



**Becoming a Health Profession Educator in a University: the experiences of recently-appointed lecturers in Nursing, Midwifery and the Allied Health Professions**

Pete Boyd<sup>1</sup>  
Caroline Smith<sup>2</sup>  
Sue Lee<sup>3</sup>  
Iain MacDonald<sup>4</sup>

University of Cumbria

1 Principal Lecturer, School of Educational Partnership and Enterprise

2 Senior Lecturer, School of Rehabilitation & Public Health

3 Director of Studies, School of Nursing & Midwifery

4 Senior Lecturer, School of Medical Imaging Sciences

With:

Paul Bunyan: research assistant

Jo Peel: research administrator

and

Annie Powell-James, Senior Lecturer, School of Nursing and Midwifery

This project was supported by funding from the Health Science and Practice Subject Centre of the Higher Education Academy in collaboration with ESCalate, the Education Subject Centre.



## Table of Contents

Executive Summary .....	1
Chapter 1 – Introduction.....	3
Chapter 2 - Background literature .....	8
Chapter 3 - Methodology .....	18
Chapter 4 - Results .....	28
The experiences of newly appointed lecturers in Nursing, Midwifery and the Allied Health Professions.	30
A: Managing self.....	31
B: Support for new lecturers .....	37
C: Activities of new lecturers.....	40
Summary of findings .....	49
Chapter 5 – Discussion .....	51
Chapter 6 – Limitations, conclusion and implications .....	57
References.....	60
Appendix 1 - Data bases and journals searched. Inclusion and exclusion criteria.....	66
Appendix 2 – The on-line survey instrument.....	64
Appendix 3 – The coding framework .....	65

## Tables

**Table 1:** Summary of professional body requirements for students

**Table 2 :** Summary of coding framework

**Table 3 :** The open questions within the survey.

**Table 4 :** Sample size and Response Rate

## Figures

**Figure 1:** Breakdown of Sample by Profession

**Figure 2:** Importance of support networks perceived by new lecturers

**Figure 3:** Individual priorities of the role as perceived by new lecturers

## Executive Summary

This study was designed to investigate the experiences of new lecturers in higher education in the UK in the professional fields of nursing, midwifery and allied health professions (occupational therapists, physiotherapists, diagnostic radiographers and therapeutic radiographers). The small body of existing research suggested that the transition for these practitioners as they become lecturers in higher education is challenging and that current forms of support during induction are not always effective. This study asks how new health care professional lecturers experience their transition from clinical to academic roles. It focuses on the first five years of experience after appointment to higher education and aims to inform strategies for academic induction.

The aim of the study was to gather data from academic staff in the full range of institutional workplace contexts with a variety of institutional priorities and expectations. An on-line survey was designed to capture some demographic data and especially qualitative data asking lecturers in nursing, midwifery, physiotherapy, occupational therapy and radiography about their experiences. Preliminary contact was made with all relevant universities to seek permission to distribute the survey and to establish the potential sample size in terms of the number of relevant staff. The survey link was then sent via named contacts in each participating university to all nurse, midwifery and allied health professional staff. The use of the online survey tool ensured anonymity of the respondents, and the method of distribution allowed for a broad estimate of response rate. A total of 504 academic staff responded to the survey. 146 of these were in their first five years of working in higher education and it is these responses that form the data for this report. The responses of the more experienced lecturer respondents will be considered in a further analysis. The responses of each professional group were coded and subject to thematic analysis.

A number of key themes emerged from the analysis. In the UK new university lecturers in nursing, midwifery and allied health professions are generally appointed after establishing themselves as expert clinicians with associated practices and identities. They find the mid career transition to their higher education roles challenging. They generally enjoy the challenge, feel well supported and are highly motivated by nurturing new practitioners. They experience considerable tensions within their transition related both to managing their new role and the different workplace activities and priorities within it. Only a small minority of the new lecturers hold a doctorate on their appointment to higher education, they mainly see gaining a doctorate and becoming research active as an important ambition but the pressures of their working lives make this difficult to prioritise.

Whilst many of the experiences of the sample group mirror those in other professional fields, some differences specific to this group of academic staff, and between the different professional fields included in the study, do exist. From a workplace learning perspective in which practice shapes their multiple identities (Wenger, 1998), the newly appointed higher education lecturers in nursing, midwifery and allied health professions respond to their experiences by holding on strongly to their identity and credibility as a clinical practitioner rather than more quickly embracing new identities as a scholar and researcher.

In light of the study findings, recommendations to enhance the induction of newly appointed lecturers in nursing, midwifery and allied health professions are as follows:

1. Newly appointed lecturers in nursing, midwifery and allied health professions should be encouraged to build on their primary motivation, to contribute to the development of new clinical practitioners, in order to see this role as also including a contribution to the development of new professional knowing through application of scholarship and research.
2. In reviewing the formal and informal provision of support for new lecturers, departments should consider what models for building an academic identity are available and how reward and recognition structures and cultures influence the selection of such role models by new lecturers.
3. Departments need to review their formal arrangements for the induction of newly appointed lecturers in nursing, midwifery and allied health professions in order to support proactive professional learning and identity work towards becoming an academic. This means that whilst development of teaching is important there is also a need to support new lecturers in their professional learning with respect to working in higher education organisations, their changed role within healthcare work settings and especially in their scholarship and research activity.
4. Departmental leaders and relevant academic development staff need to nurture informal workplace learning opportunities, such as collaborative teaching and assessment, research networks and informal mentoring, in order to move towards the development of more expansive workplace learning environments.
5. Departments and higher education institutions need to set realistic expectations for the workload of lecturers and for scholarship and research within this. They need to provide effective workplace support for time and workload management so that excessive stress is avoided during the induction period which new lecturers generally find enjoyable but challenging.

## Chapter 1 – Introduction

### Rationale for the research

Major changes in the provision of pre-registration education programmes for many health care professionals (including physiotherapy, radiography, occupational therapy, midwifery and nursing) occurred during the 1990s. Programmes which had traditionally run in a variety of settings, including hospitals (radiography, physiotherapy), Schools and Colleges of Nursing (nursing and midwifery), Colleges of Health (physiotherapy), or uni-professional colleges (occupational therapy) moved into the higher education sector, (out of the NHS service) as professional bodies negotiated degree entry status for some or all of their graduates.

The majority of university staff involved in the delivery of health care programmes have a clinical background, with a pre-requisite of employment being that they hold a recognised professional qualification, as per professional body requirements and state registration (HPC, 2005; NMC, 2004a & 2004b). Initially, many staff moved with the existing programmes, transferring from existing college or hospital teaching roles into higher education departments; more recently, senior clinicians have been recruited from practice, many having studied to Masters level (or above) and / or are actively involved in research.

Seniority in the clinical field is associated with a combination of increased clinical expertise and autonomous decision-making, clinical and managerial responsibility, postgraduate study and continuing professional development (CPD), mentoring or supervision of more junior professionals, and inter-professional liaison; on top of which the advisory nature of the health care professional's work demands abilities and skills closely associated with teaching e.g. advising clients, patients, carers and other professionals about a wide range of issues associated with health promotion and facilitation of recovery through the management of health related problems (HPC, 2005; NMC, 2005). Advancement through the professions is reflected in the NHS Knowledge and Skills Framework (DH, 2004) as part of the Agenda for Change framework.

This combination of clinical expertise & autonomous practice, teaching and mentoring experience, post graduate study, and organisational ability would suggest that health care professionals have many skills and attributes to equip them for roles as lecturers in higher education. However, the concurrent

requirement for clinical expertise, makes the more traditional route to academia, via doctoral thesis and research as in for example, history and English, less likely for health care professionals than other faculty staff. This may imply that health lecturers will be less confident in their academic abilities because of their limited exposure to the higher education environment.

Existing studies which have considered teachers (Murray, 2007) and health care lecturing staff (McArthur-Rouse, 2008; Wright, 2007; Boyd & Lawley, forthcoming) moving from vocational professional work to higher education suggest that the transition from clinician to lecturer poses a considerable challenge for many who have made the move, in spite of academic induction programmes and the provision of formal, academic qualifications in learning and teaching.

This research seeks to discover whether the challenges of moving to lecturer posts in higher education, as described by teachers, nurses and occupational therapists in the small preliminary studies, is symptomatic of the wider population of lecturers in nursing, midwifery and some of the allied health professions. The research seeks to explore the experiences of these groups of lecturers, to consider emergent themes and to identify differences between professional groups. This is done to inform future academic induction for health care professional staff, line managers and institutions, and with a view to potentially reduce attrition of staff, increase staff satisfaction, thus ultimately improving the student experience.

## **Clinical and Professional Background**

As the ownership and governance of professional programmes passed from the professional bodies to joint arrangements with higher education institutions, so the traditional route to health care professional educator has become less rigid. Prior to pre-registration courses being run in higher education, many programmes were closely linked to or based in hospitals. Teaching staff typically followed the route of specialist - professional teacher training and were often experienced and senior clinicians undertaking a (post-graduate) teaching diploma. The one year diploma offered supported and supervised teaching practice, with continuous assessment of teaching as well as academic study of pedagogical issues. This served as a type of apprenticeship, the result of which was a profession -specific qualification (e.g. DipTP for Physiotherapy, and Registered Nurse Tutor - RNT - for nursing). A high proportion of the teaching was skills based, following uni-professional, skills-based curricula.

Major changes in NHS practice included a plethora of legislation and policy guidelines regarding the development and implementation of clinical governance (Department of Health, 1997; NHSE, 1999; Department of Health, 2000; Commission for Health Improvement, 2001; National Patient Safety

Agency, 2001), evidence based health care (Muir Gray, 1997; Department of Health, 1999), and an increased emphasis on inter-professional working (Calman, 1998; Kennedy, 2001; UKCC, 2001).

These dramatic changes were reflected by changes in the pre-registration professional curricula in the past two decades. The move to higher education further reinforced the need for students (and staff) to actively engage with the academic process and critical enquiry as part of their route to qualification as competent health care professionals. University staff are increasingly required to engage with the delivery of complex curricula and to actively engage in research; research output being a priority in many higher education institutions since the introduction of the Research Assessment Exercise in 1986 (Roberts, 2003).

Vocational health care professional programmes have been described as staff intensive due to the skills based nature of the curricula, demanding relatively high contact hours (HPC, 2005) and the demand for professional competence on graduation (HPC, 2005; NMC, 2004a; NMC 2004b). All programmes require the inclusion of practice placements for students– see table 1.

**Table 1: Summary of professional body requirements for students**

Professional body	Theory hours specified	Clinical practice hours specified
College of Occupational Therapists	Not specified by the Health Professions Council. Integration of theory and practice must be central to the curriculum to enable safe and effective practice.	The number, duration and range of placements must be appropriate to the achievement of the learning outcomes (Health Professions Council, 2005). Professional Bodies recommend 1,000 hours.
Radiography		
Physiotherapy		
Nursing & Midwifery: Nursing	2300	2300 including a 3 month placement at the end of the course
Nursing & Midwifery: Midwifery	50%	50%  Enough to achieve the stated proficiencies for autonomous practice as a qualified midwife

Academic staff involved in the delivery of these pre-registration programmes, are usually involved in specific subject -based teaching, inter-professional education, curriculum development, research, and clinical partnerships either as mentors, work-based learning facilitators or in academic link visits, as well

as taking on a variety of faculty or University roles e.g. academic standards, validation etc. The Health Professions Council and Nursing and Midwifery Council, place further demands on their members in relation to ensuring currency of practice (HPC, 2005; NMC, 2004a; NMC, 2004b). Allied health professionals are required to be actively involved in professional activity, which may or may not involve clinical work. The Nursing and Midwifery Council requires that nurse teachers have a recordable teaching qualification and states that nurse lecturers must have a 20% engagement with clinical practice (although the activities this may include are not specified). Midwifery lecturers are required to be practising midwives if they are teaching the application of theory to practice, as well as possessing the recordable teaching qualification. Furthermore, any higher education institution offering pre-registration midwifery courses must have an identified Lead Midwife for Education whose role is to lead the professional speciality, as well as assessing students' suitability for the profession.

Nursing and midwifery teachers are required to confirm that they have adhered to professional body requirements for post-registration practitioner activity and continuing professional development. The professional bodies, therefore, have a significant influence on expectations for lecturers in this area, with a clear underpinning message regarding the primacy of clinical practice and specific subject knowledge. The question around the continuing clinical practice of nurse educators is contested and has implications for the range of lecturer roles and identities that may be acceptable within a university department (Barrett, 2007).

### **Professional socialisation & transition**

The path to qualification and registration as a health care professional is clearly defined, with practice placements providing students with what are effectively periods of socialisation into their chosen profession as well as a variety of templates for practice. In contrast, many new health care professional lecturers move to an academic post, and begin working as an academic by virtue of their transferable skills e.g. decision-making and subject specialist knowledge, and previous experience, little of which is in an academic setting. There is an expectation that they will develop into the university lecturer role. The Dearing report (NCIHE, 1997) identified the need for better induction for staff across the whole higher education sector and consequently many institutions extended their formal academic induction programmes to include a requirement for attaining a post graduate teaching qualification within the first few years' post appointment.

Induction programmes often provide information about the institution and its procedures. Identification of and assimilation of the responsibilities of the role of the lecturer are not prioritised, and successful socialisation into academia appears to be dependent on informal networks of support (Trowler &



Knight, 2000). Further to the operational issues of delivering the curriculum, the journey from clinician to educator to academic has been identified as having several identifiable stages (McKeachie, 1997), but a particular issue for health care professional staff seems to be related to decisions about their day to day work and the impact of those decisions and actions. Expert clinicians work autonomously, using professional judgement and the effects of their decisions are often immediately apparent. In higher education, the individual is part of an organised rolling programme of curriculum delivery and the effects of one's actions are frequently difficult to perceive or occur remotely (Edwards et al, 1999).

In the current study 'academic induction' is taken to mean a more extended period than the formal processes that many universities provide for new staff. The study focuses on newly appointed lecturers with up to five years of experience in a higher education academic role. This recognizes the social nature of workplace learning and includes a more sustained period in which ways of working, new knowledge and skills and above all identities may develop (Trowler & Knight, 2000).

Many universities in the UK offer post graduate courses to nurses, midwives and allied health professionals, and there are increasing numbers of staff working in health care who have either completed or are working towards a master's level qualification. These are frequently undertaken on a part-time basis or within an individual's own time, and so whilst newly appointed health care lecturers may have recent experience of study, most will not have been immersed in an academic or research environment prior to taking up their new post. The traditional model for University lecturers has been a post-doctoral route to becoming an academic, but in spite of the existence of large faculties of health and social care spanning almost two decades, and large numbers of academic staff who do not hold a doctorate, an 'alternative' (health professional) pathway to academia is not well documented or researched.

So, how do health care professionals fare in the transition from clinically-focused work into their new lecturing posts in higher education? What are the issues they face in the move from experienced health care professional to academic? Are there common experiences for all new lecturers or are there specific issues for this group of staff? This research aims to consider the experiences of different health care professionals during this transition and to consider how an understanding of the different experiences of that process might inform the induction process into higher education for new staff, for line managers and the institutions.

## Research Questions

- What do nurses, midwives and allied health professionals experience during the transition from clinical roles into their new posts as lecturers in higher education?
- What similarities and differences can be identified in the experiences of the different professional groups?
- What factors might influence the transition into higher education?
- What issues can be identified which might inform appointment, induction and probation?

## Chapter 2 - Background literature

This chapter provides an overview of existing literature and introduces the theoretical framework for this study.

### Scope of Literature Review

A comprehensive search of was carried out to identify existing literature to inform the research. Key words and search terms were identified and searches were carried out using Health and Social Care and Education databases. Initially, generic searches utilised terms such as 'lecturer', 'new lecturer', 'academic', 'induction', 'becoming', and 'higher education and professional socialisation'. Subject specific searches were also carried out relating to nursing, midwifery, physiotherapy, occupational therapy and radiography. Truncation symbols and Boolean operators were employed to take account of international variations in terminology and to narrow the search fields.

Academic Search Premiere was used as an initial database to give a general focus for searching, and profession specific journals were then targeted (see appendix 1a for complete list). Initial searching produced relatively few articles. The majority of published articles concerning education relate to student experiences or socialisation into the health care professions, rather than experiences of health care professionals entering higher education. Inclusion and exclusion criteria were established and these criteria were used to screen the results of the data base searches. (A table of inclusion and exclusion criteria can be found in appendix 1b).

In addition, references lists and bibliographies of the selected articles were viewed to capture other relevant articles not revealed through initial searching. Searches were repeated using key authors and citation facilities. Searches for books were carried out through the University of Cumbria library catalogue and a number of unpublished studies were obtained through correspondence with interested parties throughout the research process.

## Previous Research

Existing studies have considered academic staff from different faculties and subject disciplines (Trowler & Knight, 2000; Staniforth & Harland, 2006; Barlow & Antonio, 2007); new teacher educators, nurses and social workers (Murray, 2007); new nurse educators (Dieklemann, 2004; Boyd & Lawley, forthcoming; McArthur-Rouse, 2008) and occupational therapists (Wright, 2007). No studies were found which specifically considered the experiences of radiography, physiotherapy or midwifery lecturers, although there is a clear consensus in the literature supporting the notion that the transition from practice roles into lecturer roles in higher education is a challenging one (Edwards et al, 1999; Sim et al, 2003; Lombardo, 2006).

Several themes emerge from the literature, including the importance of professional identity, understanding and managing the new role, and the importance of support for workplace learning. There are many shared themes which arise from the studies, but all considered the views of a small sample of academic staff. While a general consensus appears to exist with respect to the challenges of transition, it is not clear whether these findings can be generalised to a wider population of lecturers within the UK. The concept of situated workplace learning was developed by Lave & Wenger (1991) and has been identified as being critical to the process of becoming an academic (Trowler & Knight, 2000) and a lecturer in nursing (Boyd & Lawley, forthcoming).

