FOR HEALTHCARE LEADERS
HSJ

TRAINING AND DEVELOPMENT

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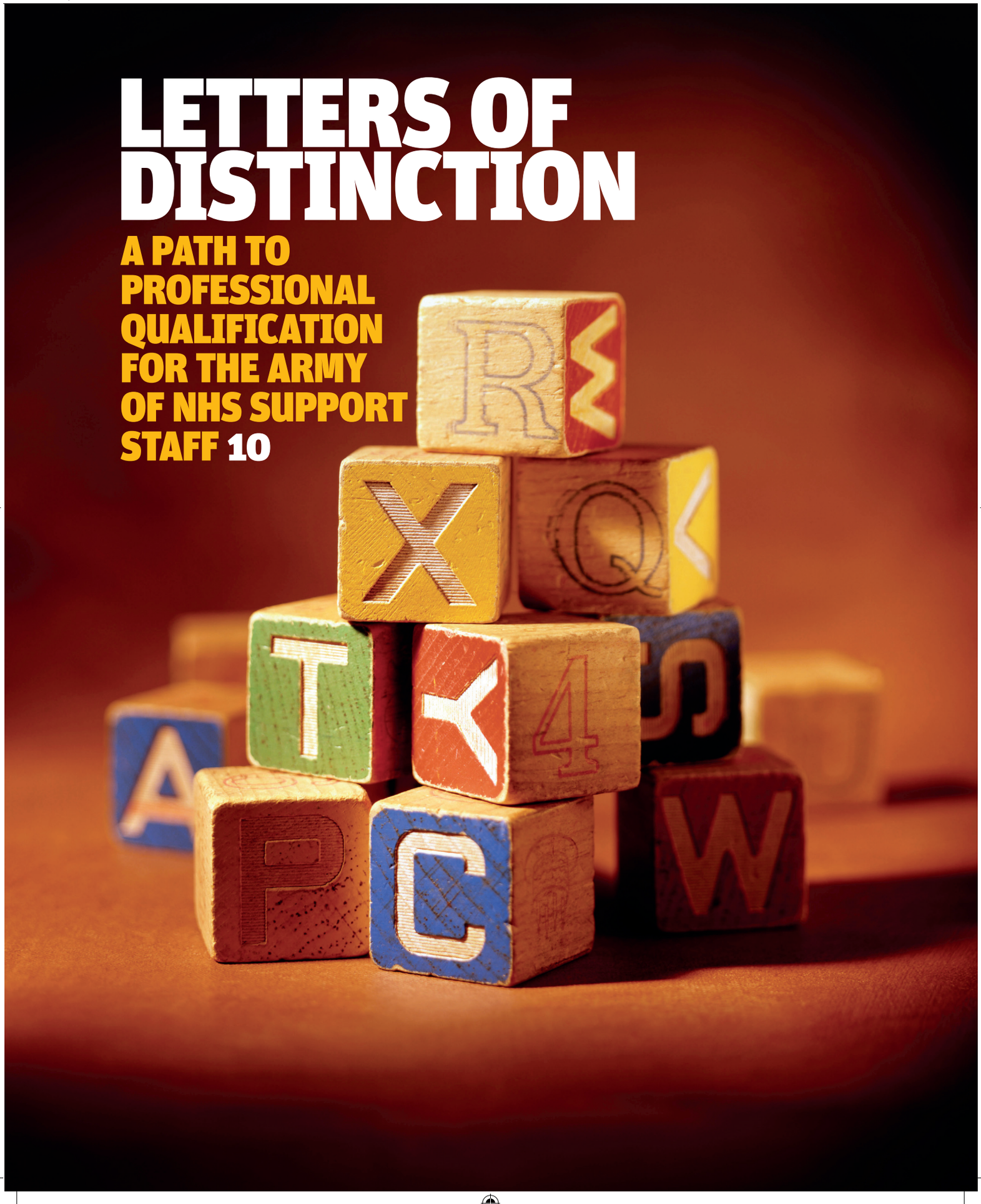

LETTERS OF DISTINCTION

A PATH TO PROFESSIONAL QUALIFICATION FOR THE ARMY OF NHS SUPPORT STAFF 10

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Supplement editor
Alison Moore

INTERPROFESSIONAL LEARNING

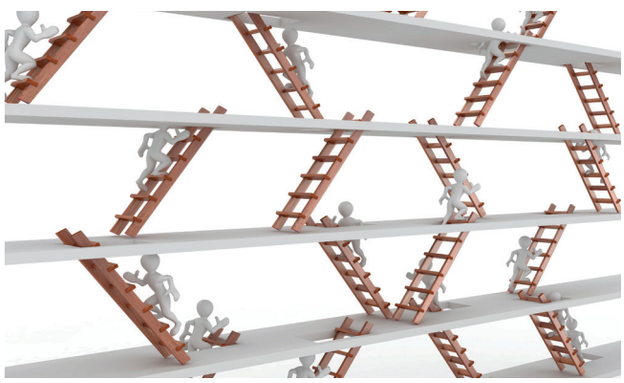
True multidisciplinary working is a vital goal for the modern NHS – with different professional groups learning together increasingly seen as a way of achieving it. And with the DH and local education and training boards now firmly behind interprofessional learning, it seems to be an idea whose time has finally come. Page 2

RESEARCH

The DH's recent announcement of £120m to be made available for university healthcare research projects is official recognition that, far from being in the stereotypical ivory tower, academics are increasingly changing practice at the coal face. Research is feeding directly into the training of staff, while partnerships between universities and NHS organisations are being formed to develop useful studies and ensure any findings are applied as quickly as possible to improve care. Page 6

CAREER DEVELOPMENT

The training and development of lower band staff and support workers has historically been neglected. Now NHS organisations are waking up to the benefits of enhancing their skills – with some offering a 'path to success' to a nursing, physiotherapy or other professional qualification. Page 10



LEADERSHIP

NHS organisations in the future will require a very different style of leadership. Experts suggest that trusts should start to think of themselves as 'holding companies' – with individual services as distinct businesses that run themselves. Organisations need to build the skills of staff to prepare for a world where key decisions are handed down, often to clinicians. Page 14

JUDITH ELLIS ON TOGETHERNESS

As the health service changes, and the public demands high quality care delivered within challenging resource limits, it becomes ever more important that we have a workforce that is not only competent but productive and flexible enough to meet the service needs of the future.

