still feel comfortable with that approach. [...], but I think that will just come with experience, and that's kind of what I said by, it was a bad experience, but it wasn't a wasted experience. I know that I coped and I will continue to cope if that happens again, and I will get better at coping. [...], yeah… so I, can't really do much more than what I did. I still did my job but I would like to be able to do it a little bit better. I think that's what's gonna make the difference between me being a good radiographer and being even better, if that makes sense.

JHL: Mmm, so you mentioned support a couple of times, so what sort of, how have you been supported do you think, during this three months?
Ben: [...], I had a preceptor, [...], and he has been really helpful... I've always known that if I wanted to go and see him, I could. [...], but to be honest, the majority of people are so approachable anyway, if I had a problem, I could speak to them and they would be more than happy to help, or push me into the right direction to get that help. [...]. I think the first kind of week could have been a little bit, it could have been more organised for me as a new starter. I could have had a bit more, [...], I dunno, I had the support, it's just that probably in my own head, I didn't expect to just go straight into it. [...], I had a tour of the whole hospital, which you never take in, because you're so nervous anyway, [...], but the preceptorship – my preceptor has been really good. But, as I say, anybody in the department, I know I can speak to if I have a problem.

JHL: So, did you ever have an induction as such, or…
Ben: I did, but it was eight weeks after I started.
JHL: Okay
Ben: Just because I went on holiday on the first one, which they had booked me into, which was two weeks after I started and then they do it after the start of every month. But, it just meant that I did it a month after.
JHL: Mmm
Ben: [...], to be honest, I've kind of found the induction a bit pointless. It was a bit like, 'oh we're gonna do a talk on medical gases', and it was three and a half hours and it was just kind of irrelevant to me. I know I've got to be safe when there is medical gases, but I didn't need to go into that kind of detail. [...], yeah, and I dunno, it kind of settled you into the ethos of the hospital, they've got this 'At Our Best' thing, which is all come about because of the care (CQC) report and all of that. [...], and that's quite a good idea. And I do kind of keep that, because of the

induction and maybe they are quite serious about that "At Our Best" thing, I do kind of keep that at heart and I kind of, you obviously try to be your best all of the time anyway, but in situations where I could perhaps do a bit more, I try and do it, even if it means that I put myself under more pressure. [...], but to be honest, the thing that has always stuck with me was what a lecturer said to me in the first year, is that 'imagine it is somebody, it is your family member.' so yeah… you kind of always, the whole thing kind of stuck in my mind for some reason and it always has.

JHL: Yes okay. It's good. So, [...], to what extend do you think the role has been what you expected it to be? I mean, have there been any surprises?
Ben: [...] yeah, loads of surprises. But, not really, [...], I dunno – not surprises. They're just more than what I thought it would be. I know that was going to happen, I knew that I would, I would go to theatre on my own. I know that I would be on my own at night. I knew that all of that would happen, but knowing it doesn't necessarily make it better when it happens, I guess. [...], I've surprised myself with theatre, I thought I would be really nervous going up there, but I actually feel, for the first few weeks, I've actually felt more comfortable in theatre than I have, than I did in main department. Just because I knew that was my job, I knew what I was supposed to do – it was in front of me and I did it and I can take pride in that. Whereas down in department it was a bit more [...], it's busy, there's lots of radiographers and it's a really small area, and it's difficult to know what your job is. It's difficult to know whether to stand out of the room and get the next card and do the next patient, or whether to go in the room and help, and make yourself useful as a team member. [...], trying to learn that balance of, 'do I just help people?' or do I say, 'oh well, I'm not going to help, I'm going to get the next card'. And I found that a bit surprising because I never really thought of having to do that. I never really thought of having to think about my workload against my colleague's workload – do I need to help my colleague or do I need to stand back and get the next card and get ready? That was difficult and I still find that difficult now. [...], it's better at night when there's only me and a band six there, because I know what the workload is again, it's there, it's in front of me, we've got to get through it and I am confident to just make the decision and get on with that. [...], but during the day, it can be, it can feel like you are completing a little bit to do X-rays, which is strange, because I have never ex – I never thought that that would be something I would have a problem with. People are like completing to get into the room. I kind of just – I like the idea of being a bit more of a team, especially in that kind of environment, when you have difficult patients come from wards and difficult patients coming from A&E. I kind of –

I like the idea of it being more team orientated, but it seems to be [...], I don't know whether it's just competition between colleagues. But, people definitely complete to see who can get in there and do the most X-rays and…

JHL: Okay

Ben: Whereas some people seem to be happier to sit back and say, 'okay well, I'll just be in there, be involved, play a vital role as a team member', but then I don't get my name signed on the card and then it looks bad because I perhaps haven't X-rayed as many patients as somebody else and I think it is really strange attitude to have, but it's definitely one that exists in there, so yeah… going to theatre just seems like a nice solution. Go up there, do my work, take pride and feel like I'm part of the team up there and I know what my job is, I do it, and I do it to the best of my ability and I hope that people notice that I'm good at what I'm doing, [...]. But when you come downstairs it's just like, walking into like a fire pit of people trying to take control of the area because have a – an alpha lead who kind of organises everything, and not really, because there isn't much to organise. [...], and people compete a little bit for who is really leading and who's getting in the thing, and they check on the PACS on who's done the most X-rays in a day and, and it's kind of a bit competitive. Which I guess you got to have that a little bit to push people, but I don't think that it does push people. I think it has a negative effect. I think that it means that the people who generally do get in there and do more, do more, and the people that don't do it, stand back and do less. And it just creates a little bit of a divide, and that's just a funny attitude, and that surprised me. Cause I've never experienced that at XXXXXX, I never experienced people kind of trying to be that competitive, but I think it's just because it's a young department, lots of band 5, newly qualified band fives, all kind of trying to put their mark on it, which is fine. And eventually I presume I'll probably get to that point as well, but that's not something that I will doing. I won't be checking to see who's doing the most X-rays. I'm quite happy if they want to call me in to say, 'you're only doing so many X-rays and everyone else is doing so many'. I'm quite happy to justify what I'm doing during the day, I'm quite happy to say to them, 'come watch what I do during the day', so I know that I'm doing the right thing – in my mind. [...], but I'm, I, I won't be a part of that whole competing against each other thing. It's detrimental to the patient, its detrimental to the department, in my opinion. And even like me saying that surprises me because I'm not normally that kind of person. I wouldn't make that kind of judgment call, [...]…

JHL: But that's how you feel though – that's what've you've experienced, isn't it?

Ben: Yeah, that surprised me that really surprised me…

JHL: Anything else surprised you?

Ben: [...]…. I can't…, yeah my training, I appreciate how well I've been trained. Especially here, and both academic and placement wise. I definitely appreciate that, and that surprised me, because you don't really know how well you have been trained until you can kind of see someone else who has been trained somewhere else. And I feel I went into that job fully equipped to be able to do my job properly, as a newly qualified radiographer there's still things that I'm not so confident at doing, but the basic things that are expected of me, I feel that I have been trained superbly to be able to do that. So, that surprised me, because like I say, you can't judge it until you see somebody who trained elsewhere. So, yeah, that's a really nice surprise to have.

JHL: That's good, that's good. So [...], I'll probably know the answer to this, but I will ask you the question anyway, if you were to reflect over the three months, what are your overriding feelings of the three months?

Ben: Mmm…

JHL: You obviously said stressful, but is there…anything else?

Ben: I try to look at the positives, because there's no point in being negative about it, because there's nothing negative, it hasn't been a negative three months. [...], the kind of, the whole feeling, it's gone from just surviving to start with, [...] just going to work and being there and doing my best and that was kind of it. To slowly coming away to now where I think, 'I'm doing my nights, I'm really starting to get a gist of what goes on and how it works'. I would imagine in another three months or so, I will be in a position where I think to myself, well actually I'm in a position now where I'm happy to go and say to people, 'well why don't we try doing something like this or why don't we do this slightly different', because I've always got that attitude anyway to want to be better as a person, and want to make the service better for people, and I want to make it better for my colleagues as team [...] yes… so it's actually really positive. The first three months have been nothing but positive, even if it has been stressful. Cause I know that it's always getting better, the first two weeks it was, 'what am I doing?', 'why am I doing this?' I really truthfully don't think I was paid enough to be this stressed. [...] and coming away and thinking, 'oh I've got to go and do this tomorrow'. To now where almost every day, there are still days, almost every day I come away from work not worrying about the fact that I've got to go back to work tomorrow and I come away thinking, 'it's really good, I really enjoy my job again, this is what I experienced as a student. I loved it,

I still love it." And I get this really strange feeling when I drive home from work and put the radio on. And some days I just sit there and think, 'yeah, this is good; it's what I trained for. This is …. I'm enjoying myself. And I'm earning money doing it. I'm earning a living, I've got a career, there's loads of potential, and there is always going to be potential'. So yeah, it's all positive for me.

JHL: Okay. So, what do you think that you've learnt over the three months? You've said that it's been this great big learning curve but what things can you share with me about what you think you've learned?

Ben: [...]… it's, there's loads of things. Dealing with stress, but we've already talked about this. Definitely, that's been a hard learning curve. [...], I kind of always put surgeons, consultants, doctors on a bit of a pedestal [...], and now I actually feel really [...] I just feel fine to go and speak to them as people now, whereas before I was always a bit sort of, standoff-ish around them. But, now I kind of see them as, although there's a lot more responsibility, a lot more pressure on them, I still feel like they're my colleagues and I can go and speak to them and I can get their opinion [...], likewise it's nice to see them come to us and I can feel confident giving my opinion now. [...], that's been a learning curve and one that I have enjoyed. What else have I learned? I've kind of just learned how to fit in and be part of the team as a radiographer. It was highlighted when the students come back because now I'm on the other side of that, and that's a learning curve in itself, dealing with students. Not one, one that I enjoy actually, I enjoy that more than what I thought I would.

JHL: Have there been any challenges with that? Dealing with students?

Ben: Yeah a little bit. Only because to start off with, they probably, I had it in my mind that they had probably done more than me. They had been there three years and I expected they should, [...], and the challenge was if they were to ask me a question, how would I deal with that if I didn't know it? [...]..but, I'm quite confident now just to say, 'well sorry but I haven't been here that long, ask such and such, they'll know'. The basic things, the things that I should know and be able to communicate to a student and feel very confident in doing. [...], if it's the tricky ones, but I'm happy to say, 'go and speak to such and such, they're the best person to ask'. [...], yeah, it's quite exciting, I find it quite exciting to have students around... It's a bit of a challenge and it's nice in your day to have that, especially in certain areas with GP patients and it's OA knee after OA knee. It's quite nice to have the challenge of looking after a student. Cause it makes that a little bit more interesting, but yes it's good. I enjoy it.

JHL: You felt quite prepared for it, do you think?

Ben: [...], I don't know whether prepared, because you can't really be prepared can you for that transition as a student radiographer to a radiographer, that's a huge learning curve in itself, and there's so many aspects of that that I've got to, and will continue to deal with. [...], but dealing with students, it's kind of, I've probably got more sympathy for them in some respects cause I know how difficult it is. And I don't want to lose, I don't want to lose that. Some, you can see, some radiographers here, the students kind of wear a bit thin on them, cause they probably have seen so many students ask the same questions and it's, but I don't want to lose track of the fact that I was a student. I still am a student, even though I am getting paid and I'm a radiographer. [...], yeah…

JHL: Do you still feel like a student then?

Ben: It's weird. In some respects I do, but since the students have come back, I don't anymore. That was kind of a turning point, it was… I kind of felt, not if I'd stayed at XXXXXX, I would have still felt like a student now because there's so many people there that are just so well-trained, and they're so high up band five ladder that there's a huge gap, I think, for newly qualifieds starting at XXXXXX, and I think I would have felt like a student in a lot of respects there. At YYYYYY I don't really feel like a student, but I still feel like someone who is quite inexperienced. And when the students come in, that was like a, "Well actually, I'm not really that inexperienced". I know just as much now as some of the band fives that started six months before me, and that's given me confidence to be able to communicate to students, I think. But, it's a nice challenge, I quite like that. And you know that there is always, mind you they were third year students, so I'll see how that is when the first years come in, I'll probably take a bit more of a backward step, because I know that is really important, the first year. Kind of getting to grips with it… I think I'll be, after a while quite confident to pitch in and do a bit, but, yeah… I don't want to push students in the wrong direction from the start, so, once I get a bit more confident. And there will probably be a turning point in that where I'll think, "actually, why leave that to someone else? I'm just as experienced as they are now, why don't I do it"… so, yeah. We'll see when first year students come in, because I think that is again, that is going to be a huge learning curve for me. It will show me how much I know, but it's communicating that to first year students is quite tough isn't it I think/

JHL: Yes, I mean that's what we say to the second years, when they're all shaky at this time, and I say "oh, wait till you get back again", they've just got into the second year and you'll realise how much you'll know when the first years start"
Ben: Yeah, yeah. Yeah, it's good.

JHL: So, overall, how do you think you've coped then in the first three months?
Ben: [...], I dunno, if you speak to my department they would probably say different. I dunno actually, I'm quite confident that I'm doing quite a good job. No, I am, I am doing quite a good job, I would be confident in saying that. [...], I don't feel out of place, I feel like I've gone in and I've settled just as well as the student that trained there, and she doesn't do anything that I wouldn't feel happy to do. So, competency wise I'm where I need to be, and where I should be. And I don't want to rest on my laurels, that's kind of the stage I'm up to now. The first three months have been tough but I don't want to stop there, I've got to look forward. Yeah, and I'm looking forward to that challenge again. But I've coped all right. I think I've, I've done what was expected of me, if not more. And I would be quite, I feel proud of the fact that I've done that. But I've got my three-month appraisal tomorrow so that might be different; I'll let you know. [...], no, I'm confident. I've gone in there and I've made a good impression.

JHL: So, you've got feedback tomorrow, which will pick up that bit where you've said you haven't really had much.
Ben: Yeah, that's been one of the challenges, the feedback, yeah constant feedback. Daily feedback. Feedback on how you dealt with a patient, feedback with your X-rays, feedback with how you've done in the morning, feedback with how you've done in the afternoon, feedback at the end of the day with your station report, feedback at the end of the week, feedback at the mid-block, end of block. You get so much feedback, all the time as a student and you'll go into the department, and boom – it's gone. There is no feedback, [...], which is probably why I like theatre so much, because you get instant feedback from the surgeon. You take your X-ray and it's, "yeah, that's good, thank you", and that's it's a really simple feedback, but you've got some feedback, as opposed to getting none. [...], that was that's been tricky, the feedback thing…

JHL: And are you still finding that hard, or…?
Ben: A little bit, in some respects. I just like to know where I stand, that's why I get on well with people, they will just say to me, "yeah, you're doing that really well", or

"you could do that...", [...]. I'll wait to see to how much actual feedback I get tomorrow. I don't know whether it will be feedback or whether it kind of like, "I've got to do a three month preceptorship appraisal", whether I get any real feedback, I think I will. Because I'm the type of person who almost will demand it a little bit. I won't let them kind of make it just a rite of passage type thing. I want feedback because I want to know how I can get better. But [...], as I say, we'll see tomorrow. I've kinda got a feeling about how it will go, and I know from feedback that I get from my colleagues, especially from the band six colleagues, that I'm doing quite well. But I want to know what I can do better, and I hope that tomorrow goes that way. I hope that it's, that they give me some constructive feedback, so that for the next three months, up until my six month appraisal, I can, I've got something to really work on. So, in three months I can say, "Look, I've really worked on this. Now, what do you want me to work on now? What do you want me to work through, I've got six months then to my year appraisal, give me something to work on. Give me something for me to be better at and I will do it". It's just not knowing, not knowing what I'm doing right, what am I doing well, and what am I doing poorly. It... what can I do to make it better? You don't even have to tell me how to do it, just tell me I need to be better at something and I will be better at it or I will make myself get better at it. [...], so we'll see tomorrow how that goes, feedback-wise.

JHL: And are you looking forward to it, or are you...?
Ben: I am, in a strange way. I'm a bit apprehensive, because I don't want it just to be, "Yes, you're doing fine, you've been there, you've signed that off, that's great. [...], we'll have one in six months and that would be the end of it". Because I really do, I crave some constructive feedback, because I want to be better at my job, I don't want to be just sit there and rest on my laurels. I don't just want to come in, work my day, get my pay check. I want to be better at it, I want to be the best I can be, and feedback is vital for that I think. [...], but that's why I'm apprehensive because I don't want it to just be, "Yeah, that's fine. You've been there, done that, that's fine, see you in three months" type thing. But I'm confident enough to say, "What do you want me to work on? Give me something to work on". If they say well there isn't anything which there may be lots of things, but if they say to me "just keep going as you are", I will kind of almost demand something because I want to be feeling like I'm working towards something. [...], whether that will make me any friends, I don't know. But, yeah that's kind of my attitude. I can't just sit here and collect my money and go home. I want to be good at it. It's going to be a long career otherwise of just sitting there doing nothing.

