Shared learning and mentoring for newly qualified staff: Support and education using an interprofessional approach

Before:
"I was not looking forward to starting my new job…It was just an all encompassing fear." (PRHO 7)

After:
"I think it was great having a nurse mentor. She's very very friendly, very approachable and has helped me out practically on a couple of occasions I probably wouldn't go to her to find out something particular as such but she certainly was someone who if I had a real problem with something I would go and talk to." (PRHO 27)

Farnaz Heidari
Clive Andrewes
Kathleen Galvin
Rebecca Pendlebury
Iain Graham

Acknowledgements

Contents

List of Tables

Executive summary

As far back as 1974, Kramer described the 'reality shock' that affects new health care professionals as they enter the workplace for the first time. Both the nursing and medical professions accept that new staff need support, in the form of mentoring and preceptoring, during their transitional period from students to accountable practitioners. With the movement towards an interprofessional approach, there is a need to examine the possibility of interprofessional mentoring and learning.

Over the last four years, Bournemouth University has been the recipient of a number of grants to explore interprofessional education and working. One grant from the NHS Executive South and West Region developed a system of shared mentoring and learning for newly qualified doctors and nurses. This idea was piloted four years ago in one Trust and developed and extended to four other Trusts.

Objectives of the Scheme

The objectives of the Scheme were:

1. To develop a system of shared mentoring for newly qualified doctors and nurses
2. To support newly qualified staff during their initial working life and with their personal and professional development
3. To develop a programme of learning for newly qualified doctors and nurses, through shared learning workshops
4. To examine the perceptions of all staff about interprofessional learning and mentoring.

Aim and objectives of the evaluation

The aim of this evaluation was to explore the perceived benefit of interprofessional mentorship and learning for newly qualified nurses and PRHOs. The objectives, therefore, were to:

- Examine the experiences of mentoring by a more senior member of staff on stress and development of junior staff
- Examine staff experiences and perceptions of shared learning
- Explore professionals' understanding of interprofessional working and shared learning
- Identify factors which support and hinder collaboration, co-operation and learning among nurses and doctors
- Develop concepts to promote interprofessional working (including

5

mentoring) and shared learning.

Evaluation

Data collection

An ethnographic research approach was used, and data collection involved one-to-one interviews, self-completed questionnaires and observation. These were conducted before the Scheme started and repeated after six months. Any documents such as evaluation forms generated from the study were also examined. Questionnaire designs used were Parsell and Bligh's (1999) Readiness for Interprofessional Learning, Brown et al.'s (1986) Group Identification Scale, and Carpenter's (1995) Professional Stereotypes.

The sample

The sampling was purposive and the criteria were explicit and systematic as Hammersley and Atkinson (1995) suggest. For the questionnaires, all mentors, mentees, Project Leads and Clinical Tutors took part (N=141). A simple random sampling was used to select the participants for one-to-one interviews (N=34) and they needed to meet the following criteria:

- Senior member of staff (at least two years of clinical experience)
- Newly qualified nurses and PRHOs
- Clinical Tutors and Post-graduate Managers
- Have an interest in interprofessional learning and working
- Voluntary participation
- Willing to take part in the shared mentoring and learning programmes.

Consent for the Scheme and its evaluation was obtained from the Trusts and all participants in the evaluation.

Findings and discussion

Shared mentoring and learning was well received by all Trusts. The shared mentoring component was more positively evaluated by all participants, and utilised by the PRHOs, than the shared learning.

Perceptions of interprofessional working and learning

Interprofessional working and learning was accepted as important in providing a seamless path for patients and improving service delivery. Most participants agreed with a need for a common, patient-centred goal, along with effective communication, understanding of professional roles, respect for the contributions of other professional groups and good teamwork.

Choosing the right topic, a suitable time and an experienced facilitator were perceived as the requirements for developing an effective shared learning programme. Even though participants had an understanding and perception of interprofessional working and learning, only a small minority had any experience. However, there were varying definitions and understandings of what interprofessional means.

Hurdles in setting up the Scheme	There were logistical hurdles for the Project Leads. Examples include: • The ability to find enough experienced nurses to act as mentors • Obtaining information about new staff starting at the Trust • Finding a suitable time for the training of mentors • Working with Postgraduate Centres in identifying areas where shared learning could occur • Finding a time suitable for the working patterns of both professions • Finding facilitators willing and able to run workshops for both professions.
Anxieties expressed by mentors and PRHOs	Apprehensions expressed by PRHOs included worries about their knowledge, decision making, responsibilities, accountability, prescribing medication, expectation of patients and other staff and not having support. Mentors expressed concerns about mentoring PRHOs as it was a new experience for many of them. However, most mentors had supported PRHOs informally in their capacity as senior staff and believed this experience would help in the new role.
Feeling supported	Over 79% of PRHOs felt supported by their mentor. Although PRHOs were the main support for each other, nurses (including mentors and nurse practitioners) were the next major group providing support, making them ideal mentors. Senior House Officers were also seen as supporting PRHOs and, with training, should be considered as mentors in the future. The same identified groups were also rated as decreasing the stress levels of PRHOs. Mentors were used by the mentees to different extents according to their individual needs.
Benefits identified	Mentors believed that, although their work load increased by 50%, they gained other benefits, such as: • Increased job satisfaction • Help with their personal development • Increased knowledge of interprofessional working and learning

- Increased knowledge of medical education.

Mentors, along with Project Leads and Clinical Tutors, also rated highly the following benefits:

- Improved patient care
- Improved communication between nurses and doctors
- Improved interpersonal relationships between nurses and doctors
- Improved working relationship between nurses and doctors.

PRHOs believed that mentors not only supported them with pastoral issues but also helped with their clinical skills, and having someone from a different profession provided them with a new perspective on patient care.

Characteristics of mentors	Mentors needed to be approachable, confident, flexible, knowledgeable, good communicators and willing to mentor in order to be effective. As much of the support was given on an ad hoc basis, mentors and mentees were ideally from the same clinical area. This also helped build interpersonal relationships, which were seen as necessary for any mentoring. In the first few days, the needs of the mentees were intense and they continued to need support for the first three to six months. Therefore, the mentoring scheme was at its most effective in that period for newly qualified staff. Support and commitment from senior and management staff to both the mentoring and shared learning components was essential. Having a Project Lead at each Trust with protected time to organise, co-ordinate, manage and support the Scheme was also important.
Identified obstacles	Time, differing working patterns and the reduction in PRHO hours were the main factors that prevented mentors and mentees meeting together. Personality and cultural differences also created barriers to the implementation and acceptance of the Scheme.
Shared learning	The shared learning was more difficult to put into practice as established educational programmes were already in existence. Two Trusts opened the PRHO core curriculum programme to nurses and a number of sessions were organised. The timing of the sessions was important to achieve maximum attendance and the topic area needed to be relevant to both professions.

Conclusion

Overall, the Scheme was positively evaluated. There were some constructive and encouraging outcomes for both mentors and mentees. The interest from other professional groups also affirmed the need for more interprofessional initiatives and the developing culture of teamwork.

Recommendations

1. Need for greater awareness of the Scheme and the Trust's interprofessional approach among all staff within the Trust, particularly nursing and medical staff in clinical areas, who should be required to incorporate this into their practice.

   - Presentations at various meetings and forums within the Trust, including consultant meetings, management meetings, ward meetings, educational programmes for all staff and induction days for new staff
   - Workshops on the theme of interprofessional working and learning providing examples of good practice
   - Provision of opportunities for staff to become involved in the Scheme and incorporate their experience into their lifelong learning and continuous professional development.

2. Involvement of all participating professional groups with all aspects of the Scheme. Collaborative working in developing a shared learning programme and in planning the mentoring component. Both professions must contribute equally to the mentoring and shared learning programme (see Appendix 1).

   - Setting up steering groups with members from all professions involved
   - Enthusiast found from all professional groups to lead in their clinical area and co-ordinate the Scheme.

3. Training and support for mentors. Involvement of senior medical staff in mentoring and developing further the criteria for selection of mentors from both nursing and medical teams.

   - Involvement of senior staff from all professional groups
   - Development of a rolling training programme for new mentors and updating existing mentors
   - Exploration of ways that mentors can incorporate their training programme and experience into their continuous professional development.

4. Training of facilitators of the shared learning workshops.

- This could involve the local universities in delivering interprofessional courses at Trusts for facilitators

- Provision of support for facilitators and in some cases providing references around the workshop topics

- Exploration of ways that facilitators can incorporate their training programme and experience into their continuous professional development.

5. Incorporating shared learning workshops as part of the educational requirements for all professions, therefore ensuring protected time is given for attendance.

- Collaboration of individuals responsible for the educational provision of all professional groups. This would involve regular meetings to identify the similarities in the educational requirements of all professions

- Identifying the most suitable time, topics, approach, environment and facilitators for the workshops

- Decentralising the teaching programmes from postgraduate centres to department or ward based teaching.

Introduction

In recent years the interest in interprofessional working and education has been increasing with the view of better teamwork and collaboration in order to improve health care delivery and services. The Department of Health (DoH) has, therefore, placed a great emphasis on an integrated collaboration and teamwork approach among health care professionals to improve patient care (DoH 2000, 1998). Since most professionals are separated during their training and are prepared to function both independently and autonomously, discovering how to work as part of a team will not be simple (Soothill et al. 1995). The advantages of interprofessional working were identified by McGarth (1991) as more efficient use of human resources, more effective service provision and a more satisfying work environment. However, many barriers to interprofessional collaboration and education have been acknowledged, which include fears of diluted professional identity, differences in schedules and professional routines, differences in language and culture, and concerns regarding responsibility (Headrick et al. 1998).

In the Bristol Royal Infirmary Inquiry the recommendations are for better training in communication skills, the development of teamwork and shared learning across professional boundaries. The development of teamwork is particularly beneficial for newly qualified staff who experience great stress in making the transition from being a student to an accountable practitioner (Grainger 1997, Kramer 1974). Mentoring has been identified by both the United Kingdom Central Council (UKCC) and the General Medical Council (GMC) as a means of providing support and guidance for the mentee in all aspects of their development. The Bristol Royal Infirmary Inquiry also proposed that medical and nursing schools should be encouraged to develop joint courses. According to Freeth and Nicol (1998) successful interprofessional learning can provide a model for effective, collaborative working and can encourage professionals to learn with, from and about each other (CAIPE 1996).

Although the ideas of interprofessional working and learning, effective teamwork and more collaboration are encouraged, the rapid changes within the National Health Service affect the implementation initiatives and ideas. The changes in the roles of sisters/charge nurses, the change in working hours for junior doctors and the greater demands on staff time, all

contribute to the pressures that health care staff are facing. Any new initiative is sometimes perceived as extra pressure on staff and therefore not always implemented or explored.