Universities are highly complex organisations which have been described as having relatively static cultures, although it is recognised that the culture is far from static, being dynamic and unbounded (Grbich, 1998). Understanding the fluidity and institutional individuality is an important consideration for all new employees and may present a particular challenge for incoming health care professionals, who have strong distinct professional identities and practices, developed through years of practice within the cultural context of health and social care. In spite of the over-arching context of higher education working and the rules and regulations which the University provides, individual departments may have distinct differences in values and day to day operations, resulting in discrete communities of

practice. Much of the knowledge of these practices is tacit, and since academic staff are frequently members of more than one community of practice, the challenge for the new lecturer is to engage with these different groups whilst discerning and responding to their similarities and differences. This is done by participation rather than formal induction.

A study by Trowler & Knight (2000) examined and compared the experiences of 24 new academic appointees to two universities in England and Canada. Their discussions focus on the importance of socialisation into academic life, relating this to activity system theory as described by Engestrom (1987 & 1990) and the concept of 'communities of practice', developed by Lave & Wenger (1991). Trowler & Knight propose that inter-subjectivity (or shared aspects of the communities of practice) is not easily achieved. Furthermore, due to the tacit nature of practice, new staff are often left to fathom this out for themselves. This view is supported by Barlow & Antonio (2007) who suggest that there is an assumption that new staff will naturally absorb the new culture of the university workplace. The importance of communication and relationships between teams and departments is a feature of Trowler and Knight's work, and the importance of a sense of control over one's working environment has also been highlighted as important for new academic staff (Knight, 2002).

Staniforth & Harland (2006) considered the induction experiences of 9 new academic staff across 3 departments, comparing these with the views of 6 departmental heads. As the authors indicate, their findings, although related to a relatively small group in one higher education institution, give cause for concern. The new academic staff did not fully understand what was expected of them and at times were not sure what was acceptable or permissible. The new lecturers and their line managers had different perceptions of the induction process, and interestingly neither side had a full understanding of the potential of the process in facilitating new appointees in becoming an academic. New staff felt continually disadvantaged by "*time wasted on unnecessary activities and an unwarranted investment of intellectual and emotional energy in coping with aspects of the new job*". In this study, heads of departments were not seen as key players in the induction process and although they protected new staff from excessive workloads, they did little to launch them into the university community, rendering these new lecturers 'effectively invisible'. The authors highlight the importance of communication and engagement with others, further supporting the ideas of communities of practice espoused by Trowler & Knight (2000).

Barlow & Antonio's study (2007) was carried out in a post-1992 University in the UK. They interviewed 17 new lecturers recruited from a variety of backgrounds, about their early experiences as a lecturer in higher education. The academic subject areas of the participants are not identified, although some had previous teaching experience. Within a single organisation, departmental practices of induction differed, but the majority of participants described a superficial process which they felt did not fully

address the different aspects of their roles. The importance of communities of practice, again, featured highly, with those interviewed valuing a team ethos and contact with other new colleagues and mentors. Tensions between research, teaching and faculty roles were perceived to be present, suggesting a degree of turbulence in becoming a member of academic staff, although in spite of the obvious frustrations of not knowing how to do the job, this study identified that it was largely viewed as an enjoyable one. The authors suggest that too little priority is given to nurturing new staff, and in conclusion, highlight induction as key to the successful integration of the new lecturer into their higher education role.

Murray (2007) suggests that one of the difficulties for new lecturing staff is the lack of understanding of the academic role. In a study which looked at ways of countering insularity in teacher education, she conceptualised the idea of second order practitioners (e.g. nurses working as educators, rather than in their first order clinical practice workplace). She interviewed 10 academic staff from each of 3 professional groups - teaching, social work and nursing - identifying four similar elements to the role: teaching, research or scholarship, contribution to the original professional field, and service to the university. Results of the interviews suggested that there were tensions for professional educators when they attempted to meet the imperatives of both higher education and their original professional fields (Murray, 2007), with particular difficulties for new starters in identifying what the academic role was, as models of work were not clearly defined. Specific to teacher educators was the perception that their department was of low status within the University.

Wright (2007), researching a group of 11 new occupational therapy lecturers described the transition as one of moving from expert to novice. Through in-depth interviews and focus group work, findings suggested that newcomers in academia experienced feelings of loss and grief for their previous identity. They felt deskilled and confused as their expertise was no longer appropriate or recognised in a new and very different environment, and had difficulty identifying a supportive community of practice. Wright's analysis identified high anxiety levels, significant drops in confidence and feelings of 'being a fraud'. Recovery from this transitional stage was related to a sense of belonging to one or more communities of practice, an ability to articulate their new role and to emerge with a new identity related to their effective functioning within their institution.

The term novice is not universally agreed as an accurate description of new lecturers. McArthur-Rouse (2008) concurs with Wright (2007) and Murray (2007) by using the term novice lecturers building from the work of Benner (1984) on the acquisition of skills from novice to expert. Although in agreement with these findings, others have interpreted the transition differently (Boyd & Lawley, 2009 forthcoming) preferring the term newcomer as defined by Lave & Wenger (1991), suggesting that 'novice' means 'no skill' or 'new to', whereas the majority of ex-clinicians are experts in their fields and

have numerous organisational and communication skills which might equip them for their new role, if only these were to be reconstructed in a positive way. McArthur-Rouse (2008) interviewed 6 new nurse lecturers, and identified a problematic transition in spite of positive experiences with their mentors. Issues which they identified included: lack of structure and direction in their new role, particularly in contrast with very structured experiences of working in the National Health Service (NHS); not knowing whether they were being effective in the role; a perception that they were excluded by some longer standing staff members; and also a strong need for acceptance within their new communities of practice.

Wright's study (2007) is also interesting in its discussion of professional identity. It suggests that occupational therapists might have a specific issues relating to the power and meaning of occupational therapy as a professional identity, and that their primary field of practice is strongly underpinned by a social model of occupation. Interviewees described themselves in these terms, e.g. "I am an occupational therapist". This is interesting and raises the question as to whether health care professionals with strong professional identities, are looking for a new identity, which without the presence of role models or a specific point of arrival, in itself is difficult to identify. The gradual process of becoming an academic may include a period of grieving for lost identity in the case of nurses (McArthur-Rouse, 2008) occupational therapists (Wright, 2007) and teachers (Murray, 2007).

In an interpretive study, using semi-structure interviews, Boyd & Lawley (forthcoming) interviewed 9 new nurse educators. The subjects came from a single subject department in a University College and had a range of between 1 and 4 years' experience of working in higher education. The data provides an illuminating account of the challenges in the process of transition, some associated with feeling new: lack of status, not feeling valued; high expectations placed upon them in the early days of their appointment ('being thrown in at the deep end'); disappearing within a large and complex organisation in contrast to their previous respected role; having to learn the language of higher education; and a lack of credibility, although the authors point out that it was not clear what the subjects wished to be credible as, and suggest this is symptomatic of a struggle with their previous professional identity.

Interviewees recognised that they brought many relevant skills and attributes to their new post, but that these valuable prior experiences were not always recognised by those in other departments, specifically identifying the postgraduate teaching course for new lecturers as failing to acknowledge existing teaching skills. The study participants had specific concern about knowledge, specifically associated with planning sessions, teaching and assessing students, indicating that activities around the student body were a high priority in the daily work rather than research activity. From the analysis, the nurse lecturers identified a strong desire to be 'up to date' to ensure credibility with students, although this related more to currency of clinical practice rather than through research or publications. Other issues

identified were the confusing systems relating to workload planning; the fluctuations in workload of which they were not aware at the outset of their new role; and an inability to say no to increases in workload due to the covert nature of workload allocation. Difficulty in finding time for scholarly and research activity was frustrating, with much of their reading relating to session planning rather than informing their research. Another element of this study relates to the importance of work colleagues who were identified as providing a strong element of support. There was scepticism about the effectiveness of the institutional induction programme and the study reported varied experiences of support from mentors, which was described as largely reactive and ad hoc.

Literature researching the experiences of radiographers, physiotherapists and midwives as discrete professions was not found. The role of the allied health professional lecturer role has been outlined by Brew (1999) and Edwards et al (1999) and some of the difficulties experienced are outlined in scholarly articles, all of which support the findings of the literature reviewed above.

Guidelines for the induction of new teacher educators have been produced (Boyd et al, 2006) by the Higher Education Academy (Boyd et al, 2007) and offer specific suggestions for influencing the uncertain survival period of the first year in academia. These guidelines have been developed from the investigations of the experiences of new teacher educators, but it is not known to what extent these guidelines have been adopted or whether they have been utilised by other professional or academic groups.

Review of the literature suggests that the transition for health care professionals entering lecturer posts in higher education is challenging. Whilst appearing to have an ideal set of transferable skills for their new role, the reality of the new job is that many cultural, organisational and professional differences exist between the practice environments of health and social care workplaces and the educational environments of universities. The early days in post can be fraught with practical difficulties, frequently related to lack of clarity of the role, leading to feelings of inadequacy and ineffectiveness. Institutional induction may well have improved, but the literature suggests that since the Dearing report (1997), new lecturers in HE may be better qualified to teach but have not necessarily fared well in their induction into the wider role. Preliminary literature concerning new teacher and nurse lecturers demonstrates many parallels to those described by new academic staff in general, although it is unclear whether these findings can be applied to the wider academic population, as no large studies have been carried out.

## Theoretical Framework - Situated Workplace Learning

Situated learning theory and activity systems theory have been presented as providing useful theoretical frameworks for analysing academic workplaces (Trowler & Knight, 2000; Knight, Tait & Yorke, 2006).

The situated learning literature signals the need to focus on professional learning that is rooted in the workplace context and on the learning of 'newcomers' as they interact with 'old-timers' within a community of practice (Lave & Wenger, 1991; Wenger, 1998). In the complex workplace of the new professional lecturers, membership of more than one community of practice seems likely. Wenger (1998) presents a model of the professional learning of new entrants to a complex workplace as one requiring boundary crossing within an over-lapping constellation of communities of practice and he argues for a focus, in research, on the interactions between individuals and workplace communities of practice.

Viewing learning as legitimate peripheral participation within communities of practice implies that much learning will be non-formal and to some extent Lave and Wenger (1991) are dismissive of formal learning opportunities involving 'teaching'. Fuller et al (2005) challenge this aspect of Lave and Wenger's work and claim that formal education / training is able to contribute to workplace learning. They do note that its effectiveness is related to its acceptance, 'it becomes possible to see structured courses as merely another form of participatory learning...but it works best when it is accepted as a legitimate activity...' (2005: 65).

The view of an organisation as a 'community of communities' is developed by Brown & Duguid (1996) and they emphasise the need to understand the informal socially based communities of practice within an organisation as well as the formal structure. To promote learning in the workplace they argue that the organisation must nurture the informal networks and activities of staff but that 'this support cannot be intrusive, or it risks merely bringing potential innovators under the restrictive influence of the existing canonical view' (1996: 77). This is where the concept of *fuzzy* learning architecture is useful, it is neither formal nor completely informal, it may be nurtured by the organisation but cannot be completely controlled. For example a faculty may nurture the formation of writing groups by offering small amounts of funding and by praising such activity but it is unlikely to be able to create successful writing groups by requiring staff to join one.



Situated learning emphasises the importance of workplace learning in informal situations (Eraut, 2000) but the potential contribution of more formal support also needs to be considered (Fuller et al, 2005). The term informal applied to workplace learning, is taken to mean learning in a workplace context where the learning is not deliberative (Eraut, 2000) but occurs through routine engagement with work. The terms informal and formal learning and support are used within the current study for the purposes of distinguishing between more or less deliberative learning processes and structures but it is accepted that the distinction is not always clear and some fuzziness may occur. An example of fuzzy support for workplace learning might be where a new lecturer in a shared office may adopt their office buddy as an informal mentor perhaps having found wanting the support of the formal mentor appointed officially by the head of department.

In developing activity systems theory Engestrom (1987; 1999; 2001) signals the need to focus on academic workplaces as collective dynamic object-oriented activity systems in which rules, tools and division of labour shape behaviour but in which social action and contributions by participants are also able to shape the system. Within an activity theoretical approach the importance of history and wider structures in influencing workplaces is emphasised and the workplace is considered to include tensions or contradictions that may drive further development of the activity system. Although contradictions are seen to create disturbances or troubles they are more than that, 'Contradictions are historically accumulating structural tensions within and between activity systems' (Engestrom, 2001: 137). Where these contradictions provoke collaborative questioning and change effort, Engestrom proposes the possibility of expansive learning in which the object of activity is reconceptualized and the activity system itself is transformed.

Fanghanel (2004) applies Engestrom's (2001) model of inter-relating activity systems to the situation of a group of new lecturers in a university who are working together within a formal post graduate course in teaching in higher education and at the same time are working in their separate departments. The empirical basis of the study was composed of interviews with the course directors and with the new lecturers. The formal course and the departments are considered by Fanghanel to be separate but inter-related activity systems with the new lecturers as the object within the formal post graduate course but as the subject (with teaching practice as object) within the departmental system. The outcomes of both systems are broadly common in terms of producing new lecturers who are effective teachers within higher education. The activity theoretical framework was used in this study to focus on tensions or contradictions, and these were presented as a typology of 'dissonances'. Fanghanel identifies an apparent limitation in the application of activity theory within the study in that it does not focus attention on the place of emotion within learning.

Self-identity is helpfully defined by Giddens: 'it is the self as reflexively understood by the person in terms of her or his biography' (1991: 53). He views identity as a 'reflexive project' that involves '...the

sustaining of coherent, yet continuously revised, biographical narratives...' (1991: 5). In the higher education context the identity of academics is influenced by intensification of academic work and a more corporate and managerialist approach within universities as workplaces (Bridges, 2000; Marginson, 2000; Becher & Trowler, 2001; Barnett, 2003). All of these authors focus largely on the experiences of academics in more traditional, as opposed to applied, subject disciplines. Significant differences in identity building might be expected between newly appointed lecturers in nursing, midwifery and the allied health professions, who are appointed largely on the basis of successful professional experience, and lecturers in more traditional subject disciplines, who usually find their way in to academic posts through doctoral research.

Working from an academic development perspective d'Andrea & Gosling (2005) usefully combine previous work by Taylor (1999) and Kogan (2000) in describing categorisations of academic identity which do include the professional subject disciplines by considering professional identity, for example as a nurse, as one sub-category. Their three categories of academic identity are 'distinctive individual', 'institutional membership', and thirdly a blend of 'discipline', 'professional identity', and 'universal academic identity' (d'Andrea & Gosling, 2005: 59). This final category reflects Taylor's idea of an idealised, mythical, academic identity (1999). This categorisation at least acknowledges the strong element of self-identity focused on their previous professional practitioner role that may be held by, for example a nurse lecturer, even after long years working as a university-based lecturer.

Castells (1997), claims that the 'late modern age' identified by Giddens (1991) is coming to a close. In considering identity within the 'information age' he identifies a collective identity-building form entitled 'resistance identity'. Henkel (2000) identified 'resistance' mainly by departmental or subject groups of academics to centralised management of change within their institutions. In terms of academics developing wider networks, often using the World Wide Web, in addition to conferences and journals, to facilitate communication and collaboration, Henkel found these to be largely associated with research identities. These wider networks were important sources of identification but were not associated by Henkel's analysis with resistance or working to bring about change in institutional or national policy or structures.

Within a situated learning perspective identity is viewed as very much being founded on social relations and as an integrated element of learning:

*We conceive of identity as long-term, living relations between persons and their place and participation in communities of practice. Thus identity, knowing, and social membership entail one another. (Lave & Wenger, 1991: 53)*

The early work of Lave & Wenger on situated learning (1991) is focussed on the experience of newcomers who are to a large extent considered to arrive in the workplace as 'innocents' with no prior

experiences to shape their engagement with the new context and the 'old timers' already established within it. The situation of new lecturers in health professional fields is different because they bring considerable experience as a practitioner within the professional field. In terms of the Dreyfus & Dreyfus model of skill acquisition (1986) they are likely to be 'expert' in the clinical practice element of their new role but may be viewed by some as being at the level of 'novice' in other areas such as research (Murray & Male, 2005).

In later work, Wenger more explicitly develops the issue of identity within social learning and argues that *'It is therefore a mistaken dichotomy to wonder whether the unit of analysis of identity should be the community or the person. The focus must be on the process of their mutual constitution'* (1998: 146).

This helps to introduce a temporal dimension to identity building; closely relating it to development of practice within a community and it creates a contrast with the individualist tendency that a focus on identity may tend to emphasise. Wenger argues convincingly that there is a 'profound connection between identity and practice' (1998: 149) and positions identity as a 'becoming'. He considers that we define who we are through negotiation and reconciliation as we steer our way along multiple trajectories related to our varying positions of membership of multiple communities. The temporal element of a trajectory is important although Wenger does not see it as a simple linear time scale. The newly appointed lecturers join their academic community *'with the prospect of becoming full participants in its practice. Their identities are invested in their future participation, even though their present participation may be peripheral'* (1998: 154).

Clegg's study (2008) adopted a direct approach to investigation of academic identity and asked a small widely varying range of lecturers within one institution about their identity. From her reading of the lecturers' narratives Clegg found that the boundaries of higher education 'emerged as porous' so that some academics were not identifying with subject discipline in a simple and traditional way but were influenced by other claims 'beyond the confines of the university'. The current study investigates lecturers in the health professions who have previously established professional identities outside of higher education and who work in educational partnerships that extend beyond the university. As Clegg argues (2008), investigating the identities of such non-traditional academics has considerable value.

## Summary

This literature review has been carried out in support this research which aims to investigate the experiences of lecturers in health professional education who have significant histories and investment in wider practitioner communities and who teach within established educational partnerships. Situated workplace learning theories and existing research has been used to inform the study which aims to

explore the experiences of nursing, midwifery and allied health professional lecturers throughout the UK.