This requires a re-examination of traditional roles and professional boundaries and an acceptance of educational provision that maximises the input from all members of a team, both interprofessional and support staff. Education based around integrated care of patients requires shared learning so that all can appreciate the contributions of all parties, including patients and carers. This must lead to a change in the delivery of continuous education and a change in traditional commissioning.

It also demands a change in professionals' protectionist views. From the start of their undergraduate education they need to appreciate that the attainment of required outcomes in their future health service career will require an understanding of, and respect for, the role played by others.

Educational provision should therefore not only be focused upon the education of different staff groups, particularly at undergraduate level, but include from the start elements of shared learning – and appreciation through service user involvement of how effective integrated learning affects patient outcomes.

There will always be a requirement for profession-specific education, which includes developmental learning, to rise to the challenge of introducing innovative professional practice but there must, in future, be more opportunities for learning and developing together.

Traditional medical schools need to consider opportunities for shared learning with non-medical educational institutions, for example at shared undergraduate level through integrated skills laboratory scenarios.

The non-medical faculties and higher education institutions also need, for the sake of patient outcomes, to feel confident about offering registered medical professionals access to professional development opportunities, seeking where possible accreditation that will support not only shared academic achievement but professional revalidation.

As local education and training boards develop, the vision is that workforce planning and resulting educational commissioning will be focused on attaining quality patient outcomes and effective, economic service delivery. The unique contribution of each professional and support staff group will be valued, as will their specific educational needs, but so will the impact of educating members of the health service team together.

Judith Ellis MBE is executive dean of the faculty of health and social care, London South Bank University
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INTERPROFESSIONAL LEARNING

FROM TEAM MATE TO CLASS MATE

Efforts to teach different professions together have often been tokenistic. That's about to change, says Alison Moore

NHS staff may feel they are living through a permanent revolution in healthcare with structures, roles and approaches changing rapidly. All of this is increasingly happening in a healthcare system strapped for cash and keen to make the best use of frontline staff.

But those changes are also being reflected in what universities are offering healthcare professionals in terms of development and continued education. This includes new approaches to learning which lessen the time away from patients, new programmes to reflect changes such as GP revalidation, and increased emphasis on key elements of team working.

One of the revolutions in healthcare over the last 30 years has been the recognition that providing quality care is rarely down to one healthcare professional but to the actions of a team working together.

This has been seen most dramatically in cancer care, where multidisciplinary teams are accepted as the gold standard, but has spread into other areas of healthcare. It is likely to become particularly important in the care of elderly people with long term conditions who don't need to be admitted to hospital.

But how can such teams be built and encouraged to work well together? While there has been a focus on establishing teams, much less has been done to look at whether there are benefits in different professions learning together at both pre-registration and post-registration levels.

This is despite support from the World Health Organisation, which said in 2010 that "interprofessional education enables effective collaborative practice which... optimises health services, strengthens health systems and improves health outcomes".

But what does interprofessional learning amount to in practice? The Centre for the Advancement of Interprofessional Education has defined it as "occasions when two or more professionals learn with, from and about each other to improve collaboration and the quality of care".

Professor Judith Ellis, dean of the faculty of health and social care at London South Bank University, points to the emphasis on multiprofessional approaches in the Department of Health's educational outcomes framework, giving new impetus to a trend which has been around for some time.

The General Medical Council has also said that medical schools should ensure that students work with and learn from other health and social care professions.

This is likely to affect training providers as this approach trickles through the system. The educational outcomes framework says that the new local education and training boards should have a "multiprofessional approach to workforce planning, quality improvement, education and training".

Boards' expectations

Professor Ellis says that this is leading local education and training boards – who commission courses – to have an "absolute expectation" that higher education institutions will adopt a multidisciplinary approach to education.

This is a big driver for universities and colleges: without LETB commissions, courses won't run. And some LETBs are already making it clear that they view this as important: for example the East Midlands LETB has effective team working as one of its four priority workforce areas.

"We need to educate professionals to know what is core to their profession but recognise that for the good of the patient the rest merges. We all know that the wards that work best are those with true multidisciplinary teams," says Professor Ellis.

Former chief nursing officer Sarah

CASE STUDIES OVERLEAF ▶

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Mullally – who has an MSc in interprofessional health and welfare studies – described interprofessional working as being like fried eggs in a pan. The whites

‘We all know that the wards that work best are those with true multidisciplinary teams’

run together but the yolks – the learning specific to each profession – remain whole.

In the past, much interprofessional learning has been tokenistic, says Professor Ellis, with a few lectures shared between doctors and nurses. “I think times are changing,” she says. “There are the imperatives of policy drivers but I think this time people are grasping it and saying this is the time.”

What is starting to happen now looks much more like what happens in clinical practice. Effective teamwork and communication are essential to modern healthcare so should be reflected in teaching.

But some professionals still find it challenging to be educated in the same room as other members of a team and learning from each other. Doctors, in particular, may be quite new to this.

With undergraduate courses for other professionals there are other opportunities to learn together. There can be some hurdles to overcome – such as ensuring terminology is shared. What a dietician means by a nutritional assessment, for example, may be very different from what a nurse means.

But what are the benefits? Professor Ellis suggests respect for the roles of other professionals and the opportunity to learn from each other are important – as well as the eventual goal of helping healthcare professionals work better in multidisciplinary teams that deliver better care for patients.

One of the ways London South Bank is responding to broader changes is setting up an institute of medical education to offer postgraduate education to medics (it does not have an undergraduate medical school). Revalidation and continuing medical education are increasing the demand for this. But for many professionals it will be crucial that courses “count” towards their revalidation and therefore they may have to meet the requirements of external organisations, such as the medical royal colleges.

And what is available needs to reflect the changing structure of the NHS – for example, London South Bank has developed resources to support clinicians involved in commissioning as power prepares to move to clinical commissioning groups. One of these is an online course made out of standalone modules on particular topics which can be accessed at a time to suit the healthcare professional. This has proved popular with CCGs and is suitable for all members – from GPs through to the lay members of the board. For GPs, completing the modules can also count towards their continuing medical education.