Objectives of the Scheme

The objectives of this Scheme were:

- To develop a system of shared mentoring for newly qualified doctors and nurses
- To support newly qualified staff during their initial working life and with their personal and professional development
- To develop a programme of learning for newly qualified doctors and nurses, through shared learning workshops
- To examine the perceptions of all staff about interprofessional learning and mentoring.

Aim and objectives of the evaluation

The aim of this evaluation was to explore the perceived benefit of interprofessional mentorship and learning for newly qualified nurses and PRHOs.

The objectives, therefore, were to:

- Examine the experiences of mentoring by a more senior member of staff on stress and development of junior staff
- Examine staff experiences and perceptions of shared learning
- Explore professionals' understanding of interprofessional working and shared learning
- Identify factors which support and hinder collaboration, co-operation and learning among nurses and doctors
- Develop concepts to promote interprofessional working (including mentoring) and shared learning.

Literature review

The trend in recent years has been for a move towards interprofessional education, training and working in order to enhance team working and improve patient care. This drive towards increased collaboration amongst health care professions has been spurred by concerns with quality and reforms in the health care system. There has been a greater emphasis in

recent years by the Government to increase interprofessional learning and working (DoH 2000, 1998, 1997) and to develop means of incorporating it into continuing professional development (CPD) and lifelong learning (DoH 2000). Although a body of knowledge is developing, there is still a lack of empirical evidence about the effectiveness of an interprofessional approach. The United Kingdom Centre for the Advancement of Interprofessional Education (CAIPE) states that interprofessional education occurs when two or more professions learn with, from and about one another to facilitate collaboration in practice (Barr 2000).

As far back as 1974 Kramer described the 'reality shock' for new workers. Health care professionals who have spent at least three years studying do not find themselves fully prepared and need support during the transitional period from being students to accountable practitioners. This has been acknowledged by both the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the General Medical Council (GMC). In 1993, the UKCC recommended the introduction of a formal support framework known as preceptorship. The Standing Committee on Postgraduate Medical Education in England (SCOPME) suggests that mentoring for medical students and doctors may be one way of providing support. A definition of mentoring is given by the SCOPME as: 'a voluntary relationship, typically between two individuals, in which the mentor is usually an experienced, highly regarded, empathic individual, often working in the same organisation, or field, as the mentee; the mentor, by listening and talking with the mentee in private and in confidence, guides the mentee in the development of his or her own ideas, learning, and personal and professional development. Mentoring should be a positive, facilitative and developmental activity and should not be related to, nor form part of, organisational systems of assessment or monitoring of performance' (SCOPME 1998, p12).

Since both the nursing and medical professions accept the need for more support for newly qualified staff in the form of mentoring and preceptoring, and with the movement towards an interprofessional approach, there is a need to examine the possibilities of interprofessional mentoring and learning.

Education of health professionals, both pre and post qualifying, is an important factor in the facilitation of current changes within the health

service. Historically, health care education and training have been delivered separately with minimal interaction between different disciplines and professions. There has always been a belief that each discipline was able to provide enough knowledge and skills within a specific professional framework. The differences in training and qualifications have led to certain beliefs, values and cultures being developed within each profession as well as stereotypical views of other professionals (Alexander et al. 1996, Carpenter 1995). People acquire notions and ideas about other health professions as well as their own and it is only through helping professionals learn from each other that these attitudes may be changed. It has been suggested that establishing a basis upon which common interprofessional values and assumptions rest can further weaken stereotyping (Carpenter & Hewstone 1996). Data examining the move from learning in an educational context to continuing the learning process within a health care working environment is still being accumulated.

Although interprofessional education (IPE) is being widely advocated, it is unclear what this means, as there is insufficient empirical evidence to substantiate it (Levenson et al. 1997). The ever-increasing body of literature on interprofessional education has not yet proved conclusively that it is beneficial (Barr et al. 1999). Several barriers to interprofessional learning and working have been identified (CAIPE 1996). Some of these include differences in culture, language, schedules and professional routines, levels of preparation, qualification and status.

Hall and Weaver's (2001) review of the literature found an agreement that learning to work in an interprofessional surrounding needs to occur early in the education of health care professionals. Horak et al. (1998) suggest that interdisciplinary collaboration can be better facilitated if shared learning occurs at the early stages of a health professional's education. However, some argue that identity with one's own profession would be lost and that developing a body of sound knowledge, an occupational identity and security in one's discipline first would be more beneficial (Mariano 1999, Soothill et al. 1995). With this occupational identity come professional boundaries and culture, which are harder to change.

Another issue impeding any interprofessional exercise is the lack of clarity and consensus in the definition. Interprofessional education happens when two or more professions learn with, from and about one another to aid

collaboration in practice (Barr 2000). This can be in both a clinical and educational setting. Clinical Governance calls for a culture of learning and multi-professional team working to provide high quality care. To do this, both service and educational providers must collaborate more closely to create a culture and environment of interprofessional learning.

Parsell and Bligh (1997) believe that successful health care teams must share a common goal and commitment to providing the best possible care for patients. With the Department of Health (DoH) giving priority to shared learning during CPD (Barr 2000) there is a need for more innovations and evaluations in the area of interprofessional learning and working to ensure that good practice is developed, acknowledged and praised. There are many initiatives at different stages of a health professional's career, from student to senior member of staff. Universities are experimenting with foundation courses for all health care professions and multiprofessional lectures. However, experimentation within the workplace is not welcomed due to perceived pressures of time, staffing levels and resources.

Over the last four years, Bournemouth University has been the recipient of a number of grants to explore interprofessional education and working. One grant from the NHS Executive South and West Region developed a system of shared mentoring and learning for newly qualified doctors and nurses. This idea was piloted four years ago in one Trust and developed and extended to four other Trusts. At the level of junior doctor and nurse some common aims have developed. For example, topics that can be facilitated by an interprofessional approach include breaking bad news, communication and infection control. An examination is needed into how this approach can be extended to more senior professionals. Three Trusts have already shown interest in developing this concept further in line with Clinical Governance and their responsibility to provide a culture of learning.

Scheme implementation

Background

With a grant from the NHS Executive South & West Region, the Institute of Health and Community Studies at Bournemouth University began exploring ways of developing interprofessional working and learning. In collaboration with a Trust in the South West of England, ideas were examined that gave birth to a project for newly qualified doctors and nurses starting on the Medical Directorate. The project possessed four component parts to promote interprofessional working and learning as well as acting as a support mechanism for newly qualified staff. These included:

- Shared mentoring
- Shared learning
- Reflective sessions
- Log books (recording of skills).

Through the pilot project, areas that worked well and were more positively evaluated were carried forward, expanded to other specialities and professional groups and became a feature of the Trust by offering a system of support through educational and professional development. The Scheme has now been operating for the last three years and is maintained and funded by the Trust through different sources.

Expansion of the Scheme

Through lessons learned from the experiences of the initial Trust, the Scheme was rolled out to four other Trusts in the South Region, with support and funding from the NHS Executive South and West Region as well as the help of the two regional Deaneries. The two areas carried forward to all Trusts were the shared mentoring and shared learning components.

Shared mentoring

The aim of shared mentoring is to support newly qualified staff and also to help them learn with, from and about each other. The mentors were senior nurses, due to their existing experience of mentoring, together with one Registrar. It was recognised that senior doctors could also offer support and mentoring to junior staff because of their experiences. However, as mentoring is new within medicine, some guidance and formalisation of the process may be required. All mentors were provided with a half-day training session at their own Trusts by Bournemouth University staff, accompanied by reference material and information.

Further objectives of shared mentoring are to increase understanding of the role of colleagues, improve communication and ultimately improve patient care.

Some practical aspects of shared mentoring are as follows:

- To discuss concerns and work related fears of newly qualified staff
- To understand the role of other health care professionals
- To hold formal meetings three times during the six months
- To conduct further ad hoc meetings at mentees' request
- To have confidential meetings, with protocol for matters arising that could be detrimental to either mentees or patients
- To make documentation where necessary
- To provide support for mentors through regular meetings.

Shared Learning

Through shared learning, newly qualified staff not only learn clinical skills, but understand the role of other professionals in providing patient care. Identification of areas applicable to all professions involved allows newly qualified staff to learn with each other.

Guidelines for implementation of shared learning include:

- Sessions facilitated by a specialist in that area
- Sessions consisting of a formally taught section followed by case studies, scenarios and discussion
- Creating opportunities for participants to understand other professionals' roles in the care of the patients
- Other educational structures considered and the shared learning incorporated to suit the needs of the Trust
- Evaluation and feedback to facilitators.

Table 1: Number of participants in the Scheme

	Trust W	**Trust X**	**Trust Y**	**Trust Z**	**Total**
Mentors	18	24	12	15	69
PRHOs	21	16	12 *	15	64
Junior Nurses	16	23	5	13	57

* 6 PRHOs on surgical side not involved due to lack of capable nursing staff

Table 2: Time scale

	Activities
March 2001	• Meetings with the Director of Education Southwest and the Associate Deans responsible for PRHO education, at both deaneries, to discuss the aims and objectives of the Scheme.
April 2001	• Information sent to Trusts throughout the Southwest region inviting them to join the Scheme.
May 2001	• The four participating Trusts were identified and discussions were held with Chief Executives, Directors of Nursing, Post Graduate Managers, Clinical Tutors, Consultants, Training Education and Development Manager, PRHO representatives, Clinical Practice Co-ordinator and senior Clinical Nurse Managers and others.
May-June 2001	• Project Leads chosen for each Trust to assist in the running of the Scheme and ensuring adaptations were made to individualise the Scheme, incorporating all existing structures within the Trust. • Project Lead day to discuss their role within the Trusts and ensure full understanding of the aims and objectives of the Scheme.
July 2001	• Choosing of mentors by Project Leads and senior members of staff. • Identification of PRHOs and newly qualified nurses with assistance from the Postgraduate Centre Staff. • Presentation of Scheme for Trust staff if required. • Mentor information/training days – conducted by Bournemouth University. • Allocation of mentors to mentees. • Identification and preparation of the shared learning programme with input from those involved in and responsible for the training and education of newly qualified staff.
August 2001	• Commencement of the Scheme. • Information given to the PRHOs during induction day and shadowing week. • First phase of evaluation consisting of questionnaires for all involved, and interviews with a selected sample at each Trust.
Sept-Nov 2001	• Project Leads supporting mentors and mentees and ensuring the efficient management of the Scheme. • Interim report. • Meetings with Trust managers to discuss continuation and development of Scheme and future funding.
Dec 2001-Jan 2002	• Second phase of evaluation conducted within each Trust.
February-March 2002	• Analysis of data.
April -Jun 2002	• Report writing and dissemination of the information to each Trust.

Evaluation

Plan of investigation

According to Reinharz (1992), evaluation is an essential part of any intervention or programme planning in health, education and health services. The body of knowledge in the area under investigation is still in its infancy, and research methods used to effectively evaluate interprofessional learning and working are limited.