The current study aims to establish whether the difficulties associated with the transition into higher education, described in small studies are applicable to the wider population. The research also seeks to address gaps in current knowledge and will therefore seek to establish any similarities and differences which exist between organisations with different priorities or between the discrete professional groups in the transition from 'traditional' health care roles to higher education. The aim of the research is to consider strategies which might be put in place to improve induction process.

## **Chapter 3 - Methodology**

The aim of the research was to collect data from a large sample of new lecturers from a range of different higher educational establishments. This aimed to gain insights into the lived experiences of the study participants to inform induction of future health care professional staff into the academic role.

### **Methodology**

Previous studies have conducted surveys, interviews and / or focus groups with small numbers of nursing lecturers (Boyd & Lawley, forthcoming), occupational therapists (Wright, 2007), nurses, teachers and social workers (Murray, 2007) and non-health care professional staff (Trowler & Knight, 2000). Whilst common themes have emerged from this body of research, no studies have been found which have considered whether the themes of intra-role tensions, disorientation and de-skilling, overload, return to the novice etc can be generalised to a larger population. Much of the data in the literature identifies the difficulties associated with the transition to lecturer whilst in contrast, the group of new lecturers studied by Barlow and Antonio (2007) suggests that in spite of the challenges encountered, the transition was a largely positive experience. This study seeks to consider the range of experiences of a larger group of new lecturers, and to identify both positive and negative experiences.

With the exception of the study by Barlow & Antonio (2007), whose data was initially collected for internal purposes, other studies do not state whether the research was carried out because of practices associated with specific institutions had led to discontent or whether researchers themselves experienced a difficult transition into higher education. Volunteers to these studies may also have been

those who experienced a difficult transition. Although Barlow & Antonio (2007) identified that a significant number of new lecturers were leaving their University after one or two years in post, neither recruitment into academic posts nor retention of academic staff was identified as a problem by other authors. With the improved remuneration for expertise and specialist skills in clinical NHS staff via Agenda for Change (DOH 1997), a lecturer post is unlikely to attract clinicians for purely financial reasons, one might assume that there is an element of satisfaction which stems from an academic career; a theme which emerges from the data provided by Barlow & Antonio (2007). It is therefore interesting that the strength of negative feelings described by the participants of the other in-depth studies emerges as a common theme. These studies have highlighted the importance of appropriate academic induction and the Dearing report (1997) recommended that academic staff should gain a teaching qualification.

The authors wished to reach a large number of academic staff, from different academic disciplines, professional backgrounds age groups and also to gain a mix of respondents from both genders and traditional and post -1992 institutions in order to examine their experiences. Given the strength of feeling highlighted in previous studies, it was felt important to ensure that participants could remain anonymous and that their institutions could not be identified.

In seeking to collect anonymous and confidential data regarding the experiences of clinical nursing, midwifery and allied health professional staff moving into higher education, an on-line survey was selected as the means to collect a large amount of both demographic and qualitative data. The survey was selected to allow ease of distribution, to provide an asynchronous and therefore flexible data collection tool for respondents to complete in their own time and chosen surroundings, to allow respondents to review their own contributions rather than relying on a second party to transcribe their thoughts, and for ease of collation of large amounts of data and negating the need for transcription or data input.

## Sample

Existing research provides an in-depth view of a small number of health care professionals working in a small number of higher education establishments within the UK. This study aims to establish whether the existing findings can be generalised to the wider population of new health care professional lecturers within the UK.

In contrast to the health care professions, where there is a distinct point of qualification as a nurse, midwife or allied health professional, there is no distinct point of arrival as an academic. Arguably new lecturers are engaged in academic activity from the day they take up post as a lecturer, and this activity

is unsupervised and autonomous, again in contrast to the new health care professional, who is deemed to be a student until, having gained an agreed level of competence, becomes qualified. New lecturers are immersed in a workplace learning environment which involves simultaneously 'doing the job' and 'learning the role'. New lecturers gradually take on the role and identity of the academic and at some indeterminate point 'become an academic'. This study seeks to examine the experiences of new lecturers in the early years of the role and has identified this period as being in post in higher education for up to 5 years. Early experiences of lecturers who have held posts for longer than 5 years are no less valid, however, reflection on past events may produce recollections modified by the benefit of hindsight. Roles may have changed, offering a different viewpoint upon early years working and induction; and also institutional changes and policy developments may have altered practice during this time. Further research will seek to compare experiences of those in their early years of working in higher education to those with more experience who are reflecting on their early years.

Obtaining data from a random sample of lecturers would provide the most reliable picture, but research on this scale is only possible where participants voluntarily contribute their experiences, thus the sample is by definition, self-selecting, potentially threatening the external validity of the findings, and making them purely relevant to the sample group, albeit a large number of people.

This research aimed to gain a national view of new lecturers in higher education, however identifying allied health professionals, nurses and midwives who work in this sector is not straight forward. A number of health care professionals are registered with the Higher Education Academy (HEA), but neither the total number working in higher education, nor the percentage number registered with the HEA is known.

## Method

### Data collection

The survey was informed by key literature and also initially by an inter-professional focus group, which considered their early experiences as a whole – from this it was identified that many positive experiences had occurred, although it was negative memories which were strongest.

The Bristol on-line survey software (Bristol Online Surveys, 2008) was selected for ease of construction questions which would provide accurate demographic data concerning the sample, allow anonymity and confidentiality to be retained, and to enable respondents to write as much or as little as they wished in relation to the open questions designed to collect qualitative data. The online survey as a data collection instrument introduces some limitation on the scope of the study and it is possible that semi-structured interviews may have achieved more insight into the experiences and identities of the lecturers. However the design of the survey, including open questions, did help to alleviate this constraint.

The sample for this study is made up of health care professional lecturers who received an invitation to take part in the trial, and subsequently opted to complete the on-line survey. The sample is thus self-selecting and the extent to which any findings can be generalised to the wider population needs to be questioned. The study refers to allied health professions but acknowledges that not all allied health professions have been represented in the study. Three main groups have been considered: occupational therapists, physiotherapists and radiographers, as these three groups represent the largest number of allied health professionals working in higher education.

The theoretical framework of workplace learning highlights the significance of the institutional and departmental context of new lecturers and yet in order to ensure anonymity for individuals and institutions in this study the key features of workplace context are only drawn into the data by self-reporting by respondents. This is a limitation of the study but on the other hand it is possible that external, apparently more objective, measures of context such as measuring how research intensive a department is by using its score in the Research Assessment Exercise, would miss the effect of mediation of that contextual feature by individual lecturers. They may feel pressure to publish even in a teaching focused departmental workplace environment.

## Data collection – Identifying the sample

Initially a database of all higher education institutions offering nursing, midwifery, physiotherapy, occupational therapy and radiography programmes in the UK was drawn up. Letters outlining the aims and purpose of the study were sent to all professional subject leads at each institution requesting permission to distribute a link to the anonymous on-line survey, to all staff working in their departments. Professional leads were asked to identify a named contact who would distribute the link to the on-line survey, thus each institution could be confident that the survey sample remained anonymous to the research team. On receipt of consent for any particular programme to take part, e-mail contact was established with the named contact person. This primary e-mail advised them of the process of forwarding the survey link and asked them to advise the research team of the number of staff in each professional group who would receive the link. This was to enable an estimation of the population to be established so that the survey response rate could be calculated. Once numbers of potential recipients had been received, a secondary email containing a brief explanation of the research and the on-line survey link was sent to the named contact, who then confirmed that the e-mail had been forwarded as requested.

The survey aimed to collect experiences of nurses, midwives, physiotherapists, radiographers and occupational therapists, however, to ensure ease of distribution and maximum coverage, the named contact for each department was not asked to discriminate between different allied health professionals or between staff of differing grades or contract of employment, but to send to everyone in their department. In practice this means that the sample included lecturers on a variety of contractual arrangements and roles including lecturer-practitioners. Recruitment to the survey was solely via this method. No advertising via professional publications or internet discussion groups were carried out. Following distribution of the on-line survey link, volunteers completed and submitted the survey on-line.

## Limitations of sample selection

The method used to recruit volunteers for this study was completed in such a way as to ensure an ethical approach that did not reveal the institution of survey respondents. This does create a limitation to the survey, not least because the institutional workplace context is considered to be very significant. However all of the relevant health professions departments across the UK were invited to participate in the survey and this included a range of institutions from research intensive universities, through post-



1992 universities and including some higher education colleges. The authors are also aware that within the higher education sector in the UK, there is a wide variation of terminology used to describe academic roles. Whilst for the purposes of this study, the term lecturer has been selected to describe all those engaged in academic activity, it is acknowledged that contacts at different establishments may well have interpreted this in different ways, leading to selective distribution. For example, it is possible that the survey was sent only to staff whose title was 'lecturer', potentially excluding other titles e.g. tutor, reader or professor.

The data for this report has been confined to those lecturers with up to 5 years experience. This group were not specifically targeted by the survey in order to keep the role of the departmental contacts as simple as possible. It is recognised that this non-focused participation request may possibly have influenced the pattern of recruitment but this was not seen as a significant risk. The survey itself asked each respondent how long they had worked in higher education and those with 6 or more years experience have been excluded from this stage of the report. The authors aim to consider this data in future publications.

A small number of relevant university departments declined to take part in the research and no justification was sought for this. Others required ethical clearance and due to time constraints this was not pursued. Others did not respond to the survey. Several attempts to elicit a reply from these institutions were made by e-mail or telephone, but this was not pursued beyond the survey launch date. Other complications occurred, with several of the originally named contact personnel changing roles or being unavailable at the time of distribution. There is no guarantee that the secondary e-mail with the on-line survey link was distributed to the professional group, although confirmation that this had been carried out was requested and received from each participating institution. Thus, the research team freely acknowledge that the survey, whilst being distributed to a large number of individual health care professionals working in higher education, did not offer all professionals working in this capacity, the opportunity to participate in the survey.

## Ethics

The research team adhered to ethical principles throughout each stage of the research and gained ethical clearance through the University of Cumbria research ethics committee. A summary of the research proposal was sent to every institution when seeking permission to invite their departmental staff to respond to the online survey. A key contact in each participating institution agreed to forward the online survey link to relevant staff. With regard to ethical controls this created a useful gap between the research team and the participants, the research team at no point had access to the names or email addresses of potential participants. A small number of universities (n=2) felt that ethical approval would

need to be gained through their own ethical procedures, but due to time restrictions, these were not pursued and the institutions were excluded from the sample. A number of institutions (n=3) declined to take part in the study. No justification was sought for this and their decisions were respected.

Permission to survey academic staff was gained from each University department. Confidentiality and anonymity of the respondents was deemed to be paramount and the use of the online survey ensured that individuals could respond fully without fear of being identified or linked to any particular institution. Participation in the survey was voluntary and individuals were free to withdraw from the study by choosing not to submit the survey on-line. An overview of the project and the ethical controls was provided to potential participants on the front page of the online survey. Once surveys were completed and submitted, it was not possible to link the responses to any e-mail address or to trace the institution, ensuring total anonymity. Prior to coding the data was subject to ethical filtering, with all information which might threaten anonymity, being removed. Quotes that were selected to illustrate the findings of the study were double checked for any data which might identify an individual or institution.

Whilst the survey asked respondents to detail their personal experiences, the questions were designed to allow respondents to draw their own boundaries, by selecting what they wished to share with the researchers. The research team were mindful that some respondents might have found their initial experiences distressing or felt that there were unresolved or emotional aspects of their role. This was addressed by the voluntary nature of the responses and also by including a final question asking if any individual had any further comments to make. A number of people commented that they had found the experience of reflection useful and had enjoyed the opportunity to articulate their thoughts.

### **Pilot study**

A number of preliminary pilot surveys were carried out amongst the inter-professional research team and other interested parties leading to a number of amendments and improvements. A further pilot study was carried out in two geographically separate universities in the UK, both of which provided a number of different nursing, midwifery and allied health professional programmes. This pilot was conducted to ascertain the validity of the data collection tool and also to test the survey distribution process. The survey was distributed to 250 staff and 39 responses were received from a range of health professionals. The pilot highlighted a number of variables e.g. previous working environment, which might be important in the success of the transition from clinical work to higher education. The survey was amended further to account for these, asking for more demographic data, improving question

design to ensure theories relating to communities of practice (Wenger, 1998) were covered fully, and to shorten the overall questionnaire and provide clearer instructions as to submission.

The full set of survey questions are attached as appendix 2. The use of the on-line survey tool provided ready-made transcripts and the results were exported to provide data sets for each question and also for individual respondents.

### **Data Analysis procedures**

Distribution of the survey did not discriminate between those with 5 or less years experience and those working in higher education for more than 6 years. Anyone with a health professional qualification, working in higher education at the time of distribution, was eligible to complete the survey. However, only analysis of data from those with 5 years or less experience has been included in this report.

Whilst the on-line survey tool provided inherent scope for analysis of demographic and quantitative data, the Bristol online survey software is not specifically designed to manage large amounts of qualitative data. Data from the on-line survey was exported to a secure data base, and any data threatening anonymity of individuals or institutions was removed from the text prior to coding and analysis by the authors. Qualitative data analysis software, Atlas Ti 5.2, was then used to manage the qualitative data and the coding of data. The more sophisticated and specific analytical tools within the software, such as the network tool, were not used and so the choice of this particular software was not felt to be a significant influence on the process of analysis.

The qualitative data analysis was informed by the framework approach (Ritchie & Lewis, 2003) so that initial familiarisation was used to develop a template based on recurring themes and on the issues introduced through the interview schedule. The template provides an initial index by which the data is then coded but in an iterative process themes emerging from the data are identified and shape the overall analysis. The initial stages of analysis describe themes arising in terms that stay close to the language of the data set. The findings, reported in chapter 4, give voice to experiences of the newly appointed lecturers. The analysis is driven up the analytic hierarchy to seek patterns, develop explanatory accounts and seek applications to wider theory (Ritchie & Lewis, 2003); this is reported in chapter 5.

A preliminary coding framework was drawn up, informed by the literature and pilot studies. The framework consisted of three main areas: of managing self; support; and activities. The data was

constantly scrutinised for other emerging themes, and the framework developed through an iterative process.

The themes identified in the coding framework are outlined in Table 2 and are discussed with illustrative quotations in the results section. Further details of the coding framework can be found in appendix 3.

**Table 2: Summary of coding framework**

<b>Managing Self</b>	<b>Support</b>	<b>Activities</b>
Time & flexibility Issues	Formal support provided by the institution	Teaching
Autonomy	Informal support	Research
Role Boundaries / Expectations	Integrated / fuzzy support	Organisational / Faculty Roles
Development (personal and professional)		Clinical Partnerships
Emotional Issues		

A clear definition for each code within the initial framework was agreed, to enable two members of the research team to work on the analysis collaboratively. Initial coding of a sample of the transcripts by two members of the research team used the framework but also involved the development of additional open codes. The initial framework and the additional codes were then re-considered, and aligned to establish shared meaning and repeatability and reliability of the coding process (di Gregorio and Davidson, 2004) and the development of an established coding framework that could be used for further analysis. As part of the early analysis the coding framework underwent a number of iterations, through frequent meetings and discussions within the research team.

As part of this process inter-coder reliability was checked to monitor consistent application of the emerging coding framework. Initially the two analysts coded 20 transcripts each and compared the frequency and consistency of their coding. An agreement level of 82% was achieved and the coding and interpretation of the definitions were reconsidered in light of this. The main differences occurred in two main areas: firstly in the interpretation of quotations relating to personal development and research, and secondly in relation to subject specific teaching and clinical currency. No precise measure of inter-

coder agreement is applicable to all qualitative analyses (Bernard, 2000) but this initial level of agreement established a strong basis for amendment of the framework and further analysis.

**Table 3 : The open questions within the survey.**

The data from these was subject to qualitative analysis described above.

**Section 6: Your experiences of your new Role**

8. Please describe your experiences of working as a new lecturer in Higher Education.
9. What are the most positive aspects of your role / experiences of working in Higher Education?
10. What have been the most difficult aspects of your role / experiences of working in Higher Education?
11. How do you feel your personal and professional strengths have been utilised in your role in Higher Education?

**Section 7: Aspects of support which have assisted you in your role as new lecturer in Higher Education**

12. Please identify the elements of "formal" support, provided in your workplace, which have been most useful?
- 12.a. Have there been any elements of the formal provision which have not been helpful?
13. Please identify the elements of "informal" support in your workplace which have been most useful?
14. Please use this space to identify any other important support networks, or anything not provided by your Higher Education Institution which you feel would have assisted you in your role?

**Section 8: Your future in Higher Education**

16. What do you see as your priorities for your own professional development in Higher Education, and where do you see yourself in 3 years time? Write as much as you wish.
- 16.a. What support would help you to achieve these future plans?

## Chapter 4 - Results

This section looks at the responses to the online survey. The survey questions are detailed in full in appendix 2. Demographic data was captured in the first section of the survey. Later sections asked respondents to sum up their experiences, the support they received and their views of the near future. Finally specific questions were asked about support for the role of their new role.

**Table 4: Sample size and Response Rate**

	Reported number of staff to whom survey distributed	Number of responses received	Responses received from staff with less than 6 years experience in Higher Education
Nurses and Midwives	1642	336 (20%)	86
Allied Health Professionals *	845	155 (18%)	60
Other Health Care Professionals	Not known	13	N/A
Total number	2487	504 (20%)	146

\*(Occupational Therapists, Physiotherapists and Radiographers)

No statistical information is available to enable an accurate calculation of the number of nurses, midwifery and allied health professional lecturers working in higher education. Similarly, it is unknown how many lecturers with less than 6 years experience are working in the sector, making it impossible to calculate the power of the sample. However, the survey was distributed to a maximum number of 2,487 academic staff and 504 responses were received, giving a response rate of 20%.

