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An interprofessional practice development group for newly qualified and new to role clinicians in community mental health

Hazel Gunning, Carol Gee, Gerry Sheppard et al

Key points

- *There is limited literature on the needs of the new to role practitioner who may be expected to coordinate care and have a complex caseload*
- *New to role nurses are expected to take on different responsibilities in the community alongside social workers and occupational therapists who may have received only minimal training in mental health*
- *Community roles tend to involve lone working and the need to establish support networks is essential*
- *Interprofessional education occurs when more than two different types of professionals come together to improve care and better appreciate each other's roles*

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Correspondence
hazel.gunning@oxfordhealth.nhs.uk

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Abstract

There is a wealth of literature focusing on the transition of new graduates to newly qualified staff members. However, the needs of the new to role practitioner, who may be expected to manage challenging caseloads and coordinate care, are rarely explored. New to role mental health clinicians, particularly in the community, can be lone working and experience complex challenges. To meet these demands, the interprofessional practice development group was formed. Clinical practice educators, alongside clinical team managers, designed a programme of six sessions of three hours to be delivered over a six-month period. The programme was delivered to two cohorts of new to role or newly qualified mental health staff from either a nursing, occupational therapy or social work background. The sessions focused on the role of the care coordinator, reflecting with the participants on how the last month had been, and discussing relevant articles and case studies. To evaluate the course, a pre and post-group questionnaire was completed by the participants. There was an improvement in their confidence and competence. However, the questionnaires did not demonstrate an improvement in their skills development at this time.

Author details

Hazel Gunning, clinical practice educator, learning and development, Oxford Health NHS Foundation Trust, England; Carol Gee, modern matron, Oxford Health NHS Foundation Trust, England; Gerry Sheppard, clinical practice educator, Oxford Health NHS Foundation Trust, England; Aidan Harker, team manager, Oxford Health NHS Foundation Trust, England; Julie Belfield, team manager, Oxford Health NHS Foundation Trust, England; Sharon Langdon, clinical practice educator, Oxford Health NHS Foundation Trust, England

Keywords

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Introduction

This article focuses on the formation of an interprofessional practice development group for newly qualified or new to role nurses, occupational therapists and social workers working in community mental health settings in a large NHS trust.

The need for a practice development group was identified by clinical practice educators (CPEs) with a background in community mental health. The idea for the group followed the implementation of a limited number of band 5 preceptorship posts in the community teams as recruitment for band 6 nurses proved unsuccessful. These posts had previously been graded at band 6 to reflect the degree of autonomy and risk carried by registered nurses working in the community setting. This change in grade enabled the recruitment of newly registered nurses into community nurse positions with reduced caseloads during their first year. Mental health clinicians often experience complex challenges so the practice development group was formed to support these staff members.

Preceptorship

Preceptorship is described by the Department of Health (DH) (2010) as a 'period to guide and support all newly qualified practitioners to make the transition from student to develop their practice further'. One of the aspects of the CPE role is to embed and champion preceptorship in clinical practice and develop staff clinically (Hampson et al 2017).

There is a wealth of literature exploring the transition of new graduates, how this affects their confidence and how this in turn affects fellow staff (Morley 2009, Ladyshewsky 2010, Phillips et al 2014, Hickerson et al 2016, Ortiz 2016). However, the literature barely considers the needs of the new to role practitioner who may be expected, due to their previous experience, to 'hit the ground running', manage the expectations of care coordination and have a complex caseload.

The NHS trust had a well-established preceptorship support programme for inpatient nurses, but no development had taken place in the community. Gardiner and Sheen (2016) describe the transition from student to registered professional as a time of great stress and that without adequate support the practitioner can quickly succumb to the pressures of work. This was a concern as roles in the community tend to involve lone working and the need to establish support networks is essential (NHS Staff Council 2013).

The CPE team also identified a need for new to role nurses to take on different responsibilities in the community alongside social workers and occupational therapists who may have received only minimal training in mental health. The need to receive additional support and education during their first year is essential. Social workers are placed on a programme after qualifying called the 'Assessed and Supported Year in Employment', which aims to improve their skills and knowledge (Department for Education 2015). However, this is not specific to mental health and, anecdotally, social workers report that this does not prepare them for their community role in mental health. Literature suggests many challenges for these newly qualified clinicians, such as experiencing the reality of clinical practice compared to the ideals of theory (Morley 2009). Alongside this, the CPE team receive many referrals from community team managers to provide support to new to role nurses, occupational therapists and social workers, which was unsustainable to facilitate individually.

Interprofessional education

The idea of a practice development group was formed, incorporating interprofessional education, of participants whose role was care coordinator as defined by the Care Programme Approach (DH 2008). Interprofessional education is described by Illingworth and Chelvanayagam (2017) as occurring when more than two different types of professionals come together to improve care and better appreciate each other's roles. The role of the care coordinator, although the clinician may come from a different professional background, will be broadly similar and therefore it is essential that these clinicians understand each other. Studies show, however, that while this style of education has not conclusively improved health outcomes (Illingworth and Chelvanayagam 2017), it does improve collaborative practice (Stepney et al 2011). Barr and Norrie (2010) reported that interprofessional education exposes clinicians to more wide-ranging knowledge, increasing their ability to manage a wider number of tasks leading to a more adaptable workforce which is less prone to burnout.