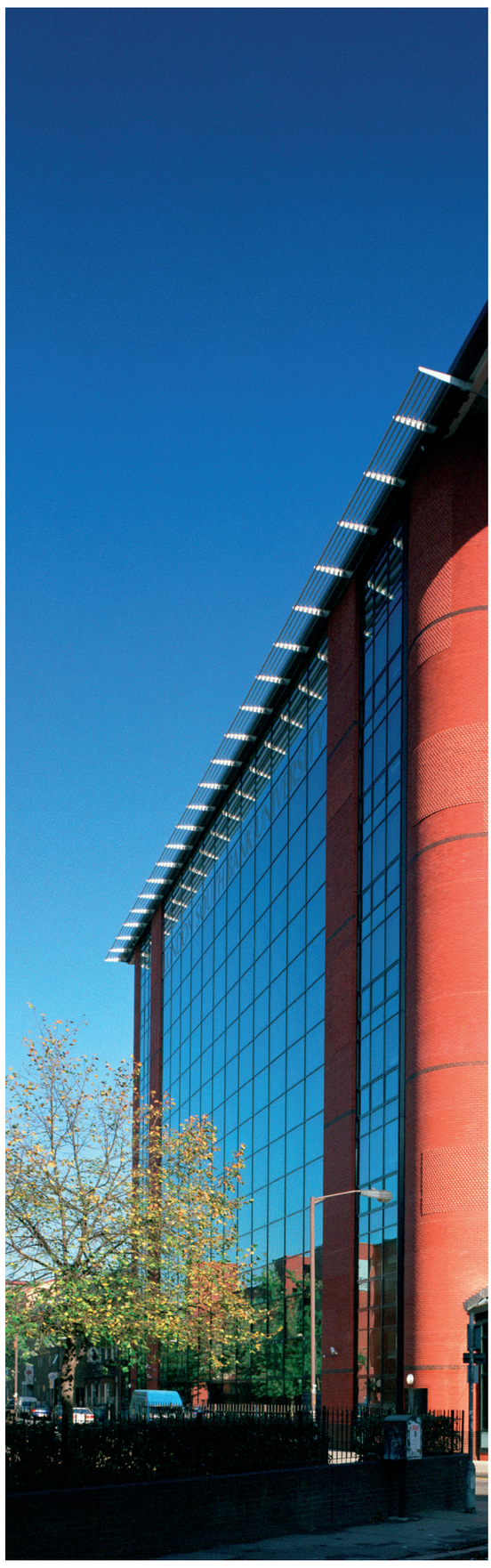
The brave new world of healthcare in the 20th century can sometimes feel frightening for staff. But many HR departments would see offering quality training and development opportunities in conjunction with universities as a key way of helping staff cope with this and ultimately improving patient care. ●

London South Bank University

INTERPROFESSIONAL LEARNING: CASE STUDIES

MOVE OUT OF THE COMFORT ZONE

How health education pioneers are opening minds by bringing different professional groups together and offering new ways of learning outside the classroom



MASTERS IN PRACTICE EDUCATION

Getting healthcare professionals from different disciplines to learn together is an idea which challenges them – but can have surprising results.

Nurses, allied health professionals, GPs and social workers have been learning together for an MA in practice education at London South Bank University. The part-time course is aimed at those who have some sort of educational role in their own clinical settings and support health and social care learners.

Joint course leader Kate Leonard says that much of what the course covers cuts across professional boundaries. There are underlying skills that practice educators need to have – and the understanding of education theory – which are fundamentally the same for the different professions, although they may be applying those within their own profession.

Reflective practice, for example, is used in many professions, although it might be called different things and each profession believes it invented it.

"We are talking to people who are going to be educating people in practice and then working together," she says.

Universal language

But care has to be taken to ensure that the course does meet the needs of all the professions. One area is around language – the language used in the six modules is carefully selected to be universal rather than taking on the words used exclusively by one or other profession. "We are not using language that reflects one profession or another," she says.

This multidisciplinary approach is demonstrated by the course staff. The two course directors come from different disciplines – Ms Leonard is from social work while her colleague is from nursing – and the staff can model the principles of working together across professions and of professionals learning from those in different disciplines.

Louise Terry, reader in law and ethics on the course, says: "What they learn in college or university they then need to translate into a clinical setting. They will then need to make assessments in clinical settings.

"Because it is a multidisciplinary pathway people learn from others and recognise when they have shared problems and get other's insights. You get those 'a-ha' moments when they realise they could learn from this.

"The classroom provides a neutral ground. It takes people out of the pressure of everyday work for a time."

But there can be some initial resistance to the idea of learning together – and learning from those in a different discipline. Ms Leonard says: "People do have fixed ideas about what we are going to be like. We have to work on some of the assumptions and attitudes about other professions."

But when students can be persuaded to become more open to different perspectives, the benefits start to come.

"It is about being able to open your mind to other examples and different professions. It makes you think outside your comfort zone."

For some parts of the course, the staff are able to group students together according to the area of clinical practice they work in – for example, a community psychiatric nurse might find they are working with a mental health social worker. This can build understanding of the viewpoint and problems that other members of a multidisciplinary team encounter in the "real world" and how seamless care can be developed despite different professional approaches.

Ms Leonard says that all too often

Patient tutors: South Bank University is even using patients to teach health workers

ALAMY

professionals only find out about each other's roles in a crisis situation; this learning together can build trust and understanding.

"This is a space where different professions can come together and learn about their role rather than in a crisis-led environment."

The course also tries to use service users and patients to teach students: an approach not all professions are accepting of and value. "That has been quite hard for some people – they don't understand how service users can have some expertise in their own care," she says.

ONLINE LEARNING MODULES

The new landscape of the NHS is creating new needs for training – but these have to be met within the constraints of a cash and time strapped environment.

Clinical commissioning is one of those areas where there is a need for more knowledge but the people who require it are probably already under tremendous time pressure and can't get away from their day jobs to attend courses.

With this in mind, London South Bank University has been working with digital agency Brickwall to develop online modules to help clinicians and others who are either involved in commissioning or just want to know more about it. Each module stands alone and can be worked through by itself – allowing users to concentrate on areas where they feel they can most benefit from the information. The modules can be purchased as a complete package or individually.

The modules are designed to encourage reflective learning and include case studies from around the county. Each module can be worked through at any time and are designed to suit clinicians who may be called away to attend to another patient and want to be able to return to where they were – one of the functions ensures they pick up at the point they left off. They are robust academically, calling on the expertise of various departments within the university including the business faculty, and have been "tested" with the Kent, Sussex and Surrey deanery. GPs there suggested a number of tweaks and refinements which have been incorporated.