An ethnographic research approach was utilised, which according to Brewer (2000) 'is the study of people in naturally occurring settings or 'fields' by means of methods which capture their social meaning and ordinary activities…' (p10). Hammersley and Atkinson (1995) suggest that an ethnographic approach uses methods that are aware of the nature of the setting with the aim of describing what happens in the setting, and how those involved see their own actions or the actions of others and the behaviour of the participants. Such an approach is generally concerned with finding out how the participants understand their experience, the meanings they attach to events and actions, and the way they perceive their reality. It is generally accepted that health professionals do have different cultural backgrounds and that health care settings also have their own culture. Therefore, this approach was deemed most appropriate.

Hammersley (1990) explained that the term ethnography pertains to any social research that focuses on the meanings of an individual's actions and explanations, rather than their quantification, evolving in design throughout the study and using several methods. Schensul et al. (1999) agree and call for the 'collection and integration of both forms of data. Both qualitative (defined as descriptions in words) and quantitative (numerical) data are vital parts of the ethnographic research endeavour' (p4). The ability to use the mixed methods of data collection provides the researcher with a richer source of data, from in-depth information on a topic to observation of the situations and events as they happen. One of the major characteristics of ethnography is 'thick description' that makes explicit the intricate patterns of cultural and social relationships. These are then put into context by adding theoretical and analytical aspects. The researcher then becomes aware of general patterns in the accounts of the participants (Holloway 1997).

Data collection

For this study, data collection involved one-to-one interviews, self-completed questionnaires and observation. These were conducted before the Scheme started and repeated after six months. According to Robson (1993) the use of multiple methods of data collection provides a means of testing one source of data against another. He suggests that if two sources generate the same or very similar messages, then to some extent, they cross-validate each other. Data from questionnaires could be superficial and by using a combination of methods (i.e. interviews) more meaning and clarification can be obtained.

Self-completed questionnaires are very efficient in terms of researchers' time and effort (Robson 1993). Questionnaires allow for the collection of demographic data, past and present views and experiences. According to Peat (2001) a well-designed questionnaire can contribute to efficient research and greater generalisability, but a reliable and valid questionnaire takes time and vast resources to test and develop. Consequently, existing questionnaire designs were used for this study.

According to Schensul (2001), 'structured ethnographic data collection offers a way to transform exploratory and semi-structured data into instruments that measure relationships among cultural domains and variables quantitatively and test their relationships with a sample of the population' (p165). A mixture of open and closed questions was used.

The sample

The sampling was purposive and the criteria were explicit and systematic as Hammersley and Atkinson (1995) suggest. According to Holloway (1997) in purposive sampling it is not generalisability but rather collection of rich data that is important. Particularly in qualitative research, a small sample of key informants can be more useful to the researcher than a large sample of general participants without specific knowledge of a topic. Patton (1990) asserts that the 'logic and power of purposeful sampling lies in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research…' (p169). Written consent was obtained from all participants.

For the interviews, a simple random sampling was used to select the participants for one-to-one interviews. Although random sampling is not

normally employed in qualitative research, it ensured that the sample chosen was independent of human judgement and the researcher was not able to select individuals who may appear more positive. The sample needed to meet the following criteria:

- Senior member of staff (at least two years of clinical experience)
- Newly qualified nurses and PRHOs
- Clinical Tutors and Post-graduate Managers
- Have an interest in interprofessional learning and working
- Voluntary participation
- Willing to take part in the shared mentoring and learning programmes.

The following were selected from each Trust, including the main individuals involved in managing the interprofessional initiative and a percentage of the main participants in the Scheme (15%):

- PRHOs n=3
- Mentors n=3
- Project Nurse Lead n=1
- Clinical Tutor n=1
- Post-graduate Manager n=1.

The questionnaire was given to all involved and participating in the programme. The interviews and questionnaires were conducted before the Scheme started and after six months.

Analysis

The questionnaires were analysed using the Statistical Package for Social Sciences (SPSS). Thematic analysis was used for data generated by one-to-one interviews and the open questions in the questionnaire as well as observational notes, which allowed the researcher to identify themes and patterns in the data.

Ethical issues

A proposal was provided for the Chief Executives, Directors of Nursing and Clinical Tutors at each of the participating Trusts. Once their consent had been obtained the participants were approached for the study. Each participant was given written information about the purpose of the study. Participation was on a voluntary basis and the participants were free to leave the study at any time.

Written consent was gained for the interviews and by agreeing to complete the questionnaires consent was obtained. Total anonymity and

confidentiality was maintained throughout the study. Contact details, tapes, transcripts and computer data were placed in a locked filing cabinet. The final report does not include any names or identify any Trust.

Results and discussion

The findings were divided into two sections (pre and post Scheme), and further divided into three parts. Part 1 incorporates a description and characteristics of the sample. Part 2 consists of data from the questionnaires, including three existing questionnaires (see below), as well as questions and scales exploring stress levels and educational development for PRHOs, in addition to the perceptions of mentors about the affects of the Scheme on practice. The final part integrates the data from the interviews and the open-ended questions in the questionnaire.

Information about questionnaires

Three existing questionnaires were used in this study:

1. Brown et al.'s (1986) Professional Identity
2. Carpenter's (1995) Stereotypes
3. Parsell and Bligh's (1999) Readiness for Interprofessional Learning (RIPLs), which has three subscales measuring specific themes:
   - Subscale 1: Team-work and collaboration
   - Subscale 2: Professional identity
   - Subscale 3: Roles and responsibilities.

The total scores obtained for the RIPLs questionnaire were:

Total score = 95.

Professional Identity total score that could be obtained was:

Total score = 50.

Pre shared mentoring and learning Scheme

The response rate for the pre questionnaires was 83.7% (118 out of possible 141) which was higher than is normally expected for postal questionnaires. The number of participants from each Trust was similar, as illustrated below:

Table 3: Percentage from each Trust contributing to total response rate

Trusts	Percentage from each Trust contributing to total response rate
W	28%
X	25.4%
Y	25.4%
Z	21.2%

The ethnicity of the majority of the participants was white (86.4%) with 68.4% females and 31.4% males; 50% of the respondents were pre-registered house officers, with 43.2% mentors and the remainder being Clinical Tutors (n=3), and senior nurses acting as Project Leads (n=4) at the Trusts.

The majority of the participants fell into the age group of 21 to 30 (63.6%). This age group consisted of all the PRHOs and some of the mentors. A further 26% were between the ages of 31 and 40 and the remainder were above 40 years of age.

The participants were divided into two groups with 49.2% having had some previous experience of interprofessional working or learning. The main clinical areas were medicine (44.9%) and surgery (28.8%) and the rest spread out into different specialities.

Results from questionnaires

Although validated questionnaires were used for this study, a reliability test was still carried out and the results were as follows:
RIPLs Total: 0.8533
Professional Identity Total: 0.7902

Table 4: Total mean scores for nurses and doctors for each scale

	Nurses	**Doctors**
RIPLs	80.3	76.6
Professional Identity	42.3	39.6

Nurses consistently scored higher than doctors did for both questionnaires. Nurses (who were all mentors) were senior staff with a number of years in clinical practice in comparison to doctors (who were mainly PRHOs) and newly qualified. Hence the years of experience could influence one's

readiness for interprofessional working and learning and one's strong identity with their own profession.

Findings from interview data

Interprofessional working and learning was universally accepted and welcomed by most of the participants. However, there was limited experience of interprofessional working by the participants and limited experience of interprofessional education at university amongst the PRHOs. There were difficulties in achieving a consensus about the meaning of the word interprofessional and therefore many ideas about the factors that promote or hinder it.

Although all Trusts were open, supportive and willing to employ the Scheme, there were complexities in implementing the new idea due to the working practices of both the organisation and the individuals with whom this Scheme was discussed and whose support was required. Since such a Scheme is about changing culture and mindset it takes time. There was a perception by most participants that resources impede development. These include funding, staffing level and the number of senior staff available to act as mentors.

The main themes that emerged from the pre shared mentoring and shared learning Scheme data are shown in the table below.

Table 5: Themes and categories emerging from the pre Scheme data

Themes	Categories
Promoting factors for interprofessional working and learning	– Team working – Common goal – patient centered – Effective communication – Respect for other professionals
Hindrances to interprofessional working and learning	– Culture of professions – Personalities – Time and resources – Lack of understanding of roles – Current working practices
Anxieties for PRHOs	– Accountability/responsibility – Not having support – Being new – Not knowing
Perceptions about the shared mentoring and learning	– Support for newly qualified staff – Improved working conditions – Improve patient care – Understanding each other's roles and responsibility

Promoting factors for interprofessional working and learning

Most participants agreed that interprofessional working involved team working but the concept of 'team' was not as clear. Some PRHOs referred to the team as the medical team and some mentors mentioned the nursing team as the main team.

I suppose when I think of myself in a team I suppose I largely think of myself as part of the team, it is me, my SHO, registrar to an extent, although we haven't really strictly got a consultant. In terms of nursing staff I suppose because we don't have a nurse attached to our team… (PRHO 5)

However the majority acknowledged the need for participation by all health professionals, naming doctors, nurses, physiotherapists and occupational therapists. A need for co-ordination of the workload and care delivered was highlighted with nurses being suggested by a number of participants particularly PRHOs.

If you're talking about ward-based care the nurse is central to it. (Clinical Tutor 4)

> *Nurses know much more, they are the link person if you like.* (PRHO 6)

Most participants mentioned that decisions about patient care should be made together rather than one profession having a higher authority on decision making.

The need for a common goal was mentioned by many of the participants who also accepted that it should be centred on patient care. This would allow all professionals involved to provide their own expertise as part of a whole team.

> *So I suppose it's the fact that you're all working towards a similar goal really, i.e. improvement of patient health care.* (PRHO 9)

> *Doctors and nurses and PAMs will be working together to support the patient and achieve better patient care at the end of the day.* (Postgraduate Manager 1)

> *The important thing is some form of communication between the professions and some sort of shared aim or goal.* (Clinical Tutor 1)

Recognising each professional group as a valued member of the team was also deemed necessary for interprofessional working to be successful. Understanding the roles and responsibilities of other professional groups and respecting their work was emphasised. Team working was seen as a way of helping to break down stereotypical views held by one professional about other professional groups. This would encourage interprofessional working and learning. Having a better understanding of roles and responsibility was seen as conducive to a team spirit and to improvement in patient care and continuity of care.

> *I think we need to respect each other* (Mentor 10)

> *Knowing what others do and what their role is, that is important.* (PRHO 1)

All participants mentioned communication as a key factor in promoting interprofessional working. Face to face communication was seen as the best method as was the use of the notes.

> *We just communicate through the notes, if they can't all meet up at the meeting then the only way to do it is communicating through the notes I suppose.* (PRHO 6)

However although doctors and physiotherapists used the patients' medical notes, nurses had their own notes for each patient, which were not always seen by other health professionals, and the nurses did not write in the medical notes as a rule. Therefore, team working through effective communication, understanding and respect for other professional's contributions, and a patient-centred goal were perceived as necessary for promoting interprofessional working and learning.