Practice development was decided on as the CPE team wanted this programme to run alongside the preceptorship programme offered to newly qualified or new to role staff. The primary principles of practice development defined by McSherry and Warr (2006) are 'centred on promoting patient centeredness through the use of a facilitated approach to team working, collaboration and partnership building'. Practice development is also considered essential by the Royal College of Nursing (2018) to develop skills and competence, and therefore fitting with the objectives of the practice development group.

Approaches were made by the CPE team to service leads and heads of nursing to gauge support for this innovation and an estimate of potential attendee numbers to make it viable for the CPE team to facilitate. The suggestion to improve the experience for new starters was welcomed, and the team moved to a planning stage.

Planning

Hall (2014) suggests that, when planning course content, it needs to be current and pertinent to the needs of the participants – a consideration for the CPE team when designing the content for this group. Little has been written specifically about practice development or preceptorship for interprofessional groups in mental health. Literature suggests that few publications show educators how to prepare for these groups. Howkins and Bray (2008) surmise that developing content can be challenging as each group has different philosophies and influences.

Clinical team managers were invited to be part of the planning process and a proposal was agreed offering six sessions of three hours each over a six month period to allow a realistic option for team managers who were struggling with staffing levels, and team members who needed time and space to reflect on their experiences as care coordinators as well as developing skills required for this role. Clinical team managers were best placed to know which staff met the criteria and who would benefit from attending, also their presence at senior managers' forums was useful to promote the group.

The Health Foundation (2016) describes education and training as 'critical'. This is essential to the role of a care coordinator. However, no formal training exists.

With limited guidance on course content, the CPE team had to adopt an innovative approach to the design of the programme. Each session was focused on the role of the care coordinator and included reflecting with the participants on how the last month had been, looking at a relevant article for discussion and using case studies to link theory to practice (Table 1).

Table 1. Programme design

Month	Session title
October	Role of the care coordinator
November	Collaborative care planning
December	Risk assessment and management
January	Physical health and medication management
February	Relapse prevention and discharge planning
March	Personal resilience and managing expectations

It was a challenge to source relevant and current articles that were suitable for interprofessional groups, which demonstrated the lack of literature on interprofessional groups and their learning. The CPE team wanted to gain some outcomes for this group and therefore a questionnaire delivered pre and post group was developed (Table 2). According to

Suhayda and Miller (2006) the way a course is evaluated should have meaning and the focus of these questionnaires was to understand if the group had assisted participants to gain knowledge, confidence, competence and skills. It was anticipated that each group member would be part of an action learning set for the participants to work together to resolve challenges. Action learning sets, attributed to Revens (1980), are known to develop the workforce and were described by Machin and Pearson (2014) as helpful for peer development and support.

Table 2. Practice development group questionnaire

Number	Question	Rating 1-5 Please circle
1.	How would you rate your level of confidence in your role as a care coordinator?	1=no confidence at all 2 3 4 5=very confident
	What do you need to improve your confidence?	
2.	How would you rate your level of competence in your role as a care coordinator?	1=not competent at all 2 3 4 5=very competent
	What do you need to improve your competence?	
3.	How would you rate your knowledge in your role as a care coordinator?	1=no knowledge at all 2 3 4 5=very knowledgeable
	What do you need to improve your knowledge?	
4.	How would you rate your skill level in your role as a care coordinator?	1=no skill at all 2 3 4 5=very skilful
	What do you need to improve your skills?	

Implementation

In October 2016, the practice development group started with 20 participants from either a nursing, occupational therapy or social work background. The CPE team received a response from 80% of community mental health teams from the NHS trust. Most of the participants had previously worked in inpatient services, statutory social care services or physical health services, although a small number were newly qualified clinicians. Questionnaires were carried out pre and post group sessions for evaluation purposes. Participants were divided into four action learning sets with the intention of them using these groups in each session for development and problem-solving. Using small groups for learning and teaching is a widely recognised strategy in education as it allows participants to network and form helpful relationships (Jackson et al 2014), which in the case of the practice development group replicated the interprofessional nature of community mental health teams. The challenges of using small groups were that not everyone was able to attend each session due to work pressures and annual leave, leaving some groups short of members.

The sessions were facilitated by the CPE team and a clinical team manager to maintain the connection to service in terms of expectations of care coordinators and their ability to be realistic about the challenges experienced. Denial and Zorn (2006) concluded that co-facilitation where one is a practising clinician improved students' knowledge and was an effective way of delivering teaching. However, the CPE team and clinical team managers struggled to find mutually convenient times to meet and plan before each session. The CPE team strongly felt that these sessions were a crucial time to access this group of staff and aimed to inspire them to become excellent clinicians for the future. Williams et al (2016) identified that having teachers who can inspire enables students to engage. However, it is vital for the programme to be designed and planned well to sustain this ideology.