JHL: Yes, absolutely. I know it is. So, do you think [...], is there anything that you want to talk to me about that has happened over the last three months that would explain your experience that we haven't touched on?

Ben: No, not really, it's just really emphasising how positive it's been. And it's really a compliment to how I was trained by the HEI and by XXXXXX. I can't, I couldn't have asked for anything more. They've put me into a situation where now it's down to me to get better, that's all I needed, that's what that's what I required, and that's it really, for me.

JHL: And now you want to carry on going?

Ben: Yeah, I'm not really, I'm not in a rush, I don't, I don't sort of think, "Oh, I'm never going to get to band six, it's really tough in this current climate, I'm not…" It's a fairly positive, it's a fairly negative attitude toward the NHS at the minute, in general. [...], but I don't get carried away with that, I just look at myself and what I can do to be better. If that leads me to band six, that leads me to band six. I'm not really, I'm not really worried about the money. Money is lovely if you get more money because you're band six, but I don't really want it because of that, I want it because of the responsibility. I want to cannulate, I want to do CT, I want to do all the things that that are expected of a band six, and it's not necessarily the money, so I hope I'm doing it for the right reasons. And I hope that that will be portrayed eventually. [...], and I hope that I come across, and that's kind of coming back to this appraisal thing, I hope I come across to the people in charge there that I am doing, everything I do is for the right reason. I have the right attitude. Because I think I have a decent attitude towards my work, and I've just kind of gotta sort of keep going with my work. I'm not really worried where it happens and when it happens, I'm just know that it will happen because I keep taking one step up, one step up that ladder, because I want to, not because I feel like I have to. I think that will show eventually. I'm positive. Even if people are negative about the NHS and the current state of affairs for us as radiographers.

JHL: Has that had a… have you noticed that being an impact?

Ben: Yeah, some, there are some days where, where I've had a bad day and I've not commented on it, but it's because people are just so negative and I appreciate that a lot of band sixes are now losing pay-protection and bits like that. It's coming to that time now where you are a year on after all the rotas have been put in place, [...], and I can understand how that has impacting on their life. But, it's not; it's not

as negative as some people make it. And I think people moan for the sake of moaning. I find that difficult; I kind of have to just step back from that because that really does wind me up. I, people, we had a situation where we had a new SOR rep, and she basically sent round an email saying 'I'm the new SOR rep, could you give me some feedback on the rota, are you happy with it?' and then from that, somebody else has gone in there and sent another email sort of ranting and raving about 'you can't keep changing the rota, it's ridiculous that you she wants to do another rota template.' And all this business, and she didn't even say that, they're missing the point completely. She's a SOR rep, she's asking for you to feedback, so that if we want it to be changed, if we want things to be better, we can make them better. It's not you having a go at her because she's not in charge at the rota. She's asking for feedback on the rota. And I find that really difficult because I hate people who do it over email anyway. You should have just gone and spoken to her if you were worried. But, I really have to fight the urge to want to go round there and say to him, say to this person, 'what are you doing? Why are you being so negative because it's not having any positive effect on us as a group of band fives? It's not having any positive effect on the department, you're just being negative, and it's being detrimental to everything'. And I find that really difficult to just [...] step back, I just delete the emails, forget that it's ever happened, I might vent it a little bit when I get home, just tell people how annoyed I am, because it's just such a, I find it a really cowardly attitude. If you've got a problem, sort it. Do it the right way. Go and speak to people, don't send round a snotty email about things because it doesn't do anything, you're just moaning for the sake of moaning. And there's a lot of that goes on, I just stay out of it to be honest, it's not my place anymore. If I was the manager, I would probably get involved in it, but I'm not the manager, I'm a band five radiographer. I qualified in July, so I don't have to deal with that, it's not my problem. If I have a problem with the rota, I would deal with it how I think people should deal with it, by not getting involved in everyone else's issues. And that's hard sometimes to, you want to say something, you want to say stop being so pathetic, but you risk doing that and upsetting people that you're part of the team, so I just have to sort of step back and say, I'm not getting involved. And that's the end of that; I'm not falling into that trap. So, that's tough, because I'm not, I don't like conflict, I hate conflict, I do anything to get away from it, but I do dislike it when people don't do things the right way.

JHL: Yeah, a lot of politics…

Ben: Yeah, I just stay out of it. At the end of the day, my job is to X-ray the patients, go to theatre, and do my job. I'll do that; I'll keep doing that. Eventually, my attitude is that it will pay off. As long as, I mean I don't mind being involved in the politics, but I'm not gonna be involved in it for the sake of being involved in it. If there something that I can affect, then I will get involved, and I will do it the right way, but I'm not doing it, I'm not just moaning for the sake of moaning. I'm sick of that, I had that a year at XXXXXX as a third year. Everyone moaning and venting about the rota, it's just, you've gotta do it. If you don't like doing it then go and get a different job, this is what it is. It's not people in the hospital that are making these changes; it's how it is. You wouldn't go and get a job in a shop and say, 'well, I don't like dealing with customers,' would you? You've just got to do it; you've just got to get on with it. If you don't like it then don't do it. That's my attitude, anyway. [...], but like is say, I just wash my hands of it, step back, do my job, got the attitude that that will pay off eventually. But that is hard at the minute; it's so many people being negative. And I think you probably get feedback from students; do you, of the same nature?

JHL: Yes
Ben: Yeah
JHL: Yes, so I don't think it's sort of isolated is it in one department, it seems to be a fairly national trend at the moment, the CQC reports and money and all the reviews coming out, it's a hard time.
Ben: Mmm, I would say that are things that did annoy me. I think the pay that we get for doing a night isn't actually representative of the work we do on the night. [...], I can't change it so I'm not gonna moan about it, [...], there's no point in moaning about it. It is what it is; I knew that when I started. But, people do moan about it, and that is understandable, because it is people's lives. You're talking about their money and for some people they are really reliant on that, I'm not in a situation at the moment where I rely heavily on my money. I've only just come from a student where I had nothing to be being paid. So, it's still nice just to have money. [...], but I definitely, I don't think what we get paid for a night is representative of the work we do, and the responsibilities that we take on. I can't change that, so there's no point in worrying about it. You can speak to your SOR rep and see what can be done, but you just got to get on with it. But some people, I think they just moan because they want to moan. And I think, I mean, the grass is always greener. People moan at YYYYYY, they want to try and go to XXXXXX, cause the rota is an absolute shambles in comparison. They've made it, at YYYYYY I have to admit, the

rota is fantastic. It's, I am happy with it. I do five weekends out of fifteen, [...], I do I think five nights in fifteen weeks, which is nothing really. If I was at XXXXXX, I would probably be doing four nights a month. Or twelve in every fifteen weeks, because it's just how tough it is there. [...], but the rota, it is miles ahead, miles ahead, but people still moan about it at YYYYYY. The grass is always greener on the other side. [...], yeah, I find it quite funny sometimes, people whinge and moan at YYYYYY, but they really do want to try and go to some of the other places. Not just XXXXXX, I'm sure there are other places that are just as bad, cause it's a big change, it's a massive change to how we work, isn't it?

JHL: Yes it is a massive change, and it will take a while for that mind-set to alter with it.

Ben: Yeah... But YYYYYY, I have to admit, they just. Which is kind of why I think the whole department deserves, whether it's new equipment or to have a slight increase in the pay for the nights that we are doing, because they've put no resistance up to it. They've accepted the rota, everybody's accepted it. They've come in and just done their job. And that's, in comparison, it's a mile apart; people weren't so willing to accept. Which is why it didn't work in XXXXXX, in my opinion, and they have more than enough staff to actually staff a 24/7 rota. But, people weren't willing to do it. [...], but, everyone at YYYYYY is willing, and that's a really nice attitude, it's really nice to be a part of that. And it's nice like the rota allows me to have, to be able to balance my home life and my work life. I know [...], well, I knew from July up until January what my rota was, so I got plenty of time to plan things and, make the most of my days off, so that I can go and do things with my family. [...], yeah I can't complain, it's great really. And we'll get another one for January; I think they're doing it till April. And then after a couple of weeks they will issue the one right up to I think it's June. So, it's great.

JHL: So, half yearly really?

Ben: Yeah, and it's all organised by people in the department. Everyone listens to each other. Everyone is open minded about it – bar a few people who moan for the sake of moaning. Yeah, it's great. There isn't really much to moan about, because it's pretty good at the minute, in comparison with XXXXXX, but that's all I can compare it to. Yeah, so I do try and remind people, or tell people, when they're moaning about it, "you've got it better here than what other people have got it at the minute", and things can only get better in my opinion. If this is as low as our profession can go, I mean it can go lower, I don't think it would survive if it goes any

lower. But, if this is as low as it can go, then it's only ever going to get better, and that is my opinion. There isn't many opportunities at the moment to progress, but there will always be opportunities eventually. It can only ever be, there can only ever be more opportunities rather than less, in my opinion. So, you just get on with it, just knuckle down and do my work, but I'm happy. Chuffed really.

JHL: Well, thank you. I can't say your name because it's confidential. But thank you very much.

JHL: Let's put the date, so it's Friday 31st January 2014. So, it's been 3 months since I spoke to you last, so I wondered, you know, how you are and how it's been going really.

Ben: [...], since the 3 month one, I've obviously gone onto the [...] the full rota, so now I'm doing nights, lates – and that's working better for me because Monday to Friday was a bit mundane, I think. [...], I enjoy my nights, and I think it's a good thing – yeah, just keep plugging away really. I've [...], I've gone in a full circle with how I feel about work personally, [...], because I got kinda bogged down with, 'where's my progression? Where's the next route? What am I doing now?' [...], and I got kind of bogged down with that, wasn't motivated to go to work, and now I've gone full circle and I've gone back to just enjoying my job, going home and enjoying my life away from work, so…

JHL: So, what do you think sort of influenced that change? When did that sort of occur? Can you think of why it might have occurred?

Ben: Yeah I think it might have occurred because that's the general attitude in the department. You got fifteen band fives there, all sort of thinking, 'Right, well, where am I going from there?' You've got a load of band sixes above who are completely hate their job at the moment, so it's all kind of stressful at work anyway, and I was feeding off of those people. Because I'm not really particularly someone who's bothered by that really, I think that if you're good at your job, that kind of thing will take care of itself. [...], but I kind of got bogged down by the people kind of influencing me, and I just got to a point where I thought, 'Well I can't do this anymore, I can't keep making myself feel like this'. I spoke to a couple of people in the department who really are quite experienced, and they were really useful. They told me to just take it back to the basic thing of doing your job, being there for the patient, [...] and that's kind of what I've done really – just stripped it right back, I'm not worried now about, 'Do I look good because I've x-rayed sixty patients in a day', I don't really mind if I do thirty, if thirty of those patients would recommend me being their radiographer again, then I've done a better job than doing sixty quickly. And that's kind of the attitude that I'm putting into practice now, and I'm feeling a lot better about it.

JHL: Because you did, you sort of highlighted that competitiveness, and that came out quite strongly actually, in the transcript about this attitude of [...], counting how

many examinations people had done and at the time, I'm not sure you were right into that, so did you, from after that three months, did you sort of then start getting…

Ben: I think you get dragged into it, because other people are checking. I have to say, I never check on myself, and I still haven't – [...] but if you're working in a team, somebody in that team is like that, then they'll pick it up and see how many you've done, and say 'Well, you've done five more than me, how's that possible? Because I've been working really hard.' And I kind of think, well then you think 'Well, actually I am working quite hard', and you kind of think, 'Well, I'd better keep that up', even though it might just have been those days where every patient that walked in was an easy patient and walked back out. And they might have had ten patients who needed extra time. [...], and you kinda just get dragged into it, but it didn't last that long with me. It was a couple of weeks, and I came away from it on the last Friday of the two week period, where I would say it was over, where I was kinda getting dragged into it a little bit, and thought to myself, 'well…' – I dunno, I'd just had one of those days where it's so busy, I went home, and I was driving home and I was thinking, 'I wouldn't even remember if I'd made a mistake', I couldn't recollect if I'd made a mistake, because of just being flat-out all day. And I'd put myself under pressure [...], and on the same day, the people I was working with, I didn't think they were working as hard as me, and I kind of felt like I was resenting them because while I was working really hard, they were kind of taking me for granted because they knew that I would just go and get the next patient and do it anyway. [...], and I hated the fact that I was resenting them because I'm not like that, as a person. I never judge other people for what they're doing in work. [...], and I hate the fact that I went home, and I couldn't remember if I'd done anything wrong. If I had done it wrong, I wouldn't have remembered, so I sat myself down – I got home, actually I talked it through with my partner and she – because she's a neutral, she's on the other side of it. And she was like, 'Why are you doing that? You're making your working life so much harder for yourself, when why don't you go back to how you was when you was a student and you didn't care about what anyone else thought of you?' And since then I've kind of implemented that. I think, I had to because it was just bogging me down – I really didn't enjoy my work, I was like…hated myself for it. But the same competitiveness still exists. You still have to be really careful about what you say to people at certain times cause they will just feed it through the rest of the department and I just stay out of it. I've got the attitude that, and I kind of spoke this through with the two people who are quite experienced when I had the chat with them, [...], I genuinely believe that, if you are good at your job, then that will pay dividends eventually. It might not be as quickly as someone who's kind of

like scheming or plotting how to do things [...], but my attitude will eventually shine through. That's how I try to approach my work now. [...], and since then, I've actually got further along with where I want to go. I've always wanted to cannulate, and I'm now on a cannulation course for the end of February, when there's band fives joining before me saying 'I haven't even done that yet'. And I think it's just because, I went in the office, just to ask about an extra shift that I was doing, and he said, 'Oh, do you want to go on the course?' And it was just because I think my attitude led me to that point, where I'd picked up an overtime shift, or I'd done a couple of shifts that people tend to moan about if they get put on. I'd been sent to BBBBB for three weeks, and most people get sent to BBBBBB moan – I didn't moan, I just got on with it and did my job. [...], and I think, because of that, when you go in there, they see you as a positive person, hence they will do something positive for you – that' just how I saw it. [...], so I'm quite excited about the cannulation thing. But, I'm not doing it – some people are doing it because it's another step – they can say 'Well, I'm at that step already, I'm higher than you'. I'm not doing it because of that, I genuinely want to cannulate, always have done – so that's how I see it.

JHL: Hmm, well it's a good opportunity, isn't it?

Ben: Yeah.

JHL: Really good. So when I sort of went through your transcript – obviously, we spoke a lot at the time about it being a very stressful period.

Ben: Oh, it was, yeah.

JHL: And, is that how you still feel?

Ben: No, not at the moment. There's periods, I think, where your job is going to be stressful, I'm kind of learning that now. To take the rough with the smooth a little bit. [...], but things that used to stress me out in the first few months, I don't get stressed out about now. I don't, whereas I go home in the first few months, there were times where I would go home and think, 'What if I get struck off? What if I've done something wrong? Did people, are people seeing me as a positive influence in the department?' I was more worried about what I thought I was bringing to the team. I don't, I'm not stressed about that anymore, because I, I feel confident enough to say that I am a positive influence, [...], I'm not stressed about that. [...], I still get a little bit stressed out with the going home, and nothing's expected of me when I go home. It almost feels like I'm cheating myself because, I go home and instead of reading or doing some coursework, which I've been so used to doing, [...], I go

home or I go to the gym – and I still feel a bit guilty sometimes, and that stresses me out. It's very strange!

JHL: That sort of adaption period... it's been quite, quite surprising, I think, for you, hasn't it, particularly?

Ben: Absolutely. I think it's obviously accentuated by the fact that I did my first degree and went straight into my second degree, so in theory I've done six years of higher education. It's just, it's very strange to come home and that's my thing. And now I'm actually developing things outside of work, which I look forward to as much as I do, going to work, or having time off. So, yeah, so it's just taken a little bit of, well, probably longer than most people – to adapt to that, but I don't feel so much stressed out at work now, because I'm not thinking, 'Oh, what have I got to do now? What do I have to do when I get home?' That kind of thing. I just go home, or go straight to the gym or go out on my bike, whatever, just… it's my time – and I'm learning to maximise that.

JHL: Mmm, so you can look back and recognise that that period was quite stressful, can you?

Ben: Yeah, what the first few months?

JHL: Yeah

Ben: Absolutely. If you said to me, 'Go and do another degree' or 'Start the job again from scratch from three months being qualified', I would say 'Go and do another degree'. The stress was that bad for me, I just, I couldn't get myself into a routine, and I like routine. Even though I had more of a routine as a qualified radiographer, cause I knew that I had to go to work, it just felt all over the place. I couldn't, I couldn't get myself into a routine. [...], and slowly and surely I have settled into that but the stress, it's the only word I can think about really. I mean, marred with the fact that, not marred – what's the word – well, apart from the fact that the team is so nice. [...], that's kind of, it's a saving grace really. If the team hadn't been so welcoming and so [...], so nice to me when I first started there, I probably wouldn't have stayed there. In hindsight, when I look back, the first two weeks, I think I probably said it last time, the first two weeks, I was like 'What have I done? Why have I made this choice? Why have I gone to a hospital where I know nobody, where I don't know any of the protocols?' I don't, I wouldn't even feel like that now. I actually feel, if I were to go back to XXXXXX, if a job came up and I was to get a job there, I'd probably feel just as stressful as if I were in the first few months in this place. Because I just don't like not knowing, I want to know – and the nights have helped. Understanding the whole department is a, is a sort of working machine, and the nights massively increase your knowledge of that I think.