Hindrances to interprofessional working and learning

There were a number of factors identified which hinder interprofessional working and learning, the most important being individual personalities. Personal views, beliefs and attitudes affected interpersonal relationships, which according to participants was a key feature in team working. Some of these views were seen as 'archaic' and linked to the culture of the profession. Participants identified that the different training patterns could be a reason for the varied views of other professional groups and the development of certain cultures within the groups, which gave each individual their professional identity.

> *There are a lot of other problems which I think are to do with professional boundaries, attitudes of all the different groups involved and lack of knowledge of what each other's expectations are of one's own role and each other's expectations of each other's roles.* (Clinical Tutor 4)

A number of participants felt team working required more time and resources. The workload, lack of nursing staff and lack of senior staff were seen as contributing factors to the inability to introduce interprofessional working patterns. This, however, was not universally applicable to all specialities or departments in each of the Trusts and some good working practices were identified; for example elderly care and intensive care.

> *I suppose time; time is a big factor.* (Mentor 10)

> *The pressure of work and finding time* (Mentor 11)

> *I think lack of time, lack of personnel, I mean there aren't enough people to do it.* (Clinical Tutor 1)

There was a general lack of understanding about the roles and responsibilities of other professional groups. This was particularly the case for PRHOs who could not distinguish between the different grades of nurses and what they were able to do.

Current working patterns for newly qualified staff were also viewed as a deterrent to interprofessional working. For example, the spread of each consultant's patients over more than one ward (sometimes spread across eight or nine wards) meant that doctors were not able to build interpersonal relationships with nursing staff on each ward.

> *I've really just been on two wards so I've probably got to know the nurses more quickly than if you were doing medicine. I think from what I've heard they have patients all over the place and so they have a couple on each ward and perhaps then it's better to be able to identify with one person because it will take longer to get to know everyone.* (PRHO 2)

Other issues about working patterns included consultants' rounds, shift work and PRHO hours.

Anxieties for PRHOs   The main anxiety expressed by all PRHOs was the eminent role change from being a student to an accountable practitioner. Having to take full responsibility for their actions and not having someone check their work was a stress factor for them. The reliance of patients on them was an overwhelming concept. Most mentioned their fear of having to prescribe and not being sure of the correct dosage or being the first at an 'arrest scene'.

> *You are almost scared that you'll be put into a situation*
> *you can't manage and can't deal with.* (PRHO 6)

Not having support was also a major concern for the PRHOs. The level of support varied for each PRHO depending on the consultant team they were working with and the time of the year, with seniors being on holiday in the first few weeks of their job. There were also uncertainties about what kind of support they would be able to get from which individual.

Being new was a worrying factor. Not knowing the rules and regulations, the staff and the working routine of the Trust created some apprehensions about starting as a doctor, even down to knowing where the blood forms were kept. The whole fear of not knowing was mentioned by a number of the PRHOs. This included not knowing simple practical aspects of day to day working as well as not knowing what to do in emergencies and not having the knowledge to care for patients. Most PRHOs seemed to have an expectation that they should know everything because that is why they had spent five years in medical school.

> *Fear of being on call and having no support…Also I*
> *guess it's such a big life change from being a student*
> *which is so much fun to being responsible and people*
> *relying on you which I don't really like the idea of.*
> (PRHO 7)

Therefore the anxieties of accountability, responsibility, not knowing and being new were real for the PRHOs who wanted support to be able to cope with them.

Perceptions about shared mentoring and learning

All those interviewed saw the shared mentoring as a mechanism for providing extra support for newly qualified staff. For PRHOs it was reassuring to have a named nurse they could go to with any questions, anxieties or problems. This support was particularly important because they were new and did not know the staff.

There were mixed views about who should act as mentor i.e. from one's own profession or a different one. Most PRHOs believed that having a nurse mentor would be very beneficial as they could help them understanding the nursing care and roles and would be someone outside their own profession giving a fresh perspective to their work and learning.

There was also a safety issue of sharing problems or concerns with someone who was not part of their own medical team and not responsible for their teaching or assessment.

> *I mean I'm sure all of us are going to need at some point, someone away from your team of doctors that you're actually working with in the day…nicer to have someone from a different profession because I suppose that would help the interprofessional sort of learning and team work because then you'd understand the other profession's problems more I think. A different profession would not be sort of directly involved in my teaching and my appraisal and things like that.* (PRHO 10)

However, a few PRHOs mentioned that having an SHO or Registrar would be more useful as they could support and help them with the medical management of patients which nurses would not be familiar with.

> *It would be advantageous to have someone from your own profession.* (PRHO 7)

Although mentors had concerns about mentoring PRHOs and not being fully aware of their previous experience, their training and their needs, they felt that through their years of experience of working with PRHOs and their mentoring skills they would be able to take on this role. However, a number felt it would be valuable if senior doctors could also take part so that newly qualified nurses gained similar experiences to PRHOs, thus sharing the workload amongst the senior staff.

> *…Maybe if doctors starting mentoring nurses it might ease the workload of senior nurses.* (Mentor 2)

Most of the participants believed that both shared mentoring and learning would help the professionals understand each other's roles. Being aware of the contribution of all professionals towards patient care was deemed important in order to collaborate and co-ordinate the care provided. Both doctors and nurses acknowledged that they did not fully know what kind of training the other professional group received and what they were or were not able to do.

> *I mean I don't know what nurses do in their training whether it be at university or college or whatever. I mean I don't know how much time they spend on the wards*. (PRHO 10)

Better understanding would lead to better working conditions and help break down barriers to interprofessional working and learning according to the participants. Improved working conditions would include better communication, co-ordination of work and referral patterns. Most participants believed that this would ultimately improve patient care. A couple of mentors gave examples of speeding up discharge plans for patients if there was better communication.

Post shared mentoring and learning scheme

The response rate for the post questionnaires was 70.8%. However, for the purpose of analysis, only those who completed and returned both questionnaires (53.9%) were used. This was still a satisfactory response rate. The numbers include 38 doctors (all PRHOs) and 38 nurses (all mentors).

The distribution from each Trust was as follows:

Table 6: Percentage from each Trust contributing to the total response rate

Trusts	Percentage from each Trust contributing to the total response rate
W	30.2%
X	22.4%
Y	22.4%
Z	25%

The ethnicity of the majority of the participants was white (89.5%) with 75% females and 25% males; 50% of the respondents were pre-registered house officers, with 44.7% mentors with the remainder being senior nurses acting as Project Leads (n=4) at the Trusts.

The majority of the participants fell into the age group of 21 to 30 (59.2%). This age group consisted of all the PRHOs and some of the mentors. Thirty

percent were between the ages of 31 and 40 and the remainder (10.5%) were above 40 years of age.

The participants were divided into two groups with 50% having had some previous experience of interprofessional working or learning. The main clinical areas were medicine (39.5%) and surgery (32.9%) with the rest spread out into different specialities.

Findings from the questionnaires

Table 7: Total mean scores for nurses and doctors for each of the scales post mentoring

	Nurses Pre %	Nurses Post %	Doctors Pre %	Doctors Post %
RIPLs	80.3	78	76.6	72
Professional Identity	42.3	42.5	39.6	38.7

There was no significant positive change for both RIPLs and Professional Identity. The changes over time were minimal and not all total scores increased. However, it was difficult to control all the variables that would influence the staff's responses to the questionnaire.

Stereotypes

For this questionnaire, scores ranged from 1 being the least applicable characteristic to 7 being the most applicable. Scores higher than 4 have been highlighted.

Table 8: Comparison of results given by doctors and nurse before and after the shared mentoring and learning

Characteristics	Nurses		Doctors	
	What they think of doctors Mean score	What they think doctors think of them Mean score	What they think of nurses Mean score	What they think nurses think of them Mean score
Pre mentoring				
Arrogant	3.97	2.63	2.34	**5.71**
Caring	**4.61**	**6.32**	**5.59**	3.87
Confident	**5.00**	**4.68**	**4.79**	**5.71**
Dedicated	**4.95**	**6.00**	**6.13**	**5.45**
Detached	**4.05**	2.89	2.51	**4.82**
Dithering	2.87	3.13	2.78	2.65
Do gooder	1.92	3.95	3.26	2.92
Good communicator	**4.03**	**5.42**	**5.18**	3.89

Characteristics	Nurses		Doctors	
	What they think of doctors	What they think doctors think of	What they think of nurses	What they think nurses

	Mean score	them Mean score	Mean score	think of them Mean score
Post mentoring				
Arrogant	3.57	2.67	2.41	**5.17**
Caring	**5.05**	**6.16**	**5.78**	**4.16**
Confident	**5.34**	**4.95**	**4.44**	**5.54**
Dedicated	**5.38**	**5.79**	**5.70**	**5.24**
Detached	**4.14**	3.00	2.62	**4.41**
Dithering	2.69	3.66	3.26	2.73
Do gooder	2.08	3.27	3.22	2.81
Good communicator	**4.35**	**5.16**	**4.69**	**4.35**

From the table above it is evident that the scores given for the characteristics were very similar for both professions. Interestingly, how doctors saw nurses was exactly how doctors did score nurses with no change in the pre and post scores. Nurses initially scored doctors as caring, confident, dedicated, detached and good communicators, but doctors thought nurses viewed them as arrogant and not caring or good communicators. In the post results the nurses had not changed their view of doctors but doctors now believed nurses viewed them as caring and good communicators but still felt they were perceived by nurses as arrogant.

Doctors only

Doctors were asked if they felt they were supported by their mentor, to which 79% said yes and only 21% said no. The following table demonstrates where PRHOs received their support from:

Table 9: Support for PRHOs from different professionals

Who supported you?	Frequency	Valid Percent
PRHO	10	32.5
SHO	7	22.5
Registrar	1	3.2
Educational Supervisor	1	3.2
Nurses	1	3.2
Nurse Practitioner	2	6.4
Mentor	4	12.9
Others	5	16.1
Total	31	100.0

The following four tables demonstrate the answers given by PRHOs about their stress levels, educational development, stress factors and how mentors supported them in reducing those factors.

Table 10: The extent to which other professionals affected PRHO's stress levels

To what extent did the following individuals affect your stress levels?	Decreased stress levels %	No affect %	Increased stress levels %
Nurse Practitioner	77.7	13.9	8.4
SHOs	76.3	13.2	10.6
Other PRHOs	72.9	10.8	16.2
Nurse Mentor	58.9	41.2	0
Educational Supervisor	57.9	34.2	7.9
Senior Nurses	52.6	13.9	33.3
Consultant	47.3	13.2	39.5
Clinical Tutor	37.1	60.0	2.9
Registrars	30.1	13.5	24.3
Professionals Allied to Medicine	29.4	58.8	11.8
Post graduate Manager	28.6	65.7	5.7
Junior Nurses	27	29.7	43.2

Consultants, registrars and nurses did appear to increase the stress levels of

PRHOs to some extent. It is important to highlight that mentors, nurse practitioners and SHOs had the highest scores in decreasing the stress levels of PRHOs. It could be that the best mentors for newly qualified staff, particularly PRHOs, are SHOs and Nurse Practitioners.