Feedback from the first cohort was positive and clinical service managers made it clear they would like another run of the course. With the second cohort, there was an increase in demand attributed to the involvement of clinical team managers. A decision was made to run two cohorts on two sites to allow for manageable group sizes of 14 in each and to enable clinicians easy access to this training and development opportunity.

The second cohort was again facilitated by one of the CPE team and one of the clinical team managers. Feedback was largely positive, but one criticism was that at times the groups were too small due to problems with attendance from some of the participants. One group was facilitated in a clinical environment and this led to staff feeling that they could not separate from their clinical roles either by responding to emails while in the group, leaving early due to service demands or not attending. As the action learning sets had not been a success in the previous cohort, a decision was made to divide the group into smaller supportive groups giving instruction that they could contact each other outside of the group to problem-solve and gain support from each other about clinical matters.

Evaluation

Pardue (2015) discussed the importance of putting time aside for the evaluation of a programme and linking this evaluation to the learning outcomes of the sessions. Each session, conducted over the two cohorts, was evaluated using various methods such as the 'stop, start, continue' approach (George and Cowan 1999), and the NHS trust approved evaluation forms. The 'stop, start, continue' method is, according to Hoon et al (2014), reported to give rich information from participants about the quality of teaching in comparison to other methods. At the end of each programme, post-group questionnaires were carried out and compared to the pre questionnaire to see if there had been any effect on confidence, competence and skills.

Pardue (2015) described the process of evaluation as looking at the response from students as the 'lowest level' and suggests that this should be expanded to consider stakeholders' perception of the student's improvement. The evaluation, conducted by the CPE team, using the lowest level of evaluation, demonstrated that the participants believed there to be an improvement in their confidence and competence. However, no improvement in their skill development was shown.

When applying this to the practice development group, the CPE team first considered if objectives were being met and concluded that the group had achieved its aims of being interprofessional and meeting stakeholders' expectations of supporting those newly qualified or new to role. Each session, with is focus on the role of the care coordinator, looked at main aspects of the role. When considering if the activities were effective, feedback from participants in the second cohort evaluated that some of the articles used were too long and unhelpful. Participants commented that they found the session relating to resilience repetitive of work they had undertaken in pre-registration programmes. However, there is a wealth of literature to suggest that resilience, and addressing this in training, remains important in health service workers (Jackson et al 2007, McAllister and Mckinnon 2009, Rudman and Gustavsson 2011). With the interprofessional nature of the attendees, they commented that they would have preferred a range of clinical team managers with broader professional backgrounds and training. The participants highly rated activities that involved case scenarios and offered them resources as these provided them with skills to take back into practice. Wood (2006) describes such activities as problem-based learning (Barrows 2000), which is a method used in nurse and social work education. Wood (2006) related problem-based learning to mental health nursing and found that with some students this improved confidence to practice. Participants also evaluated the benefits of having time and space with their peers and senior clinical managers to reflect on practice using a problem-solving approach.

Looking at the efficiency of the group, the CPE team concluded that having two groups running concurrently was not efficient and a huge drain on resources, particularly given the numbers that attended each group. The groups ran on time, apart from one of the final groups, which had to be rearranged due to events beyond the control of the CPE team. This did, however, allow the CPE team to put the groups together for the final session which resulted in participants giving rich feedback on the practice development group.

Evaluation with stakeholders was arranged via a meeting with facilitators and other interested parties. However, this meeting was cancelled due to poor attendance. The CPE team sought evaluation from these parties via email. Systems were

in place for evaluation from students, facilitators and other stakeholders as this innovation was being shared in wider preceptorship discussions and forums in the trust. Evaluation of impact suggested that there had been an increase in confidence and competence. However, as previously discussed, there was no recorded increase in skills levels. The CPE team were aware that when they met with participants out in clinical practice, sometime after the group finished, participants reported how they had been using and sharing resources with their caseload and with their peers. This is suggestive that skill levels may increase over time and warrants further evaluation.

The CPE team suggest that further exploration could be carried out to see if the original objectives of the practice development group of providing support, increasing knowledge, competency and skills carried into the future. It would also be useful to know if this has had any effect on the resilience of the participants, as well as effects on recruitment and retention of this interprofessional group. The CPE team, along with clinical managers, will explore with stakeholders the potential opportunities for other senior clinicians from social work and occupational therapies to help facilitate future groups. The facilitation team also plan to condense aspects of this course to offer to agency clinicians appointed to long lines of work to prepare them for their roles and maintain standards in the NHS trust.

Conclusion

The practice development group offered support to newly qualified or new to role clinicians, an increase in confidence and competence but has not conclusively been shown to increase skills. Participants consistently evaluated that they benefited from time to reflect, away from their clinical area, with peers, experienced clinical team managers and the CPE team. It is essential that the CPE team, along with clinical team mangers, continue to consider what the evidence suggests to reassess, implement and evaluate the content of the programme for it to remain meaningful for participants and effective for stakeholders.

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