Because you're forced to, there's two people, and if the band six is in CT and somebody phones up and is asking something, you've got to know it, and if you don't know it, you look stupid. So, you learn it quickly, because you're kind of forced to, and that's helped me. I don't feel so stressed anymore about not knowing things – especially taking telephone calls and dealing with doctors. So, yeah.

JHL: Interesting, because I think [...], you sort of, I kind of picked out, if I'm right, from what I've read and thinking about what we've spoken about last time, [...], some of the things you were struggling with was that autonomy and decision making, it was very different to how you'd trained. It was a bit, almost, laissez-faire, 'well you could do this, or you could do that, if you want to?' and you were kind of struggling with it, and 'actually I just want to know what I need to do'.
Ben: Yeah, that's exactly. And there's still elements of that. Some people, say you're working in A&E, some people will do one shoulder view, and somebody else will do another shoulder view. And I think, 'Well why? Surely the radiologists can't like that, surely they want the same two set views that they can report on'. And even in A&E, when people look at them, they think, 'Well I never really look at that one, I always use PA Y view or…' And some people do modified and some people do a PA Y view and some people do an AP Y view – and I'm just sort of like, 'Well, what do you want me to do, because I will do any one you want, just tell me which one you prefer'. [...], but I think that's exciting for me because I can do some research into that and I can be the positive influence and I can research into why we should be doing modified. Or why we should be doing PA Y view. [...], so that's kind of my next thing that I want to pick up. I want to do some research to help the department – perhaps get a protocol in place, things like that. [...], I think I'm just settling into that really – the knowing what's expected of me. I don't worry anymore, if I decide to do a PA Y view, I know, I can trust myself with what I know, to be able to justify why I did it. [...], that's what it kind of counts to me, but I think the department definitely need a bit of help in terms of, I think we should just work to a stricter protocol sometimes, because it's easier for the patient, easier for the A&E doctor or the A&E nurse and definitely easier for the radiologist, so [...], yeah. I think, I looked at it as a negative thing to start with, but I actually think it's a positive thing because it leaves space for me to go in and develop what I think should be done, if that makes sense. Not that I will change the world in a day, but it's nice to have that little bit of room to say, 'Well, I want to research that and I want to potentially bring something positive to the department', so that's how I look at it now.

JHL: And do you, have you got used to that sort of responsibility of [...], you know, that decision making?

Ben: Yeah, there's still times where I kind of, I send something through and I think, 'Oh, should I have?' but I think people who have been qualified for ten years still do that sometimes. [...], but yeah, I actually quite enjoy the responsibility now. Kind of see it as a nice thing. And I feel confident that if an A&E doctor or an A&E nurse come round and said 'What do you think?' I would feel more comfortable now to be able to kind of give them my opinion. And that all comes down to the responsibility thing. [...], and I went on a, I don't know whether this was before or after the last one – I think it was potentially the last meeting was before this – but I went on a red dot course in London, which was very good. That was [...], who's the other author to Raby?

JHL: [...], Truman, isn't it?

Ben: I'm not sure, but it's basically the actual A&E A to Z thing they do with junior doctor. It was Raby and someone else – it was that other author, he did the lecture, and it was a full day. It was a really good experience, and I came away with…

JHL: Berman?

Ben: Mmm maybe?

JHL: I think so.

Ben: No, well it's definitely him anyway. [...], but that, that was really useful and that gave me a lot of confidence in making my decisions and being responsible for them, definitely.

JHL: Yeah, because I remember you always sort of said about how you like a methodical approach and how you were almost still trying to find your way of working within the environment, so do you think that has changed over the six months?

Ben: Yeah, certain areas of the department are easy to fit into a methodical approach. Outpatients is very easy, because the card's there, you take it and you X-ray it and I can, I can quite easily have my methodical approach there. [...], but in places like A&E and inpatients, it's all kind of bundled into one, it's very confusing, as an area within the department. [...], and it's still confusing. Sometimes I go in there and there's ten radiographers and it's just, it's too many people in a small space. It's too hectic sometimes. I think it's very difficult to try and have my approach where I like to be methodical [...]. But I just, I guess, that's probably why I prefer working out of hours, it's just me and the band six there, sometimes somebody up until twelve, and I can have my methodical approach, go and do my thing – you know, post-process, go and do my thing, go out and be very methodical,

which is why I kind of like my nights and my lates. [...]. During the day, I tend to just try and go to theatre as much as I can, because again there, I can be methodical. But, the only place is A&E and inpatients and it's because it just so crammed into a small space with lots of people. I can work, I can do my work there, but I don't feel like I'm as comfortable there as what I should, am everywhere else. [...], not saying I'm not confident in my ability to work in there – I just like to have that methodical – but I don't feel like it's less acceptable to make a mistake, if I have that approach, so I always kind of feel I work a bit harder, concentrate more when I'm working in there. I just don't like the, I don't like the environment in truth, and that probably has a knock-on effect with me trying to work like that as well. Because you get five people who just stand around doing nothing, and five people who want to work, and you sort of get this clash in the middle. I just want to work, I just want to do my work and get out of there, next patient – do my work, get out of there. And that's how I am trying to work. [...], but I will just keep sticking at it, working at it – I don't feel unconfident when I'm there during the day, I just – if I get the choice to go to theatre or stay in the department, I go to theatre, because I quite like theatre anyway.

JHL: Yes, I think you were sort of talking about the sort of pressure of work, I think, last time – and how you weren't able to sort of have your own way of working within that pressure. And you were sort of going home worrying that you'd made a mistake, or not done something that you should have done, or whatever, and you couldn't – you know, you coped with the pressure, but you felt like you almost needed to…

Ben: I was always on the edge.

JHL: Mmm...

Ben: I was on the edge of working to my maximum ability and making mistake, and I don't like being that close to the edge. So, and that again comes down to just being more confident with my own ability and not really caring about the pressure that's put on us. Because there is a lot of pressure put on us as band five radiographers, [...], to just kind of work and get through the work. I'm just not buying into that – at the moment, there's this thing where they're kind of auditing how many X-rays people do in a day, which, personally I think it's one of the worst things you can do. [...], I think it will have a negative effect on the whole of the department. I think people will start looking out for themselves, rather than looking out for the patient and the department, and I think they're doing it because they want to get a more productive team, but I think it will actually have a negative effect and it will actually get less productive. [...], people are fighting over cards. I did the majority of X-rays, so I get my name on it so I get my number, and all of that. I don't really

care – it's had, I know it sounds, I do care, but I don't care about being called into the office and saying, 'Why did you only do twenty patients today?' and I said, 'Well come and watch me work and you will see why I only did twenty patients.' Because I'm not afraid to do the long shopping list and it take me twenty minutes, as opposed to other people kind of sit there, stand back, pick a chest up – in/out – 'That's another number for me'. I'm confident enough in ability to not buy into that pressure anymore. [...], and I will work to how it's best suited to be because I know that if I work like that then I'm a better radiographer.

JHL: So, how do you think you've developed that confidence? What sort of things have helped you?

Ben: Talking to people, talking to experienced people, because some of the – I think the main competition comes from the band five radiographers, because there's fifteen of us. Some people want to do it, want to progress because of the money, some people want to progress because of the responsibility, some people just want to progress because they want to have that extra little power.

JHL: Status?

Ben: Yeah, I don't. I'm quite detached from all of that. I'm not really bothered. If I'm happy with what I'm doing with work, then I'm not really bother what band I am. [...], don't get me wrong, it's lying to say I wouldn't want extra money, but I can't force that at the moment. [...], and I would rather have the responsibility and the extra work, than the money – in a sense. Because it's a long career, if I'm genuine about it, it's forty years. Forty years is a long time. I've got thirty-nine and a half years' worth left, so there's no point in me rushing for it. [...], yeah I think the, I think a little bit is I just don't care anymore – I don't really care what other people think about me. [...], but I think that's - I can, I have the luxury of feeling like that because I – I kind of feel like I am a positive influence in the department and I can just get on with my work. And when I do work to my own [...], with my own approach, that I'm not, I'm not hindering the team – I am helping the team. [...], so other people want to go off on their own and do their own thing, that's fine, it doesn't bother me. But I kind of have it in my mind that the team will outlast somebody that's in there for themselves. So, in that sense I don't care about the pressure. [...], but as I say, just talking to experienced people, and them just giving me the reassurance that I am doing the right thing and that fundamentally we are there for patients, not for numbers, not for making ourselves look good – we're here for patients and I just keep that in mind now. I know that if, like I say, if I get called into a room and get 'Why do you only do this?' or 'Why did you only do that?' I'm confident enough to

say, 'Well, go and speak to my patients and you'll see why'. And I'm pretty confident that most patients that I come into contact with would say, 'Yeah, if I had to have an X-ray, I would want him to do it again'. So that's…

JHL: Is that… well, you did talk a lot about patients last time, and that's obviously still very important to you?

Ben: Yeah, there's no point in… I don't feel that there's any point in me doing this job if I'm not interested in patients, because, without them, we wouldn't be here, so… yeah, it all… Doris said, in first year, 'Imagine each patient is someone in your family' – it's just stuck with me, always has.

JHL: She got that from me, you know!

Ben: Did she? Well, it's definitely stuck with me, and so much so, to the point where, I've gone round to resus before and I've gone in and – my granddad wears this funny little brass bracelet thing, some weird Chinese medicine thing, gets his migraines away – not sure if I believe in them, but anyway, I walk round to resus and there's loads of people around this patient and all I can see was of his arms, and he was wearing one of those copper bracelets. And it kind of took me back, I actually stopped with the machine and thought, 'Oh, I don't know whether I want to be here', cause it felt like they were going to step back and it was going to be my granddad, and I would just crumble onto the floor. So I had that experience and I thought, 'Well no way, that can't happen to me'. So, I just said to everyone in my family, if you ever get taken into Colchester hospital, you have to tell me first – I have to be one of the first persons, people to find out, because if it's me walking round and I find you like that, in resus, or in A&E, then I would just crumble, so… just don't let happen to me. But that's almost how I want to see, I want to see that every patient…

JHL: Do you think that's mirrored, you know? Do you think that other radiographers are like that?

Ben: For the most part, the majority are. It's difficult, isn't it? If you speak to me in five years' time, I probably wouldn't feel as strongly, because you desensitise to it. I hope I don't, I hope that in twenty years, in thirty years' time, if I'm still in this career – that I still have the same attitude towards patients, but sometimes I think there are a lot of other factors that can stop you feeling like that. [...], and to be fair, going to some places, places like PPPPPP, without sounding horrible, some of the patients that you get from some places like DDDDDD are very difficult to deal with. [...], just because of their lack of education, their social standing – they can be very difficult to deal with. They come in there and they're almost ready to have a fight with you. It's kind of how their life is in all walks of life, not just coming into hospital. [...], but

then I see that as a challenge. At the start, I have to admit, I kind of thought 'Well, why am I, why am I doing this to you if you are going to treat me or talk to me like that.' But now, I've kind of flipped it and I see the challenge. [...], and if they come in and they are ready to argue, or they come in and they're, they're not the easiest patient then it's a challenge for me. That's exciting for me because if I can get them going in with that attitude, but coming out with a different attitude then I've done my job properly, or I've done a good job – that's how I see it. [...], I would like to think in ten years, I'm like that – I still feel like that. [...], but some people who have been there ten years, I think they are just desensitised to it. And patients become another number, or another card or another CT-head or another elbow X-ray – whatever it is that [...], I think people – I'd like to think that everybody has the same opinion, the same attitude as me, but I think that you'd be quite naïve to think that was the case. But, I think the majority do yeah, I think the majority do. Like, I would, I would definitely feel confident enough to pull somebody up if they wasn't – I mean not everybody would feel the same dedication to a patient but you've got to still treat them with dignity and respect, and act professional. And I think that I'm confident enough to just have a quiet word with somebody if I don't think they are doing that. [...], and not even to the extent that I'm right and they're wrong – it's just nice to have a conversation with somebody that perhaps how I feel sometimes. But I wouldn't say that my attitude is better or worse than everybody else, no. I'd like to think that everybody has the same attitude.

JHL: Yeah it's interesting isn't it? So, [...], I think sort of when we were talking about, sort of, sometimes you said you still felt like a student, and have you still got that feeling at all now, is it pretty much gone?

Ben: Pretty much gone now, I'll say, [...]...

JHL: Can you pin point when that might have changed, or anything that might have sort of helped it change?

Ben: [...], I think it's just time really, and building up my own confidence. [...], yeah, I think it's just time. Just getting used to people, people getting used to you. [...], I perhaps went in and did things slightly different to how other people did them because I didn't train there. [...], perhaps they got used to some of the things that I might do differently. Or I might have changed how I work slightly, and now we're kinda in the middle ground, so people don't feel like they have to kind of, say 'why don't you do this?' or 'Why don't you do that?'. I think people are kind of getting used to me as how I work, and I get used to how they work and yeah, I don't really feel like a student anymore.

JHL: And have you got used to the lack of feedback… that you spoke about? Because, I mean, there was quite a big discussion we had about when you said about, 'Well, we used to have daily report, and all of a sudden, now I've started, I've got absolutely no idea how I'm doing – except someone may send a patient back'?

Ben: Yeah, [...]… I don't really know.

JHL: Is it still as important you at this point, as opposed to three months ago?

Ben: Feedback? [...], no I don't think so. I just think that having confidence in my own ability is, that's kinda the biggest learning curve from last time I spoke to you and now – is that I've got more confidence in my own ability. I don't feel like I need to have that feedback anymore. When someone does give you that feedback, it's nice to say 'well, obviously I'm going in the right direction'. It's nice to get a gentle reminder from time to time. [...], but like I say, I've kind of – feedback for me is kind of putting me on a cannulation course because they obviously think that I'm doing something right – so that's positive feedback. [...], and I do feel like I do get rota'ed to the places where you're expected to work hardest, which in a sense, is nice, because although my day tends to be more tiring and more hard-work than some of the other places, it's still a compliment to say I can deal with that. [...], just people giving me more responsibility in the department. People helping you deal with that, rather than dealing with it for me – [...] that's positive feedback for me, because it's obviously someone saying, 'Well actually I do trust you to do this quite important thing'. [...], I've also, I'm really trying hard with my – it doesn't work all the time, but – I really try hard at the moment with, if I red dot something, I always try to put an image comment on it, on [...], CRIS. Just because, then, if for example, I think there's a fracture, but I'm not sure, or if there's some sort of doubt in my mind, and I query red dot it – then I will still put a query red dot on CRIS and say what I thought I could see. Take down the number, and two days later I will go in and check it and they'll either confirm it or say no – and it's kind of using that as a learning tool as well.

JHL: Mm, brilliant.

Ben: But that's a nice way, because, when I'm on nights sometimes, I'll red dot something, and then the next night, I'll go in and I'll go through the ones that I've 'red-dotted', and it's nice that I've got the majority right, which again is good feedback for me. I'm kind of, just taking more onus on myself to get the feedback, in a sense.

JHL: So you've kind of just built your own strategy, really?

Ben: Yeah, definitely.

JHL: Yes, and trying to recognise those things, like you said, they might not overtly say 'Ben, you're doing a great job', but there are little indications that you're fitting in and you're doing well.

Ben: Definitely. And to be honest, after three months, it felt like I was a member of the team. After 6 months, I feel I am definitely a member of the team, so that's also positive feedback. People have, people will be less willing to accept you into the team, if you're not pulling your weight or if you're not very good at what you're doing. [...], so the fact that I kinda settled in quite quickly, I think that it's a positive thing. People, I think people wouldn't let you into the team, and be so open about you being there, if you weren't doing your job properly, so that's quite nice. So yeah, I just kind of feed of the things I hear, and I don't analyse it too much anymore. I just, like I say, I'm more confident in my ability to – to do my job. I kind of, sometimes I feel like the challenge isn't to maintain my confidence, it's to stop myself from getting too confident – and becoming complacent, or [...], upsetting people because I have kinda got a strong personality. So, really it's just keeping myself in the middle ground and just keeping working hard and doing my job. I think that attitude will pay off for me eventually. I'm not someone who is going to scream and shout and make lots of noise, so I don't need that feedback anymore. I don't feel like I do. Like I say, it's nice to be reassured from time to time, but I don't feel like I need the feedback, because I'm just confident in what I'm doing. I know that if I do something wrong, someone will come and tell me – that will come back to me pretty quick. So, [...], in a way it's, you're getting feedback all the time really.