Table 11: The extent to which other professionals and activities contributed to PRHO's educational development

To what extent did the following contribute to your educational development?	A lot %	Moderate to a lot %	Slight %	Not a lot %
Registrars	64.9	13.5	21.6	0
SHOs	51.4	32.4	10.8	5.4
Consultant	45.9	37.8	13.5	2.7
Educational Supervisor	30.6	33.3	30.6	5.6
Other PRHOs	20.0	31.4	42.9	5.7
Core Curriculum	13.9	61.1	22.2	2.8
Clinical Tutor	9.1	27.3	36.4	27.3
Senior Nurses	5.6	38.9	50.0	5.6
Post graduate Manager	3.0	27.3	27.3	42.4
Nurse Mentor	3.0	15.2	39.4	42.4
Nurse Practitioner	2.9	29.4	41.2	26.5
Junior Nurses	0	13.9	47.2	38.9
Professionals Allied to Medicine	0	33.3	36.7	30.0
Shared learning sessions	0	33.3	41.7	25.0

PRHOs responded that Registrars, Consultants and Educational Supervisors (who in most cases are the Consultants whose team they work for) contributed to their educational development. Interestingly, the shared learning sessions, although not well planned or established, were still seen to affect the educational development of PRHOs and are therefore worth exploring further.

Table 12: Factors affecting stress levels

To what extent did each of the following affect your stress levels?	Increased stress %	No affect %	Decreased stress %
Work load	88.9	8.3	2.8
Responsibility and accountability	88.9	11.1	0
Long hours/shift patterns	77.8	22.2	0
Medical staff	37.2	42.9	20
Nursing staff	44.1	35.3	20.5
Lack of support	52.9	41.2	5.8
Patients	47.2	41.7	11.1
Educational requirements	25	75.0	0

The above table demonstrates the extent to which certain aspects of their work, namely workload, responsibility/accountability, long hours/shift patterns and lack of support. Hours of work and shift patterns are currently being reviewed and changed. Responsibility and accountability were also identified in the interviews before the start of their post as a major anxiety factor.

PRHOs were then asked to rate how having a mentor helped them to manage the factors that affected their stress levels.

Table 13: Mentors helping PRHO manage factors that affect their stress levels

To what extent did having a mentor help you manage your stress levels with the following?	Positive affect %	No affect %	Negative affect %
Lack of support	40.6	59.4	0
Nursing staff	33.3	66.7	0
Patients	30.3	69.7	0
Work load	21.9	78.1	0
Medical staff	21.2	78.8	0
Responsibility and accountability	18.2	81.8	0
Long hours/shift patterns	12.1	87.9	0
Educational requirements	3.1	96.9	0

Mentors were perceived as having a slight positive effect for PRHOs in

managing the stress caused by nursing staff, patients and the lack of support they receive. The aim of the mentoring was to support newly qualified staff and help them understand other professional roles and responsibilities. From these results it is clear that, even in its early stages, the mentoring achieved its aims to some extent.

Mentors only

The following three tables demonstrate the mentor's perception of shared mentoring, the effects of being a mentor and the perceived effects of shared mentoring.

Table 14: Mentor's perception of shared mentoring

Mentor's perception of shared mentoring	Moderate to a lot %	Slight %	Not at all %
Increased mentor's knowledge of interprofessional working and learning	76.3	15.8	7.9
Prepared for role as a mentor	73	13.5	13.5
Helped mentor's own personal development	60.5	28.9	10.5
Increased mentor's knowledge of medical education	50	42.1	7.9

Positive outcomes of the Scheme were personal development of mentors and an increase in their knowledge of interprofessional working and learning. Through the mentoring, the mentors were also able to increase their knowledge about medical education.

Table 15: Effects of being a mentor

	Increased %	No effect %	Decreased %
Affected mentor's job satisfaction	65.8	34.2	0
Affected mentor's work load	57.9	42.1	0
Affected mentor's stress level	28.9	71.1	0

Although nearly 50% stated that the mentoring slightly increased their workload, 45% felt it also slightly increased their job satisfaction.

Table 16: Effects of shared mentoring

Shared mentoring affected	Improved %	No affect %	Worsened %
Working relationship between nurses and doctors	89.2	10.8	0
Communication between nurses and doctors	86.5	13.5	0
Interpersonal relationship between nurses and doctors	83.8	16.2	0
Patient care	62.1	37.8	0
Duplication of work	28.6	71.4	0

Most mentors expressed how mentoring in their view had improved communication, interpersonal and working relationships amongst doctors and nurses as well as patient care. This is a very positive outcome of the Scheme.

Findings from the interviews

Shared mentoring

Table 17: Themes and categories emerging from the post Scheme data

Themes	Categories
Perceived outcomes of mentoring	– Improved communication – Understanding other professional roles – Better and faster development of working relationships – Interest in Scheme from other professional groups within the Trust
Experience for mentors	– Personal development – Better understanding of needs of newly qualified staff – Formalisation of what was happening already – Increased knowledge of medical training
Experience for mentees	– Being supported – Having someone to go to – Providing guidance and learning – Not part of assessment or appraisal – Better understanding of the nursing profession
Contributing factors supporting mentoring	– Quality and experience of mentor – Flexibility – Preparation of mentors – Working in the same environment – Developing a personal relationship
Identified obstacles	– Lack of time – Different working patterns – Interpersonal clashes – Attitudes and beliefs – Practicalities

Perceived outcomes of mentoring

The shared mentoring component of the Scheme was considered more successful than the shared learning. Even though the shared learning appeared to be the easier aspect of the Scheme, the shared mentoring was evaluated more positively.

> *'Mentoring front I think that has been a great success...*
> (Clinical Tutor 1)

A number of participants highlighted improvement in communication between PRHOs and nurses on the wards. This was particularly evident when newly qualified nurses and doctors were mentored together. The

Scheme also opened avenues for communication between the postgraduate manager and those responsible for post-registration nursing education at the Trust.

Both mentors and PRHOs felt they had gained a better understanding about the roles of other professional groups particularly nurses. Mentors were able to help PRHOs recognise different grades of nurses, appreciate their work stresses and recognise their expertise and experience.

There was evidence for many participants that newly qualified staff were more communicative, more aware of each other's training background and more informed, conscious of each other's stresses and anxieties and more supportive towards each other.

> *They* [PRHO and newly qualified nurse] *found it very useful because they learned a little bit more about each other's jobs and they now appreciate how frightening and stressful it can be to start off in life and I did quite often find them chatting to each other on the ward more than you would perhaps see and gaining support from each other, which I thought was very positive.* (Mentor 6)

> *I think we had one nurse who was dragged along (to a core curriculum teaching session) by the PRHO she was being co-mentored with*. (Clinical Tutor 4)

> *They* [newly qualified nurses] *think because we are doctors we know what we're doing and they don't really appreciate straight away that we're fresh out of medical school so those first few days we don't have a clue. So I think maybe she understood that a bit better and yeah I understood the other way round. So I think there was some benefit to it.* (PRHO 7)

Most participants believed that working relationships had improved between PRHOs and the nursing staff. The mentoring also allowed for a faster development of relationships between the staff. This was seen as an enormous advantage particularly as PRHOs had patients spread across six or seven wards or more, and had to foster a working relationship with so

many teams of nurses.

> *I think the benefits we are seeing quite early on in terms of improved communication and better working relationships; that was quite a big plus.* (Project Lead 1)

All Project Leads mentioned that interest was generated from amongst the staff at the Trust such as consultants. Other professional groups also expressed a wish to become involved in the Scheme. These ranged from midwives, physiotherapists and radiographers. This demonstrated the need for initiatives that promote interprofessional working and learning.

Experience of mentors   A number of mentors believed mentoring had helped them with their own personal development. Having to take on the challenges of mentoring a PRHO helped them develop other skills and gain new knowledge. This included a better understanding of medical education. They were able to find out from the PRHOs the pattern of their training and their clinical experience before starting their first post. For example, one mentor mentioned how she realised that PRHOs could go through their whole training without carrying out some basic clinical procedures such as catheterisation.

> *I very much enjoyed the experience and I gained so much from understanding how doctors think, work and have been trained.* (Mentor 110)

Mentors also expressed how they had gained more insight into the needs of newly qualified staff and the stresses that they face. Although senior nurses have worked with PRHOs starting their first job they had not fully appreciated or understood their anxieties, worries and the level or kind of support PRHOs receive. Some mentors were surprised at how little support some received from their medical team. Acting as a mentor gave them the freedom, the opportunity and the confidence to ask PRHOs more about their training, experience and feelings.

> *I think that they* [the house officers] *are very much left on some shifts without the support that they need and I feel for them.* (Mentor 11)

> *I have worked closely with my mentee and have gained a better understanding of the stresses that junior doctors are under...* (Mentor 402)

> *Very satisfying. Has improved my awareness of the role of a junior doctor and increased my empathy.*
> (Mentor 112)

More senior mentors had been informally supporting PRHOs during their first few weeks for many years, and a couple of Clinical Tutors also agreed that Sisters have always carried out this practice on the wards. However, due to changing roles and PRHOs spending their time on so many different general wards, this has not been as easy as before. Therefore, it was felt that this Scheme formalised what was already happening in some places and ensured that in other places where it did not occur and was possibly needed, the support and guidance was provided for newly qualified staff.

> *I worked officially longer hours but worked far less hard when I was working because I had loads of informal support. All my mates were round and you'd see them a lot of the time and there was a reasonable amount of time sitting drinking coffee in the mess, or sitting chatting to the nurses on the wards and you got loads of informal support that way. And I think they've lost most of that. I mean I think there are ways in which there's a bit of me that thinks it's a shame we're having to replace all the informal ones that worked well with loads of formal ones but I'd rather have the formal ones than nothing.* (Clinical Tutor 4)

The attitude of some mentors about the Scheme or their own contribution was very dependent on the mentees drawing on their time and expertise. If mentees had not come to them with problems or contacted them, the mentors either felt that they had not performed their role well or that the Scheme had not worked. However, overall, the mentors expressed a positive opinion about the Scheme and many felt that both themselves and the mentees had gained some benefits from the experience.

Experience of mentees   The most positive outcome of the Scheme for PRHOs was feeling supported. Prior to commencing their post they had mentioned the importance of this, and the mentoring provided exactly what they wanted. Most PRHOs stated that they felt supported by the mentor, and each PRHO used the mentor to differing degrees and for different purposes. A few had not used the mentors at all and did not feel they needed nurse mentors. Some were pleased about having a named mentor but again had not felt the need to use them. They felt that mentors were there if they had difficulties or in crisis only and therefore had not used them because they had not encountered any problems.