The above table identifies the distribution of the survey. Nursing and midwifery staff have been grouped together, this is because University departments often combine both professions. Contact was made with occupational therapy, physiotherapy and radiography (both diagnostic and therapeutic) departments and these have been grouped together and termed as the allied health professions within the table. The authors acknowledge that not all of the professional groups that are considered by the Health Professions Council, to be allied health professions, have been included in this research. A few chiropodists, podiatrists, speech and language therapists and others (n=13) who were working in the

participating departments did respond to the survey, but they have not been included in the analysis because they were not in a professional group targeted by the study. Largely due to the nature of the online survey tool no spoilt surveys were received. The analysis included all respondents with less than 6 years experience.

### Demographic Data of Lecturers with less than six years experience in Higher Education

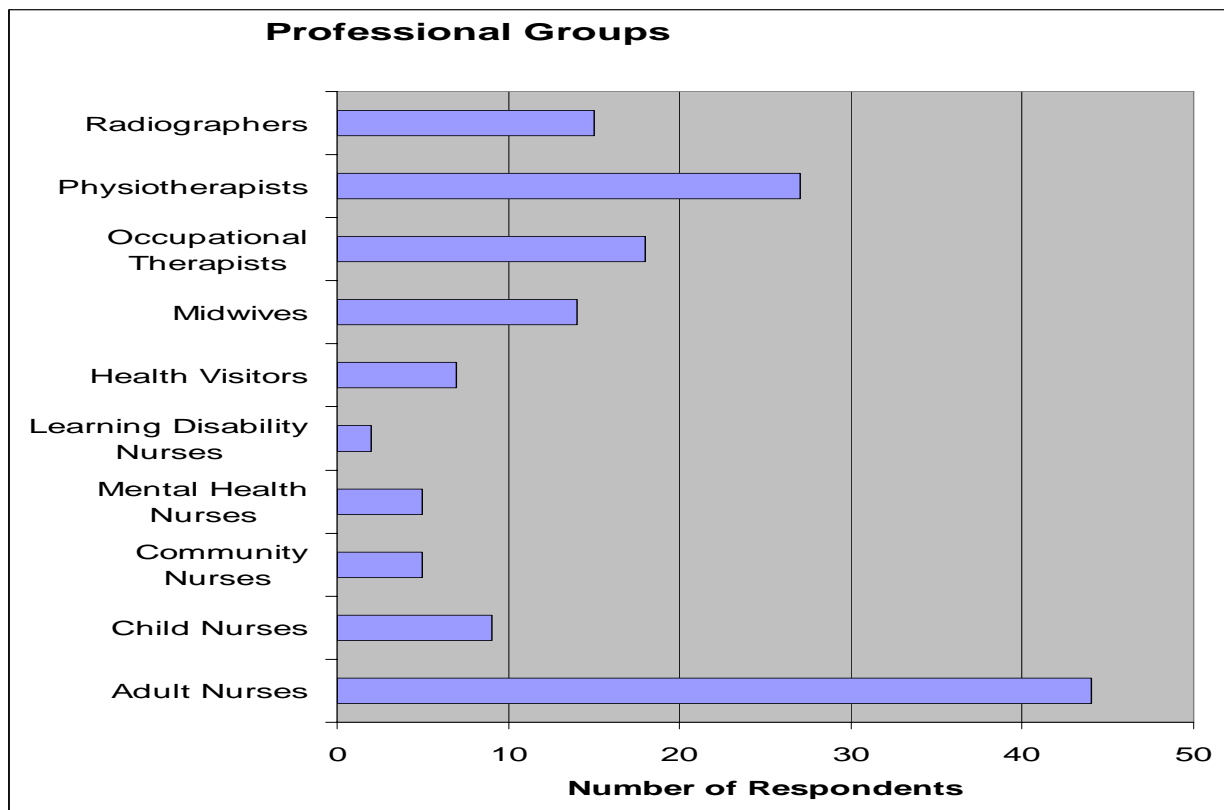
Of a total of 504 survey responses, 31% (n = 155) were from lecturers with less than six years experience in higher education. Of these, 146 of these were from branches of nursing (including health visitors), midwifery or occupational therapy, physiotherapy and radiography (diagnostic imaging and therapeutic). Of the 146 sample respondents 82% (120) were female, 18% (26) male, reflecting the wider distribution of gender within health care practice. Of these, 67% (98) respondents were full-time, 33% (48) held a contract that involved part-time work in higher education. The part-time participants included a small number of lecturer-practitioners (8). Although lecturer-practitioners are an interesting group and may reward further research it was beyond the scope and resources of this study to pursue analysis of them as a distinctive group. The remaining data from 69% respondents (n= 350) and those respondents from speech and language therapy, chiropody and podiatry (n=9) do not form part of this report, but will be the subject of future analysis and publication.

In terms of the ages of sample respondents 4% (6) were aged 20 – 29 years, 32% (46) 30 – 39 years, 53% (78) 40 – 49 years, 11% (17) 50 – 59 years. Prior to taking up employment in higher education, 27% (40) of sample respondents had up to ten years clinical experience, 57% (73) had between 11 and 20 years clinical experience, 21% (31) had between 21 and 30 years clinical experience, and 1% (2) had over 31 years clinical experience.

The age distribution of respondents demonstrates the majority of health care professionals make the transition to higher education in mid or late career and have acquired substantive clinical experience before making the transition to higher education (79% of new lecturers with less than 6 years experience, had more than 10 years clinical experience). This raises important questions about changing roles from clinical practice to being an academic, having possibly established a strong professional identity, and the mechanisms and processes required to support the transition.

Figure 1 shows the breakdown of the sample in relation to professional groups. Of the total sample 49% (72) were nurses or from nursing backgrounds. [Adult nurses 30% (44), children's nurses 6% (9), community nurses 3% (5), mental health nurses 3% (5), learning disabilities nurses 1% (2) and health visitors 5% (7)]. Midwives made up 10% (14) of the sample. The other responses which numbered 81 in total, covered a range of allied health professionals made up as follows: physiotherapists 18% (27), occupational therapists 12% (18), radiographers (diagnostic imaging and therapeutics) 10% (15).

**Figure 1: Breakdown of Sample by Profession**



**The experiences of newly appointed lecturers in nursing, midwifery and the allied health professions.**

The online survey contained a number of questions which aimed to capture the experiences of the new lecturers. A general question asking about the respondent’s experiences so far, was followed by questions specifically seeking the positive experiences and those that had been more difficult. Respondents were asked whether they felt that their skills and attributes had been fully utilized and where they saw themselves in 3 years time. Questions concerning support for the role were also posed.

In this section the analysis of self reported experiences of the respondents are presented and quotes from the survey are used to allow the voice of respondents to come through. Quotes have been selected because they are illustrative of the theme identified and quotes from the range of professional groups have been used. Each quote used is presented in the context of the relevant survey question with details of the respondent’s professional group, gender and experience in higher education. Further biographical data available has been withheld in order to maintain anonymity.



Through the iterative data analysis process, three clear themes have emerged which the authors have identified as:

**A. Managing Self**

**B. Support for new lecturers**

**C. Activities**

These will be considered in greater depth in the subsequent sections. This section considers the results under each heading and then highlights the key issues emerging from these themes which are summarized prior to a discussion in section 5.

**A: Managing Self**

The theme 'managing self' focuses on the way that new lecturers described their individual handling of their new role and work context.

The new lecturers viewed autonomy as a positive aspect of their higher education role. This was similar for all professional groups within the sample. Working in higher education was considered by the majority of respondents as having a greater degree of autonomy than in their previous roles, with a small minority suggesting that this took time to get used to. Frequent reference was made to the enjoyment and satisfaction which comes from managing ones own time. This may well be seen as positive as many new lecturers identified that they had good time management skills as a result of working in clinical practice for many years. In a few cases, however, a few individuals felt that the lack of support available to them made them feel that the level of autonomy was too great. Some individuals complained of a lack of autonomy in relation to the perceived bureaucracy and administration involved in higher education.

***P78: [Question 8: What have been your experiences so far?]***

*I have found the new role very exciting - I was pleased to move away from the set parameters of the NHS - I feel this role has given me a lot of autonomy. As time has moved on, the job has become increasingly stressful - time management is crucial and the amount of administration is colossal - even though it is my second year, I am [responsible] for a cohort and have been amazed at how much there is to remember and organise - the job is fairly relentless. We are a small team so I have found the support great - don't think I could have survived without it.  
**Midwife. Female. 2 yrs in HE.***

Strongly related to autonomy was the issue of time and flexibility, which featured repeatedly throughout the transcripts in all professional groups. Beyond the comments relating to managing one's own time and role flexibility, having 'time to think' is viewed as a luxury. In contrast to this, the problems of insufficient time for the role as a whole and specifically in relation to completing scholarship and research were highlighted.

**P79: [Question 10: What have you found most difficult...]**

*The time - there does not seem to be enough time to effectively prep for session or undertake marking and the basic role expected of me. My role is expanding by the weeks which is good but there is no extra time.. [for research]...*

**Midwife . Female. 2 yrs in HE.**

**P 115: [Question 8: What have been your experiences so far?]**

*..... There are subtle ways in which time is used and abused. Expectations are that there are peaks and troughs to your workload, when in reality my perception would be normal working day with the peaks added around marking schedules and academic boards. ....*

**Physiotherapist. Male. 2 yrs in HE.**

Time was reported by new lecturers from different and sometimes conflicting perspectives. For nurses, the flexibility and self management of their new role was viewed as a positive aspect; this was sometimes noted in relation to having previously worked shifts or in relation to being able to fit in with family responsibilities. In direct contrast, some respondents commented on their experience of excessive workload, sometimes in relation to unfair or excessive teaching allocation, and finding it difficult to manage time, especially in relation to completing scholarship and research activity or even taking holidays. The need to 'self moderate workload' and be assertive is noted.

Lack of time appears to be a concern for the future in that respondents hoped to be in a position where they had dedicated time for projects or recognition of the time required to complete research. There is a suggestion that in reality time is afforded to organisational and teaching tasks rather than protected for research, in spite of the expectation that the latter will occur.

**P 117: [Q16: Where would you like to be in 3 years time?]**

*Would like to do PhD but difficult on part time contract. [I would like] recognition of the time required to do this. This is there in theory, but in practice research time is eroded by other departmental priorities i.e. teaching and admin.*

**Physiotherapist . Male. 3 yrs in HE.**

The issue of the boundaries of the role emerges as a theme from the data. Respondents from all professional groups identified difficulties in maintaining a work-life balance and the amount of work that was required to be carried out in one's own time. Lack of clarity of the role was highlighted in contrast to clinical practice, where workloads can be heavy but an individual's role is usually well established. Respondents identified lack of fairness with regard to teaching allocation, constantly expanding roles and concerns about saying 'no' to ad-hoc increases in workload.

**P101: [Question 10: What have you found most difficult?]**

*Knowing when to stop. Blurred boundaries working at home means that have to be assertive about own time especially at the start when lots of preparation work was necessary. Not knowing what other members of the team are doing. Varied roles means that sometimes there is a feeling of working harder than other people. ....*

**Occupational Therapist . Female. 4 yrs in HE.**

Amongst the midwives and allied health professionals who responded, there are frequent references to the lack of clarity about the expectations of the role or what is expected of them. Some refer to a DIY environment where they have to find their own way, expressing this as a difficult situation and do not appear to be comfortable with the lack of direction they experience. In contrast, others refer to the lack of rigid structure as a positive experience and part of the challenge of the new role, viewing the freedom to plan one's own path as something to be valued.

**P112: [Question 8: What have been your experiences so far?]**

*It was very isolated at the start. I had no idea what was expected of me and very little guidance. I still feel I don't receive much feedback as to whether what I am doing is right or not. It has been very much a make it up as you go along approach. I felt and still very much feel that there is an expectation that you are a mind reader and should know what is going on but don't. Initially my workload appeared very manageable, now it has increased hugely and is just about manageable, but again, I'm not sure if I'm doing the right thing or not. I have concerns about the quality of my teaching and the information I give to students. I am the only person from my area of speciality and nobody appears to be checking up on what I'm telling the students! I find university and departmental politics most bizarre and try not to get involved, which is easy as most of the time I haven't got a clue what they are talking about, it must have been the same when I first started in the NHS, but then I was a junior with senior support, now I feel like I should know what's going on!*

**Physiotherapist. Female. 2 yrs in HE.**

Within the data there was little specific reference to identity but many of the comments made relate closely to theories of academic identity. Vocational degrees include many hundreds of hours of clinical practice where the process of socialisation occurs as part of the gradual process of becoming a professional in a chosen field of study. The lack of clarity of expectations highlighted in many of the replies, suggests lack of role clarity, absence of role models or suitable identities. For new lecturers with a vocational background, the engagement in academic practices is the most likely route to becoming an academic, although the point at which one achieves an academic identity is not clear cut. Although the majority of respondent's state they are looking towards completing a PhD in future, and some are already actively engaged in research at this level, there are many who will work in higher education for many years without achieving this level of qualification. There is room for debate and further research into the range of suitable academic identities in post 1992 universities.

Previous literature has made reference to the feelings of being a novice (Wright 2007), but interestingly, the data collected in this study made little reference to the novice or feelings of fraud. A very small number of respondents remarked that their clinical skills weren't recognised and this appears to relate specifically to those involved with PBL programmes, suggesting that these respondents were not necessarily involved in teaching areas of their clinical expertise. Another small minority identified that their management skills were not recognised, and one person was frustrated that their teaching and research experience appeared to have gone unnoticed.

**P104: [Question 9: What have you found most difficult?]**

*I felt de-skilled as if I was a novice and my 20 years [clinical experience] seemed to count for nothing. As we run a problem based learning programme, I didn't feel I could use my expertise, and was required to facilitate subjects that were completely new to me.*

**Occupational Therapist . Female. 5 yrs in HE.**

A much large number of allied health professionals, particularly physiotherapists and diagnostic radiographers suggested that all their personal and generic skills had been used to the full and found that whilst they were not necessarily always teaching their subject specialism, they found the engagement with other aspects of professional practice stimulating and enhanced their own knowledge base.

**P132: [Question 11: ..utilisation of personal strengths]**

*I think my strengths have been well utilised as I have moulded these myself, I'm not sure anyone has identified my strengths and consciously tapped into them.*

**Physiotherapists . Female. 5 yrs in HE.**

Personal, professional and career development was a strong theme in the data. There were frequent references to the learning acquired in the early parts of the new role, described as a significant part of both personal and professional development. The majority of respondents from all of the professional groups highlighted the opportunities available to them. One example given was simply having time for reading but other examples included attending seminars, working with bright colleagues, and formal courses such as a post graduate teaching programme. The potential for creative development of teaching and of research projects is seen as beneficial. There are some comments made about the negative impact of this open-ended work on overall workload and this is linked to comments on time for scholarship. Interestingly a small number of allied health professionals felt there were fewer opportunities for career development and a lack of defined career pathways. When prompted to consider their future career development the nurse lecturers identify different priorities and routes; the majority focus on gaining formal qualifications at masters or doctoral level and on publishing research but some focus on gaining promoted posts and some on developing teaching and learning.

**P 108: [Question 11: utilisation of personal strengths]**

*The freedom to choose your own path and working style has its benefit in getting the best out of you. Hence the university has helped to allow[me] to grow in [the] direction I am interested in rather than pushing [me] to where they[the University] need you to go...*

**Physiotherapist. Female. 1 yr in HE.**

**P150: [Questions 16: Where do you see yourself in 3 years time?]**

*I love teaching and I would see myself continuing with the same role as I have now. Our university does not value those members of staff who do not engage in research and do not have any clinical facilities on their campus for research in radiotherapy so I will not get any promotion but as long as I can develop my teaching skills and provide high quality education experiences for the students I will be satisfied to continue doing so.*

*I would like the opportunity to attend more conferences in the fields of cancer/radiotherapy/nuclear medicine, to keep up to date with current developments but again cannot do this unless I am presenting papers at the conferences. I cannot present papers if I am not carrying out research, I cannot carry out research if we have no facilities.*  
**Therapeutic Radiographer . Female. 4 yrs in HE.**

Nurse lecturers appear to be very aware of their changed status and express their feelings of having lower status in higher education than in their previous role, this is felt particularly strongly by those who had previously held management posts. The metaphor of being a 'small fish' [in a big pond] is the most frequently used to illustrate their feelings of being in a low status within the university especially compared to their previous workplace role in a practice setting where even if not in a management position they felt known and respected for their professional expertise and experience. This was not a theme which emerged from the midwives or allied health professionals.

The emotional issues associated with the transition into higher education were clearly articulated. Terms used to describe the new role included exhilarating, exciting, really enjoyable, and stimulating although this contrasted with those who made reference to different frustrations within the role.

**P38: [Question 8: What have been your experiences so far?]**

*My time at the university has; so far, been fantastic! I've had many opportunities to develop my skills further and have been offered the most appropriate support throughout. However, like all large organisations (for instance: the NHS) it brings with it a lot of bureaucracy and politics. This can be frustrating at times and impinges on my time for teaching/clinical visits and research/academic enterprise activities. .... The one thing I do have at the university (that I did not seem to have when in practice) is more freedom to manage my time. .... In my role as lecturer, although I'm extremely busy (and enjoy it that way!) I tend to have longer to work on projects thus adding to the quality of my output.*

**Adult Nurse. Female. 5 yrs in HE.**

Generally respondents were extremely positive about the move, however some nurse lecturers report that their transition had been challenging and in some cases stressful. The majority of respondents identified issues they found challenging, with some referring to the transition as a roller-coaster ride, but had plans for the future mainly relating to research, either being involved in research development within their departments or working towards a PhD.

Stress is a key theme within the data. Different issues link to stress in a variety of ways and are often interlinked.