JHL: Yes, I think, sort of, last time you sort of had that uncertainty, didn't you, about how would I know if I was doing something wrong and actually how quickly that got back to you? But maybe now you've got a, you've got an idea about…

Ben: Yeah, just seeing other people doing things wrong and, there's been a couple of incidents where – and again, this is sort of positive feedback – there was an incident in theatre, where I went up and did a case, but I had to be relieved and I went back down, and the person that went up made a mistake. Instead of the surgeon phoning up to the person who had gone to relieve me, he phoned me, because he remembered me being in there. Which, is kind of, it's a bit of a, it's a positive and a negative. The positive is that he remembered me and obviously I made a positive impression on him. And the negative is that he thought that I made the mistake. [...], but yeah, just, and that comes so quickly – that was in the afternoon that I came back, so it was in a matter of three or four hours that it came

back to the person that made the mistake. It's just that he thought it was me, but it wasn't. [...]…

JHL: So, did you tell him that it wasn't you?

Ben: Nah, I just – he was asking, basically the images had been put into the wrong folder. I just say, 'no it's fine, I'll sort it out for you'. So, I just corrected the mistake and that was fine – I'm not really big into saying, 'it wasn't me'. It doesn't make any difference, it's been made so sort it out and get on with it, to the next thing. I think the department had a word with her, with the radiographer. Just to say, 'be careful, don't do it again', sort of thing. But I certainly didn't say anything, I just got on with it and got it changed – got it put in the right folder. I'm not, I'm not in a position where I should be making that kind of call, so… I'll leave it down to the managers. They get paid a lot more money than me, so, they can deal with that kind of stress. Yeah, I'm not; I'm not in it for myself. I'm quite happy just doing my job and…

JHL: So, last time you were about to have your appraisal, I think – your three-month appraisal? So how did that go, because you were hoping that you were going to get some…?

Ben: Feedback…

JHL: Constructive feedback on areas to work on. You talked a lot about wanting to use it as a way forward and to sort of develop really.

Ben: Definitely, yeah. It was [...], it was nice to get the feedback, and again, there wasn't a lot of 'You're doing this well', or 'You're doing that well' – it kind of just, everything was going fine, and that, in itself, is a compliment to me and what I'm doing in the department, so – but from that they said, 'What do you want to do from now? What's you're, kind of, goal?' And, to be honest, I haven't got a clue where I want to go in this career, I'm quite, I dunno, I really don't know where I want to go. [...], I'm just quite happy doing my job, [...], so when they said, 'Where do you want to go', and even I've got my six month appraisal on Monday, I still don't know. And they keep saying, 'Where do you want to go?' I don't know, I really don't know. [...], I want to get into CT, I want to get cannulation trained, and I wanted to go on a red dot course – well, I've done two of those since the three month and that's kinda my feedback saying, I want to do, I want to get onto a cannulation course, I want to get onto CT and I want to go on a red dot course. Two of those have happened – CT is still pending. [...], but, as I say, I've got a long career. I'm not that worried – if I get in there now, I get in there now. If I don't then my time will come. And when you get in there, it's the same attitude that will take you across everything. If I'm on the bench, playing rugby, and I get on, that's my chance to show them how good I am,

or how good I want to be. [...], when I go into CT, I'll go in there and do my best job. If that works for them, I'll soon know about it. If it doesn't then I'll go and try again and try and develop and get better as – every time I get the chance. When the chances come, I'm pretty confident that I can take them, so that's kind of my attitude. And the three-month appraisal kind of just confirmed that I'm right thing, that they don't expect too much from me for the first two years really. It's kind of just getting used to the job, understanding the department, which I'm still learning about every day. [...], but also getting used to being qualified. As I say, I'm still getting used to going home and I feel guilty about not doing something. I still do that thing where, if I don't know something, I feel like I've got to know it instantly. I like to know things, I do, but I think there's a lot more development that I need to do away from work, as well as in work – to get myself in the position where, I am ready to progress really. I've given myself, in my mind; I've given myself two years. And that's what I said in my three month appraisal, that – I'll keep working, I'll keep trying to pick up little strings to my bow – cannulation, red dot courses, image comments on red dots. All these things help me learn, [...], help me take on extra responsibilities like cannulating, [...]. In two years, I'll sit down and I'll look at kind of what I've acquired over the two years and then, then I'm in a position where I can say, 'well, actually now I do know what I want to do. [...], this is what I can do, this is what I need to be doing so that I can do this', and that's kind of my attitude really. Just keep getting on with my job, keep learning. Keep picking up extra skills and knowledge and…

JHL: So, you've got a six month appraisal coming up and then, when's the next one, twelve months?

Ben: Yeah.

JHL: Okay.

Ben: And then you just go onto the yearly appraisal things.

JHL: And then, is the year point the end of your preceptorship, or is it at six months?

Ben: Six months, yeah. But technically it was on the fifteenth of January, so I'm really out of my preceptorship now, but Monday will be the finishing bit. But to be honest, even from day one, I felt confident enough to be able to talk to anybody in the department. If I've got a problem, I still feel like that – whether they are my preceptor or not. That's the one really nice thing about the department, is that people really are willing to help each other. [...], some people kind of will use it to give themselves a bit of a leg-up sometimes but I think you get that in any department. I think you get that here, I think in any job…

JHL: Oh yes, you do.

Ben: I think people [...], use what they can to make themselves look a bit better. But I've kind of got a core group of people that I know, if I really want to talk to them about something, I can go and talk to them, so… yeah.

JHL: That's good. So a shift system started.

Ben: Yep.

JHL: And how are you finding it overall?

Ben: [...], yeah – I actually prefer it, I think. The Monday to Friday thing eventually will be something I look for – I will look for a role, which means I can do Monday to Friday. [...], potentially no nights, but at the moment, I like, I like the diversity in the work. I like having some days off during the week. [...], I don't actually mind, I don't dislike working weekends. Sometimes it can be a bit, a bit of nightmare if someone else is doing something – or my family is doing something, and I have to miss out, but it's not, it's not really a big drag on me at the moment. [...], but I love the shifts, I love working nights, I'd say, not just because I'm on my own but I just like the whole staying up thing and I don't sleep much anyway [...], just makes you feel like you're doing something, I guess. But yeah, I love the shifts, I like the diversity.

JHL: So, how do you think that's helped you develop over the last three months, the shift system, or doing out of hours work?

Ben: What, so you mean when I was a student, or? Or, since I started?

JHL: No, since you started work?

Ben: Well, the nights definitely, because, as I say, you're thrown into the deep end sometimes. Band six is off doing the CT thing, you might have 10 cards on the table, you have two doctors in the waiting room asking for you and you're kind of just trying to manage all of the beeps going off, phones going off, and you're just having to try and deal with things [...]… You make mistakes, I've taken messages and got them wrong – or gone up to recovery instead of resus. But, that's just part of the learning curve. [...], if I make a mistake, I'm always confident enough that I don't see it as a negative thing. Always trying to take the positive from it – [...], I don't feel like I've made lots of mistakes so, I haven't really had too much to learn from a negative experience. [...], but yeah, I love being thrown into the deep end; I love that feeling that you're trying to keep your head above water. It's quite a nice feeling, [...], but yeah the nights definitely – you learn so much, so quickly, because it's just you. It can be just you, and if it's not you, then you've got the band six there and it's a lot easier to pick up from what they do, how they work when it's just the two of you – so that works a lot better. I'm not keen on the lates – the lates are

weird. I like to either get up and go to work, or sit around and wait around to go to work later in the night and do the whole night. The lates are, you kind of get up and you have two hours, what are you supposed to do for two hours? Then you go to work and I come home at the time where everyone else is kind of just about ready to go to bed. I don't really like them very much, but I think that's just a timing thing rather than the actual work. I quite like the work – you get in and you go to theatre and get down about five o'clock so all of the worst bit is done. And then you're effectively working the night until eight o'clock. [...], yeah, I really quite like it – I don't think I dislike it at the moment. I think that will change, when my personal situation changes – if I have kids and all that business, then obviously I will probably want to be spending more time with them, and I won't want to do so many nights. But at the moment, they suit me, I quite like it.

JHL: Sounds like, what you said earlier, it's almost been like one of the pivotal factors in developing your confidence?
Ben: Definitely. Yeah, it probably definitely is. I can't… yeah. If I think back to the first couple of nights that I did – because we do two back to back, the first two, like I say, just trying to keep my head above the water. And then, as I've done, I don't know how many I've done now – I must have done at least ten, I guess. [...], now, I don't do that thing where you answer the phone, but you don't want to answer it because you don't know whether you'll know what they are going to ask you. I don't even think like that anymore – I just pick the phone up and I'm confident that whatever they chuck at me, I can deal with. [...], but I'm also confident enough to say, 'Sorry, I'm sorry, I don't know. Look, let me pass you over to the band six' or 'I'll take a message and get back on bleep' or whatever. [...], yeah – I think you're probably right actually. The night's developed my confidence quite a bit, because you're making your own decisions and you've not got anybody standing over the top of you, so definitely nights. I hadn't seen it like that, but you're probably right.
JHL: It's just that, I suppose, I was thinking about what you've been saying about how actually having a lot of people around isn't helpful to you.
Ben: No, it's too chaotic.
JHL: [...], and you're on your own, and then, of course, you can be methodical, like you said earlier and you can make your own decisions and in doing so, you pretty much get your feedback straight away as well, don't you? So…
Ben: Yeah, the other thing is, if, if you're likely to make a mistake, it's most likely to be on a night, because one: you're tired, two: there's lots of things going on and three: you're on your own for periods of the night. [...], and I think, personally, I

learn more from having a bad experience than I do from having a good experience. [...], I had one bad experience at CCCCCC where, I'd had a really awful patient, they just didn't want – they wouldn't cooperate. I'd try and position them, and they would just move; and not because they had anything, they had any healthcare issues that would cause, they were just being…

JHL: Difficult?

Ben: Yeah, difficult. [...], and then the next patient that came in, kind of walked in for an ankle X-ray and I was kind of less sympathetic than what I would have been if I hadn't just dealt with that patient, and it turns out that they had a fracture. And I felt awful because I'd been less sympathetic about their pain, and it was purely just a hangover from the last person. And the rest of the day had been fine, I'd done my job, and I felt really good about myself, but that one experience – that one walking away, or walking that patient over to the minor injuries unit just left me hating the whole day, because I thought, 'If I'd shown that man a little bit more sympathy' – I mean I wasn't, I didn't do anything unprofessional, and I certainly wasn't unkind – I just wasn't my normal self. [...], and I come away thinking, 'That's not right. That shouldn't happen. I've got to learn to cope with, if one patient comes in and they are very difficult, you've got to have a clean slate before the next person comes in.' [...], but what I'd done was I'd done the other patient, straight out, straight in with the next one. If I have a tricky patient or a disruptive patient or just someone that's not going to cooperate, then I'll go and PI the card, I'll check something that I was just waiting to check. I'll just take a minute just to reset and then get the next card – read it then go in. Then you've reset myself. So, I learn a hell of a lot from that. It wasn't a particularly bad experience, really. I mean, it wasn't any different to what some radiographers are like all the time, but I just wasn't as sympathetic as I normally am – [...], so I learnt a lot about that. I think, I have more of those type of experiences whilst working nights because of the situation, so, you just tend to build your confidence up like that, I think. Because, you're, I do personally learn from bad experience more than I do from good experiences.

JHL: Are there any more experiences that you can think of that…?

Ben: [...], I think I told you about the one with the orthopaedic doctor shouting at me, didn't I?

JHL: Yeah.

Ben: That was in my first few weeks. That was another one where I learnt a load from.

JHL: And do you think [...], sort of, I can remember you saying that you'd never used to go around to speak to the consultant on their own, and actually it turned out to be a quite positive reaction in the end?

Ben: Yeah, yeah, absolutely.

JHL: And are you still feeling pretty confident about dealing with… other professionals?

Ben: Absolutely, 100%... Absolutely, since then I go up to ITU now, the nurses recognise you, or go to SCBU and the nurses recognise you – they might not know your name but they say, 'Oh excellent, we've got the happy radiographer', because some people don't like going there. [...], but people remember who you are, it's just, people remember my name and I have to admit, I'm really bad with names – but people, when I go up to theatre say, 'Oh, are you alright Ben?'. 'Oh no, I don't know their name!' But it's just because I'm kind of settling in and talking to people. When I'm in theatre, I like to help PAT-slide. I just try and buy into the team, whatever team I'm in. [...], and to be fair, the doctor that I had that experience with in the first couple of weeks – I see him in theatre or walking around the hospital, and he always says hello to me. He knows my name, says 'How're you doing Ben?' he knows I'm waiting for an operation – he asks 'how's your knee' and stuff?'. He just, from that experience, I kind of know now that I can't be afraid to talk to people because most people just want to get on and just being part of a team is a good thing. So, yeah that was a positive. That probably was one of the biggest positives that I could have had in the first two weeks, yeah. Because I don't, I'm not bothered now. If I go to theatre and some surgeon do it different there's, you know, it's like in the department they'll say, 'oh, by the way, it's such-and-such's list' and then everyone's like, 'oh, I don't want to do that really'. I just go up there, be myself. I talk to them and say, 'I'm really sorry, I haven't done your clinic, or list before. How do you like it to be done?' And I think that they instantly have respect for you because you've not gone in there and tried to muddle through. You've just spoken to them, and then they'll talk to you through the whole thing. And that one particular case where, he's quite an eccentric character, and he likes things done in a really specific way. I hadn't got a clue, people told me, he likes this thing, he likes that, but until you've spoken to the person in flesh and blood, then you don't know, do you? So, I just went in there and said, 'to be honest, I haven't done any of your lists before. Could you just tell me exactly how you would like it to be done?' and he talked me through the first patient on the list, [...], and he was teaching me the whole afternoon. He spent the whole afternoon teaching me things that I don't even learn in my job. He was teaching me about why he's doing certain thing, and again

– another really positive experience, just from having the confidence to go in and talk to people, so… yeah. I put that, I genuinely put that down to the way I was brought up, to be honest, because I've never shadowed away from people. My parents always gave me the confidence to talk to people. I can go into a room of strangers and I will be able to talk to people, so – I feel quite fortunate that I've got that within me to be able to do that, because I've learnt so much from it. I've learnt, I know more about what he was doing, than what I was doing at the time, so – it was a really good experience.

JHL: It was good, really good.

Ben: [...], I'm trying to think about anything other experiences really, that I could – like notable experiences. Can't really think of any that stick out to be honest.

JHL: So the tiredness? Has it still continued in the same…?

Ben: [...], sometimes. When I'm coming off the back of a nights, so I really struggle to get back into my sleeping pattern. Again, over two nights I probably get six hours sleep. [...], I'll get home about 8.30am, or 8.15am or 8.45am, and I'll sleep till about twelve. And then, after the second night, I'll come home and sleep until about twelve. I don't set an alarm, I just wake up at twelve. [...], but last night, I just laid in bed until three o'clock in the morning, I just couldn't go to sleep. I just wasn't tired, so I might just have to kinda cut the bullet and say, I don't sleep at all after my second night, just stay awake. And then I probably could get myself back into my sleeping pattern. It's just, I think it's just managing myself, but…

JHL: Well, I suppose that's a tiredness due to the shifts, whereas before it was more…

Ben: Yeah, mental. Mentally and physically tired, before. I'm not, I don't think so, no. Sometimes I get home and I'm physically tired. [...], if you spend the whole day at CCCCCC, and it's a really busy day. Or a whole day in a GPs service, it's really busy day, you're on your feet all the time. I can go home and instead of going to the gym, I really want to go home and just sit in front of the TV, but I force myself to go to the gym. I just try not to let it get on top of me – I don't notice the difference now really. I actually feel really good when I do, when I'm not doing lates or nights. I feel really good, I don't notice it anymore.

JHL: So it's improved then, a lot?

Ben: Yeah, it did when I was a student. The first, the first three or four weeks were just horrendous. I'd go home and just go to sleep. [...], and it was the same when I started a job. Now, I kind of settled down, the same as when I did when I was a student.

JHL: Good.

Ben: It's just I feel mental fatigue more than I do physical fatigue. Mental fatigue – I just can't cope with it. I play rugby, I play football – I can deal with the physical thing, it doesn't really bother me. But the mental – I'm just not very good at coping with it. And when I get mentally tired, I feel my stress and that's why I force myself, I've come home and I've had, [...] mentally fatiguing day, then I just go to the gym. As much as I don't want to, I just go there, because that, in theory, that's kind of the out. That's what stops me from falling deeper into that rut, gets me out of that, so. I can see, I think if I let myself slip, I could quite easily develop depression. I know that I'm that type of person. I've kind of had little bouts of that in the past anyway, [...], I even had that when I was a student. Yeah, if I let myself, I would slide into that, I'm sure of it. But, I just don't let myself get there, just keep doing the things that I know work against that – going to the gym, playing rugby. I struggled just before Christmas, because I'm waiting for a knee op, so I can't play at the moment. [...], I couldn't, it's just as much as I could do to go to work. I couldn't go to the gym; I couldn't go the rugby club, because everything reminded me that I can't play. And potentially could never play again. [...], but I just, I forced myself to do the things that I didn't want to do, which was go to the gym and go to the rugby club, and I do all of that now, and I feel much better for it now, so that was a learning curve, big time. I just don't want to slide into that, because I know it's a really horrible thing, depression. I know it will get me at some point in my life, but as long as I am prepared for it.