Jon Brichto, director of Brickwall, says they realised there would be a need for such approaches as clinical commissioning was being more widely talked about but clinicians seemed to see it as a burden rather than an opportunity. Initially the focus was on GPs but as the outline of commissioning has developed there has been more focus on involving other clinicians and potentially also lay members of clinical commissioning groups. "We have recognised that in the educational programme so that it is not just suitable for GPs but is for any clinician involved in commissioning."

Potentially it could also attract the voluntary sector and other providers seeking an understanding of how commissioners work, or clinicians who are not on a CCG but want to influence it. It has been recognised by the Royal College of General Practitioners as contributing towards a GP's continuing medical education, so fits in with revalidation.

Users include practice managers, practice nurses and community matrons as well as GPs. Although it was originally envisaged as a relatively basic introduction to commissioning, some CCGs have acquired it for their board to work through.

In the future the university and Brickwall want to develop additional modules which could specialise in commissioning particular areas such as COPD.

Such online courses mean that universities are no longer bounded by geography in whom they can reach. But sometimes a blended approach, combining online learning with interaction with fellow learners, is necessary.

'The university and Brickwall want to develop additional modules which could specialise in commissioning particular areas such as COPD'

London South Bank has been piloting a blended learning course in clinical leadership with Guy's and St Thomas's Foundation Trust which offers 20 credit points towards a masters degree. As well as three face-to-face sessions, this involves online learning and an online discussion group accessed by students and tutors. This enhances understanding of areas that students have worked on online.

The approach has been very popular with learners and has attracted people from a number of different disciplines, including nursing and allied health professions. It avoids some of the problems with pure online learning, where students can feel a little isolated, by creating a community of learning. "Just because something is online does not mean it is not engaging," says Mr Brichto.

Yet from the trust's perspective it is still a good use of staff time: were it run totally as a taught face-to-face module, it would mean releasing staff for three hours each week for 12 weeks. "This ticks the boxes for leadership education while enabling them to still run their service," says Alex Mears, director of the institute for leadership and service improvement in the faculty of health and social care. And potentially the course could be run with institutions further away with Skype or similar applications used for the face-to-face sessions. ●

STANTON NEWMAN ON RESEARCH IMPACT

The school of health sciences at City University London has been involved in training health professionals for over 120 years and we are engaged in world leading interdisciplinary applied healthcare education and research in areas such as nursing, midwifery, mental health, optometry and visual science, radiography, health policy, health management, health services research, public health, speech, language and communication.

We are focused on providing the best practitioners for the frontline. We work with over 70 per cent of London trusts and our graduates work across the country in a variety of roles. The most recent *Guardian University Guide* rated us as the leading provider of nursing training in London.

As a university we have an emphasis on research excellence. For us not only does that mean academically excellent but also research that has a meaningful and enduring impact on patient outcomes. We have invested heavily by appointing a number of research-excellent academics who will inform our teaching and consolidate our position among the leading applied healthcare schools in the UK. Many of them still work on the healthcare frontline too.

Our programme of infrastructure investment includes a state-of-the-art clinical skills lab and replica hospital ward in the university. Our approach to clinical training has prepared thousands of clinicians for the front line.

As the organisation of care provision changes so do we. An example of this is the creation of our advanced practice courses which have been developed following consultation with our NHS partner trusts. These new courses allow healthcare professionals working in clinical and social care contexts to learn about the latest theoretical and clinical developments in a number of specific areas such as adult mental health, midwifery and radiography.

Our academics are involved in research that is changing practice. Professor Alan Simpson has been a leading figure in developing peer support workers who are becoming more common in mental health services. Professor Simpson's research revealed that patients were especially anxious around their discharge from hospital. These insights led to support workers who could provide practical and emotional support to service users.

The My Home Life (MHL) initiative works with Age UK and Dementia UK and leading care home providers to implement best practice in care homes. The effective management of care homes can relieve a great deal of pressure on hospital resources and MHL has already started to make an impact.

These are just two examples of our work and we will to continue to invest in research excellence and serve our partner trusts and the wider healthcare community.

Professor Stanton Newman is dean of the school of health sciences, City University London
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RESEARCH

WINNERS IN THE VARSITY MATCH

Academics who can make a real difference at the NHS coal face are much in demand. By Alison Moore

It's easy to think of health services research as something which goes on in ivory towers and has little impact on those delivering the service day in, day out.

But that is not the case: healthcare academics argue the work they are doing can affect practice at the coal face and ultimately make a difference to the care patients receive.

The Department of Health recently announced £120m was to be made available for research projects involving universities and their surrounding organisations.

And health secretary Jeremy Hunt highlighted the importance of this field. "If we can have better tests, better technology and make better use of the skills of NHS staff, we will be in a better position to tackle the changing needs of our population and ensure patients get the care they deserve," he said.

That approach is music to the ears of universities with a reputation for helping NHS organisations deliver better care. "All of our work is ultimately coming back to how the patient experience can be improved," says Carol Cox, professor of nursing and associate dean for research and enterprise at City University London.

Professor Stanton Newman, dean of the school of health sciences at City, says research can provide the evidence for action but he also stresses the importance of implementing the evidence – and recognises that this is often more difficult than knowing what works. Much of City's work is around helping implement evidence into practice. "Getting people to apply the evidence is a struggle," he says, pointing to the practical difficulties which have to be overcome.

Consequently, City's research is often done in partnership with NHS organisations who are keen to get evidence and, just as importantly, implement it to improve patient care and experience.

City has recently been awarded European Union funding for an international study focusing on the implementation of telehealth. This follows on from some work the university did on the effectiveness of telehealth.

The project will look at congestive heart failure and possibly also diabetes and City will both design and evaluate it. Among the outcomes to be studied will be patient-centred ones as well as clinical and cost effectiveness.

But research at City also looks at self management – something which almost certainly will play a greater role in healthcare in the future. Professor Newman points out that people have self cared for years but research is starting to pinpoint what can be done to make this more effective and also safe.

One example is those with congestive heart failure who can weigh themselves each morning, check for oedema, and then call a nurse if there are changes or they are concerned. Patients can also be successfully taught to "read" their own blood results and decide to seek healthcare input when they are outside the normal range, rather than having an appointment simply to be told that everything is fine. Research by City has suggested that, with a little training, patients can be as accurate as nurses in determining when bloods are outside the normal range.