> *'I think it was great having a nurse mentor…she certainly was someone who, if I had a real problem with something, I would go and talk to.'* (PRHO 5)

> *Some had used their mentor and found them useful and some hadn't felt the need to use them at all but knowing they were there, that on its own was positive.'* (Clinical Tutor 1)

More than 50% expressed how beneficial it was to have someone they could go to with problems and to know they were 'looking out' for them. PRHOs mentioned a number of reasons why they found mentors useful, as illustrated by the following direct quotes:

- *Was ready to listen*
- *Helped with pastoral and educative needs*
- *Noticed when I was stressed – advised and provided coffee*
- *Gave an alternative port of call to medical team*
- *Overlooked what I was doing and pointed me in the right direction*
- *Useful to have experienced staff who understood my concerns*
- *Mentor would always have time*
- *Someone to debrief with*
- *Someone to air worries and concerns and talk to when things get hectic*
- *Confidence building*
- *To make sure that no harm is done to any patients as a result of my inexperience*
- *Support with clinical skills*

- *Help with how the organisation works*
- *Very knowledgeable with teaching.*

PRHOs commented on how nurses were able to provide guidance and help with their learning. A number mentioned how the mentor helped them to learn clinical skills and gave assistance and advice about carrying out different activities.

> *She has been really good, I mean I don't know how to do something I'll ask her and she will show me or tell me and a lot of other senior nurses have been really good…*
> (PRHO 10)

A couple did note that having someone from their own profession would have helped them with aspects of the medical management of patients which some mentors were not familiar with. However, what made the mentoring scheme more advantageous was its freedom from assessment and appraisal. A few PRHOs expressed the benefits of being able to share their problems with someone who was not responsible for their assessment and final appraisal, which had implications for their registration.

Many PRHOs mentioned how they had come to have a better understanding of the roles and responsibilities of nurses. Much of this was due to frequent contact with nurses in their daily work, but a number saw that having a nurse mentor provided more insight into the stress and pressures they are under as well as giving a different perspective to patient care. This allowed them to understand the theory behind nursing care, which they might not have had without the Scheme. There was a general consensus that mentoring was something different from the role of educational supervisor and helped more with interaction between professions.

> *The way I felt about it* [mentoring] *was intended to be something apart from your educational supervisor in terms of your profession…it allowed you a way of interacting with other professions.* (PRHO 4)

The timing of the mentoring was also important. Most PRHOs felt the first few weeks were the crucial times; when they were new to the environment

and their role, and therefore needed more support. Once PRHOs had got over the first three to six months, they had less need for the support. Those who were on their second allocation did not find themselves needing to use the mentoring scheme but still had reassurance that there was someone there for them.

> *I don't think it really made a difference to me but it was*
> *nice knowing she was there*. (PRHO 3)

Contributing factors supporting mentoring

The quality of the mentors was a crucial factor to the experience for the mentees. Senior nurses were seen to have the clinical expertise, the mentoring experience and the ability to communicate effectively with other professionals. Other qualities which were identified by the participants as being needed by the mentors were:

- *Approachability*
- *Flexibility*
- *Friendliness*
- *Confidence*
- *Knowledge*
- *Good communicator*
- *Willingness to mentor.*

The flexibility of the scheme was also important. Some PRHOs liked the informality and others believed it would have been more beneficial if the meetings between mentor and mentees were more formalised. The reasons why mentees utilised the mentors and the level of support needed were left to the mentees. This allowed those who needed more support to have access to it and those who preferred other means of support not to be pressurised into the Scheme. This did require tremendous skill and understanding on the part of the mentor to be able to gauge and provide the

appropriate support.

The practicalities also required flexibility. It was not always possible to go off the ward into a private area, and informal sessions took place in corridors, treatment rooms, over coffee and, on a couple of occasions, socially outside work.

The preparation of mentors was fundamental to the experience of all participants. Most mentors felt they were prepared for their role because of the years of practice in mentoring nurses but they still had some apprehension about mentoring PRHOs and about not having much knowledge of their training and needs. More than half felt they were able to mentor PRHOs as they had experience of working with new PRHOs over a number of years in practice. However, some did suggest that more preparation in this area would have been useful.

Most participants believed that working in the same environment was essential. Much of the mentoring occurred on an informal basis on the wards when the mentor and mentee were working together. Those whose mentees were on different wards found it much more difficult to meet. Developing an interpersonal relationship was also seen as a key component of the Scheme and of interprofessional working. Building a relationship with the mentees created the right environment for them to express any worries or concerns. Therefore, being on the same ward allowed for more interaction between the mentors and mentees and greater opportunities for them to develop a relationship more quickly. The interprofessional approach of the Scheme was seen as a contributing factor.

> *'It is important that the mentors are there because it immediately gives this support as a multi-professional team and at the end of the day we cannot work without each other…If the junior doctors can be involved in that in the first place I think it sets the standard and the way forward for working within a multi-professional team. That's how I see it and I think the mentors play a key role in that one when they walk on the ward, welcoming them, showing them around, being there, listening to them, the junior doctors not feeling scared to ask. I think if they feel part of a team to start with and let's face it, the nurse is the more static person in the ward, gives*

continuous care to the patient and the house officers will feel more secure and gain confidence. So that is where I see the mentors playing a key role.' (Postgraduate Manager 1).

During this Scheme the needs of the mentees were very specific. In the first few days, mentees mentioned needing to be supported and being told what to do and where to start. The first weeks were also stressful times for the newly qualified staff as they had to become used to the environment, their responsibilities and the working patterns. Most participants agreed that the first three to six months are the most useful time for having a mentor. Seeing the mentor on the first day was deemed as most beneficial.

Identified obstacles

Almost all participants mentioned that finding the time to meet was the principal obstacle. A couple of Clinical Tutors clarified that the reduction of PRHO's working times had placed more pressures on them. They were required to do the same amount of work but in shorter hours and therefore the length of time they were on the wards was more intense and allowed little time for any activity other than patient care. This also had implications for developing interpersonal relationships as time for coffee breaks with other staff or chats by the nurses' station were scarce. Lack of senior nursing staff also meant that the mentors experienced greater demands on their time and expertise, particularly as many nurses have taken on extended roles.

Different working patterns also meant that arranging or working with the mentees was difficult. Night duty and weekend shifts meant that nurses were away during the weekdays, which was the main time PRHOs were on the wards. Generally finding a time when all were available was difficult in many instances.

…Whereas you can have two people working completely opposite shifts and they might not meet for weeks. (Mentor 6)

…which means it's really difficult because I might be free, I go there and they are not on shift, they have gone for a break, or they have left early, or they are coming in late, or they are on a doctor's round. (Mentor 1)

There were some personality clashes between the mentors and mentees. As mentioned before, developing an interpersonal relationship was important to mentoring and therefore it was essential that mentors' and mentees' personalities matched. It was not practically possible to know which personalities would match before the start, but the more experienced mentor would be able to ensure a good working relationship or arrange an alternative such as change of mentor.

> *Personalities too…There are some personalities that don't want to admit that they need to ask questions.* (PRHO 11)

Attitudes and beliefs also caused a barrier for the mentoring. There was an agreement that stereotypical views did still exist. These attitudes were not unique to one profession or to the participants. One mentor stated:

> *Stereotypes are there for a reason because unfortunately they come about because a few people do believe them…Like nurses do see doctors as arrogant and aloof…and doctors undoubtedly perceive nurses to be intellectually inferior.* (Mentor 3)

Those who were not participating in the Scheme were sceptical and did not believe the Scheme would make any difference. According to participants, some nurses felt it would increase their workload, as mentors would have time away from the wards. Also, some senior doctors commented that nurses cannot mentor doctors and vice versa. Some still felt that the differences between the two professions are vast and hence they cannot be mentored together. This was also partly due to their lack of understanding and information about the aims of the Scheme.

> *I think the ethos starts back in medical school. They would not think they should be asked to like empty a bedpan. I don't think they should be but I'm sure some of them would if they were asked. Their attitudes are changing but again I think that at the end of the day we have to remember that medical students want to be doctors. Being a doctor isn't emptying a bedpan it's making people better.* (Clinical Tutor 3)

There were mixed attitudes amongst the participants. Some mentors felt they might not be taken seriously by the PRHOs and did not think it was fair that they were taking on extra roles while senior doctors were not participating.

> *I do feel that this is nurse led and it would be nice to see*
> *doctors as mentors from the beginning.* (Mentor 411)

A few mentees also felt that they would be better off having someone from their own profession mentoring them because nurses would not be able to help them with their patient management and educational needs. However the majority of participants were in agreement with the principles of the Scheme and believed the Scheme would help with collaboration between the two professions.

The practicalities of setting up the Scheme caused a number of obstacles. Finding enough senior staff who could and wished to act as mentors on the wards where PRHOs were starting was problematic; hence some mentees had mentors working in a different clinical setting to themselves and were not able to see them as often as they wanted.

> *I feel that being a mentor to a doctor in my own work*
> *area would have proved more effective.* (Mentor 103)

In addition, there were not the same numbers of newly qualified nurses starting on the same wards as PRHOs to enable joint mentorship to take place. In the majority of cases PRHOs start their first jobs in August when they finish medical school, whereas newly qualified nurses can be recruited at any time as their courses start and finish at different points throughout the academic year. This is changing since many of the Colleges of Nursing have amalgamated with Universities and therefore intakes are now beginning once a year in September and completing at the end of the academic year (June/July).

The rotation of PRHOs caused great difficulties as well. Some were on two monthly rotations, which meant they either had to have a new mentor or continue with the same one who would be in a different clinical area. Both had their advantages and drawbacks. Changing mentors so quickly meant that they could not build a close relationship with the mentor in order to

feel confident in sharing problems or needs with them. However, they would have a mentor on the ward where they were working. Keeping the same mentor allowed for continuity but much of the support and mentoring occurred on an ad hoc basis on the ward; if the mentor and mentee were not in the same clinical area it made meeting up more complicated.

Obtaining information about newly qualified staff starting within the Trust (for example, their ward or consultant allocation) required tremendous effort from the Project Lead. This made the allocation of mentors difficult and delayed the initial work of the Scheme. There were a number of obstacles, such as time, attitudes, and number of senior nurses, which required the Project Leads to obtain support from others and think of innovative ways of dealing with them.

Shared learning

The shared learning was embraced by all Trusts to differing degrees as demonstrated below:

Trust W   Three shared learning sessions were organised in the latter part of the Scheme which were chosen from the PRHOs' core curriculum teaching and appeared to be relevant for nurses. These were chosen by the Postgraduate Manager and the individual responsible for nursing education at the Trust. The topics were 'infection control', 'neurological emergencies' and 'human rights'.

Trust X   Twelve shared learning sessions were organised by the Project Lead and were delivered during the PRHOs' core curriculum teaching. There are two reasons why nurses attended only some of these sessions: the timing of the sessions was not practical for their working pattern, and some said they felt 'uncomfortable and threatened' to go. From the evaluation of the sessions, the two that were deemed applicable and useful were 'acute confusional states' and 'fluid balance'.