JHL: Hmm, interesting. So, students, one of the other things you talked about last time was teaching students and that. How's that going?

Ben: Good, we've now had our first years come in. [...], I think when I'd spoken to you last, we'd had the third years.

JHL: Yes, you had.

Ben: And, they're a piece of cake, aren't they, really? You're kind of just topping them up every so often. They're pretty good at their job, you just add your little touch, or add their – you kind of just confirming that their doing the right things. Second years, like a tiny step back. And then the first years is just like, 'What am I doing?' They walk into the room and like, at first I kind of expected them to know more than what they would, and why would they know more? They've never been there before, so… I quite like it, I quite like the challenge, but it is my first time around. I know that next year, when we get another load of first years, I know that I will be much better equipped to, to teach them. But this was the first time around,

and I kind of just stood back a little bit – kind of picked up on how other radiographers dealt with first years. [...], some I approved of and some I didn't approve of. [...], but I kind of, it's something that's completely new, isn't it? You've got to learn it again. It's one thing knowing what you're doing, but trying to helpful somebody else how to do it. [...], I think I'm polite and I'm friendly and friendly where I can, but for the most part, if there's someone there that's [...], I know who's better with student go off with them, because it's not fair for me to use them to develop my skills to better them, in a weird way – do you know what I mean? I can't use them as an experiment to make myself better at teaching students. You kind of have to stand back and watch how people are with students and then, kind of replicate that from what they've done. If it works – if it doesn't work, then don't replicate it. That's kind of my attitude, so. But, I, as I say, I'm always friendly and helpful. I'm there for them if they want to talk to me, so…

JHL: But, it's just a little bit too much, do you think, at the minute?

Ben: No, I enjoy the challenge of it and if it's just me and a first year student there then I will teach them and I will get into the room and explain things to them – and it's actually quite nice because it kind of refreshes my kind of, makes me search out what I'm talking about. And I had obviously listened in the first year. [...] yeah, so I kind of just, if I'm there and it's just me and a student then I will do my best to teach them. You don't get feedback on that kind of thing, do you? So, yeah, if, but I'm not afraid of it, and I won't shy away from it, but if there is somebody there who can do a better job of teaching them, then I will let that happen, because that's their education – it's not for me to mess around with. But, that's how I see it. Until I [...], I say next year – next year will be a different kettle of fish, I'm sure – because I actually quite like teaching, I just want to make sure I'm doing it the right way – so I just have to stand up and let people do what they're doing for a little while. Pick up my experience and observe – that's how I see it.

JHL: So, do you think there is anything else that is important to me to know about this sort of period of time, and this six months?

Ben: [...], not really, to be honest. If I was to summarise the whole thing, it's just developed on so quickly. If I could plot a mark of a chart which incorporated everything how I feel; my knowledge, my skill level – then I'd be kind of half way down the chart. It's kind of doubled know, and I expect it to double again, eventually I hope. But I'm definitely going in the right direction. That's how I feel. [...], but I, the training I had was good – from here, from XXXXXX, was good. And I trust that completely. It's not really those things that I've struggled with. The things that I've

struggled with is dealing with like the pressures that are put on you; other people's attitudes sometimes. In the past I've been very quick to say, 'Oh, I don't really like them' or 'I don't like the way they work', but I would have but as a student I would have said, 'I don't really like working with that radiographer', so 'I don't like the way they work'. Now I just [...], let people be who they are. And I think, it's partly me developing in the job and partly me developing as a person anyway. [...], sometimes people do things that are incredibly stupid, or they just have no common sense. And I used to let it bother me, and I'd get, I'd get angry with myself because they're doing something that is so stupid. And, now I just think, 'Well actually, that's who they are – let them be that way'. I can't influence everybody. Yeah, just chill out and worry about... It sounds almost hypocritical – just worry about myself. But when I do that, I worry that – not worry about myself – but if I concentrate on myself, then I'm confident enough that what I concentrate on will have a positive effect on everybody else. If I try and worry about what everybody else is doing, then I forget about what I'm doing and then I'm a negative effect on everybody else, so – without saying that I'm in it for myself, I'm not, I just don't that worrying about what other people are doing will help, I think it's a negative thing. So, that how I would summarise really. I love my job, I genuinely do love my job. [...], some days it's stressful, but I still love what I'm doing. I still take the mickey out of myself, being a button pusher, I don't mean it – obviously there's a lot more to the job, but I do push a button. It's kind of a joke in my house, because my dad is a bricklayer, and he goes out and it's raining and it's wet and he goes out in it. And I say that I go to work in my air-conditioned room and push my button all day, and just wind him up. But, I do like my job and that's it really, just keep going on with it. Just making sure that, as I say, just worrying about myself and I think that will have a positive effect on the whole team. I'm certainly not going to put my attitude, let my attitude be detrimental to anybody else. It's strange, because it sounds hypocritical, because I don't worry about myself, but if I – does it make sense?

JHL: It does, because what I think you're saying is that you can really only worry about what you're doing because you can't change other people. And you can't change other people's behaviour. But what you can do is change the way that you react to them, and I think that's what you're saying isn't it? And actually, don't let them get to you.

Ben: Yeah, don't let them hinder me. [...], I've always been a strong believe that to be a good leader, you've got to lead by example. [...], I don't think that a leader that goes in and shouts and hollers. There's a place for that, and I'm confident I could do that, but I think for the most part, you lead by example, and I would rather be that

person, than the person that goes in and makes a lot of noise. So, that's kind of how I would summarise it really - if that makes sense.

JHL: It does indeed, thank you.

JHL: Okay so it's the fourth of August I'm here with Ben. So, yes this is brilliant. So, what I was going to do was just get you to talk through your theme board - the images you've chosen, why you've chosen them and what they mean.

Ben: Yeah.

JHL: Um, and we can sort of kind of reflect back on your year. It's been a year now so it's has it gone quickly.

Ben: It has yeah.

JHL: Yes.

Ben: Too quickly I don't know where the year has gone

JHL: Okay.

Ben: I think I'm a year now in and I don't know where that's gone a year … it's mad. [...] I just tried to I think all the images say a little bit about me anyway [...] but I've kind of stuck that one in the middle cos it just feels […] that's kind of what it all feels like. It's obviously been a nice boat at some point but it's kind of just not been cared for and everything feels like it's just needs a little bit more [...] care from the system rather than me it's not it's not very much me it's about where I work and how I'm expected to work. It's kind of that if somebody's going to come and inspect this boat there would be a mad rush to get it perfect again. [...] but that's kind of how I feel about work is it's kind of just me it needs a bit of tender loving care really, it's quite prominent that image for me. [...]

JHL: Do you think that's your department specifically or do you think it's the whole NHS environment?

Ben: Obviously, I can only answer from my own personal point of view and I kind of feel my department.

JHL: Mmm

Ben: It's like that but I wouldn't be surprised if it kind of branches out a bit at this stage as well.

JHL: Mmm okay.

Ben: There's like for me to say this boat really is quite symbolic that's why I was kind of drawn to it quite quickly and I was looking through images and that [...] it's quite symbolic really because if they were of like I say this boat at one point was a really nice boat and it was a really nice you could go and sit on it on the lake and you feel you have a lovely time.   Now you'd sit on it and you'd be thinking is it gonna sink it's not going to sink and you're looking for somebody to make a decision do we fix the boat or do we not fix the boat? Or do we get a new boat but it doesn't do anything it just sits there and that's kind of what it feels like to me it just it needs somebody to come and grab the department, my department specifically by the horns and say right the boat's a right off, get rid of it and do it again. We'll get a new boat or let's put some care into this and make this boat work but for the moment it just sits there and nobody's actually making that decision.
JHL: Right.
Ben: That's kind of how I feel…um probably quite a generalised.
JHL: That is your experience isn't it of where you're working at the moment?

Ben: And even at the start of when I first started a year ago the department did seem happy in itself like a nice place to work [...] but all almost during my time there it's kind of just got worse and worse and worse very slowly. I don't know if that's my perception or that's just the case in this department where we actually had, we had the right number of band fives the right number of band sixes the rota was working quite well [...] and just over time somebody left or somebody's moved on and not backfilled or whatever's happened but it just feels like over time it's slowly kind of decaying away a little bit which is quite sad thing to think about, I think.
JHL: How does that affect the way you feel about your role?
Ben: Well ... I don't want to be in a sinking ship, it's kind of I want to be good at my job and I want to have some job satisfaction but I don't want to be, I don't want to get myself to the point where I go right I'm going to change it for myself now forget everybody else they've had their chance to change it. I'm going to save myself and it's too late and I'm already sinking or I've already sunk [...] so I'm always just trying to keep my head above water make sure that all my options are always open because I want to do this job and I want to enjoy it. [...] yeah that's about as much as I can say really.

JHL: Okay. So where do we move to next?
Ben: Err I like this little dog, cos that's kind of how I, I'm useless at chess and so I kind of look at that and it made me laugh because that dog would probably beat me

but he kind of looks a bit confused. He's staring at the chess pieces and that's kind of how it feels sometimes at work I'm kind of like probably do stand there like 'what is going on why is this?' really because chess is quite a simple game [...] but you can obviously make it more difficult and that's what it's like this is a really simple job we get to speak to patients we get to do our job and it should be fun but it'd be like uhh I can't why is it so difficult to come to work and be happy [...] and that's kind of that's linked to that picture as well ..

JHL: Um..

Ben – I kind of sometimes imagine that I probably stand there like that at work and look very blank I don't know the right word, forlorn is it?

JHL: Mmm.

Ben: Kind of just a bit like that's how I looked at her

yeah sometimes I just think it's so simple it's such a simple job, it doesn't need to be difficult, doesn't need to be stressful and it makes it stressful and that's what I imagine playing chess with a little dog would be like…

JHL: Okay, good.

Ben: [...] this one's quite, I quite like this one 'cos the team at YYYYYY is very good [...] they kind of muck in or muck through it and get on and sometimes it's really tough but the team always kind of works together to get through it especially if you're in small teams like that. But I think, like a weekend shift sometimes, the weekend shifts can be really horrible but the four/five of you there really do knuckle on and get it done [...] so that's kind of that's kind of a positive for me.

JHL: Um.

Ben: It's that I've always felt like most of the time when I go to work the team will always kind of pull you through and pull the team through to get what needs to be done as it can be quite bad on a weekend for example or even a night when there's even three of you got through and it's kind of you kind of do feel like that because you're in this tiny little room half the size of this and all the work's coming in and you're kind of like you just feel like sitting round a computer what am I gonna do and that's like kind of like that image.

JHL: Okay

Ben: This one was obviously the Dartford tunnel I think that's just kind of how my work is sometimes I feel it's like a conveyer belt one car through one car through one car through and I don't like that cos I like patient care. Sometimes the pressure from the job can be, how I'm expected to work can be too high for what I want, how

I want to work , how I want to be with patients and that's what I kind of imagine my job being like one car through gate goes up one car go. I get sick of hearing my own voice 'can you tell me your date of birth? Hello I'm Ben.' I've probably said it about sixty times in a day and I'm a bit like I actually resent introducing myself to you even though if you'd come in the morning I would have been happy as pie to introduce myself but because I've done it sixty times I'm kind of a little bit like oh I've got to introduce myself again, got to ask date of birth again, got to ask you to lay down on your back again ... all this kind of thing [...] specifically when I go to ZZZZZZ the [...] X-ray place there, you kind of have to repeat yourself a little bit more 'cos the patients are elderly they don't hear so well um it's all a bit confusing when you ask them to put two gowns on and it is confusing. I would feel confused with someone telling me that one goes on back to front that one goes on like a dressing gown, oh what am I doing? Sometimes you can feel like I've said this so many times and then you try and change it and you get it completely wrong and you've got a massive traffic jam like the Dartford Tunnel that's how I imagine it.

JHL: So, the workload is quite intense at times?

Ben: Yeah and it's kind of strange but I think sometimes I resent the fact that I have to work so hard for my money when I know there's places like AAAAAA for example where it isn't so busy and I can't imagine what it must be like for people who work in BBBBBB where it must be just all day non-stop and then kind of felt you get away from BBBBB or a big city it comes, slows down a little bit and it's not so um full on all day you kind of sometimes think well oh hang on a minute why am I working so hard? There must be somewhere else someone somewhere else who's not doing half of what I'm doing getting paid the same amount of money [...] but having that's just the walk of life isn't it?

JHL: Yes.

Ben: This is the job. You don't, you know it's not resent so much, it's kind of like you kind of just think ooh I'd like to be working there right now rather than working here where it's so busy [...] but then other days you're kind of quite grateful it's busy cos it makes your day go so quick and you can really get into a rhythm and really enjoy your day so it's a bit give and take I think.

JHL: Mmm.

Ben: I'm not, I'm not unrealistic. I know what my job entails so I'm happy to work hard it's just that sometimes when you've had two or three days or even a night when you're full on all night it's just tiring and you want to go to bed sometimes you do think why am I doing this but I think that's normal for this kind of job.

JHL: Mmm.

Ben: I don't resent it, I think resent is the wrong word but sometimes you just do kind of take stuff and think what am I doing ... how am I working this hard this is mad [...] Yeah you can feel like that sometimes and I don't like that because I like patient care that's one of the parts I really do like about my job so yeah that's kind of I do resent that feeling that I'm just a technician just in and out in and out I don't like that very much […] What other one? These ones, these kind of … I do have some really happy times at work [...] I have some good friends at work so these kind of ones are just point out that I do enjoy myself sometimes I feel really good [...] and yes that kind of thing I love walking all these things are symbolic of me being happy at work I love that as a photograph so that's kind of…I also take photos I do there's a lot a few on here that I kind of yeah I do have good times at work and it is positive there are days when I come away and think I've had a really good day at work um kind of sometimes get a bit overshadowed by everything else but there are days when I have that and there is I have some really good friends at work so

JHL: So what makes the good days you know?
Ben: I just want to be able to do my job and when I go in and I think sometimes the job is made harder than it needs to be and more stressful than it needs to be [...] when that, days when that doesn't happen they're days that I really enjoy go in and I'll go up theatre and come back down I'll be in A&E for a bit kind of talking to patients, I might have a patient that I'll really just click with it kind of sets you on the right mood for the whole day [...] I can't I don't really know really what it is that makes it a good day I just come away thinking yeah that was good I enjoyed that today. Normally it's actually my nights so I come away from my nights thinking yeah I've really enjoyed that either I'm really tired, I don't want to be there anymore but I do think yeah I've enjoyed my job I've done what I trained to do and I'm proud of that. I think that's what it comes down to being proud of the job that I've done that day so I like job satisfaction sometimes I don't get that so if I feel like I'm going forward and I think for me to go forward I have to be happy so I get happy first then try to work out how to go forward and still continue learning cos that's what I enjoy
JHL: Okay

Ben: And that this one is kind of symbolic of that sometimes I feel I'm on an uphill battle to not just go forward but retain my knowledge there's times where I think the course that I did the degree actually kind of over trained me, not over trained me, trained me to what I should be but a lot of the knowledge I got as a student I don't have to use a lot of the time so it is kind of sometimes an uphill battle just to retain

the knowledge that I got on the course and have built up, it's kind of that weighing it up do you do you fight for what you got or do you move on and try and get something new in there to take its place. It just feels like that sometimes I don't know why I think it's perhaps because there's the department's very there's a lot of people who are very career minded and they want to progress and they want to go forward which is a good thing but I think sometimes the department has to or the management have to stifle it back a little bit because obviously it would just end up with a department full of band sevens who don't want to do any plain film X-rays they all want to be in CT or want to be reporting they don't want to do the job [...] and I don't want to give all that up I just want to be learning. I like to learn it engages me and gives me some job satisfaction ..

JHL: Mmm.

Ben: So that's kind of what that one points towards […] some days I have really bad days where it feels like I'm being hunted by a shark or where it's I kind of like that picture anyway but it's a waterfall sometimes it just feels like it's all too much and it just it's all coming pouring down on top and you can't do anything to get your head above water and that again like I don't really understand how the difference between a good and a bad day. The bad days I just sometimes come away and I think what am I doing this for? I don't, I've not had any job satisfaction today I've not learned anything new, I've not had any patients that I particularly sort of bonded with, I had a good experience with. I just feel just like I'm a horse and I'm being whipped and that's it just get back to work and that's it just work we don't care about anything else just get the patients X-rayed it doesn't matter [...] sometimes it can feel like that I think they're the bad days. The bad days are the bad days for me when I just I'm just expected to get on with it and you know, you get people saying what are you checking the X-rays for just send them we're too busy to be checking X-rays and you think that isn't my job? I'm not a technician, I'm not a machine that brings one patient in and presses a button and you walk out. That isn't my job, I'm here to make a difference and if I spot a fracture and send a patient back to A&E with a red dot on it the doctor might miss that but because I've red dotted it that makes a massive change to the patient and I think those are the kind of days when I don't enjoy it. Sometimes it's a bad team of old-fashioned radiographers who don't think your job is to check X-rays and put red dots on or [...] who think you are spending to long with a patient because you said like oh have a nice holiday because they've brought that up in conversation just little things. I think mainly it's down to team and again those people that make the job stressful when it doesn't

need to be if you get stuck in a team in the department when all they're doing is moaning, all they're doing is rota this…I don't want to work weekends, I don't want to work nights. Basically you just don't want to do your job and you're putting that on me, I do want to do my job let me get on with it let me be happy doing my job whereas I think some people resent the fact that you're quite content doing your job and they don't let you do it, they want to stifle you because it makes them feel better to bring you down to their level […] I think they are my bad days

JHL: Mmm.