**P73: [Question 8: What have been your experiences so far?]**

*Stressful in terms of adapting to a new environment and working under different pressures whilst feeling the need to be credible. Exciting (as [ mentioned ] above). Being aware of the hierarchy and pecking order. Developing skills, experience and knowledge in new post.*

**Mental Health Nurse. Male. 5 yrs in HE.**

There are a minority who do not feel at one with higher education and the role of lecturer and these lecturers see themselves returning to clinical practice.

**P91: [Question 16: Where do you see yourself in 3 years time?]**

*At this moment in time I feel very despondent about this career move. Whilst I thought I was prepared for a difference, I had underestimated just how much the difference would impact on me and how I felt. There are many positives to this role but I am very uncertain if this job is for me. Academic colleagues have described to me their experiences and a 2-3 year minimum transition period - just at present that feels like a very long time! I cannot envisage at all three years hence.-I have to spend some time considering my options. I have shared my initial feelings with my line manager and the struggle I have had trying to manage competing demands of my role, and the difficulties of trying to take in so much new information. I shall, I think look for another job as a practitioner, though my options are now very limited. In the meantime I shall try to make the best of my situation.*

**Occupational Therapist . Female. 1 yr in HE.**

Others see themselves as remaining in the sector despite a difficult or stressful transition associated with the workload and daily problems of engaging in all facets of academic practice. This would appear to have links with the amount of actual or perceived support. Returned surveys are illuminating when viewed as individual transcripts. Some new lecturers have found themselves in supportive environments, usually in well established departments with existing programmes of study. These respondents expressed a more positive experience of the transition. Those in small departments, or those newly established, identified the lack of direction as particularly stressful, described as 'making it up as you go along'. They identified feelings of isolation at the outset, although those with several years experience appeared to have found a course through the maze.

**P93: [Question16: Where do you see yourself in 3 years time?]**

*I am incredibly happy in my new role - even 18 months in I still pinch myself at the amazing opportunity I have been given. The attainment of this post represents the fulfilment of a long held wish to move into teaching & research. The 50:50 teaching research split is what makes it for me though - I would be less happy with a full time teaching role. That said I am pleased to have an opportunity to pass on my clinical experience and perspectives to new students and in doing so hopefully influence the future practice of occupational therapists. I find the university environment really stimulating but welcome the chance to work from home quite a bit.*

**Occupational Therapist Female. 2 yrs in HE.**

Seeing students develop into qualified practitioners and being part of that process, emerged as a very positive aspect of the role of new lecturers. This appears to be particularly important for a large number of nurses who view this as a key area of enjoyment and satisfaction in their role. Occupational therapists and physiotherapists share this view to a lesser degree, but interestingly there was little mention of this aspect of the role by midwives or radiographers. It is possible therapists who are involved in rehabilitation and spend much of their clinical life nurturing patients to maximise functional ability and independence, enjoy this aspect of their work and identify closely with student development.

**P38: [Question 9: What have you found most enjoyable?]**

*Supportive environment, motivated individuals, some very good role models, opportunity to network within a wider field, having an impact on the education/knowledge/skills/competencies of my students, knowing that ultimately this will have an impact on the quality of care for the patients in their care.*

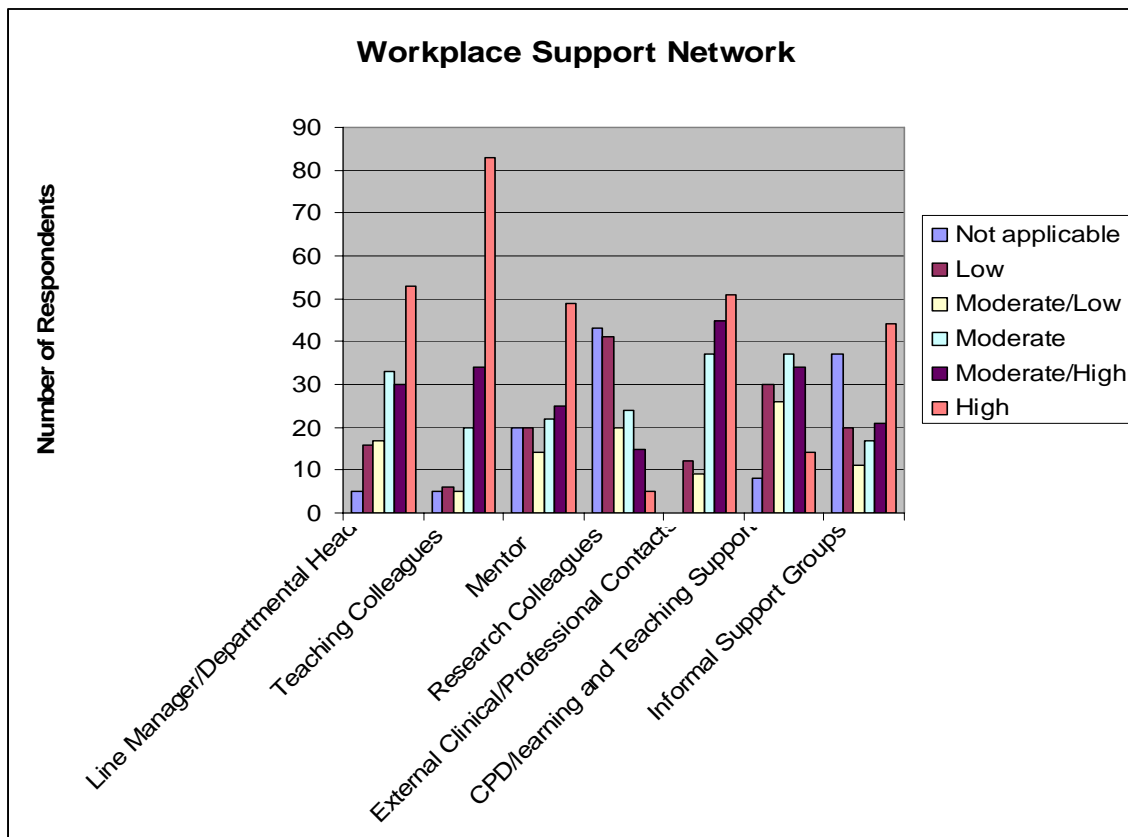
**Adult Nurse Male. 5 yrs in HE.**

**B: Support for new lecturers**

The theme of ‘support’ focuses on the formal and informal ways that new lecturers were helped in their work and professional learning.

In general new lecturers felt well supported in the workplace. They identified different sources of support including both formal activity such as post-graduate courses and informal support from teams and individual colleagues. Teaching colleagues were most frequently mentioned as providing support , followed by line managers, mentors, external clinical and professional colleagues, mentors and informal support groups.

**Figure 2: Importance of support networks perceived by new lecturers**



The majority of respondents identified several individuals or groups as providing significant support.

The distribution of responses shows that a large proportion of the sample (54%) of new lecturers viewed

teaching colleagues as being highly important in providing a workplace support network. This links to the priority assigned to teaching activity (see section C: Activities below) and indicates the importance of colleagues in helping new lecturers navigate their new role as a teacher. Respondents recognise that teaching colleagues also assist them in understanding the organisational processes of the institution. Just over a third of respondents deemed their line manager / departmental head as being highly important in providing support. Arguably, one might expect this to be higher, indicating perhaps that formal mechanisms do not always include the line manager because support is sometimes delegated to a close teaching colleague or mentor. Importantly new lecturers place high value on informal networks for support and this aligns with the significance placed on non formal learning within workplace learning literature (Lave & Wenger, 1991; Wenger, 1998; Evans et al., 2006).

The majority of sample respondents identified external clinical/professional contacts as being of moderate/high to high significance. Again this indicates the importance attached to clinical practice by new lectures and the importance attached to relationships built up in the frontline over years of clinical practice. Research colleagues were seen to be of low to moderate significance, corroborating the low priority accorded to research activity for relatively new lecturers. The role of CPD/learning and teaching support had a relatively even distribution of responses tending towards being viewed as of moderate significance, indicating perhaps that there is much work to be done by universities to develop relevant and stimulating programmes of professional development for new staff or to ensure time is available to devote to this.

A small number of respondents from all professional groups commented on feeling isolated when working in higher education in contrast to their previous clinical settings. Comments centred on the fact that there is a large amount of teamwork in clinical workplaces, often of a multidisciplinary nature, which is less apparent in the academic environment. The autonomous nature of the academic role was seen as promoting individual rather than team working.

***P12: [Question 8: What have been your experiences so far?]***

*.....However I did feel rather lost and unsure of my new role - there were induction days but these were filled with equally unsure 'new' lecturers. I commenced a PGCE 6 months after arriving and this helped me to understand my role in terms of teaching but in terms of the workings of the university - I am still not sure what my role should be. Academics seem to work alone and I miss the team approach that I had in practice. I have recently begun to voice this uncertainty and find there are many who feel the same.*

***Adult Nurse. Female. 2 yrs in HE.***

Few differences were apparent concerning support between lecturers in different professional fields. Formally appointed mentors and CPD programmes leading to teaching qualifications are most frequently mentioned as helpful. New nurse lecturers identified appraisal as a key activity whilst other professional groups made little mention of this. A small number of nurses questioned the value of appraisal as they felt it was action-oriented or that agreed actions were not carried through. Some



discussed the structured probation period as helpful although others dismissed it as 'box-ticking'. Line managers appear to have played an important role for many new academics, although for a number of allied health professionals, the line manager was viewed as playing little part in them becoming familiar with the new role. Institutional induction was a varied experience and to a considerable number was highlighted as being ill-timed and not reflecting their individual need.

A large number of the new lecturers described the formal mentoring they had received as being effective and a key element of support, but this was not unanimous. A small number found their mentor to be unhelpful or simply absent or felt the wrong person had been allocated to this role. It is important to note that a very small number of new lecturers claim that their workplace is lacking in formal support.

Postgraduate courses in teaching in higher education were identified as useful by the large majority of respondents. They valued the opportunity to develop skills in teaching and found the peer support extremely valuable. However in a number of cases, new lecturers identified that they were finding it difficult to find the time to attend and to complete assignments, this was especially the case where they had started to study for a Masters level qualification as well. Even where 'protected time' was available for new lecturers to attend the post graduate course the new lecturers still reported problems in attending and in completing the associated work. In a small number of cases new lecturers mentioned attending sessions focused on the academic role and found these useful. These sessions were either part of the postgraduate course or free-standing provision within their institution. Some new lecturers also found workshops run by their institutions useful.

There was overwhelming significance given to the importance of informal support, received on a day to day basis from their colleagues. The majority mentioned other lecturers as the main source of informal support but other colleagues specifically mentioned included administrative staff, other new appointed lecturers, their fellow participants in the postgraduate course, tutors on the postgraduate course and internal or external interest groups or networks. Supportive colleagues have enabled many new lecturers to navigate the myriad of tasks required of them, and to become familiar with the workings of the institution.

**P30: [Question 9: What have been the most positive aspects of the new role?]**

*I work with some fantastic colleagues and we do a lot of team teaching in our practical lessons - so there is a lot of creativity and a lot of mutual support and encouragement. ....*

**Adult Nurse. Female. 4 yrs in HE.**

Within the responses, the idea of formal and informal support are often combined, with a more integrated support emerging as highly important. The new lecturers emphasise the significance of physical location by frequent mention of particularly gaining support from those colleagues with whom

they share an office space, a corridor or a coffee room. The majority of new lecturers felt they were able to be able to ask these supportive colleagues 'endless' questions. Some new lecturers explained that they had set up informal 'probationers' groups with other newly appointed colleagues. A considerable number of new lecturers had sought out their own informal mentor and found these colleagues to be a very effective support.

Provision of formal support and the informal, integrated or fuzzy support gleaned from the different communities of practice encountered in the workplace are significant for new lecturers. However, in a minority of cases, work colleagues have been perceived as obstructive to newcomers. A small number of new lecturers identified difficulties with existing staff who do not share departmental aims but have their own agendas; feeling that colleagues are not open to discuss approaches to teaching or assessment and are reluctant to share ideas and resources. Departmental politics were identified as hindering progress for some, with unfair allocations of workload or unfamiliar subjects to teach and some new lecturers feel they have been subject to bullying.

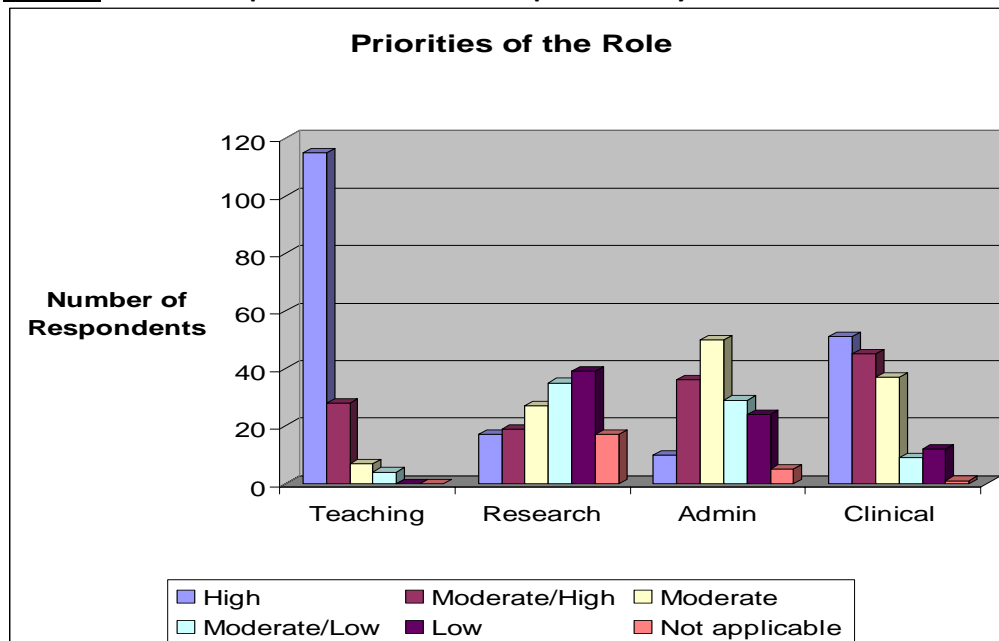
### C: Activities of new lecturers

The four main activities of new lecturers were found to be **teaching; scholarship & research; organisational issues; and clinical partnership.**

### Identified Priorities in Current (or first) Post in Higher Education

Respondents were asked the question: *"In your current (or first) post in Higher Education, what do you feel are (or were) your main priorities in the role"*. Figure 3 below shows the distribution of responses.

**Figure 3: Individual priorities of the role as perceived by new lecturers**



Teaching activity (including personal and academic student support) was identified by 92% as being a high or moderate/high priority. None of the respondents identified it as a low priority and only 6% (n=9) rated teaching as low or moderate/low priority. Research activity had a broad distribution but fewer respondents identified this as a high priority. In terms of contribution to the university, i.e. department or faculty role, (admin in the bar graph) 66% reported this as being a low to moderate priority. A high proportion of the sample (62%) reported clinical, professional or practitioner activity as being a high or moderate/high priority.

The distribution of responses indicates that for the majority of new lecturers teaching activity is seen as a high priority activity. This may relate to the importance new lecturers place on developing students to become competent practitioners or a desire to establish credibility and competence as a teacher with students and colleagues. Research is seen by fewer respondents to be of high priority.

The significant proportion of the sample reporting clinical, professional or practitioner activity as a high priority as a new lecturer may relate to issues of identity, in terms of credibility with students and colleagues, but may also relate to the satisfaction new lecturers gain from nurturing students (see later results). When responses were analysed in specific professional groups, there was no difference between professions, with all groups being equally represented in each level of each category.

In the survey the question of priorities was reframed to ask new lecturers about *departmental* priorities. The responses to this separate question mirrored the individual priorities shown in figure 3, above. This suggests that teaching was considered by new lecturers to be a departmental as well as an individual priority.

## Teaching

Teaching related activities are a key priority for new lecturers, both as a personal and departmental priority. New nurse, midwifery and allied health professional lecturers comment on many issues around teaching, including developing and having confidence in their teaching skills; preparation and planning teaching activity and the time involved in carrying this out; subject specialist areas and allocation of teaching; the assessment process; and a strong commitment to the development of new professionals.

A large number of allied health professional respondents felt they had existing teaching skills, which they had developed in their clinical careers. They brought experience of teaching, good communication skills and confidence within their knowledge base. Teaching itself was not an area the majority of allied health professionals found challenging, although virtually all welcomed the opportunity to undertake a formal teaching qualification i.e. PG certificate or diploma. A small minority commented on particular challenges they had experienced, e.g. strategies for encouraging interaction from students, or dealing with large groups, but the data suggests allied health professionals are relatively confident in this area of their role. Fewer new nurse lecturers commented on this aspect of the role, although many new nurse lecturers highlight the development of teaching and learning as an area of activity and professional interest.

The issue of teaching clinical skills is raised by new nurse lecturers. Some of them mention teaching clinical skills as an area of subject knowledge strength for themselves and as an area of interest and contribution that they are able to make to the students' programme. This may reflect the extent of clinical skills which undergraduate nurses are taught on placement. This was not commented upon by allied health professionals or midwives.

***P 6: [Question 9: What are the most positive aspects of your role?]***

*Teaching advanced clinical skills - it's always rewarding to see students develop these skills in conjunction with professionalism, allowing for further job satisfaction. One-to-one tutorials and placement visits*

***Adult Nurse. Female. 2 yrs in HE.***

Respondents made frequent reference to workload planning including large amounts of time dedicated to preparation for teaching. The majority of those who commented on this issue claimed that they spend considerable time in the evening and at weekends completing this work. This links closely with the feelings of stress arising from the lack of clarity of expectations of the role and workload allocation. For new nurse lecturers, preparation for teaching is seen as taking up considerable time with some new nurse lecturers feeling they had been thrown in at the deep end with little or no preparation time before they were expected to begin teaching.