Trust Y   This Trust delivers the ALERT course, which involves all professional groups. The Project Lead in consultation with the Clinical Tutor organised three shared learning sessions. The first, however, was very specific and for PRHOs. The facilitators were from both professions.

Trust Z

This Trust has been providing a number of shared training opportunities for staff which include areas and courses such as ALERT, law, resuscitation, mental health and appraisals. However, these have been attended mainly by nurses with fewer doctors. For this Scheme the Project Lead set up fortnightly one hour teaching sessions predominantly taught by specialist nurses. These sessions were in addition to the PRHOs' core teaching and the nurses' preceptorship programmes. The sessions were open for all Trust staff but were mainly attended by nurses, even though PRHOs were bleeped half an hour before the start and lunch was provided.

All Trusts

Unlike the mentoring which was new and unique to the Trust, the shared learning aspect was more difficult to implement as there were existing educational and training activities within the Trusts for both professions. Most participants acknowledged that the shared learning was not as positively welcomed or taken up as the shared mentoring and was more problematic to organise. The interviewees identified several reasons for this. Most Trusts already had training and educational programmes up and running for the staff and some of these were bound by the requirements of regulatory bodies. For example, the deaneries require that PRHOs attend a certain percentage of the core curriculum programme which was developed by them and given to all Postgraduate Centres to implement in the most practical way for the Trust.

All Project Leads had to firstly access what was being provided for the newly qualified staff then identify what was compulsory and what commonalties there were. By doing this they were able to assess which topics could be delivered jointly and were relevant to practice for both professions. Some topic areas were perceived by the participants to be of relevance to both professions and would be better taught together so the two professional groups could learn the roles and responsibilities of the other professional group. Such topics included 'breaking bad news', 'fluid balance', 'discharge planning' and 'resuscitation'. One PRHO stated:

Make some of the House Officers teaching shared and focused on topics with most cross over e.g. discharge planning. (PRHO 5)

The shared learning sessions were evaluated positively by some of the participants.

Joined in a few shared teaching sessions, which were great. It was

nice to know that there was a nurse around who I could talk to if I wanted to. (PRHO 530)

The teaching sessions were very valuable and I would have liked more. (PRHO 314)

It was clear from the participants' comments that sitting in a classroom environment was not a suitable approach to shared learning and that a problem-based learning or case study approach allowing group discussion and interaction would be more conducive to learning.

There were other practical issues such as the timing of the sessions, finding facilitators who had an understanding of the educational needs of both professional groups and who could accommodate them. It appeared that lunchtime sessions were difficult for nurses because of the ward routine and staffing levels, unlike PRHOs who found short lunchtime sessions suited their working pattern. It was easier for nurses to have an afternoon off the ward for their educational programme but the PRHOs' timetable would not allow it. For this reason sessions were not always well attended by both groups. PRHOs were given protected time to attend the core curriculum teaching and, in two Trusts, newly qualified nurses were given time off the ward to attend teaching sessions as part of their nursing preceptorship programme. However, the shared learning sessions were seen as 'extra sessions' and therefore protected time was not allocated. Their incorporation into the mandatory educational programme delivered for both professions would improve attendance. This needs creativity, innovation and experimentation and simply placing one professional group into another's programme would not be conducive to learning.

I think there's bags of room for experimentation and I think, as I said, somebody needed to start something new. I don't think it will work by trying to fit one profession into another profession's learning pattern which is the way we've thought about it so far. (Clinical Tutor 1)

Most facilitators had very little experience of preparing for educational sessions where more than one professional group was participating. Some facilitators were not sure what information the other professional group

required and how much background knowledge they already had. It appeared to some of those interviewed that the priorities and interests are different amongst the two professions. Therefore, provision of information about the educational requirements of each professional group is necessary for facilitators to be able to plan the session.

> *I think the interprofessional learning side of it hasn't worked so well. There has been not a very large turn-out from junior nurses* [attending the PRHOs' core curriculum teaching sessions]…*and often the teaching seems to be aimed at quite a lot of medical tasks. It has not really given the opportunity for much actual interaction between us.* (PRHO 5)

> *I don't think the lunchtime tutorials are appropriate for interprofessional learning. As new PRHOs we have specific needs that aren't relevant to nurses. If the sessions are tailored to be suitable for nurses as well, we miss out on learning that may be valuable. Maybe one or two sessions with nurses where appropriate issues could be discussed would be more useful for everyone. I'm sure the nurses who did turn up didn't really benefit from our teaching sessions and the speakers who took note of the fact that the nurses would be present just seemed to 'dumb down' the sessions, which surely isn't the point.* (PRHO 1122)

The level and knowledge base of each profession is still an issue being debated. It was evident that there are areas specific to each professional group but there are still ambiguities around whether it is just the topic that is the issue or the 'level' at which it is taught. This also highlights the lack of consensus as to the purpose of interprofessional education being more than giving of information but an opportunity for bridging the gap between different professions, by understanding roles and responsibilities and developing concepts of team work.

> *I think that's a really good idea. I was talking about that earlier about how learning clinical skills together would be really beneficial for relationships between professions*

> *really because there are problems but if you're looking at case studies together you'll get opinions from one profession how they deal with it and then another profession how they deal with it, and it's understanding why the other one has decided to go that way and then perhaps telling them why you've decided to do it slightly differently and sort of working together.* (PRHO 10)

Three of the Trusts were very positive about continuing to experiment with the shared learning, and good working relationships were developed between postgraduate managers and Project Leads.

> *Well we are taking it forward in as much as I'm sitting down with the nurse lead to identify areas in the next core teaching well in advance that we can actually involve nurses and doctors together in so that they can have lunch together, network, then go into a lecture and we thought that was the best way forward.* (Postgraduate Manager 1)

It is important to note that learning also occurred on an informal basis through the shared mentoring component. This involved learning about the day to day functioning of the ward and the Trust, understanding the roles and responsibilities of other professional groups in the care of patients, understanding the co-ordination of care that is needed to ensure patients experience a seamless service and basic clinical skills. These occurred through mentors being more aware of the needs of PRHOs and their role in supporting the work of newly qualified staff. One mentor, for example, identified a particular clinical skill that a PRHO needed to learn and ensured that if the opportunity arose the PRHO was able to observe or carry out that particular task.

Some ideas for improving shared learning:
- Find appropriate time for all staff, for example, avoiding lunchtime hand over for nurses

- Incorporating the shared learning sessions as part of the educational requirements for both professions
- Giving protected time to the shared learning sessions as part of their

educational requirement

- Informal sessions at directorate level
- Further training for mentors to identify learning opportunities for newly qualified staff during day to day working in clinical settings
- Identification of individual specialists from all professional groups willing to facilitate shared learning sessions who also have the skills to work across different professions
- More training for facilitators in conducting the sessions. Bournemouth University to develop a training package to help facilitators with shared learning sessions
- Various professions getting together to work on a project of common interest, each learning about other professions – not in a lecture theatre, would need a more creative approach
- The use of problem-based learning or case study approach
- Deaneries to encourage Clinical Tutor and Postgraduate Medical Centre to provide opportunities for the Core Curriculum to be delivered using a shared learning approach.

Conclusion

The shared mentoring and learning was well received by all Trusts as the Scheme rolled out. The shared mentoring component was more positively evaluated by all participants and utilised by the PRHOs than the shared learning.

Interprofessional working and learning was accepted as important in providing a seamless path for patients and improving service delivery. Headrick et al. (1998) suggest that shared goals around patients' needs are necessary in interprofessional working and can help transcend traditional barriers. Most participants agreed with a need for a common goal which is patient centred to help interprofessional working. Effective communication, understanding of professional roles, respect for the contributions of other professional groups and good team work were the other key factors highlighted for the success of interprofessional working. This is in conformity with the literature on interprofessional education and working (CAIPE 2001, Freeth & Nicol 1998).

Choosing the right topic, a suitable time and an experienced facilitator were perceived as the requirements for developing an effective shared learning programme. Even though participants had an understanding and perception of interprofessional working and learning, only a small minority had any experience. Very few PRHOs had encountered shared learning at university, which consisted of one or two sessions of teaching with nurses and professionals allied to medicine, and only a couple of mentors and Clinical Tutors had worked in areas where interprofessional working and learning had occurred. However, it must be pointed out that there were varying definitions and understandings of what interprofessional means.

There were logistical hurdles for the Project Leads. Examples include:
- The ability to find enough experienced nurses to act as mentors
- Obtaining information about new staff starting at the Trust
- Finding a suitable time for the training of mentors
- Working with Postgraduate Centres in identifying areas where shared learning could occur
- Finding a time suitable for the working patterns of both professions
- Finding facilitators willing and able to run workshops for both

professions.

Apprehensions expressed by PRHOs were very similar to both the medical and nursing literature about the anxieties of making the transition from being a student to a qualified professional. Worries about their knowledge, decision making, responsibilities, accountability, prescribing medication, expectation of patients and other staff and not having the support they needed were expressed by the majority of the PRHOs. These expressed anxieties were similar to those of other studies (Paice et al. 2002). Mentors also expressed concerns about mentoring PRHOs as it was a new experience for many of them. However, most mentors had supported PRHOs informally in their capacity as senior staff and believed their mentoring experiences would help them with this extended role.

Over 79% of PRHOs felt supported by their mentor and found that mentors helped them particularly with the lack of support received generally, nursing staff and patients. Although PRHOs were the main support for each other, nurses (including mentors and nurse practitioners) were the next major group providing support for PRHOs, which therefore makes them ideal mentors. Senior House Officers were also seen as supporting PRHOs and, with training, should be considered as mentors in the future. The same identified groups were also rated as decreasing the stress levels of PRHOs. Mentors were used by the mentees according to their own needs. Some used the mentors a great deal while others were satisfied with knowing there was a named individual they could turn to if needed.

There were no significant changes in the pre and post questionnaire for the three sections using already existing tools (RIPL, Professional Identity and Stereotypes). This was a short-term project and therefore not expected to achieve significant quantitative changes especially as changes in culture and attitude require time, but has accomplished qualitative changes. Mentors believed that, although their work load had increased by 50%, they gained other benefits, such as:

- Increased job satisfaction
- Help with their personal development
- Increased knowledge of interprofessional working and learning
- Increased knowledge of medical education.

Mentors also believed that the mentoring had other general positive effects.

Other participants such as Project Leads and Clinical Tutors had also made the same observations. These included:

- Improved patient care

- Improved communication between nurses and doctors

- Improved interpersonal relationships between nurses and doctors

- Improved working relationship between nurses and doctors.

PRHOs believed that mentors not only supported them with pastoral issues but also helped with their clinical skills. Having someone from a different profession provided PRHOs with a new perspective on patient care.