Ben: Oh.

JHL: It has a habit of doing that because we don't move around enough. So do you think from when we first spoke at the three month period you had, you know you were finding it all quite stressful weren't you so do you do you still find the job stressful but for different reasons?

Ben: Yeah, the first three months I felt stressed because everything was new to me it was all my responsibility and that was daunting. I think it was more fear that was causing stress whereas now it's just, I think it's the system that causes me to be stressed and sometimes the people I work with cause me to be stressed. It's not the job anymore…the job I love doing there isn't… I remember when I was a student I'd think oh no it's a lumbar spine I don't like doing lumbar spines I think I'd see if I could get out of doing that one or you'd just kind of you know you'd got that apprehension about doing a specific examination. I don't have any of that anymore I don't care just send me to do it, send me to an outpatient clinic and inpatient clinic, send me into CT. I don't care really I'm quite content with and confident in my job which doesn't cause me any stress anymore [...] the stress has completely changed it all comes from politics - the departmental politics [...] people wanting to make it an unhappy place to work because it suits their agenda. That's where all my stress comes from…it's the people in the department and the system, it's not the job I love the job that's the bit that keeps me going back every day

JHL: So when do you think you became confident going in everywhere doing everything? How long how far along the line was it until you felt like that do you think out of the year?

Ben: Probably about six months. I felt quite confident then and it's becoming like a distant memory now that I felt like that but I felt stressed to be at work because I didn't want to make a mistake or I didn't want to, I always had this thing as a student I wanted everything to be perfect. I wanted the perfect lateral wrist, the

perfect lateral ankle, the perfect mortise view always such striving for the perfect image. Whereas now I'm a little bit more realistic that you're not always going to get every every X-ray perfect and it's about understanding whether you need to repeat or not. That's kind of where the stress came for me was unless I got it perfect textbook I always thought that's it I've got to repeat it because it's not perfect textbook not to say that my standard has dropped, I just kind of weigh up the extra radiation and need to actually repeat it for diagnostic purposes.

JHL: Okay

Ben: [...] I think I'm much better at that now, it causes me less stress but yeah I'd say about six months

JHL: And so as, as that drops off is that when you start to …become sounds like you almost sort of ... sort of concentrate on your own you know your own world at that point about how you're going to get through the day

Ben: Yeah

JHL: And as soon as you feel confident you start to…

Ben: Take everything else in

JHL: Take everything else in and is that really when you start becoming more aware of other people and their agenda and politics?

Ben: I think I was aware of it in the first few months of leading up to that first six months ... you just kind of choose to ignore it whereas now because I've got a bit more extra time I don't when I'm PI'ing I'm not thinking 'was that okay did I do that properly/' I'm now thinking about something completely different and when I'm PI'ing I'm not having to concentrate on PI'ing so you're actually listening to the person that's kind of rabbiting on in your ear about how bad things are and you kind of just taking more of it in because you've got less to worry about from your own personal point of view

JHL: Mmm

Ben: [...] on a daily basis I think ... I think bad days come when I allow that to get on top of me and I allow people to push me down cos [...] I take a lot of pride in my work. I don't really, I know this sounds bad I don't really care what they do providing that they do their job and they're not making my job any more difficult [...] I've kind of got to that stage now where unfortunately because it's like you say it's, I find it's other people that drag me down and I've now moved myself into a position where I just fight for my own corner and that's kind of a negative against the department and the team which I'm also big on. I love the team atmosphere that's why I picked that image I love the team atmosphere because I think that makes your whole working life better. You spend so much time at work you should want to

come and be social with your colleagues and we should feel like you're wanted as part of a team but I think that's probably where the downfalls come, is that people are just looking out for themselves and I'm, I can't even say that I don't do that now because I do that because if I indulge myself in the team too much I find that the stress becomes too much and I end up thinking 'well I don't want to do this job anymore' so I have to distance myself a little bit from it which I don't like ... yeah I think that's ...

JHL: Um interesting

Ben: There's a couple of people sleeping I quite like.... I think it's normal for anybody to feel tired in their job from time to time. I think with the shift pattern it's something I have to get used to or have got used to over the last year or so, like learning when I need to sleep cos before I just thought I'm young I just get on with it go to work if I'm tired and I think sometimes that has a negative effect on me at work. If I go to work already tired then everything everybody says to me becomes worse for some weird reason because I'm already tired I'm thinking 'I'm tired' and you are talking to me about the rota instead of you just going it's just the rota which I would do if I wasn't tired when I'm tired it goes in and it's really annoying me I can't get wound up and then I go home and just go to bed and sleep and the next day I'm fine. That's something I've really had to learn to manage in the first sort of year, is that it's making sure that I don't go to work tired especially with the shift work, making sure that I've got an actual plan for how to get my shift and how to get my sleeping pattern shifted back into a normal [...] pattern cos before just two days after nights I'd be awake four o'clock in the morning getting up at eight and going to work just feeling awful. So now I've actually got a way of getting back into my sleeping pattern and I kind of respect myself a bit more instead of just thinking you'll be fine just muddle on through but yeah I just do take a bit more care of my sleeping and looking after myself cos I've got to do it for a long time so it makes it easier if I go to work and I'm not tired the job's easier...
JHL: Okay.

Ben: There's a couple of bits in here - I think that one is kind of the last one I put on there. It's just because where I work the management I think, use their power almost to make people fear them as opposed to respect. For me, I always respect people if they've got a lot of responsibility, I work better if I respect them rather than fear them and there's a lot of checking how many X-rays people do in a day and all

this stuff because there's people that kind of like to look busy doing nothing [...] They kind of start doing all this management stuff doing these different things about many X-rays you did in a day, how many you did a month and they do a league table of like who's done the most X-rays. And it's just not the right way to go about it for me cos everybody's then thinking, I've got to look after myself, got to get my numbers up and people stopped helping each other so you're doing like a ... pelvis lateral hip type thing and you're kind of moving the trolley, round under the trolley, nobody's helping you because they think well I've got the next card so I've got to get my numbers up. It's kind of they're kind of trying to frighten people into doing more work whereas I think people tend to work better if you're respected, if you respect your manager you go to him with a problem and they actually listen to your problem whether it's warranted or not. [...] I think there's very little respect for management at YYYYYY and that makes it very…can make it a very don't know what the right word is but it's basically bitchy it becomes very bitchy because there's nobody saying this is how it is get on with it or don't …just don't stand there moaning. [...] I remember in my interview for the job in the first place which was a year and a bit ago they asked me a question about what I disliked most about work and I said then I said I dislike it when people moan for the sake of moaning, kind of being a little bit naive I kind of thought that if I had a problem I'd sort it out and I wouldn't moan to somebody who can't sort it out, I wouldn't moan to my band five colleague about how much I hate doing that shift because what's the point I've got to do that shift [...] but you do kind of get caught up in that and in the last sort of six months probably since the last meeting I've been working really hard on just drawing myself back from it all and if I've got something that's upset me to the point where I don't think feel I can carry on I'll go and deal with it and go to management and speak to them. They don't always help me out and listen to what I'm saying but at least I've put it in writing or verbally spoken to them and said this is my problem [...] if they don't sort it out my decision is what do I do then but it's better than me moaning to my colleague, my peer because he's not going to change it anyway. [...] and that's kind of little one up here I always keep trying to remind myself to keep smiling

JHL: Yes

Ben: At work I remember in a lecture here once, I don't know who it was who was giving it but it was basically about going along to interviews and somebody told the story was that somebody had gone to a hospital for an interview and they'd smiled at somebody walking down the corridor on their way to the interview. It just so happened that the person they smiled at was the person who was going to interview her so they thought it's kind of this person has got a nice disposition so you've gone

in on the front foot already and I keep trying to remind myself that when I started this job. I was always smiling whether I felt like it I was smiling, I still smiled and I'm trying to get back into that because I like being happy, I like being happy at work and I've just got to stop letting everybody else and ignore all the rubbish which is pretty insignificant. It's not insignificant it's just there's no point in being miserable about it until there is a viable option to make it different ...

JHL – Mmm

Ben: Yes I just keep trying to smile and…

JHL: Excellent. What about this one?

Ben: That's just a bad day sometimes I come away and I just…it's frustration more than anything because you've gone in to do and really it is like it keeps coming back to this one really it's a simple job but you should have fun. You're talking to new people all day which I love so I should enjoy that I'm doing a job which I like doing, I like taking images whether it's X-rays, going out with my camera I still like producing images and I like to make them aesthetic so I take pride in my work. Everything should be really simple and enjoyable for me it's just when it gets…it becomes too much and that's when it's just how I feel just facial expressions sometimes I'm riding my bike and I'm thinking that I probably feel like my face is like that even though it's not. I'm still trying to put this smile on but inside that's what I'm feeling just frustration at such a, it's just such a shame because it is a good job, it's a nice job to have I enjoy it still and I want to enjoy it for as long as I can. I just, yeah, it's just how I feel sometimes inside and then sometimes I put this one in here sometimes I ride my bike home and I feel like that and I kind of feel like everything's good it's [...] but recently I'd say it's more been like that than it has that

JHL: More the frustration than the enjoyment?

Ben: Yeah... probably frustration is the biggest one I put this one in there because sometimes like I say the team are really good [...] but it still doesn't stop you having some days and feeling a bit sort of lost and a little bit is this really going to be my life for the next however many years? I have to do this cos it is it's not a short term thing it's a very long term thing [...] is this really going to be my life am I really going to be stuck in this happy one day, miserable for the next three, happy one day? And always kind of this hope and that's what some of these sunsets ..this kind of hope that you're gonna wake up and you're gonna have a nice day and then you go to work and it just falls apart and you have a horrible day but sometimes you do have a good day and you come home like that so…

JHL: And is it that hope that gets you to go in the next day?

Ben: And yeah it scares me that I'm gonna wake up and not have that hope cos then I'm thinking like what I do then, do I search for a whole another job? Is that even going to be any different, is it me, is it is it me that makes myself unhappy? Or I don't know, kind of analyse it sometimes and that's why I put that one in sometimes I get home and everyone's eating their dinner and talking around me I feel like I'm just sitting there I'm just lost sort of in the middle of nowhere om my own. It sounds really morbid doesn't it but I think it's kind of my own thought process though just I like to know where I'm going and I like to know how I'm going to get there and if I have a problem I like to solve it and that's where the frustration comes in cos there is no solution to the problem and I think well sod it all I'll go back to having my own job satisfaction and enjoying it and I have two or three good days and it flips back it's just like a vicious circle and I probably say it's me rather than I don't know maybe I'm being a bit hard on myself ...

JHL: It sounds like you know it's the environment that you're working in … to a certain extent that sort of culture perhaps of the way things are?

Ben: Yeah, I think you're probably right but until I go anywhere different and see if it's the same anywhere else I wouldn't know that. So that's basically what it comes down to, do you just keep sort of plodding along trying to make the most of things trying to make the best of it or do you seek to do it somewhere else in the hope that it's better there? [...] it's fifty: fifty about that I don't want to leave my job, I don't want to leave the department do the job anywhere else but if this is how I feel why am I not having that as a serious option? I just want like you say, just trying to get back to doing my job I loved it .. as a student I don't think I ever had a day when I came away thinking ooh I don't want to do that I don't want to work for that department any more. I loved it and I loved the whole student experience as a radiographer [...] it's probably a bit naive to think that you can go back to being like that cos you're not a student you've got to have some pressure on you else you're not doing your job I guess..

JHL: Mmm

Ben: I think the main thing for me is job satisfaction. I want to go back to enjoying my job and I want to have something to work on to be better rather than just kind of going in to to that every day which it can be. I want a little break in-between all the cars coming through so I can do something to better myself. Cos you don't get a chance to …. the actual techniques, practice makes perfect that's where you have so many hours as a student in practice but once you've got past the point where you need to practice to make things better, you get to a point where you think right

well I need to go and do something different that's gonna grab hold of me again. Like I had a week in [...] barium swallows that kind of thing which we don't seem, we don't get much diversity where we are at YYYYYY so I had a week in there training on some new equipment and I it was like somebody had flipped a switch. I'd gone back to ahh, this is great, this new equipment looking at new examinations I hadn't seen for a year and a half because I've been doing other things and I had such a good week. The week after that I was put back at an outpatient clinic a GP clinic and I was just like it it's like being flogged it's just .. all day it's two rooms three radiographers and you're doing 150 patients and it's just all day and it's not like fingers and hands it's, for some strange reason it's both knees, both hips, lumbar spine and it's almost every patient can be like that some days and it's…you don't get any time to learn and I don't mind having those days I just want to have the days where I can do something that's going to make me engage my brain and feel like I'm learning again not even learning just something where I have to actually stretch my brain rather than just the monotony of the same old thing all the time I don't, maybe I'm unrealistic ..

JHL: But you're right I mean in some ways there's a way of steering the boat ... and navigating this, so I mean what you've picked up on is really interesting it's all to do with work pressure and of course the pressure of imaging has increased a lot hasn't it but there's got to be a way of keeping afloat with your boat hasn't there while navigating this pressure?

Ben: Yeah, yeah absolutely.

JHL: And that's kind of where you've where I think you've kind of felt your mismatch and you're not quite sure how you're going to solve that problem…

Ben: Yeah ...... yeah while all these cars are coming through all these brand new cars coming through it all looks very nice for the car but everything else is kind of decaying round it everything's looking really old fashioned and sort of run down and that's what I feel like. I think all these new people coming through all the time and everything else around me is rundown, the equipment is run down, the equipment's like hanging on by a thread all the time it's always packing up so you're down to one room and it's just it just needs a little bit of .. I don't know it needs somebody to get hold of it and just pick it back up put it on a pedestal again rather than just think that's fine just get on with it cos I don't think that's the right attitude. I wouldn't want a radiographer to X-ray me if he had the attitude of I'll just get on with it. I don't want it to be like that I don't want to work like that, I don't want to be expected to work like that. I'm happy to do that providing that you can take care of what we're doing, don't don't push that down and just think they're just a radiographer, they are just

doing their job. We are just doing our job but don't treat us like that,treat us as though we deserve a little bit a little bit of like..... What's the wage we kind…of we don't do this job because we want appreciation for what you do, you just want to know that people do appreciate you for it. Does that make sense? You don't want somebody to sit you down and say you're doing a marvellous job, you're doing really well, it's such a wonderful place to work. You just want people to, you just want to know that people know that ….don't you don't want to be sung praises about you just want to know that people do appreciate it

JHL: So what's the hare about then?

Ben: Sometimes I just feel like running away. I love hares anyway, sometimes I feel like just... when a hare gets out of its burrow it'll get up and it'll do this stretch thing over their legs. They stretch their bodies out and then they run to get rid of their energy to stretch their muscles and I kind of feel , that's kind of how I feel I'm in a burrow at the moment and at some point I'm going to get up I'm going to stretch and I'm going to run for whatever. I don't know whether it's to a different place to work [...] and hopefully be happier and get some more job satisfaction or whether it's run off to something completely different I don't know [...] but that's sometimes how I feel like I'm waiting for that to happen. When I get up and I think right I'm ready to I'm making a decision now cos you can't just keep pushing me down, I will get up eventually and I'll make my own decision if you're not gonna change things make things happier take it into my own hands that's kind of how I feel

JHL: So would you say if you reflect over your year that it's had ups and downs?

Ben: Big time

JHL: Is it? Was it more ups to start with than, I mean how's it feel if you reflect back on your year, what you've actually been through and how you felt about your first year to where you are now?