**P67: [Question 8: What have been your experiences so far?]**

*..... That doesn't mean the 'learning curve' isn't steep, because it is. It's a matter of how you apply your knowledge base, it's done in a different way than other roles. I've also found out a few areas I need to revise and reappraise to come into line with the way things are done in HE. It's nice having more time, on one hand, to actually look in depth at topics, issues and areas. On the other hand it seems to take such a long time to put lectures together, at a level, and to the depth that is appropriate for the students you are teaching. I realise that I need to give myself time, and that I shouldn't compare myself with more experienced colleagues.*

**Learning Disability Nurse. Male. 1 yr in HE.**

A key area for new nurse lecturers appears to be the negotiation or allocation of teaching both in relation to the expertise of the lecturers and in relation to workload. Some nurse lecturers find that they are mainly teaching within their area of expertise and in addition to making them feel confident in the classroom this is also seen as recognition by the department of their experience and the practitioner knowledge that they bring. Others find that are required to teach outside of their area of expertise and new nurse lecturers from both of these groups describe a slow process of negotiation in order to pick up more teaching in their specialist area of interest.

For allied health professionals and midwives, a range of comments were made about the subject specialist areas, and there seemed to be no majority experience. Respondents commented on a range of experiences, although the majority appeared to be teaching within their subject specialist area and this was considered to be a positive aspect of the role. A small number of respondents were involved in problem based learning programmes and felt frustrated this was not utilising their subject specialist knowledge. However, those required to teach subjects they did not normally consider to be within their area of expertise enjoyed the challenge. This may reflect the specificity of the allied health professions, whereas nursing, often grouped under a common umbrella heading might be considered as a common name embracing a multitude of professions.

Issues within the professional field as a subject discipline are commented on by nurse lecturers in relation to their own development, for example the limited scope of work at pre-registration level compared to post-registration and the status of clinical skills within nurse education. This is related to the debate around the value of skills within the subject discipline and to the idea of nurse lecturers holding a scale in terms of the prestige associated with teaching in different programmes. The issue of status in relation to under and post graduate teaching did not arise for midwives and allied health professionals which may relate to the relatively smaller staff teams amongst these groups of professionals. Within smaller teams, it is likely that all staff will be involved in both pre and post registration programmes, whereas in larger teams, staff may not gain this breadth of experience.

Assessment is another issue raised by some nurse lecturers who see a need for staff support in the marking of student work and in getting to grips with the assessment process including regulations and

the exam board process. In response to Question 10, “which areas of the job did you find most difficult?, marking emerged as a fairly strong theme. All professional groups share a concern about the responsibility of marking and the difficulty of understanding the vagaries of academic grading. Time for marking was an issue for many of those who raised this as a problem, with several comments concerning excessive marking loads. Interestingly, virtually no reference was made to setting or planning assessments.

**P67: [Question 10: What have been them most difficult aspects of your role..?]**

*Not knowing how it all works, it's the first time in a long time that I've felt as helpless, in some ways, as I did the very first time I started work when I was 16. Wondering when it will all become clear. Not knowing at what point you are expected to know how to do things that are expected of you. Getting used to marking assignments/exams. All of these areas are to do with my perception of myself and my role, particularly as I've only just started. I ... don't quite have that self assured attitude I had in my 20's and 30's.*

**Learning Disability Nurse. Male. 1 yr in HE.**

The difficulty of getting to grips with this aspect of the role emerges again under academic structures, rules and regulations, as exam boards caused difficulties for some, particularly as assessment marks were under scrutiny when the specific content of the curriculum was not subject to quality control.

**P80: [Question 8: What have been your experiences so far?]**

*I was very surprised at the quality mechanisms, i.e. we spend hours in examination boards to ensure that the awards are true; yet, there is very little time spent checking the quality of the information given to the students. ....*

**Midwife . Female. 3 yrs in HE.**

Health care professionals have a strong public commitment, with standards of practice and competence being governed by professional and government bodies. This commitment is a strong emergent theme from the data, but especially in relation to teaching. A large number of respondents identify nurturing students and developing new professionals as a highly satisfying element of the role and indeed a priority. It appears that developing professionals who are competent to practice is of greater importance than the development of professional knowledge at this stage of the new lecturers' careers.

**P50: [Question 9: What have been your experiences so far?]**

*Student contact time - especially going out on clinical visits and working with the students in a clinical area. This appears to have a lot of rewards for both myself and the students and puts a lot of the theory back into a clinical area which makes most sense for the students. Clinical skills teaching - running electronically simulated training with the students.*

**Child Nurse. Female. 4 yrs in HE.**

Additionally new nurses identify student 'appreciation' and feedback as being highly valued. Previous authors (Boyd & Lawley, forthcoming) have suggested that nurses grieve for the loss of affirmation they

receive from patients in their clinical roles and may see student feedback as a substitute for this. This was absent from allied health professional and midwifery responses.

## Scholarship and Research

Although teaching is the priority activity for the majority of new nurse, midwifery and allied health professional lecturers, research is also seen as important. For the majority of respondents further academic study is a priority and being engaged in research or studying for a PhD is where most, but not all, new lecturers see themselves in 3 years time. In addition to pursuing a doctorate there was also a strong general desire to develop as an academic writer and to publish. Those who do not see this as a priority either see themselves primarily as teachers or returning to practice.

Only 4% of the new lecturer respondents had completed a doctorate prior to being appointed to their higher education post and 8% had completed it since their appointment, giving a total of 12% of the respondents who currently hold a doctorate. In a few cases, nurse lecturers reported considerable pressure on them to begin a doctorate but that they did not see this as feasible for themselves. In some contexts the pressure to publish was seen as very strong, even within their first year of appointment, and in one case the respondent used the term 'extreme'. The pressure to research and publish appears to be linked where research is a strong department or institutional priority. As identified previously, a small number of nurse lecturers expressed a preference for contributing through development of teaching and learning, rather than through a doctorate and publication of research, although these lecturers identified an apparent lower status of teaching and the high status for research activity within their institutions. It is clear that not all new lecturers have completed a higher degree with some identifying a Masters level programme as their next goal.

For the majority of would-be researchers, there appears to be a considerable tension between research and the other aspects of the role. Lack of time to do research is a strong theme, with urgent tasks such as teaching, faculty roles and general administration taking priority over the important but less urgent issue of research.

***P63: [Question 16: Where do you see yourself in 3 yrs time?]***

*[I] would like to develop knowledge regarding teaching and learning for example programme development. [I would] like to embark upon a PhD. [I] see myself in [my] current role for [the] next 3 years - however [I] would like to make time to complete publications etc. However [I] feel that .. this is curtailed by full time teaching role/practice/and the fact that I have youngish children therefore there is a limit on the amount of time that I have available for extra hours of work. [To achieve this, I need] Time.*

***Health Visitor. Female. 3 yrs in HE.***

The majority of respondents identified as a key priority the need to ring-fence time for research activity. They positioned research as personal development required to fulfil their academic role. The challenge of developing research skills was not specifically raised, but many see support for research as being a vital factor for them to achieve their goals in this area of the lecturer role. For radiographers and those wishing to engage in clinical research, the issue of researching in the University setting may pose particular problems if strong clinical partnerships do not exist or their University does not have state-of-the-art equipment. Many of the tensions are interlinked, as this respondent demonstrates clearly:

**P150: [Question 8: What have been your experiences so far?]**

*I found the transition from clinical to academic quite testing. I could easily have gone back to clinical if it were not for the support of close team members with lots of teaching experience. I really missed the patient contact and wish that there had been the opportunity to take on a role that included a clinical aspect. The university really wanted me to be involved in research but this was impossible because of the break I had to make with the clinical department. Senior staff did not understand that irradiating people for research is very different to some of the research carried out in other [allied health] professions and it was not possible to generate research projects easily. I came to the university expecting to be valued for my teaching role but found that university priorities are NOT teaching the students - good educators don't seem to be valued as much as good researchers. Now I don't care if I don't have the respect of the senior members of the university as long as I know that I do my best for the students and they are competent practitioners when they graduate.*

**Therapeutic Radiographer . Female. 4 yrs in HE.**

Although preparation for teaching is a key competitor with research in terms of available time, this is not explicitly viewed as scholarly activity by the new lecturers, although confidence in one's own knowledge base features as an important theme within the data.

A small minority of respondents make a strong point about confidence within their own knowledge base. Some have found the move to higher education as being liberating – being able to think about practice and identify an increase in their level of confidence within their subject. Others have highlighted a discrepancy between theory and practice which they find difficult to deal with. The lack of a strong evidence base for current clinical practice presents a dilemma and how to address difference of opinion within small teaching teams. This dilemma appears to be a particular difficulty for a small number of allied health professionals, with a minority deciding on a return to practice:

**P 115: [Question 16: Where do you see yourself in 3 years time]**

*I have resigned my post within higher education as I do not see that my overall development is progressing. I also feel that I am not suited to working in this environment, I do not have the attitude that what I say is 100% correct, as our profession (Physiotherapy) does not have the research to support this. I say this as the lecturers who have thrived and established themselves seem overtly confident in what they teach, even though I have seen old principles and evidence adopted. I wish to return to clinical practice and work through advanced practitioner routes where I can begin to develop myself (very selfish) further and also expand my knowledge of clinical research with like minded peers. ....*

**Physiotherapist. Male. 2 yrs in HE.**



## Organisational issues

Throughout the data, the issues of understanding organisational structure and educational systems and practices, and the lack of clarity of expectations of the role, emerge repeatedly. Role boundaries have already been identified as an issue which creates difficulty for many new lecturers. The tacit nature of the operational aspects of higher education is highlighted, and although the majority of new lecturers have taken part in an induction programme, a large number identified that the formal induction process lacked specificity to their everyday role. Frequent references to 'being thrown in at the deep end' or 'hitting the ground running' suggest a need for clarity.

**P91: [Question 8: What have been your experiences so far?]**

*I was ready for a next in terms of my professional career development. In my.. [previous clinical] .. role I contributed to an education programme and taught on university accredited modules as a visiting lecturer. As a clinician I had an active profile in student education and had research experience. Whilst I anticipated there would be obvious differences between working as a clinician and an academic, I was unprepared for the total shock this experience has been. The cultural differences are immense, the university has a language all of its own, I am phased by academic policies, procedures etc and mourn the loss of my professional identity.*

**Occupational Therapist . Female. 1 yr in HE.**

Overwhelmingly, new nurse lecturers report finding the language of higher education and of their institution a very challenging aspect of their induction experiences. Language is raised by the majority of new nurse lecturers when discussing the challenging aspects of their experience. Within their comments about having to learn a new language they describe terminology and acronyms as particularly difficult issues but also refer to having to produce documents for example 'written in a very 'academic way'. The university regulations are frequently named as a difficult area of learning and new lecturers also claim to find structures and processes of higher education confusing or at least difficult to learn:

**P51: [Question 8: What have been your experiences so far?]**

*"..[even after three years in post] ...I still do not understand many aspects of the university system and sometimes I do feel conspicuous, in that I will get recognised as a weak link, because I do not use the academic speak."*

**Child nurse. Male. 3 yrs in HE.**

**P138: [Question 8: What have been your experiences so far?]**

*There was an assumed understanding of university terminology and procedures which was very confusing. There was an assumption that I knew how modules were formulated and the levels at which they were set. There is a more individualist (rather than team) approach used in the university.*

**Radiographer Diagnostic . Female. 2 yrs in HE.**

The tension expressed in the above quote is particularly identified in the areas of assessment and validation procedures which are seen to be confusing areas of institutional knowledge. Assessment processes, including assessment boards are seen as carrying considerable tension:

**P20: [Question 10: What have been the difficulties of the role?]**

*“Understanding the exam assessment process and having to present results... I have seen people really demeaned in these meetings if they have made a mistake, I still feel very nervous at these events. I don't think this is just me, you can tell that the atmosphere is charged in the room even with very experienced tutors.”*

**Adult nurse . Female. 3 yrs in HE.**

Many new lecturers viewed their higher education institution as an unwieldy bureaucracy and described it as a more hierarchical structure than their previous health trust while others saw it as a flat structure. New lecturers found it difficult to work out who is who within the hierarchy. They expressed frustration at what they saw as excessive administrative duties. A further frustration that emerged related to the micro-organisational issues, described by some as internal politics. For some nurse lecturers, departmental politics included poor working relationships, and a small number made direct reference to experiencing bullying from their colleagues or line managers. Unfair workload allocation is seen as a particular problem by this group. Direct reference to department politics did not feature highly within the data collected from allied health professionals or midwives, although these groups are not immune from inter-personal tensions.

**P82: [Question 10: What have been the difficulties of the role?]**

*“...[there is a] ...dinosaur culture...[with] power struggles and internal politics – people always trying to take me down a peg or two...”*

**Midwife. Female. 3 yrs in HE.**

Reference is made to colleagues who had been obstructive or had personal agendas, with the suggestion that research and academic enterprise was not readily shared, but “...surrounded by cloak and dagger”. Again, there were tangential references to workload allocation and the lack of openness in this area, giving the impression that some people were doing a lot more work than others, however, the large majority of allied health professionals alluded to the high level of support they had received from their colleagues in all aspects of their new role.

### **Clinical partnership issues for newly appointed lecturers**

New nurse lecturers generally emphasise their recent clinical practice as important for gaining credibility with students and they view their ability to teach clinical skills as a strength of their knowledge. They

adopt a range of strategies to maintain currency in clinical practice. Some see their role as clinical placement visiting tutor as being sufficient to maintain currency. Others see it as important to attend clinical update courses, for example in life support, in order to maintain and develop clinical skills. Several lecturer practitioner respondents report on the challenges of the role but also claim that maintaining a 'hands on' clinical role has considerable benefits for their teaching.

***P56: [Question 10: What have been the difficulties of the role?]***

*This is [not my first experience] as a lecturer - I work in university, get clinically de-skilled, panic, then go back to practice. This time I am maintaining my clinical role outside to supplement my teaching. It's hard work (extra hours on top of full time teaching) but it is more fulfilling & the students really value my clinical expertise. .... I maintain contact with clinical colleagues in 2 clinical areas - alongside my own clinical practice they keep my feet on the ground.*

***Community Nurse. Female. 2 yrs in HE.***

In contrast, clinical currency is not a strong theme for either midwives or allied health professions. There are comments in relation to subject specialist teaching, where some respondents feel their clinical specialist skills have not been well utilised, although several respondents acknowledge that students value clinicians who were recently in practice. Those mourning the loss of clinical skills are considering or are returning to practice.

## Summary of Findings

### Similarities in experience across professional groups

Many of the experiences of the health care professionals who responded to this survey are common to all professional fields. The themes which emerge from the survey responses will be discussed in the following chapter but can briefly be expressed as:

- The transition is a positive one. For the majority of respondents in the sample of 146 new lecturers with less than 6 years experience, the experience of moving from the clinical field into higher education has been a very positive experience. Notwithstanding some of the challenges associated with understanding some of the operational aspects of their new role, new lecturers enjoy nurturing new professionals; they enjoy the flexibility and autonomy of their role; the move is viewed positively and strongly in terms of personal development; and they look forward to influencing educational practice in future.
- Self Management. This is a strong theme, suggesting that considerable energy is involved in becoming a lecturer. This includes lack of clarity regarding role boundaries and expectations;

the difficulties of maintaining a work-life balance and understanding the requirements of the role and the organizational structures, featuring strongly.

- Support for the role of new lecturer is highly important, although this may be via both formal or informal routes or of a 'fuzzy' or more integrated nature. Line managers and mentors are highly valued, whilst teaching colleagues appear to provide the key to surviving on an everyday basis.
- Activities. A number of tensions exist within the new role. The initial emphasis of the new role is on teaching, although tensions exist between teaching, faculty roles and the pressure to research.
- The primacy of teaching. Health care professionals exhibit a strong professional loyalty and see their role in developing competent professionals as a priority in the initial stages of their careers in higher education. This is highlighted in the importance placed on teaching and the priority this takes over research and consequently in the development of professional knowledge.
- Pathway to Academia. The results demonstrate that few new lecturers hold a doctorate on their appointment to higher education. Many have years of managerial and clinical experience, but the majority come into their university post with a Master's Degree or with plans to complete one. This identifies a clear non-academic pathway into higher education roles, in contrast to non-vocational subjects, where the award of a PhD is the stepping stone to academia.

### Differences in experience between professional groups

The experiences of becoming a new nurse, midwifery or allied health professional lecturer have highlighted demonstrate that both positive and difficult aspects of the transition are shared across the professional groups. Some differences do exist, although these are far fewer than the shared experiences. Broadly, the responses of the professional groups who took part in this study, can be grouped into two main categories: Firstly the nursing professions – including adult nurses, child nurses, health visitors, community nurses, learning disability nurses and mental health nurses and secondly the allied health professionals and midwives.

Suggested differences are:

- Clinical Partnerships – the issue of clinical currency is perceived as more important for the nursing professions.

- Teaching expectations – nurses appear more likely to be expected to teach subjects they do not consider as being within their specialist subject area, finding this a frustration of the role. They expressed greater concerns than midwives or allied health professionals about unfair teaching and workload allocation, and identified issues of difference in status relating to teaching on undergraduate and postgraduate programmes. Allied health professionals largely view an extended teaching remit as being a positive aspect of the role.

## **Chapter 5 – Discussion (Patterns of workplace learning: becoming a professional educator in the health professions)**

This chapter will discuss the relationships between the emerging themes within the experiences of new lecturers. In the first section the themes will be discussed in relation to the theoretical framework of workplace learning. In the second section the findings will be considered in relation to the existing research base.