The qualities and experience of the mentor were essential to the success of the mentoring Scheme. Mentors needed to be approachable, confident, flexible, knowledgeable, good communicators and willing to mentor in order to be effective. Preparation was also required particularly as mentoring someone from a different profession was new for a number of them.

Being in the same work environment was conducive to the Scheme's success because much of the support was given on an ad hoc basis and this could only be done if mentors and mentees were in the same clinical area. This also helped build interpersonal relationships, which were seen as necessary for any mentoring. In the first few days, the mentees' needs were intense and they continued to need support for three to six months. Therefore, the Scheme was at its most effective in that period for new staff. Support and commitment from senior and management staff to both the mentoring and shared learning components were essential. Parsell and Bligh (1998) also describe the importance of support at the most senior levels for shared learning. Having a Project Lead at each Trust with protected time to organise, co-ordinate, manage and support the Scheme was central. The involvement of both professional groups in setting up and supporting the system was highlighted and Parsell and Bligh agree that interprofessional learning needs to be planned, organised and delivered by all professional groups involved.

There were some obstacles identified with time being the major factor that prevented mentors and mentees meeting together. This was further exacerbated by the different working patterns of the mentors and mentees, which sometimes meant they were working on different shifts for a couple

of weeks. Also the reduction in PRHO hours meant that, although they were doing less hours, the intensity of their work was greater, therefore reducing their time for any other activity besides patient care.

Personality differences also contributed to unenthusiastic comments about the Scheme. Cultural differences between the professional groups and organisational structures caused barriers for both implementation and acceptance of the Scheme within the Trust. Headrick et al. (1998) also identified differences of history and culture as barriers to interprofessional collaboration and education.

The shared learning, although believed to be important and useful by most participants, was more difficult to put into practice. Already established educational programmes were in existence and the suggestion of changes to them was met with some hesitation. Unlike the mentoring, which was quite uniform across all Trusts, the shared mentoring varied to a great extent. Two Trusts opened the PRHO core curriculum programme to nurses, which unfortunately was not utilised by the nurses, both because of the timing and because of the unfamiliarity of the experience. Trusts organised a number of sessions specifically as part of the Scheme, the number varying from two in one Trust to ten in another.

The timing of the sessions was important to achieve maximum attendance, and the topic area needed to be relevant to both professions. Finding facilitators with experience in teaching more than one profession and who were able to conduct interactive sessions meeting the needs of both professional groups was challenging. It was clear that the sessions needed to be more interactive using a case-study or problem-based learning (PBL) approach. Hall and Weaver's (2001) review of the literature also agrees that teaching methods should be non-traditional using PBL. The evaluation of the shared learning sessions was mixed, depending on the facilitator and the relevance of the topic.

Overall, the Scheme was positively evaluated. There were some constructive and encouraging outcomes for both mentors and mentees. The interest from other professional groups also affirmed the need for more interprofessional initiatives and the developing culture of teamwork.

Recommendations

1. Need for greater awareness of the Scheme amongst all the staff within the Trust, particularly nursing and medical staff in clinical areas. All staff should be aware of the Trusts interprofessional approach to health care and be required to incorporate this into their practice.

   - Presentations at various meetings and forums within the Trust, including consultant meetings, management meetings, ward meetings, educational programmes for all staff, and induction days for new staff

   - Workshops on the theme of interprofessional working and learning providing examples of good practice

   - Provision of opportunities for staff to become involved in the Scheme and be able to incorporate their experience into their lifelong learning and continuous professional development.

2. Involvement of all participating professional groups with all aspects of the Scheme. Collaborative working in developing a shared learning programme and in planning the mentoring component. Both professions must contribute equally to the mentoring and shared learning programme (see Appendix 1).

   - Setting up steering groups with members from all professions involved

   - Enthusiasts found from all professional groups to lead in their clinical area and co-ordinate the Scheme.

3. Training and support for mentors. Involvement of senior medical staff in mentoring and developing further the criteria for selection of mentors from amongst both nursing and medical teams.

   - Involvement of senior staff from all professional groups

   - Development of a rolling training programme for new mentors and updating existing mentors

   - Exploration of ways that mentors can incorporate their training programme and experience into their continuous professional development.

4. Training of facilitators of the shared learning workshops.

   - This could involve the local universities in delivering

interprofessional courses at Trusts for facilitators

- Provision of support for facilitators and in some cases providing references around the workshop topics

- Exploration of ways that facilitators can incorporate their training programme and experience into their continuous professional development.

5. Incorporating shared learning workshops as part of the educational requirements for all professions therefore ensuring protected time is given for attendance.

- Collaboration of individuals responsible for the educational provision of all professional groups. This would involve regular meetings to identify the similarities in the educational requirements of all professions

- Identifying the most suitable time, topics, approach, environment and facilitators for the workshops

- Decentralising the teaching programmes from postgraduate centres to department or ward based teaching. This would mean that attendance would be easier for staff, there would be smaller numbers and a better mix of professional groups.

References

BARR, H. 2000. *Interprofessional education: 1997-2000. A review*. London: CAIPE.

BARR, H, HAMMICK, M, KOPPEL, I & REEVES, S. 1999. Evaluating interprofessional education: two systematic reviews for health and social care. *British Educational Research Journal,* 25 (4), 533-543.

BREWER, J. 2000. *Ethnography.* Buckingham: Open University Press.

BROWN, R, CONDOR, S, MATHEWS, A, WADE, G & WILLIAMS, J. 1986. Explaining intergroup differentiation in an industrial organisation. *Journal of Occupational Psychology,* 59, 273-286.

CARPENTER, J. 1995. Doctors and nurses: stereotypes and stereotype change in interprofessional education. *Journal of Interprofessional Care,* 9, 151-161.

CARPENTER, J & HEWSTONE, M. 1996. Shared learning for doctors and social workers: evaluation of a programme. *British Journal of Social Work,* 26, 239-257.

CENTRE FOR THE ADVANCEMENT OF INTERPROFESSIONAL EDUCATION. The work of CAIPE. www.caipe.org.uk/work.html. (Accessed January 2001).

CENTRE FOR THE ADVANCEMENT OF INTERPROFESSIONAL EDUCATION, 1996. *Principles of interprofessional education*. CAIPE Bulletin, 11 (1).

DEPARTMENT OF HEATLH, 2000. *The NHS Plan: a plan for investment, a plan for reform*. London: Stationary Office.

DEPARTMENT OF HEALTH, 1998. *Modernising Health and Social Services, National Priorities Guidance.* London: Department of Health.

DEPARTMENT OF HEALTH, 1997. *The New NHS: Modern and Dependable*. London: Stationary Office.

FREETH, D & NICOL, M. 1998. Learning clinical skills: an interprofessional approach. *Nurse Education Today*, 18, 455-461.

GRAINGER, C. 1997. *Junior doctors – morale, job satisfaction, stress and their interrelationships*. Leeds: University of Leeds.

HALL, P & WEAVER, L. 2001. Interdisciplinary education and teamwork: a long and winding road. *Medical Education*, 35, 867-875.

HAMMERSLEY, M. 1990. *Reading ethnographic research: a critical guide*. Harlow: Longman.

HAMMERSLEY, M & ATKINSON, P. 1995. *Ethnography: Principles*

in Practice. Second Edition. London: Routledge.

HEADRICK, L, WILCOCK, P & BATALDEN, P. 1998. Interprofessional working and continuing medical education. *British Medical Journal*, 316, 771-774.

HOLLOWAY, I. 1997. *Basic concepts for qualitative research*. Oxford: Blackwell Sciences.

HOLLOWAY, I & WHEELER, S. 1996. Qualitative research for nurses. Oxford: Blackwell Science.

HORAK, B, O'LEARY, K & CARLSON, L. 1998. Preparing health care professionals for quality improvement: The George Washington University/George Mason University. *Quality Management Health Care*, 6 (2), 21-30.

LEVENSON, R, JOULE, N & RUSSELL, J. 1997. *Developing public health in the NHS: The multidisciplinary contribution*. Kings Fund Publishing.

MARIANO, C. 1999. The case of interdisciplinary collaboration. *Nursing Outlook*, 37 (6), 285-288.

MAYS, N & POPE, C. (eds). 1996. *Qualitative research methods in health care*. London: British Medical Journal Publishing Group.

MCGARTH, M. 1991. *Multi-disciplinary teamwork*. Aldershot: Avebury.

PAICE, E, RUTTER, H, WETHERELL, M, WINDER, B & MCMANUS, I. 2002. Stressful incidents, stress and coping strategies in the pre-registration house officer year. *Medical Education*, 36, 56-65.

PARSELL, G & BLIGH, J. 1999. The development of a questionnaire to assess readiness of health care students for interprofessional learning. *Medical Education*, 33, 95-100.

PARSELL, G & BLIGH, J. 1998. Interprofessional learning. *Postgraduate Medical Journal*, 74, 89-95.

PATTON, M. 1990. *Qualitative evaluation and research methods*. California: Sage.

PEAT, J. 2001. *Health science research. A handbook of quantitative methods*. London: Sage Publication.

REINHARZ, S. 1992. *Feminist methods in social research*. Oxford: Oxford University Press.

ROBSON, C. 1993. *Real world research*. Oxford: Blakewell.

ROSS, F & SOUTHGATE, L. 2000. Learning together in medical and nursing training: aspirations and activity. *Medical Education*, 34, 739-743.

SCHENSUL, S, SCHENSUL, J & LECOMPTE, M. 1999. *Essential ethnographic methods*. Ethnographic tool, part 2. California: Altamira Press.

SOOTHILL, K, MACKAY, L & WEBB, C. 1995. *Interprofessional relations in health care*. London: Arnold.

STANDING COMMITTEE ON POSTGRADUATE MEDICAL AND MENTAL EDUCATION, 1998. *Supporting doctors and dentists at work. An enquiry into mentoring*. London: The Stationary Office.

THE BRISTOL ROYAL INFIRMARY INQUIRY. The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary, 1984-1995. *Learning from Bristol*.

Appendix 1

Possible working model

Input from and collaboration with local Universities.	Input from and collaboration with local Deaneries.	Input from other sources, i.e. consumers, regulatory bodies.

Steering group at Trust including representatives from all professional groups.

Scheme co-ordinator (two days per month) to train mentors and facilitators, to support all involved in Scheme, review current research and practice in interprofessional working, learning and mentoring, feedback to steering group and explore ways of moving forward the concept of shared mentoring and learning.

An assistant co-ordinator and a number of facilitators for each speciality. Co-ordinators would support mentors, ensuring that mentors and mentees meet, and identify new mentors. Facilitators (who could be mentors, specialists, nurse and medical consultants) would facilitate case study workshops relevant to their speciality. These could be for newly qualified staff and also run at an advanced level for more senior staff in the clinical area.

Participation by all staff in both the mentoring and shared learning. This would create an interprofessional culture and lead to experimentation with team working and collaboration. Ultimately this would improve communication and patient care.