Ben: [...] it's kind of as I expected it... people said to me the first year you learn more in the first year than you do in the three years as a student. I don't know if that's entirely true I think that's a bit of an exaggeration but you learn about things that aren't necessarily to do with the job […] in any walk of life any job you do you can have good days and bad days […] it's how they implicate or how they change how you work it's how they affect your work. Sometimes I think I've had a really good week but then I come crashing down I don't mind having a good week and it sort of tapering off or plateauing or but where it's up crashing down then you've kind of got pick yourself up and dust yourself off again and then you kind of slowly go up

crashing back down and that's how the whole year has felt. The first three months it was all about, I felt it was all about me getting to grips with the responsibility of being a radiographer having my own registration, fitting into the team and I felt that it was all quite good because I felt like my training was very good. I was very lucky to receive a very good training, I felt very confident to do my job and it was like a slow thing and then I went straight onto the rota and it came crashing back down again cos I'd gone in to nights and weekends and then you're again, you're having to build yourself up 'am I doing the right thing at night, do I feel confident at night, do I feel confident at weekends?' And you're slowly building yourself up, got to six months there's nothing else for me to then work on, again they're not going to throw anything new on me. I'm not going to start going in to CT, I'm not going to start going in to MR, I'm not going into interventional it's just about doing my job. At that point I kind of wanted it to just plateau and it can dip either way of that plateau based on a good or a bad day but it didn't it just crashed straight back down and now it's at the stage of six months onwards trying to get back up to something that gets me back up to that line again but there isn't anything, I'm just I'm kind of plateauing but I'm below where I want to be if that makes sense? So it's just it's just trying to find something that gets me back up there and then once I'm there it's kind having the, I don't know what it would be .. just having - being able to keep myself there, keep myself on that plateau so that I've got job satisfaction and that's what it comes down to really

JHL: So what caused the six month sort of fall?

Ben: It was just the sudden realisation that I felt very confident in my job and that was it, that's what I was going to be doing…the realisation I'm just going to come in…to monotony of it I think that's when I hit a wall that just well you feel confident so what do you do now...

JHL: This is it?

Ben: Yeah and I want to be pushed out of my comfort zone I think that's what it comes down to for me is that I need to be out of my comfort zone for me to enjoy my job whereas at the moment I just think I'm just in a plateau and where I'm being taken out of my comfort zone there is no answer to it. I'm being taken out of my comfort zone with the rota, the people being unhappy, the people leaving their job, people don't want to do nights, people don't want to do this and I've been dragged out of my comfort zone into that but there is no solution for that there is? I can't do anything, all I can do is do my job but now I've got this on my back as well so I want to get rid of that and get something that takes me out of my comfort zone in the right

way so I get back up there and then I can start hopefully get on my plateau and just continue learning [...] yeah that's what it feels like

JHL: So that learning is still important to you?

Ben: Hugely important I don't, I don't really care about the money obviously it's nice that you don't care about the money, you do else you wouldn't do it in the first place [...] but I don't care about promotion I don't care about getting up to the top of band five I don't care about getting to band six. I just want to be learning and I just want to come home from work and think I've been really good to my patients I've X-rayed today but I've also. I've also kind of pushed myself to be out of my comfort zone. Again it's…I don't know where I get that from, that's the hardest thing at the moment I'm kind of am, I am hanging fire waiting to get experience and then applying for band six jobs… am I hanging in at YYYYYY to apply for band six jobs cos they'll get me out of my comfort zone cos then you're expected to take a leadership role and then you're expected to do CT out of hours on your own? That is a whole other thing, am I holding on for that? Am I what am I doing, I just feel like I'm in a like a no man's land probably the best way of describing it. I don't know what my direction is, I'm kind of lost it comes back to that picture really [...] just kind of lost what am I doing, where am I going with this? I'm not ever going to be somebody who sits still, I'm not going to be able once I've achieved something, I think I've got to say what am I trying to achieve now and it's not because I want to climb the ladder it's not because I want to go anywhere I just like the challenge of having to get somewhere new and bettering myself really that's it and […] I think that's why I crashed and I stayed down there it's because I've not got anything to really engage me ..... I try to, I try to that's when it comes back to trying to keep happy. The patients and doing the job does keep me happy...

JHL: Mmm

Ben: But because I've got nothing else to focus on, it's always a toss-up between being happy because I'm doing my job with patients and all the other rubbish that is just completely irrelevant there's no point to it whatsoever other than people making themselves feel bad because they're moaning about it [...] This one I put in I was going to put in a picture of my family but I thought I would just put a picture of these two because they are kind of family, my family's kept me going ... so ... that's really important to me I wouldn't have […] there's been days where they've kind of kept me on the straight and narrow. It's not like I'm gonna go off and just do a runner and disappear sometimes they just bring everything back in to [...] what's the word

JHL: Perspective?

Ben: Perspective yeah. [...] I go home as soon as that happens they, it normally happens when I'm in a really bad way with work and I just think what am I doing why am I doing this? I come home and something will remind me…putting it back in perspective and it'll all go back and settle down again so. But it's for me from now on it's just kind of it's just trying to find something else to engage me just to keep me going cos I'm not very good at sitting still.

JHL: And what are you going to do then about that do you think?

Ben: I don't know at the moment.

JHL: Is it still for a bit longer?

Ben: I have applied for other jobs and it's kind of because of the two reasons at the moment I don't get any experience in typical band six roles which would be CT, MR [...] interventional. I don't get any rotation through those so I kind of feel if I get to eighteen months I'm applying for band six jobs elsewhere I'm already at a disadvantage to people who have had that rotation as a band five so that kind of worries me and that comes back to the sinking ship I don't want to be stuck as a band five radiographer with no prospects. [...] so sometimes I feel like it would be wise for me to get into a department that's got a more versatile rotation through different departments

JHL: Yes

Ben: There isn't much scope at YYYYYY it's fairly narrow in terms of the kind, of the general consensus is that you apply for band six once you've got your band six post then you get CT competent and that's it. You're then back on the horrible what am I doing thing. [...] whereas there's hospitals elsewhere fairly locally that would offer much more even if you were a band six radiographer where there's potential for going off and doing being a mentor being CT, MR trained ..

JHL: Okay

Ben: [...] nuclear radiographer, nuclear medicine that kind of thing there's so many different ways you can go with your career whereas YYYYYY's it's almost like staring down the barrel of a gun sometimes you think do I even want to be a band six? Do I want to go on the rota, do I want to just get stuck in a different monotony which is CT everyday CT in out in out? That's what CT is but there's a difference between doing that and where I was, where I trained where it seemed to be accepted that everybody was always learning, they was always trying to make things better not for the sake of moaning but because they actually wanted to make it better for the patient, for them. So I don't know what ... I kind of I'll apply for jobs, I'll interview and even if it turns out to be experience but at least for the time being

I'm out of my comfort zone because I'm thinking ooohh I might have to interview somewhere and that makes me nervous and that makes me think ohh I've got to read up I've got to sharpen up I've got to...

JHL: Research?

Ben: Yeah and just... appear as though I'm not just stuck in a rut so that's kind of nice ,that's kind of forced it out of me and in the last couple of weeks I have been applying for other jobs and I have kind of been slowly working my way back up and actually feel a lot better at work because of it. Whether it's going to put me in a nice position if I get offered another job cos the I've got to make a decision but at least for the time being I'll cross that bridge when I get there

JHL: Mmm

Ben: I need to be engaged and I'm not very good at monotony I don't deal very well with just the same old thing every day I want to be challenged and I think this career does give it, I just think that the department I'm in isn't that kind of department I think it's ... just a little bit narrow for me I think I don't know if that's the truth but...

JHL: But it's your experience of what and how it is for you that's important. So what would you say to a new graduate about their first year what kind of thing would you say to them well you know?

Ben: [...]...

JHL: Any advice you'd give them?

Ben: Just be prepared, just to be prepared to deal with the ups and downs of it cos there will be ups there will be downs and it's... it's learning how to deal with those negative and positive experiences. The positives are great but I don't necessarily think it's how you react when things go well it tends to be how you react when things are going bad that kind of show you the type of person you are so.. yeah I would just tell people to be open minded just try and enjoy their job try not to get involved in all the stuff that is doesn't mean anything just for the sake of it […] ..I don't know what else what I'd say to them really just try and enjoy. Just remember the patients are the reason we're there in the first place I think sometimes that can get a little bit overshadowed. Always remember the patients are there and that's why we're there not for any other reason. We're there for the patients [...] I do I've got like a little it's not a project it's just, if I just have a funny experience with a patient I, if I have an experience, even an experience that upsets me I've started um documenting them obviously anonymising them I don't put anything serious it's just little things that kind of make my day good. I had an experience with a kid where she had a doll and I said 'so what's the doll's name and she said it's a doll why

would I give it a name?' and just things like that just they cheer you up when you're at work and I just write down the whole experience in a bit more detail it's actually like turning into a little bit of a small book really

JHL: Interesting

Ben: Of all these experiences I've had cos we meet so many people there's very few jobs where you meet so many people on a daily basis that are from different walks of life. I kind of try and get back to that and that's probably another reason why I'm kind of trying to work my way back up again because I'm just trying to actually indulge in the good parts of my job, a good part of my job which is kind of […] what I, that's the experience or the advice I'd give people is indulge in the good parts of the job and disregard the rubbish stuff because it's not important and it's working out what's important to you and what's not important to you...

JHL: Mmm

Ben: It's all the clichéd stuff that you get in like in job books and career advice and it's true for a reason. I think you probably won't admit it but that would be my advice really enjoy and take hold of the good stuff and try and disregard the rest because it's not important...

JHL: Good. Brilliant. Thank you very much

Ben: It's all right

APPENDIX XIV:

The Research Ethics Wheel (Hammick, 1996, p37)
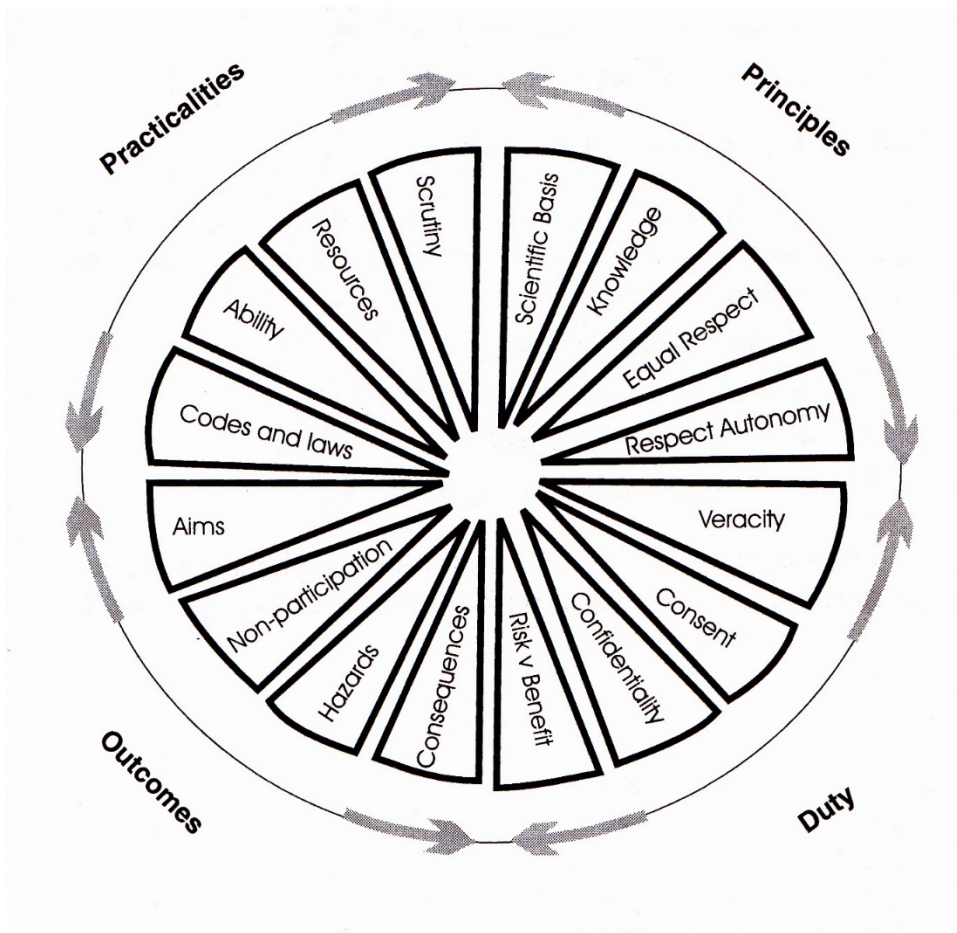
APPENDIX XV:

Participant Consent Form

Informed Consent Form

Title of Research Project: An exploration of the experience of newly qualified practitioners during their first post as a diagnostic radiographer in the NHS

Researcher details:

Name: Jane Harvey-Lloyd

Contact Address:

Contact email address:

Please read the following statements and put your initials in the box to indicate that you have read and understood each statement:

1) I confirm that I have read and understood the information sheet (dated) for the above study.	
2) I have had the opportunity to consider the information, and to ask questions and I have had these answered satisfactorily.	
3) I have read the information sheet and I understand the principles, procedures ands possible risks involved	
4) I understand how the data collected will be used and that any confidential information will normally be seen only be the researchers and will not be revealed to anyone else	
5) I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. This will not adversely affect me in any way.	
6) I agree that should I withdraw from the study, the data collected up to that point may be sued by the researcher for the purposes described in the information sheet	
7) I understand that interviews will be audio-taped, and that any quotes may be used in publications. I understand that I will not be identified from any quotes used.	
8) I agree to take part in the above study.	

Name of Participant:

Date:

Signature:

Name of Person Taking
Consent:

Date:

Signature:

APPENDIX XVI:

Summary of Individual Participants' Journeys

James

At the first interview, James was clearly disillusioned by the lack of structured support he had received and had very much felt that the first few weeks were a 'whirlwind of ups and downs.' He compensated for this lack of support by forming a very strong peer group network with two other new starters with whom he discussed how he was feeling during this time. However, James was quite confident in his abilities and coped well with the other challenges such as learning new protocols, working with new equipment etc. but similarly to other participants found the early weeks very tiring. He was quick to pick up on the hierarchy within the department and felt that this was underpinned by the culture within the department which expected the newly qualified radiographers to pick up all the extra shifts and bank holidays. James was very ambitious even at the three month interview and was already starting to look at band six posts, by the time I interviewed him again at 6 months he had applied for two posts. Learning to manage students was a key learning point for James as he had to develop patience whilst teaching, learning to step back whilst still taking responsibility for the patient.

James developed his independence quickly and was an active member of the team and interprofessional teams early on. At the twelve month interview, he was proud to have made a positive contribution to the department and regarded being part of the developments during his time with them a privilege. Picking up on what his described as apathy within his department, he was at this point looking to move where there would be more opportunities and where he hoped he would be more successful. James left for another band 5 post after just 12 months at this hospital.

Ben

Ben found the first few months of transition to his new department very stressful. Although he had a preceptor, there did not seem to be any structure to this support and this left him struggling at times. He found learning the new protocols and new ways of working very challenging as he likes routine and in the early days he found it really difficult to establish a consistent approach to his work. The lack of clear guidance was clearly something he initially found problematic and this was exacerbated by a lack of feedback which again he found difficult to come to terms with. To cope with the lack of feedback, Ben spent much of his time working in the operating theatre. Due to the role of the radiographer in theatre, immediate feedback is received from the surgeon on the images acquired and this helped to fulfil Ben's need for feedback. The steep learning curve during the first few months combined with the increase in working hours often left Ben exhausted and to begin with he slept when he got home from work and some weekends to recuperate.

At the six month interview, Ben had started working shifts and was feeling more comfortable in his role. He was enjoying the independence that shift work offered him

and the opportunity to work in much smaller teams. Although throughout the interviews Ben spoke about the importance of teamwork and the support of the team he had also identified a competitive culture within the department whereby radiographers compared the number of X-ray examinations that has undertaken against each other. This is something that Ben found difficult to understand and actively avoided taking part in. At about six months, much of Ben's stress had turned to boredom and he spoke candidly about how monotonous parts of the role were already becoming. He felt that the promotion prospects where he was would not open up quickly enough and as a result at the end of the first year he left the department for another band 5 post.

Adam

Adam was one of quite a few new starters. He found the amount of learning he had to undertake in the first few weeks very overwhelming. This was compounded by the preceptorship scheme which contained a lot of task-orientated activities. On further discussion, this also seemed much more akin to an induction scheme which Adam found irritating as he felt that at times this held him back from progressing more quickly. However, the department did arrange for newly qualified radiographers to be rotated around the department in pairs and Adam found this form of peer support really useful, especially in the early weeks. Adam was also at this time feeling lonely and isolated having moved from home to a new place, although he was pleased to be working with a younger group of radiographers than where he had been as student. He rapidly became very attuned to his working environment, recognising the need to be accepted into the team quickly and he worked very hard on this by getting to know the people he worked with. He also went above and beyond to help out when needed and as soon as he was able to he began working some of the less popular shifts.

Adam developed an interest in teaching quite early on but struggled with the fact that the students came from three or four different universities. When we spoke at six months, students where one of his biggest sources of stress. However, one of the things that Adam readily adapted to was being able to liaise with other healthcare professionals, something which he had struggled to do as a student. This helped him to enjoy the shift work, although he got frustrated with the lack of knowledge that other healthcare professionals had about the role of the radiographer.

