CPD and training: enabling professionals to practise *effectively* and *confidently.*
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Background

In the evidence reviews conducted thus far for the Programme Development Group (PDG) for '**Type 2 diabetes: prevention of pre diabetes in high risk groups'** a number of evidence statements arise (See Appendix 1). These lend themselves to suggesting that the PDG needs to understand more on how best health professionals should be trained in being more effective at engaging, with Low SES and BME communities.

The purpose of this expert paper is to look at proven methods such as Preceptorship and using the Kirkpatrick model of training evaluation (amongst others) and seek to apply this to support health professionals to practice effectively and confidently with populations from low SES and BME communities.

Some considerations around training and development:

- A key question has been whether more education, training and skills are enough or whether training needs to be embedded in the strategic context of the organisation. Indeed there is evidence that training is most effective when there is a strategic association between training and development policy and business strategy (*eg* Keep *et al.* 2002; Thomson *et al.* 1997; Mabey and Thomson, 2001).
- There is evidence that training is associated with productivity improvements and softer benefits to organisations. Dearden, Reed and Van Reenen (2000) found connections between more training and higher labour productivity across a number of UK sectors.
- People have to be committed to change and also want to change. If people take ownership and accountability for changing behaviour as a result of a training intervention then it is more likely to happen. One way of doing this is gaining commitment to change behaviour and linking it to outcomes. Putting behavioural measures in place and monitoring them. This could be done by getting people to report back through case studies, success measures and linking to shared outcomes (e.g. "at risk" person/community, NHS professional, community champion)
- In training expert circles it is in general accepted that to change a habit or behaviour it takes at least 21 days.

Preceptorship

What is Preceptorship?

- "An enabling process helping practitioners to develop their knowledge and skills in an atmosphere of trust, with colleagues who have experienced for themselves, and who have been prepared for, and understand, the challenges confronting the beginning practitioner". (UKCC, 1993)
- Myrick and Yonge ; Ohrling and Hallberg define preceptorship - to empower students to learn and critically think whilst in practice. Support and guidance delivered by person(s) who has considerable knowledge and experience in the similar field
- Preceptors will empower, support and give guidance throughout an agreed period in a trusting safe environment; enabling the Preceptee to respond effectively and confidently to their challenges
- In clinical settings – Preceptorships have been used for newly qualified nursing/pharmacy staff. It is used as 'a period of support and guidance for newly qualified nurses, nurses returning to practice and nurses entering a new clinical environment'. Recommendations for Preceptorship suggest a period of support lasting between four and nine months. Time periods will vary amongst individuals according to individual needs, targets and the roles that individual practitioners will undertake
- Sometimes preceptorship gets confused with mentoring and teaching. The attached table gives the differences between these terms.

difference between precepting mentoring

When developing a preceptorship programme, the role of the Preceptor is key and a certain type of profile of person is required. Some qualities that a Preceptor needs to possess are

- Leads by example and is a good role model

- Supports the concept of Preceptorship and accepts the challenges being a preceptor will place upon them
- Demonstrates a willingness to support staff/students and share their knowledge & skills
- Has some experience of mentoring, assessment and teaching in practice (not necessarily academically trained)
- Demonstrates good communication/interpersonal skills and a trusting non-judgemental attitude to colleagues

Other practical considerations when setting up a Preceptorship Programme include doing a baseline assessment of health professionals knowledge and understanding on the subject area vs. that of the Preceptor; from the gap analysis structure an experiential programme to address the gaps, set mutual learning outcomes and evaluate throughout the programme (including measurement of satisfaction of the recipient of the preceptee activity).

Kirkpatrick and other models for training method evaluation

Kirkpatrick developed his four-step model in 1959 and provided a simple and pragmatic model for helping practitioners think about training programmes. Donald Kirkpatrick developed a model of training evaluation in 1959 that has served the training community like no other.
This 4-level model is arguably the most widely used approach in the world-even today. It's simple. Flexible. Complete.
It presents four types of evaluations: reaction, learning, behavior and results.
See attached presentation for more details on Kirkpatrick

Assessments_and_Kirkpatrick_Model.ppt

Other models are unrelated to Kirkpatrick, having a rather different approach to how training evaluation might take place. These include:

- responsive evaluation (Pulley, 1994), which focuses on what decision makers in the organisation would like to know and how this might be met
- context evaluation (Newby, 1992), which focused on appropriate evaluation for different contexts, and
- Evaluative enquiry (Preskill and Torres, 1999), which approaches evaluation as a learning experience using dialogue, reflection and challenge to distil learning opportunities, to create a learning environment and to develop enquiry skills.

The final group of models emphasise the importance of different measures of impact, including the learning outcomes approach of Kraiger et al. (1993) linking training evaluation to cognitive, skill-based and affective learning outcomes, and the balanced scorecard approach of Kaplan and Norton (1996), which focuses on different perspectives of finance, customers and internal processes.

In Summary

The PDG should consider recommending proven training models and evaluation techniques to support health professionals get to the root cause of factors affecting at risk communities that will in turn enable them to respond effectively and confidently with these communities when trying to prevent pre-diabetes. Gaining a deeper knowledge and understanding of communities and knowing how to apply this in context (and changing “own” behaviours/attitudes/assumptions), delivered via structured training interventions with key outcomes planned from the outset, can achieve this.

Appendix 1

PDG Review 1:

Evidence statement 21: Acceptability of interventions

21 a) Attributes of health workers

- There is evidence that information is more accessible and interventions more acceptable where key workers possess the appropriate knowledge, skills and personal attributes, such as empathy and trustworthiness.

PDG Review 2:

Evidence statement 4: Lack of understanding

- There was evidence from one focus group study (Grace *et al.* 2008++) of lack of understanding between professional and lay groups in terms of Islamic teaching and its relation to healthy lifestyle practices. There was also evidence from the same study of communication difficulties arising from health literacy deficiencies in lay Bangladeshi people and cultural sensitivity deficiencies in professionals which obstruct appropriate health promotion messages.

Evidence statement 5: Religious influences

- There was evidence from four focus group and two interview studies that religious customs can become barriers or facilitators to lifestyle change.

PDG Review 3

Evidence statement 1: Extent of available evidence

- Evidence from two survey studies (Lazenbatt *et al*., 1999, 2000 +; Pope & Cooney 1995 -) (and lack of available evidence generally) suggests that UK interventions whose aims include raising awareness in health professionals and /or assisting health professionals in identifying and advising groups at high risk of pre-diabetes (such as low income and BME groups) are lacking rigorous evaluation and dissemination, making it difficult for practice to be evidence-based. Lazenbatt *et al*. (2000 +) in their overview of the contribution of nurses, midwives and health visitors working in the community highlight that it is not always feasible to use the RCT approach to measure the effectiveness of interventions in the community setting.

Evidence statement 3: Lack of understanding

- There was evidence from one focus group study (Grace *et al.* 2008++) of lack of understanding between professional and lay groups in terms of Islamic teaching and its relation to healthy lifestyle practices. There was also evidence from the same study of communication difficulties arising from health literacy deficiencies in lay Bangladeshi people and cultural sensitivity deficiencies in professionals which obstruct appropriate health promotion messages.

Evidence statement 5: Cultural influences and differences

- There was evidence from nine qualitative studies that cultural influences and issues of identity can be barriers or facilitators to lifestyle change.

Evidence statement 6: Lay workers

Promotion of culturally sensitive messages

- Evidence from two evaluations (Hampton *et al*., 2000 +; Kennedy *et al*., 2008 ++) suggests that the training of lay workers to identify and disseminate health promotion messages to members of their community is a way of reaching hard to reach and high risk groups.

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