### **Self Management**

The main theme arising from the analysis is the importance new lecturers place on self management of their challenging transition experience. This self-management by the new lecturers may be viewed as identity-building work in the sense that it is the ‘mutual constitution’ of identity and workplace (Wenger, 1998: 146). The change in the lecturers’ role is experienced and expressed through the activities of teaching, scholarship and research, organisational issues of working in higher education context and working in clinical partnerships. The developing practice of the lecturers in these areas of workplace activity reflect the elements of academic identity identified by D’Andrea and Gosling as ‘institutional membership’, ‘discipline’, ‘professional identity’, and ‘universal academic identity’ (2005: 59).

The approaches they adopt during these activities are influenced by the formal, informal and ‘fuzzy’ support that they find for their professional learning, with the majority of new lecturers taking an active stance towards learning the new role in spite of tensions and challenges. Whilst tensions are apparent for new lecturers between different aspects of the role and between the issues of professional knowing and the need for acceptance of health sciences as academic disciplines (Oldnall, 1995) the majority of the survey respondents appear to enjoy the challenge.

## The Primacy of Teaching

Teaching and supporting students, seen especially as helping new practitioners to develop, is a key motivator and enjoyable aspect of a lecturer's new role. This appears to be a strand in the developing identity of the new lecturers; they see themselves as contributing to their professional field by nurturing new practitioners. An interesting silence within the data is that the respondents do not raise the possibility of contributing to the field by developing new knowledge, except perhaps as a secondary consequence of completing their doctorate.

Teaching is a key focus for the new lecturers in terms of time and effort; they see it as being a dominant part of their role and as a priority of the department. As they struggle with managing their time they place teaching as a priority, the rules of the workplace appear to influence this. Within teaching activity assessment of student work, including marking of student work and the exam board process, is a particular area of challenge felt by the new lecturers.

The new lecturers in nursing feel that teaching takes up a great deal of their time and causes a shortage of time for scholarship and research activity. Lecturers in Allied Health Professions and Midwifery also find it difficult that teaching that takes up their time, they include administration and other faculty roles as also being significant. The majority of new lecturers, despite the departmental priority placed on teaching, feel under considerable pressure to gain a doctorate and to publish research papers and a good number of the respondents are currently completing, or at least planning to start, their doctoral studies with lack of time being presented as a major obstacle to this work.

New lecturers feel that there is an element of autonomy in their new higher education role and this is mostly seen as a positive aspect. However in practice teaching allocated to them, sometimes in their specialist area of knowledge but sometimes not, appears to dominate and control their time. This raises the question of whether the perceived autonomy actually exists. Many respondents appear to be thrown into the job 'at the deep end' in terms of teaching workload? Many new lecturers report that they are working long hours and often not maintaining a healthy work-life balance. The lecturers may feel that they have a significant level of autonomy but in practice the heavy workload reduces this to a low level of operational decision-making. This echoes the recommendation of Knight et al (2006) who highlighted the importance of control of one's working environment for new academics.

Overall the new lecturers experience a tension (Engestrom, 2001) within their workplace setting in the division of the new lecturers' work between research and teaching activity. Despite the fact that gaining a doctorate and publishing research papers may be a priority, in practice this may be an implicit rule which contradicts the experience of the lecturers who feel that teaching and supporting their students dominates their time.

## Professional knowing

The overwhelming majority of respondents in their first four years of lecturing have been appointed due to professional expertise rather than holding a doctorate and being an active researcher (only 4% of respondents held a doctorate on appointment). They feel they are newcomers in terms of research activity and most of them express an ambition to gain their doctorate. The new lecturers generally felt a pressure to become active researchers due to the status of this activity within the higher education work context. This highlights the accepted practice in the UK of a route into higher education employment as a lecturer, through recognition of clinical expertise rather than the traditional route in many disciplines of first gaining a doctorate. This reveals a tension within the experience of the new lecturers, the rules of selection and appointment appear to place value on clinical expertise but the new lecturers recognise that in the higher education context holding a doctorate is seen as an essential requirement for credibility as an academic.

A common theme for all respondents was the perceived lack of time that they were able to find for research and the tension that seems to lie between the different aspects of the role. Teaching is identified as being a high personal and departmental priority but alongside this is the priority of research with apparently no ring-fenced time to carry this out. A large number of respondents when outlining where they would like to be in 3 years time, highlighted that they would like to be engaged with their PhD or doing research, but many added that they would need time set aside to achieve this as a personal and institutional goal. Many new lecturers identified that they would hope to have future support for this aspect of their role, emphasising the perception of limited skills in the area. Although other demands are given as reasons for lack of scholarship and research activity it may be that new lecturers are trying to make decisions about priorities. They appear to prioritise operational and student focused demands on their time at the expense of research activity. This priority may be related to the value they place on nurturing students as new clinical practitioners as opposed to attempting to make new contributions to knowledge within their professional field. The new lecturers appear to be aware of pressure to become research active as part of their personal development but they prioritise the apparent departmental priority for operational work.

The nurse lecturers, in particular, express a need to maintain credibility as clinical practitioners. This appears to be connected to the dominance of teaching in their work and the student audience is perceived as placing high value on clinical credibility, in terms of up to date practitioner knowledge and clinical skills. Not surprisingly the new lecturers find that they have limited time for engaging with clinical practice, despite their professional body, the Nursing and Midwifery Council, requiring that nurse lecturers continue to engage with clinical practice. This requirement has been challenged by Barrett (2007) at least to the extent that not all nurse lecturers need to continue with an element of clinical practice. The Health Professions Council (HPC, 2005) do not state the requirement for clinical currency in such stringent terms, simply identifying the requirement to be engaged in the practice of one's profession in order to retain state registration. Interestingly, both education and research are considered by the Health Professions Council as meeting this requirement.

A very small number of the new lecturers express feelings of not being at one with their new lecturer role and claim to be actively planning to move back into clinical practice. A wider number express a sense of loss of expertise in clinical skills and practice. Some feel that they are losing rather than gaining in terms of expertise; that from being at the top of their profession they are moving backwards.

Overall the respondents appear to experience a tension between the demands of their students, who are viewed as novice practitioners, to maintain credibility as a clinical practitioner, and the pressures in their new role as a lecturer to become an expert in teaching adults and in research activity. The pressure from students resonates with the new lecturers' own desire to retain their status as an expert clinician and with the primacy of teaching in their day-to-day work. While the new lecturers are motivated by nurturing new clinical practitioners, they do not appear to view research activity as relevant to this purpose.

## Organisational Issues

The language and jargon of higher education appear to undermine the confidence of the new lecturers because they make learning about the role and the institution much more difficult. New lecturers feel frustrated by their difficulty in learning how institutional systems, such as assessment procedures, work and by their feeling that line management hierarchies, structures and protocols are not clear. This may be partly explained by the long experience of most of the new lecturers within National Health Service settings where they claim that more explicit hierarchies and protocols exist and the perceived lack of clarity of role and the apparent high level of autonomy in higher education may also be part of this



feeling. The perceived lack of explicit rules in their new workplace seems to unsettle the new lecturers and they felt that in their position as an experienced practitioner, they 'should know' how things work, and sometimes felt reluctant to ask.

This challenge caused by language and systems of higher education after serving for a long period in health settings is consistent with previous small scale studies for example of new nurse lecturers (McArthur-Rouse, 2008; Boyd & Lawley, forthcoming). Perhaps the real problem is that this challenge is largely invisible to experienced colleagues within the higher education context so that the need for support of new lecturers in this area of learning is not fully recognized.

## Workplace Support

Despite the challenges of their transition the vast majority of new lecturers felt that they had found support in their workplace, only a small minority felt isolated or unsupported. This support came from a range of sources and varied considerably across the sector:

Some elements of formal induction activity were not generally seen to be helpful, for example corporate induction was often experienced simply as information overload. Many new lecturers valued the support of a formally appointed mentor although having some choice of mentor was seen as helpful. Also completing a postgraduate course in teaching and learning or a Masters degree were valued by the majority of respondents.

Sometimes inadequate formal support was replaced or complemented by informal arrangements. For example informal mentors were frequently found to be useful and sometimes these were a replacement for formally assigned mentors. The new lecturers generally found informal support from colleagues in departments, teaching teams, shared offices or other work groups to be very helpful. However an element of 'departmental politics' emerged that was largely confined to some of the nurse and health visitor lecturer respondents. Some nurse lecturers identified that there needed to be more respect for what new lecturers might bring to the department. They also felt that some improvement might be possible in reducing the apparent low status of undergraduate or pre-registration and clinical skills teaching. In addition this small group of mainly nurse lecturer respondents felt that the impact of difficult colleagues, unfair allocation of teaching workload, and in some cases of bullying, needed to be controlled within their workplaces.

Overall the significance of informal learning, highlighted by the workplace learning literature (Lave & Wenger, 1991; Wenger, 1998; Trowler & Knight, 2000), seems to have been confirmed in the case of

these new lecturers. There is evidence that formal structures and processes such as those related to formal programmes of study were also valued and this supports a critique of situated learning theory as being too dismissive of formal learning opportunities (Fuller et al, 2005).

## The context of the findings

The findings of this study sit well with existing research. The strong theme of managing self resonates clearly with the work of Boyd and Lawley (forthcoming), Barlow and Antonio (2007), McArthur-Rouse (2008); Murray (2007); Staniforth and Harland (2006); and Knight et al (2006). The lack of clarity of the expectations of the role, of role boundaries and models of work; and the difficulty of maintaining a work life balance were highlighted by large numbers of respondents in this survey, suggesting that these issues can safely be generalised to the larger population. Role tensions featured strongly and the importance of support for workplace learning also add weight to previous research.

Findings of this study did not support the conclusions of Wright (2007), that new lecturers feel they are making a transition from expert to novice as they move from the familiar clinical role to the higher education sector. Whilst the survey did not include specific references to the terms novice or expert, these terms were rarely located in the responses. Another silence within the findings was that of status. Previous studies have suggested that new lecturers from certain professional fields e.g. teaching (Murray 2007) and nursing (Boyd & Lawley, forthcoming), feel they have a low status in relation to other disciplines. Again, this was not a question specifically posed to respondents, but status did not feature within the responses. It is possible that not holding a doctorate may contribute to this sense of inferiority, but this was expressed in terms of personal goals and ambitions rather than lack of status.

The positive view of the transition into higher education in spite of the many challenges supports Barlow and Antonio's study (2007). The majority of respondents identified a number of difficulties they had faced but were keen to point out that their overall experience was positive and that the opportunities for development outweighed the irritations and difficulties highlighted. This finding contrasts with some smaller studies (Wright 2007; Boyd & Lawley, forthcoming) and may reflect the impersonal nature of the survey instrument in contrast with the face to face interviews.

Overall the workplace experiences of new lecturers appear to encourage them to hold on to their identity as a credible clinical practitioner despite the inherent contradiction that this is no longer a

realistic position due to their new workplace setting. In this area of the new lecturers' experiences Wenger's emphasis on the connection between practice and identity is very significant (1998). As the new lecturers negotiate their way along multiple interwoven trajectories of identity they appear to hold on to their identity as a practitioner and as supporters of new practitioners. They do not strongly focus on building new identities as higher education teachers or as researchers within their professional field. In the case of the new lecturers, particularly those in nursing, the influence of claims 'beyond the confines of the university' (Clegg, 2008) appear to have a very significant influence over their identity building work. It is the clinical practice and procedural knowledge elements of the professional field that appear to have a priority status in the minds and practices of these new lecturers. From Wenger's perspective (1998) the new lecturers appear to be building a new identity trajectory as 'teacher' but also working hard to maintain their existing trajectory as 'clinical practitioner'. They feel pressure to build a new identity as 'researcher' and many have plans for this or have even taken concrete steps in this direction, but they find it difficult to prioritise this area of activity within their everyday practice and workload.

## **Chapter 6 – Limitations, conclusion and recommendations**

### **Limitations**

This study is based on an online survey of new lecturers in which the responses were anonymised in order to satisfy ethical requirements for confidentiality. In particular the anonymity is a considerable limitation because the respondents are based in a range of UK higher education institutions but additional contextual data on the workplace setting of the respondents is not available. In particular it is not possible, except for self-reported information provided by respondents, to identify from institutional policy documents the formal expectations for probationary periods of newly appointed lecturers with respect to research and publication activity. The variation between workplace settings with respect to pressure to gain a doctorate and become an active researcher is likely to have a very significant impact on the academic induction experiences of new lecturers.

## Conclusions

In the UK new university lecturers in nursing, midwifery and allied health professions are generally appointed after establishing themselves as expert clinicians with associated practices and identities. They find the mid career transition to their higher education roles challenging. They generally enjoy the challenge, feel well supported and are highly motivated by nurturing new practitioners. They see teaching as a priority and it takes up much of their time and energy. The new lecturers experience underlying pressure to complete a doctorate and be research active as a contradiction to the priority for teaching. From a workplace learning perspective, in which practice shapes their multiple identities, the newly appointed higher education lecturers in nursing, midwifery and allied health professions respond to their experiences by holding on strongly to their identity and credibility as a clinical practitioner rather than more quickly embracing new identities as a scholar and researcher within their professional field.

## Further Research

This study has adopted a workplace learning theoretical framework that emphasises the significance of situated and social learning within workplace settings. This literature signals the need to build explanatory analysis of workplace learning of new lecturers through close investigation within particular departmental and institutional settings. Although this survey is able to provide some insight into the experiences of the new lecturers as a generic group it is no substitute for more in-depth ethnographic investigations within specific institutional and departmental workplace settings. There appears to be scope for biographical research that may allow analysis of gender, race and social class. This further research may benefit from an element of network analysis in order to identify the informal overlapping activity systems that new lecturers belong to within their work setting. Specific to the current study there is further useful work to be done in analysing the responses of more experienced lecturers to the induction of newly appointed colleagues.

## Recommendations

This study aimed to inform the induction of new lecturers and the research team present the following recommendations:

1. Newly appointed lecturers in nursing, midwifery and allied health professions should be encouraged to build on their primary motivation, to contribute to the development of new clinical practitioners, in order to see this role as also including a contribution to the development of new professional knowing through application of scholarship and research.
2. In reviewing the formal and informal provision of support for new lecturers, departments should consider what models for building an academic identity are available and how reward and recognition structures and cultures influence the selection of such role models by new lecturers.
3. Departments need to review their formal arrangements for the induction of newly appointed lecturers in nursing, midwifery and allied health professions in order to support proactive professional learning and identity work towards becoming an academic. This means that whilst development of teaching is important there is also a need to support new lecturers in their professional learning with respect to working in higher education organisations, their changed role within healthcare work settings and especially in their scholarship and research activity.
4. Departmental leaders and relevant academic development staff need to nurture informal workplace learning opportunities, such as collaborative teaching and assessment, research networks and informal mentoring, in order to move towards the development of more expansive workplace learning environments.
5. Departments and higher education institutions need to set realistic expectations for the workload of lecturers and for scholarship and research within this. They need to provide effective workplace support for time and workload management so that excessive stress is avoided during the induction period which new lecturers generally find enjoyable but challenging.

## References

- Barlow, J. & Antonio, M., (2007). Room for improvement: the experiences of new lecturers in higher education. *Innovations in Education and Teaching International*, 44 (1), 67 – 77.
- Barnett, R., (2003). *Beyond All Reason: Living with Ideology in the University*, Milton Keynes: SRHE / OUP.
- Barrett, D., (2007). The clinical role of nurse lecturers: past, present, and future. *Nurse Education Today*, 27, 367-374.
- Becher, T. & Trowler, P., (2001). *Academic Tribes and Territories*, 2<sup>nd</sup> Ed. Milton Keynes: SRHE / OUP.
- Benner, P., (1984). *From novice to expert: excellence and power in clinical nursing practice*. Addison Wesley: Menlo Park, California.
- Bernard, H. R., (2000). *Social Research Methods: qualitative and quantitative approaches*. Sage: London.
- Boyd, P., Harris, K. & Murray, J., (2007). *Becoming a Teacher Educator: Guidelines for the induction of newly appointed lecturers in Initial Teacher Education*. Bristol: ESCalate, Higher Education Academy. [Online] Available at: <http://escalate.ac.uk/3662> (accessed 30.04.09).
- Boyd, P. & Lawley, E., (2009, forthcoming). Becoming a lecturer in nurse education: the workplace learning of clinical experts as newcomers. *Learning in Health and Social Care*.
- Boyd, P., Baker, L., Harris, K., Kynch, C. & McVittie, E. (2006). Working with Multiple Identities: supporting new teacher educators in higher education, in Bloxham, S., Twisleton, S. & Jackson, A., (Eds). *Challenges and Opportunities: Developing learning and teaching in ITE across the UK*, Bristol: ESCalate, Higher Education Academy. [Online] Available at <http://escalate.ac.uk/2419> (accessed 30.04.09).
- Bridges, D., (2000). *Back to the Future: the higher education curriculum in the 21<sup>st</sup> century*, Cambridge Journal of Education, 30 (10), 37.
- Bristol Online Surveys (2008). Available at [www.survey.bris.ac.uk](http://www.survey.bris.ac.uk).
- Kennedy, I., (2001). *Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary Inquiry 1984 – 1995 (CM5207)*. Department of Health, London.
- Brown, J. S., & Duguid, P., (1996). Organizational Learning and Communities of Practice: towards a unified view of working, learning and innovation, in Cohen, M. D. & Sproull, L. S. (Eds). *Organisational Learning*. London: Sage.
- Calman, K., (1998). *A Review of Continuing Professional Development in General Practice. Report by the Chief Medical Officer*. Department of Health: London.
- Castells, M., (1997). *The Power of Identity*. Oxford: Blackwell.