At the twelve month interview, Adam was feeling bored at times by the repetitive nature of the role and also discussed the pressurised working environment. However, he had begun taking on extra responsibilities with students and had also been to teach at a university. Now settled and feeling that the department had allowed him to become the radiographer he wanted to be, he was applying for internal band six p

Harry

Harry, a naturally quiet person and by his own admission inherently laid back, did not seem to experience the level of shock or stress that the others did. He was disappointed by the lack of formal support but overcame this by using his peer group for this purpose. This strategy seemed to work well and helped Harry cope with the first few weeks. Although Harry thought he had been well prepared for the role his biggest challenge was to believe it and to become confident in his own abilities. This was exacerbated by a few of the experienced radiographers coming in to the X-ray room where he was working and taking over the examination. It made him feel like a student again and he pulled back and let them take control by going to do something else. However, when we met at six months this had changed completely and he found people asking him for advice.

The hierarchy within the department was something that Harry picked up on quite quickly and he felt that at times more experienced staff pressured the newly qualified radiographers to undertake additional or unpopular shifts. There was also a culture whereby the new starters were expected to undertake other meaningless tasks, some of which were unrelated to radiography. He did not feel that he could raise this with anyone for fear of how this might affect his progression.

When we met at six months, Harry was finding the additional stress of having to supervise and teach students difficult to cope with, particularly when busy. He gave an example of when he lost his patience with student because of this and although he did apologise to the student at a later date it did make him feel guilty. Despite the fact that Harry had discussed the apathy of the radiographers he worked with, in his twelve month interview he spoke about his pride in becoming a super user and core trainer. He felt that his knowledge and expertise had been recognised and was relishing these roles. As a result he seemed content to stay at the hospital and reinforce and expand his knowledge and experience.

Gareth

Gareth was also one of a few new starters and was impressed by the thorough induction he was given. There was also a six month preceptorship scheme in place but again this seemed very task focussed and he found the amount of information given at this stage overwhelming. As well a meeting with his appointed mentor he also met with the superintendent radiographer every other week in a group with this peers. All the newly qualified radiographers were sent regular weekly emails with updates and positive feedback. He was impressed with this support and level of feedback he had been given and felt that they had put a lot of support mechanisms in places for the new starters. By the time we met at the six month interview, this support has decreased significantly but Gareth seemed comfortable with that. The main issue for Gareth in the first few months was getting used to working with different imaging equipment and learning new protocols, this was compounded by being in a new department where the structure was very different to where he had been as a

student and he often felt out of his depth. However, Gareth progressed quickly from this feeling to times where he used his initiative and started to lead a small team within the department and this something that he relished.

At his six month interview, Gareth reflected on how welcoming and dynamic he had found the department and felt that this may be related to the younger age range of the radiographers. He did however, quickly pick up on the hierarchy within the department although by six months he had already started to prove himself a valued member of not only the radiography team but also the interprofessional team. At this stage he had already started to think about specialising. Nevertheless in his final interview he was having second thoughts about staying in the profession altogether, or at least taking a few years out to reassess his future.

Jane

When we first met, Jane was evidently disappointed that the department she had joined no longer ran a preceptorship scheme, although she had been appointed a mentor. They met a few times but Jane was happy to rely on other staff to support her. Jane found the first few weeks an immense shock and this was linked to fitting into a new department, learning new ways of working and dealing with the responsibility of the role. She felt that she had started again, from the bottom and was desperate to prove her worth and to feel useful. This heavily impacted on her enjoyment of the role in the early days of transition. At this time she was also unsure that if the watchful eyes of the experienced radiographers were there for support or making a judgement and she linked this to the fact that she had undertaken her practice placements elsewhere. She felt as though she needed in some way to be given a seal of approval and initially this affected her confidence.

By the time Jane spoke at her six month interview, she had begun to develop her confidence and was beginning to feel a useful member of the team. Although she had noticed the hierarchy when she started she had only spoken about radiographers that were obviously in charge. Now, however she had begun to notice the more subtle hierarchy and internal politics of the department. When reflecting at her final interview, Jane was really starting to enjoy the pressure and responsibility of the role even if a times it felt like a conveyor belt when it became busy. Her interprofessional communication had improved and she was now readily able and willing to liaise with a range of professions in her role. As she began to feel comfortable and settled wider professional issues had started to surface which as a student she had paid little attention to. Now enjoying herself, Jane seemed more than content to stay at the hospital and build up her knowledge and experience.

Rebecca

Rebecca was the only new starter in her department and was the first newly qualified radiographer to have commenced for some months. On speaking at her three month

interview, she had found the experience of changing from a student to a radiographer scary. She linked this to the overriding responsibility of making decisions and felt that she lacked confidence with undertaking this and still sought the approval of others. During the first few weeks she was given competency-based training which focused on developing skills in particular areas of the department, she was also given a mentor. Rebecca found the staff to be very supportive of her but admitted that for her fitting in was the hardest aspect of her transition to a newly qualified radiographer.

Rebecca had moved to a very large hospital and the workload pressures were very challenging. In the early months she lived in constant fear of making a mistake because she felt compelled to rush through examinations due to constant demand. She started working out of hours within the first three months and was regularly working long hours. Although constantly tired she found that this experience helped her to develop her confidence and when we spoke again at the six month interview she felt that she had started to trust her instincts when making decisions. One of the things that Rebecca was struggling with at this point was dealing with angry patients and also caring for those patients for whom English was a second language.

Even in the first few weeks, Rebecca loved working with students and even though some had been challenging she had felt comfortable teaching them. However, giving them constructive feedback had proved more difficult to master. By the time Rebecca reached the twelve month interview, she felt much more confident and assertive in her role. She was evidently proud of what she had achieved and was happy to stay where she was and develop further.

Ruby

From very early on, Ruby felt under a lot of pressure to learn and progress quickly and she admitted that she found this terrifying. At the time she spoke about herself being a ticking time bomb as she was in constant fear of making mistakes. She spoke in detail about her frustration and disillusionment about the lack of support she was given even though there were a couple of new starters. She had a four week induction during which she as supposed to remain supernumerary but in practice this only happened in the first week.   There was no structured support given and because she had moved away from home, she had also lost her previous support networks on which she had come to rely. One of the managers was particularly difficult and would often belittle staff and Ruby found this difficult to cope with in the early weeks. The department was very short staffed and Ruby found herself undertaking a lot of extra shifts early on in her transition period and although this was at the time difficult she felt as though this helped to develop her confidence.

Ruby openly spoke about how she struggled to cope with students and her reluctance to let them do anything as she felt uncomfortable putting her trust in someone else. As time went on she began to get used to her new environment and began to settle in.   At her twelve month interview, she spoke candidly about her absolute determination to survive during those early months and the department remained very

short staffed.   However, she was loving her job and proud of being a radiographer. The patients were central to this as Ruby often saw patients on a recurring basis and was able to build up relationships with them and their family. Ruby seemed settled and was planning to stay to gain more experience.

Charlotte

Charlotte was one of a few starters and found the first few weeks absolutely petrifying. She found it difficult to come to terms with the weight of the responsibility she now held and was constantly worried about making a mistake and being struck off. The new environment resulted in her lacking confidence in her own abilities and she was only given a very short induction. Although Charlotte was appointed a mentor she had never met with them. One of the other aspects that Charlotte struggled with was adapting to working with different equipment, some of which was much older then she had previous experienced. This took her out of her comfort zone and also some time to get used to and she was pleased to have had a supportive team around her. There were also a lot of young radiographers and some new starters in the department who she felt able to share stories with and this helped her to put some of her concerns into perspective. This was a really positive experience for her.

When we met again at six months, Charlotte had increased in confidence and was feeling much more part of the team. It was important to her to feel able to fully contribute to the team and she was beginning to feel that this had become a reality. She was still finding working with students challenging but had started to overcome this. Initially, she struggled to manage students because she felt that still developing herself and it was an additional pressure. At her final interview, she was feeling much more comfortable about communicating with other healthcare professionals across the hospital and working out of hours had helped her to do this. Charlotte was now noticing some of the wider issues and in particular the changes to radiographer's shifts which was going to have a huge impact on the staff within the department. Despite this she was feeling happy and settled and content to study in order to increase her knowledge and experience.
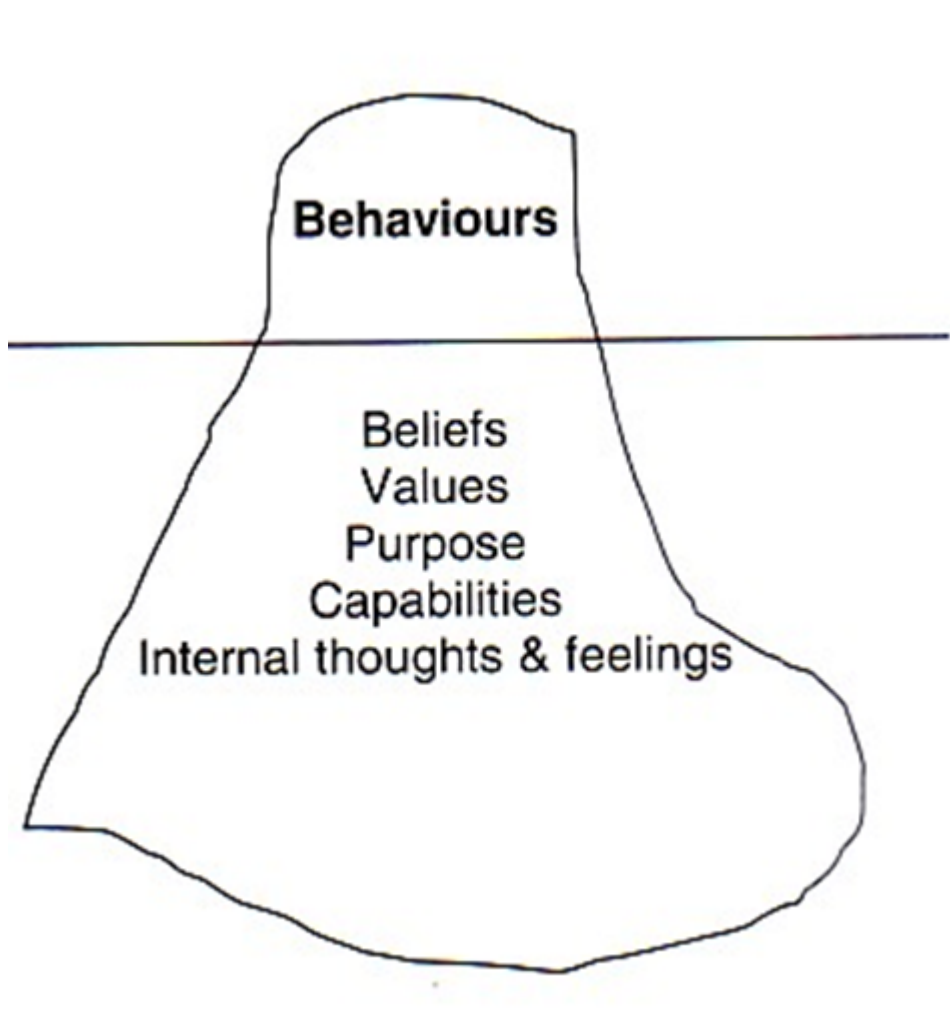
APPENDIX XVII:

Bath People and Performance Model
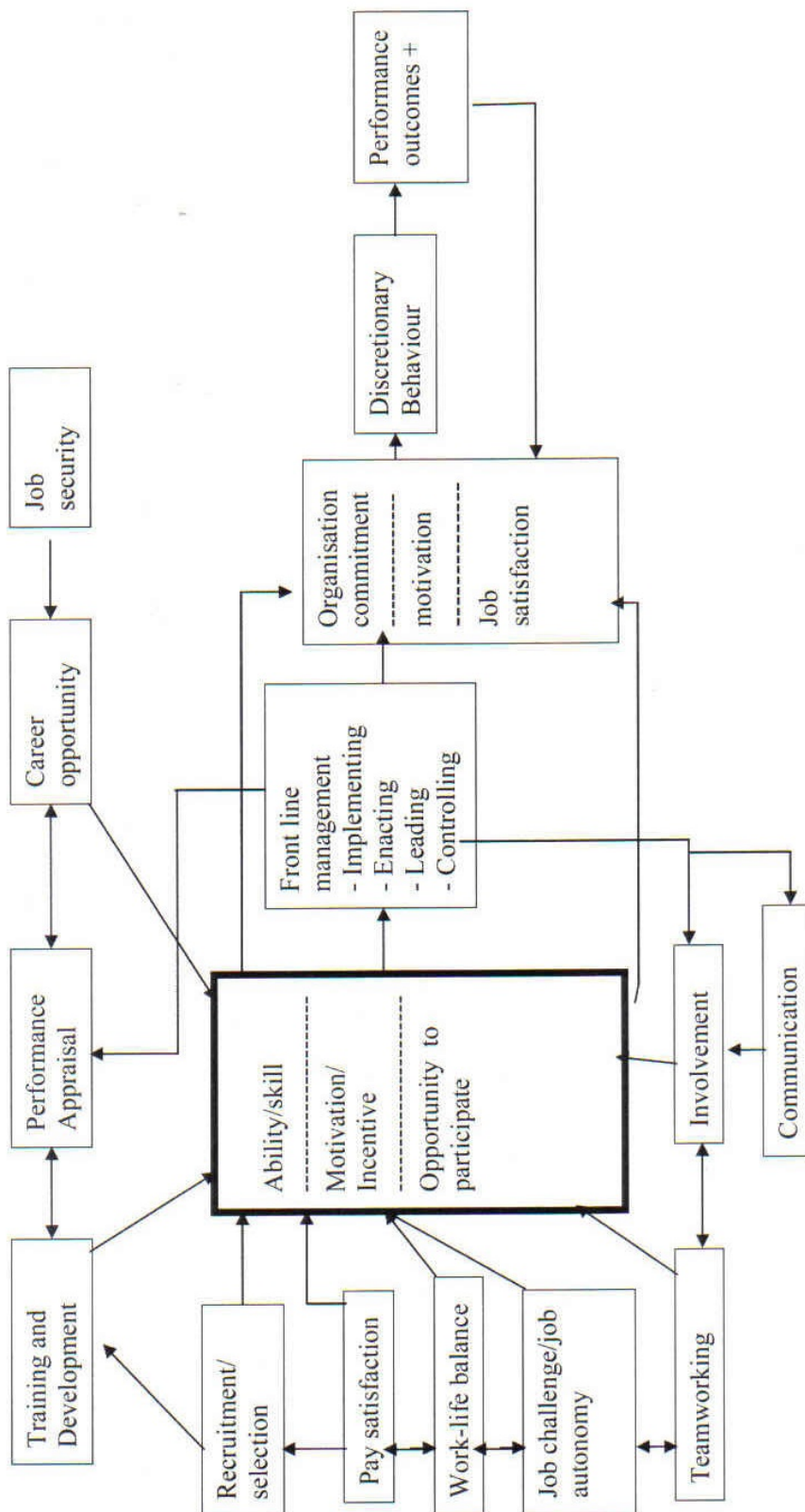
(Purcell et al., 2004)

APPENDIX XVII:

The Iceberg Model

Behaviours

Beliefs
Values
Purpose
Capabilities
Internal thoughts & feelings

(Knight, 2002)

APPENDIX XIV:

Dissemination from PhD to date

Harvey-Lloyd JM (2016). Utilising them boards as a tool for reflection in education and research. *Achieving Excellence in Radiography Education and Research 2016, 25th-26th November 2016. Birmingham Conference & Events Centre, Holiday Inn Birmingham.*

Harvey-Lloyd JM (2016). The transition of diagnostic radiographers during their first twelve months in practice. *BJR Congress series. Proceedings of the UK Radiological Congress 2016: p-247*

Harvey-Lloyd JM, Stew G & Morris J (2016). Being and becoming a radiographer. *The National Association of Educators in Practice Conference 2016, Identity and Practice: Responses to future needs. 15th April 2016. Coventry University.*

Harvey-Lloyd JM, Stew G & Morris J (2015). Exploring the transition period of diagnostic radiographers during their first six months of practice. *BJR Congress series. Proceedings of the UK Radiological Congress 2015: p-167.*

Harvey JM (2014). Being and becoming a radiographer. *University of Brighton, Annual Doctorate Conference 2-4th July 2014. .*

Harvey-Lloyd JM (2014). Exploring the transition period of diagnostic radiographers during their first three months of practice. *BJR Congress series. Proceedings of the UK Radiological Congress 2014: p-143.*

Harvey JM (2013). Exploring the experience of newly qualified practitioners – being and becoming a radiographer*. University of Brighton, Annual Doctorate Conference 5th July 2013.*

Harvey JM (2013). Exploring the experience of newly qualified radiographers. *University Campus Suffolk Annual Research Colloquium, 27th June 2013.*

Harvey JM (2013). Being and becoming radiographer – methodological challenges. *Engaging With Methodology Conference 31 May 2013, University of Brighton.*

Harvey-Lloyd JM, Stew G and Morris JM (2012). Role transition: From student to practitioner. *Synergy Imaging and Therapy Practice, June 2012, p9-14*

Harvey JM (2012). My Professional Doctorate journey so far. *University of Brighton, Annual Doctorate Conference 20th July 2012.*