One of the projects Professor Cox has been supervising has looked at developing standards for an expert patient programme for patients with chronic open angle glaucoma: the aim is to help patients self care more effectively, for example through better understanding of their medication, and therefore gain a better quality of life.

This sort of initiative both empowers patients and makes it much easier for them to live a "normal" life.

Professor Newman suggests there could

CASE STUDIES OVERLEAF ▶

Weigh yourself: heart patients are monitoring key health indicators as part of self care efforts being assessed by City University

be major savings for the NHS with such approaches across a range of conditions. The ritual three or six month outpatient appointment for long term patients could be replaced with appointments when the patient felt they needed it, potentially based on the results of their monitoring of their own condition, and telephone contact with staff. This would free outpatient clinic appointments for those who needed them, including new patients who might currently have to wait.

But often the most immediate impact of research is on what is taught to students passing through universities. Research will influence what is taught in pre-existing courses but also helps to identify the need for new courses. Professor Cox's work on ophthalmic practice led to the development of a model of practice which is reflected in a BSc run by the university, for example.

Projects looking at the impact of dementia such as My Home Life (see case study, overleaf) are now reflected in the classroom teaching the university offers.

"Research such as our advanced practitioner work is also being translated into the development of new programmes," says Professor Cox.

'Often the most immediate impact of research is on what is taught to students at universities'

From later this year the university will offer an MSc in advanced practice in health and social care, which will provide the opportunity for specialisation.

This will equip students to do their own research but its approach is also underpinned by the research evidence on such subjects. The university already has masters courses in health management and research.

"The fundamental underpinning of the teaching at City is around evidence-based healthcare," says Professor Newman. "That requires people to be very clear about what the evidence is so as to inform practice."

This research then translates into, for example, the best way to care for people with chronic conditions or the frail elderly.

"We have done a lot of work on telehealth and that feeds back to our students so that they get the best evidence on, for example, the role of telehealth in helping manage chronic conditions."

But it is important that teaching also help students understand the perspective of patients and those who care for them and this underlies much of City's teaching and research.

Research also impacts on government policy and that of regulatory bodies. Some of the work at City has helped inform policy on standards for advanced practice published by the Nursing and Midwifery Council, for example. And work on home births and the care that women receive has impacted on government policy.

Professor Newman describes this as a "virtuous circle." The process can start with an area where there is thought to be poor delivery for patients. Research will help pinpoint ways of improving it and this can then be fed back into the NHS – sometimes with help on implementation. But the same evidence base will be reflected in what the university is teaching the next generation of healthcare workers and can also be used to influence policy makers inside healthcare and in the wider arena. ●

CITY UNIVERSITY LONDON

RESEARCH: CASE STUDIES

BABY STEPS TO BETTER PRACTICE

How research is impacting directly on services, including helping expectant mothers make more informed choices

PEER SUPPORT WORKERS IN MENTAL HEALTH

Mental health research carried out at City University London is having an immediate impact on services, and is being shaped and influenced by both service users and provider organisations.

Professor of collaborative mental health nursing Alan Simpson says the university wants to avoid a gap between practice and teaching and works closely with the East London Foundation Trust. Trust managers and clinicians are involved in the selection of students and as honorary lecturers contributing to the development and teaching of courses.

But this relationship can also lead to research projects which focus on real issues for mental health providers. "Our work is not ivory tower. It is geared to the needs of the NHS, trust managers and service users – we hear and respond to what they are saying. The challenge sometimes is that the research process can be slower than the NHS would like," he says.

One example of this collaboration is around peer support workers who are becoming more common in mental health services. They can offer something which is complementary to the support of professional staff and can benefit both the service user and the peer support worker.

Research on the use of containment methods on mental health wards across England showed 60 per cent of patients said they were anxious about leaving the ward to return home, and did not look forward to discharge. The service user involved in the research suggested that a "buddy" system might help and Professor Simpson looked at the research around mutual support.

"We wanted to look at having peer support workers who are trained up to provide emotional and practical support at the point of discharge," he says. Suitable service users were recruited and trained and then the university ran a pilot random controlled trial looking at the outcomes for service users with support from peer workers compared with those offered the normal after care. This showed benefits for both those receiving the additional support and the peer support workers themselves, who gained in confidence, skills and self esteem.

The findings of the pilot have encouraged the trust to roll out more training, based on evidence of positive outcomes. That's important when trusts have little money to spare and want to make the most worthwhile investments – but may need evidence of what works to guide that.

Professor Simpson is now embarking on research into care planning with colleagues from Wales which will compare both countries and tease out the factors which enable care planning and coordination in community mental health services to focus on individual's personal recovery.

Service user involvement is embedded in research projects: every proposal is examined by the university's service user advisory group on research. This has 14 members who currently or have previously used mental health services and can bring their experience to bear on research proposals. Professor Simpson says: "Without fail we find that we are challenged and some of the core premises are questioned and there is a very constructive dialogue."

The group members are given training and development opportunities and the mental health research team is increasingly recruiting former service users to collect data and carry out interviews for research studies.

But they are also bringing a unique perspective to students' education with service users taking part in teaching sessions.

'People who have used mental health services can bring their experience to bear on research proposals'

For example, a service user took part in a session in care planning together with a manager from the East London Foundation Trust, the local mental health provider, and Professor Simpson. It was a "very rich experience" for the students, he says, especially when the service user played some of his own rap music.

The university also makes use of users' experiences through blogs and videos to add to the students' understanding. One experiment involved an online discussion between students and service users as part of an enquiry based learning session. "Quite often the service users are more confident in this environment and were encouraging the students to ask questions," he says.

"Whenever we have had service users involved we have had good feedback. It fits in well with the whole emphasis on compassion in nursing care."

Informed from the start: the Birthplace study has built an evidence base to help staff and parents

ALAMY

Service users are happy to talk about the positive and negative experiences of care – and the difference that nurses can make in the bad times. Very often it is the human touches which turned a difficult experience into a positive one for them – a valuable lesson for nurses.

MY HOME LIFE INITIATIVE FOR CARE HOMES

The need for health and social care to offer a high standard of care to the growing number of people with dementia is increasingly being recognised. But much of that care will take place outside the hospital sector in areas such as care home where two thirds of residents have some level of cognitive impairment.

Julienne Meyer, professor of nursing care for older adults at City University London, has been instrumental in the My Home Life initiative (www.myhomelife.org.uk). Working with Age UK and Dementia UK, she has started by looking at examples of good practice in care homes and seen this blossom into a movement pushing for better care.