- Clegg, S., (2008). Academic identities under threat? *British Educational Research Journal*, 34 (3): 329-345.
- Commission for Health Improvement, (2001) *Clinical Governance Review Framework*. DH, London.
- D'Andrea, V. & Gosling, D., (2005). *Improving Teaching and Learning in Higher Education: a whole institution approach*. Berkshire: Open University Press.
- Department of Health, (1997). *The New NHS: Modern, dependable*. HMSO, London.
- Department of Health, (1999). *Making a Difference: Strengthening the nursing, midwifery and health visiting contribution to healthcare*. HMSO, London.
- Department of Health, (2000). *A First Class Service*. HMSO, London.
- Department of Health, (2004). *Knowledge & skills framework*. HMSO, London.
- di Gregorio, S. & Davidson, J., (2008). *Qualitative Research Design for Software Users*. Berkshire: Open University Press.
- Dieklemann, N. (2004). Experienced Practitioners as New Faculty: New Pedagogies and New Possibilities. *Journal of Nursing Education* 43 (3), 101-103.
- Dreyfus, H. L. & Dreyfus, S. E., (1986). *Mind over machine: The power of human intuition and expertise in the era of the computer*. Oxford: Blackwell.
- Edwards, H., Higgs, J. & Everingham, F., (1999). Developing as health professional educators, chapter 32 in Higgs, J. & Edwards, H., (Eds). *Educating Beginning Practitioners*. Butterworth Heinemann: Oxford.
- Engestrom, Y., (1987). *Learning by Expanding: an activity-theoretical approach to developmental research*. Helsinki: Orienta-Konsultit.
- Engestrom, Y., (1999). Innovative learning in work teams: Analyzing cycles of knowledge creation in practice in Engestrom, Y., Miettinen, R. & Punamaki R.-L.(Eds). *Perspectives on Activity Theory*. Cambridge UK: Cambridge University Press.
- Engestrom, Y., (2001). 'Expansive Learning at Work: toward an activity theoretical re-conceptualization', *Journal of Education and Work*, 14 (1) 133–156.
- Eraut, M., (2000). Non-formal learning and tacit knowledge in professional work. *British Journal of Educational Psychology*, 70, 113-136.
- Evans, K., Hodkinson, P., Rainbird, H. & Unwin, L., (2006). *Improving Workplace Learning*. Abingdon: Routledge.
- Fanghanel, J., (2004). 'Capturing dissonance in university teacher education environments', *Studies in Higher Education*, 29 (5), 575-590.
- Fuller, A., Hodkinson, H., Hodkinson, P. & Unwin, L.. (2005). 'Learning as peripheral participation in communities of practice: a reassessment of key concepts in workplace learning', *British Educational Research Journal*. 31 (1) 49-68.

Giddens, A., (1991), *Modernity and Self-Identity: Self and Society in the Late Modern Age* Blackwell: Oxford.

Grbich, C., (1998). The academic researcher: socialisation in settings previously dominated by teaching. *Higher Education*; 36, 67-75.

Health Professions Council, (2004). *Standards of education & training*. HPC, London.

Health Professions Council, (2005). *Your guide to our standards for continuing professional development*. HPC, London.

Henkel, M., (2000). *Academic Identities and Policy Change in Higher Education*, London, Jessica Kingsley.

Knight, P., Tait, N. & Yorke, M., (2006). The professional learning of teachers in higher education. *Studies in Higher Education*; 31(3) 319-339.

Kogan, M., (2000), Higher Education Communities and Academic Identity, *Higher Education Quarterly*; 54 (3), 319–339.

Lave, J. & Wenger, E. (1991). *Situated Learning: legitimate peripheral participation*. Cambridge: Cambridge University Press.

Lombardo, P., (2006), Concerns for medical radiation programs in Australian universities. *Radioagraphy*; 12, 332-338.

Marginson, S., (2000). Rethinking Academic Work in the Global Era. *Journal of Higher Education Policy and Management*, 22 (1), 23-35.

McArthur-Rouse, F. J., (2008). From expert to novice: an exploration of the experiences of new academic staff to a department of adult nursing studies. *Nurse Education Today*; 28, 401-408.

McKeachie, W., (1997). Critical elements in training university teachers. *International Journal for Academic Development* (2) 67-74.

Muir Gray, J. A., (1997). *Evidence-based health care : how to make health policy and management decisions*. Churchill Livingstone, London.

Murray, J., (2007). Countering Insularity in teacher education. Academic work on pre-service courses in nursing, social work and teacher education. *Journal of Education for Teaching*; 33.3

Murray, J. & Male, T., (2005). Becoming a teacher educator: evidence from the field. *Teaching and Teacher Education*, 21 (2), 125-142.

National Patient Safety Agency, (2001). *Introducing the National Patient Safety Agency: Learning from adverse events and near misses in the NHS*. DH, London.

NHSE, (1999). *The NHS Performance Assessment Framework*. HMSO, London.

NICHE (1997) (National Committee of Inquiry into Higher Education – ‘The Dearing Report’). Available at <http://www.leeds.ac.uk/educol/ncihe/> (accessed 30.04.09).



- Nursing & Midwifery Council ,(2004a). *Standards of proficiency for pre-registration nursing education*. NMC, London
- Nursing & Midwifery Council, (2004b). *Standards of proficiency for pre-registration midwifery education*. NMC, London.
- Nursing & Midwifery Council, (2005). *The PREP handbook*. NMC, London.
- Oldnall, A., (1995). Nursing as an emerging academic discipline. *Journal of Advanced Nursing*, 21, 605-612.
- Ritchie, J. & Lewis, J., (Eds), (2003). *Qualitative Research Practice: a guide for social science students and researchers*. London: Sage.
- Roberts, G., (2003). *Joint funding bodies' Review of research assessment*. [online] <http://www.ra-review.ac.uk/reports/roberts.asp> (accessed 30.04.09).
- Sim, J., Zadnik, M. G. & Radloff, A., (2003). University and workplace cultures: their impact on the development of lifelong learners. *Radiography*, (9)99-107.
- Staniforth, D., and Harland, T., (2006). Contrasting views of Induction: the experiences of new academic staff and their heads of department. *Active Learning in Higher Education*. 7(2); 185-196.
- Taylor, P.G., (1999). *Making sense of academic life: Academics, Universities and Change*. Buckingham: SRHE / OUP.
- Trowler, P. & Knight, P. T., (2000). 'Coming to know in Higher Education: theorising faculty entry to new work contexts', *Higher Education Research and Development* 19 (1), 27-42.
- United Kingdom Central Council for Nursing, Midwifery & Health Visiting, (2001). *Professional Self-regulation and Clinical Governance*. UKCC, London.
- Wenger, E., (1998). *Communities of Practice; Learning, Meaning and Identity*, Cambridge University Press.
- Wright, R. (2007). *From expert to novice: an investigation into professional identities of occupational therapists who move from clinical practice to occupational therapy in higher education*. Unpublished doctoral thesis, University of Cumbria.

## Appendix 1

Summary of databases & journals searched		
Professional Group	Databases Accessed	Specific Journals Searched
<b>Nursing, Midwifery and the Allied Health Professions</b>	Academic Search Premiere CINAHL	Nurse Education Today
<b>Nursing</b>	CINAHL	
<b>Radiography</b>	CINAHL	Radiography Radiologic Technology

<b>Physiotherapy</b>	PEDro CINAHL	Physiotherapy Physical Therapy Physical Therapy Reviews Physiotherapy Research International
<b>Occupational Therapy</b>	CINAHL	British Journal of Occupational Therapy
<b>Midwifery</b>	CINAHL	
<b>Academic Staff</b>	Academic Search Premiere	Journal of Higher Education Journal of Educational Policy

## Appendix 1 continued

### Inclusion criteria for literature:

<ul style="list-style-type: none"><li>• Literature published in English or where English translation was readily available</li></ul>
<ul style="list-style-type: none"><li>• All literature relating to the research aims, i.e. those concerning experiences of all lecturing staff in higher education.</li></ul>
<ul style="list-style-type: none"><li>• Literature relating to experiences of academic staff in further education</li></ul>
<ul style="list-style-type: none"><li>• Literature specifically relating to health care professionals working in higher education published since 1980. Prior to this date, few health professional courses were linked to higher education establishments.</li></ul>
<ul style="list-style-type: none"><li>• Literature relating to experiences of academic staff in subject disciplines outside health ca</li></ul>
<ul style="list-style-type: none"><li>• Literature relating to experiences of academic staff in higher educational establishments in all countries with similar higher education systems to the UK.</li></ul>
<ul style="list-style-type: none"><li>• All types of data were considered, including scholarly opinion to experimental designs</li></ul>

### Exclusion criteria for literature:

<ul style="list-style-type: none"><li>• Literature where accurate translation into English was not available</li></ul>
<ul style="list-style-type: none"><li>• Literature relating to student experiences in higher education</li></ul>

## Appendix 2 - the on-line survey

The survey was delivered to lecturers in relevant professional fields via an agreed contact person within the institution. The survey was accessed by the lecturers through a web link within an email that had been forwarded by the contact person and was completely anonymous.

The open-ended questions\* allowed respondents to write as much as they wished. The closed questions had drop down menu of choices or allowed an open response but limited in length of text.

### Section 1: Professional Background

1. What do you consider to be your main professional group? *AHP / Nurse / Midwife / other*
- 1.a. What do you consider to be your main profession / clinical specialism?
- 1.b. Please state the (approximate) year in which you qualified in this profession.
- 1.c. If you hold a dual qualification or have followed a different career pathway, please outline briefly below (including approximate dates of qualification).

### Section 2: About You

2. Are you *Male / Female*
- 2.a. Are you *20 – 29 / 30 – 39 / 40 – 49 / 50 - / 60 – 69 / 70+*

### Section 3: Previous Employment

3. Prior to your appointment to Higher Education, what was your main role / job in Health and Social Care?  
(See more info for details. Also, please offer an explanation of the title if you feel this is necessary).
- 3.a. Please indicate roughly what percentage of your most recent job was a clinical role
- 3.b. Please identify your "main" workplace setting, prior to working in Higher Education e.g. Acute care, community team etc

### Section 4: Current Employment

4. Please state your role title in Higher Education (see more info for details).

- 4.a. What type of contract do you hold with your Higher Education Institution?
- 4.b.i. If you have a part time or fractional post, please state what percentage contract you hold.

#### Section 5: Working in Higher Education

5. How long have you been employed in Higher Education?
- 5.a. Please add a brief explanation if necessary
6. In your current (or first) post in Higher Education, what do you feel are (or were) "your" main priorities in the role? [Identify the priority level for each aspect of your role]
- a. *Research Activity*
  - b. *Teaching Activity (including personal and academic student support)*
  - c. *Contribution to the University (Department or Faculty Role)*
  - d. *Clinical, Professional or Practitioner Activity (including placement visiting)*
7. In your current (or first) post in Higher Education, what do you feel are (or were) the main "departmental" priorities for your role? [Identify the priority level for each aspect of your role]
- a. *Research Activity*
  - b. *Teaching Activity (including personal and academic student support)*
  - c. *Contribution to the University (Department or Faculty Role)*
  - d. *Clinical, Professional or Practitioner Activity (including placement visiting)*

#### Section 6: Your experiences of your new Role

- \*8. Please describe your experiences of working as a new lecturer in Higher Education.
- \*9. What are the most positive aspects of your role / experiences of working in Higher Education?
- \*10. What have been the most difficult aspects of your role / experiences of working in Higher Education?
- \*11. How do you feel your personal and professional strengths have been utilised in your role in Higher Education?

#### Section 7: Aspects of support which have assisted you in your role as new lecturer in Higher Education

- \*12. Please identify the elements of "formal" support, provided in your workplace, which have been most useful?
- \*12.a. Have there been any elements of the formal provision which have not been helpful?

- \*13. Please identify the elements of "informal" support in your workplace which have been most useful?
- \*14. Which of the following individuals, groups and teams are (were) significant in terms of providing a workplace support network for you in your new role?
- a. Line Manager / departmental head
  - b. Uni and inter-professional teaching colleagues
  - c. Formally appointed mentor
  - d. Research colleagues
  - e. External clinical / professional contacts
  - f. CPD / learning and teaching Support
  - g. Informal support groups
- \*15. Please use this space to identify any other important support networks, or anything not provided by your Higher Education Institution which you feel would have assisted you in your role

### Section 8: Your future in HE

- \*16. What do you see as your priorities for your own professional development in Higher Education, and where do you see yourself in 3 years time? Write as much as you wish.
- 16.a. and what support would help you to achieve these future plans?

### Section 9: Professional Background and Qualifications

17. What level of academic qualification do you hold and when did you attain these

*Professional Diploma / Graduate Diploma; Bachelors Degree (BA, BSc, BEd, etc); Post-graduate Certificate; Post-graduate Diploma; Masters Degree (MA, MSc, MPhil etc); Doctorate; Other.*

*and*

*Completed prior to taking up post in HE; Studying for this when took up post in HE, now completed; Studying for this when took up post in HE, not yet completed; Commenced since taking up post in HE, now completed.*

18. If you answered other to Question 17, or would like to clarify you own situation, please outline what qualifications you hold below and when study commenced in relation to taking up your academic post in Higher Education

### Section 10:

- \*19. We hope this survey has allowed you to describe your journey to becoming a lecturer in Nursing / Midwifery / the Allied Health Professions in Higher Education. Please feel free to add any further comments here (in relation to that journey, or about the survey) if you would like to.

## Appendix 3 - Coding Framework – [4<sup>th</sup> iteration]

The coding framework developed throughout the period of analysis. Two researcher coded data independently and then through discussion, the codes were explored, amalgamated and incorporated into a new framework.

<b>The newly appointed lecturer</b>		
<b>MANAGING SELF</b>  Relates to organisation of oneself as an individual within the organisation / HEI. Personal issues or individual characteristics / experiences	Time / flexibility	Planning working day; time management, flexibility within own time; absence of formal daily timetable or structure; absence of shift patterns and regimented work patterns; comparison to previous working environments.
	Boundaries	Issues concerning the boundaries of the role or lack of clarity; work-life balance; volume of work; saying no; balancing different demands; links with expectations of the role and the challenges of managing this.
	Autonomous Professional	Autonomy; autonomous working; making decisions and taking responsibility for these decisions.
	Emotional Issues	Feelings associated with change in role. Positive or negative emotions; metaphors. Comments relating to change in role; novice; apprentice; disorientation; feeling de-skilled.
	Academic Identity	Confidence in academic role; Emerging Identity. Dilemmas. Feelings relating to credibility; fraud. Close links with emotional references to novice or apprentice
	Development	Personal and professional and career development . Relates to ambition to progress; opportunities to develop; lack of opportunity to develop; Learning experience associated with the new role.
	Developing New practitioners	Nurturing students; the satisfaction of seeing students develop; satisfaction of supporting students and enabling them to achieve.
	Other	Other issues associated with managing self – coding to be reviewed as themes emerge
<b>Support for the new role / transition to the new role of lecturer</b>		
<b>SUPPORT FOR THE ROLE</b>  Relates to teaching, research, faculty roles and all activities of the role	Formal Support	Academic induction; HEI allocated mentor; CPD opportunities for teaching qualifications; other HEI provided / supported training; access to training and development opportunities; expectations v reality.
	Informal Support	Communities of practice; networks of colleagues; office buddy; teaching peers etc. Any informal support; one off events or ongoing meetings.
	Fuzzy or Integrated Support	Combinations of support e.g. networks of colleagues met through CPD opportunities;
	Other	Other issues associated with support for the job – coding to be reviewed as themes emerge

<b>Activities of the job / Doing the Job</b>		
<b>TEACHING</b>  <b>Relates to teaching in higher education</b>	Subject Specialist Area	Subject areas which respondents are required to teach. Focus on own specialist area; requirement to teach subjects outside own area of knowledge or expertise; options for teaching different subjects; lack of choice in subject areas. Inter-professional / uni-professional teaching.
	Preparation for teaching?	Preparation - time spent in engaging with literature on the subject content of sessions – a form of scholarship?
	Planning for teaching?	Planning sessions for teaching; planning timetables, course programmes; preparation of course documentation including validation docs etc. Influencing education
	Confidence within teaching role	Doing the teaching job; previous experience and skills in teaching; feelings associated with teaching; supporting students academically and personally;
	Assessment process	Getting to grips with the assessment process. Planning assessments; marking assessments; judging students; knowledge of different study levels; moderation.
	Other	Other issues associated with teaching – coding to be reviewed as themes emerge
<b>ORGANIS- ATIONAL ISSUES</b>  <b>Relates to systems rules structures and language of the institution and HE sector</b>	Systems Rules Structures	Understanding how institutional systems work. How decisions are made. Academic rules and regulations; assessment regulations; understanding how to do the job within the rules. Institutional hierarchies; who's who;
	Language and Jargon	Issues associated around language of and jargon used within HE.
	Politics	Departmental politics; staff with own agendas; obstructive colleagues; issues of personal gain; issues of unfair teaching or workload allocation;
	Ways of working in HE	Relates to culture. Fighting off old culture – those who want to move from old culture; Those who don't want to accept new culture – not at one with the role.
	Other	Other issues associated with organisational issues – coding to be reviewed as themes emerge
<b>PROFESSIONAL KNOWING, SCHOLARSHIP AND RESEARCH</b>  <b>Relates to all types of knowledge</b>	Priorities / time issues	Making, ring-fencing, prioritising time for research; knowing what and how to research
	Confidence in own knowledge base	Having confidence in one's own knowledge in the academic environment; tacit knowledge; belief in one's subject; acknowledgement of professional knowledge and theoretical knowledge; developing own and new professional knowledge.
	Other	Other issues associated with research – coding to be reviewed as themes emerge
<b>CLINICAL PARTNERSHIPS</b>  <b>Relates to work in and with health settings</b>	Currency	Need to retain clinical credibility with clinical peers, academic peers and students. Issues around balancing academic work and clinical practice. Keeping up to date.
	Partnerships	Maintaining clinical partnerships; visiting tutor roles; supporting students on placements; supporting students and workplace/clinical educators.
	Other	Other issues associated with clinical partnerships – coding to be reviewed as themes emerge