"We have worked very closely with care homes to explore what support and help they need to improve quality of life," says Professor Meyer. "We are focusing on what we know residents, relatives and staff want and what works."

In terms of improving care, it is important to tackle this in a way which is likely to engage the health and social care workforce in care homes – for example, with DVDs and a storytelling approach, utilising individuals' experience. And she says the approach needs to be appreciative of what has been done. Among the outcomes has been one care home group employing specialist dementia nurses.

One finding from the My Home Life research has been the need for leadership development and support for care home managers: a programme which has been drawn up with the care home sector is now being used in a large number of areas involving a four day course and then monthly action learning sets. "What is different about it is it is not about bringing care home managers into a classroom and telling them what to do. We are creating a safe environment where they can share experiences and learn from each other and explore their leadership styles. They are saying this is having an impact on how they and their staff are working with residents and relatives."

Work with the NHS and local authorities, which will have a part to play in supporting people with dementia, is also intended to be supportive, encouraging understanding of other professionals' positions and problems. Care homes have been looking after people with dementia for a long time and there is much that can be learnt from them, she says.

Professor Meyer characterises her work as "action research" – and says not only does it impact on care, it also feeds back into education. The focus on "relationship centred care" for healthcare professionals is core to the My Home Life approach. The university has developed a new masters programme in long term conditions which she has influenced and where dementia care is threaded through the core modules, as well as a specialist module.

THE BIRTHPLACE STUDY

Choice of where to give birth has been talked about in the NHS for many years. But there has not always been a good evidence base to help healthcare professionals offer appropriate information for women and their partners who want to exercise that choice.

The "Birthplace" study, which involved City University London, Oxford University and King's College London, has helped to establish evidence around safety for women judged to be low risk for the various places in which they may give birth. It is now being used in different ways – to provide an evidence base for midwives when they are talking to parents, to guide NHS organisations and policy makers seeking to offer choice, and to influence teaching of midwives. City University London has led a follow-up study looking at the organisation and management on midwife-led units.

Christine McCourt, professor of maternal and child health at City, who was involved in the programme of work around Birthplace, says that getting the information to professionals in a form which was useful to them was particularly important. "We had to do a lot of translation work and there is still more work to be done," she says. But she says there is evidence that views on the safety of settings for low risk births have started to shift since the work

Dissemination of the work is continuing. "We are going to do a series of regular workshops with midwives, managers and commissioners to talk through the findings of both the Birthplace study and the one on midwife-led units," she says.

The economic findings around place of birth are also important for policy and decisions in trusts, with the full cost of interventions during birth highlighted more clearly. "That is having a big impact on commissioners," Professor McCourt adds.

The university is trying to reflect the detail of the Birthplace findings in its teaching. "We are trying to equip the students for the world of practice where evidence is not standing still. We are trying to help them become evidence-based practitioners. It is good for students to see the interaction between research, education and practice," she says. ●

DR LIZ CLARK ON INVESTING WISELY

What will the year ahead bring? Further change is inevitable. There is growing consensus that in its current form the NHS will struggle to cope in the future and will no longer be able to continue delivering high quality care to everyone who needs it.

Policy documents across the UK highlight the need for transformational change to create a sustainable health service against a backdrop of financial constraint, ever-higher public expectations, demographic changes and a rapid growth in the number of people with chronic conditions, advances in treatments and an ever increasing demand for care.

In spite of some high profile, shocking cases where standards have fallen short of even the most fundamental care, we have been brought up to believe that everyone is entitled to receive the right care, at the right time and in the right place, with the best outcome and a good experience along the way.

Effective leadership is essential to tackle the tough challenges ahead. But equally important is investment in learning and development. When finances are tight, it is tempting to cut the education and training budget at a time when it is crucially important to invest in all frontline staff, including healthcare support workers, to ensure they are competent to deliver the best possible personalised, safe and clinically effective care. With the recent publication of the Francis report, which will affect every hospital, it is essential to be confident in the knowledge, skills and values of the workforce and the readiness of staff to speak out when they see failings.

Collaborative working in integrated teams delivering joined-up, evidence-based services across geographical and organisational boundaries will be fundamental to making the best possible use of available resources. This will not happen without a well educated and competent workforce. Developing staff to build their confidence and achieve their potential will be essential.

As a global leader in supported open learning, we understand that cost-effective learning should not involve time away from the workplace and that busy practitioners need flexibility about when and where they study to fit around work and personal commitments. We also understand how to support learning, which is why The Open University is the only university to feature consistently in the top three places in the annual National Student Survey since its introduction in 2005 – a testament to the quality of the student learning experience.

As a national provider of flexible learning, the OU works with large and small organisations to generate innovative and cost-effective learning solutions that help to achieve their goals.

Dr Liz Clark is senior lecturer in the faculty of health and social care, The Open University

www.openuniversity.co.uk/choosehealth

CAREER DEVELOPMENT

LADDERS THAT WE CAN ALL CLIMB

NHS staff in lower bands are getting more chances to develop their skills and move up. By Alison Moore

Training and education in the NHS can often focus on doctors and nurses – but a majority of the NHS's staff don't fall into that category yet may still be involved in frontline care.

Giving these staff the skills they need as the NHS – and possibly their role – changes and offering them a career pathway is an issue trusts can't afford to ignore. "Many of these frontline staff are taking on more and more responsibility and doing the majority of patient care," says Dympna Brett, the director of business development in The Open University's faculty of health and social care.

Many staff are not regulated and it is the regulated professionals who take responsibility for work delegated to them. "It is very important to ensure that healthcare workers have sufficient training and support and understand the responsibilities they are taking on," she says.

Caroline Waterfield, deputy head of employment services at NHS Employers, echoes this concern that all staff get access to training and development to grow skills and improve patient care. And she adds that there are issues which will cut across all health and social care workers, such as dealing with people with dementia.

But while there are well established pathways and funding for healthcare professionals' training and continued development, the position is less clear cut with other staff such as support workers.

Some organisations are excellent at offering them training opportunities – which can range from enhancing their skills to better do the job they do now to launching them on a path towards a nursing or physiotherapy degree. But that is not the case universally.

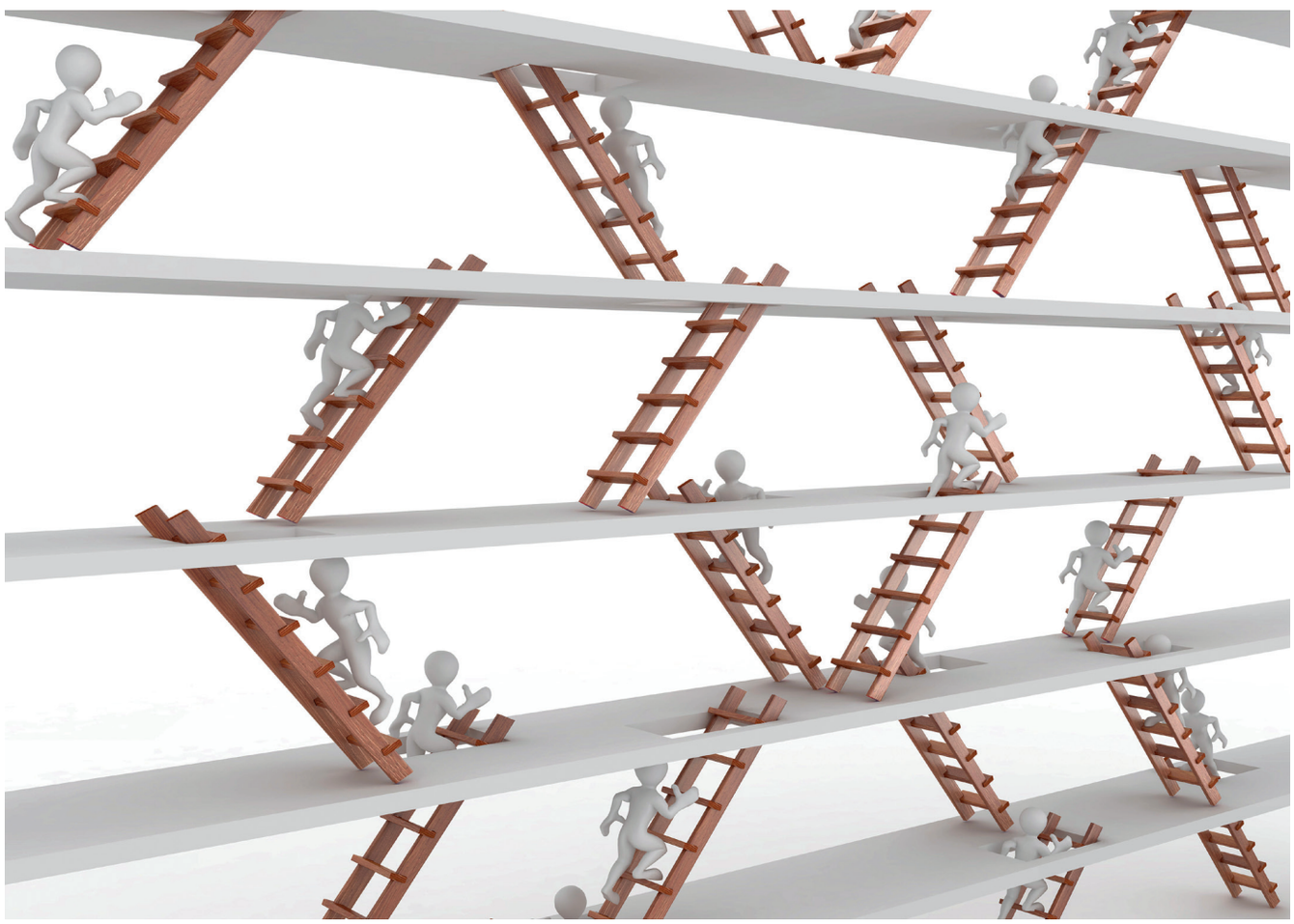
Prime Minister David Cameron recently drew attention to this with his announcement that £13m would be spent helping support workers develop and the Care Quality Commission would also be asked to look at the training of staff.

Lisa Bayliss-Pratt, director of nursing at Health Education England, says that it is vital that the right staff are recruited in the first place – and this includes ensuring that they have the values needed in the NHS. But once they are in place, their developmental needs should not be forgotten.

For some support workers this will mean offering them a "path to success" which would lead to qualification as a nurse, physiotherapist or similar regulated profession. Some staff won't want this but can still be helped to do their job better through development and training opportunities. "Fundamentally, it has to start with valuing these roles," she says. "We have to see their roles as integral to the team. They are really important and I do think they have been a bit neglected – although many are highly valued at a local level."

HEE is working with universities, many of which already offer progression routes for staff, but there are also learning opportunities in the workplace, she says.

CASE STUDIES OVERLEAF ▶



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Many managers would welcome this high level commitment to helping staff advance. But there's a challenge for trusts to ensure that lower band staff get these opportunities in a cash-strapped environment where the needs of patients still need to be put first.

Releasing staff for courses can be difficult – especially if several of them in one area are going through the same programme. And courses can pose problems for staff who might normally work nights or part-time and have other commitments during the day. While many employers want to raise the qualifications and skills of these staff, they need to do so in a way which is both affordable and is feasible in that it fits in with the operational needs of the organisation.

Ms Waterfield says that managers are often looking for on-the-job programmes rather than sending staff off on a long course. They want to see training which really does help employees do their job better and can be evaluated to show there has been a return on their investment.

"We have scarce resources but we also know we need to continue to invest in staff as the only way to make improvements for patients," she says. Employers have been enthusiastic about the local education and training boards and they may improve opportunities for lower banded staff.

'A "path to success" would lead to qualification as a nurse, physiotherapist or similar regulated professions'

So do different ways of learning offer a better option to engage some of these staff, rather than a focus on university-based courses? The Open University has a range of courses aimed at people currently in bands one to four of Agenda for Change. These can offer a step up in career terms – for example, eventually leading to credits towards a nursing degree or preparing staff to work as assistant practitioners – but should also bring benefits in the short term for the employer. The aim is to integrate theory and practice with work-based modules.

Flexible learning

But crucially these courses can be done at a time to suit the student's work and other commitments – at work or at home. Ms Brett says that this is about moving to a partnership between staff member and employer, with both committing to their ongoing training – the employee through doing some of the work in their own time, the employer through paying the cost of the course. The employee will get a recognised qualification which should help them move forward in their career, potentially to a foundation degree which could then give them credits towards pre-registration nursing courses. But the employer also benefits as staff gain new skills and knowledge while continuing to perform their day job.

Ms Brett says there has been increased interest in such courses as trusts feel the economic pinch and find it harder to release staff from their jobs to attend courses. Some trusts have moved healthcare assistants onto the OU certificate of higher education in healthcare practice precisely because it better fits with the demands of the organisation to have staff on the frontline as much as possible.

And she points out that the courses are very much founded in the sort of values which underpin good healthcare – including compassion, dignity and person-centred care – which are central to the Francis report. ●

CAREER DEVELOPMENT: CASE STUDIES

‘CURIOSITY GOES THROUGH THE ROOF’

Trainers see an ‘unbelievable’ transformation in staff when they are offered opportunities to develop their skills and qualifications

WORK-BASED NURSING TRAINING FOR HEALTHCARE ASSISTANTS

Healthcare assistants are often some of a trust’s most loyal workers. Frequently mature and based in the local community, they are likely to spend many years working for the same organisation.

Support workers often have great technical and interpersonal skills – yet few opportunities to develop in their career. In the East Midlands the SHA turned to The Open University’s work-based pre-registration nursing programme as an innovative way to help them develop and become registered nurses, while remaining employed. This is going to be continued by the new local education and training board for the area.

At Northampton General Hospital Trust HCAs do an Open University course, involving a mix of independent study such as online learning, tutorials and written assignments, while still spending part of the week on their ward. The rest of the time they are supported by a practice tutor and mentor for clinical/practice learning. They will average around three shifts at their original job a fortnight – and the cost of backfill means they need to have support from their directorates before applying for the four year programme. Fees for the course are paid by the SHA – now part of NHS Midlands and East.

With just 20 places available across the East Midlands, clinical placement facilitator Gillian Ashworth is delighted that the trust has been so successful in getting HCAs onto the scheme. The first cohort has just graduated and have all been found jobs within the trust, she says.

“Normally they would have to leave the trust and attend university to become a registered nurse,” she says. “They tend to be mature people with financial commitments. They could not give up the job and go off to study for three years.”

Many have found they enjoy the way in which the course operates, allowing them to get ahead if they have more time available rather than having to wait for a lecture.

Ms Ashworth says as the course progresses they become “very different HCAs”, bringing their new knowledge to bear on their jobs. “The difference is unbelievable. They find their voices, they are more confident, they know how to constructively challenge and their knowledge and curiosity goes through the roof,” she says.

They are also exposed to different environments – as the Nursing and Midwifery Council requires. An HCA on a medical ward may spend time on a surgical one, as well as in the community and will be exposed to mental health issues that they might not have encountered in their job. These required clinical placements will expose them to different experiences in a supportive atmosphere.

But there can be challenges. Ms Ashworth says it’s important that other staff recognise when healthcare assistants are on the course and don’t treat them “just” as the ward HCA. Also, there can be valuable learning opportunities to encourage HCAs to think more deeply when they are doing their work and good mentors can ensure that they take advantage of them.

Students also have to meet minimum standards for maths and English – and the maths side in particular can cause angst for would-be applicants. Many find filling in the application forms with the appropriate level of detail and precision an early hurdle, and need support through this process.

“If we have a difficulty with a new placement area, The Open University is always very willing to come across and support us,” Ms Ashworth says. “I can get a response very quickly. The Open University is very responsive to my needs and to any student needs.”

But what are the advantages for the trust? It has offered an opportunity for staff to develop to their full potential and has helped the trust to recruit nursing staff who are often hard to find. Furthermore, these staff are likely to stay in the area, sometimes want to return to the ward where they previously worked, and have a commitment to the trust. They may also have a different perspective to bring to the workplace.

Learn while you earn: the OU foundation degree in paramedic science takes four years

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PARAMEDIC SKILLS FOR AMBULANCE SERVICE STAFF

The role that ambulance service staff play in caring for patients is changing rapidly. Rather than simply conveying someone to hospital, there is an increasing emphasis on giving ambulance staff the skills and judgement to provide "right care at the right time at the right place".

An innovative scheme set up by South Western Ambulance Service Foundation Trust is offering staff on band three of Agenda for Change the opportunity to gain a foundation degree which provides them with the skills and qualifications to register to become a Health and Care Professions Council registered paramedic.

This "learn while you earn" approach is offering a progression route for band three staff and supports the trust in meeting its future workforce needs.

Lizzie Ryan, education business manager and placement development lead (clinical) at the trust, says there are band three staff in various positions around the trust including in the clinical control hub and working as emergency care assistants on ambulances, and on non-emergency patient transport services, who can potentially access this development pathway.

For the last few years they have been able to apply to do a four year foundation degree in paramedic science with The Open University. Candidates have to undergo a selection process and a foundation course.

Once they have gained the foundation degree, they can then become a paramedic once a job is available in the service.

Ms Ryan says that the students' skills develop during the four years of training, as both their technical knowledge and their practical experience increases.

'The first cohort of students are providing a high standard of care, she says. "I'm really proud of them"'

The course includes an element of online learning, combined with handbooks. The trust backs this up with workshops and practical experience, where students work alongside and are supervised by experienced registered paramedics.

"They are basically practising their skills and using their skills under the supervision of experienced paramedics," she says.

Entrants to the course have a mix of qualifications but even those with just one year's ambulance experience or four GCSEs at C grade have been able to complete the course. "With the OU the type of learning provided allows you to take someone with GCSEs and develop their skills over the period of the course," she says. Their ability to write and to research improves dramatically – as does their confidence.

The trust had been using the HCPC/IHCD qualification, which allowed emergency care staff to progress from direct entry technician to paramedic level, to develop its staff for a number of years. It began using the OU degree pathway four years ago.

This has provided a career pathway that supports the developing role of paramedics in providing optimum patient care while ensuring a move towards diploma or degree qualification for new entrants. "We need our staff to develop their autonomy, clinical and decision making skills as well as their ability to provide optimum patient care," Ms Ryan says. "This approach addresses the skills we will need in the future and makes sure we meet the requirements of the commissioners and the communities we serve."

The first cohort of students recently graduated from the course and most have been able to get jobs as paramedics with the trust. They are supported during their first few months by a preceptorship system. However, the mix of theoretical learning and practical skills involved in their training means they are well equipped for the challenges of the job.

"The reports that I am getting back from the managers at the frontline is that they are providing a high standard of care and professionalism," she says. "I'm really proud of them."

For many band threes it is a superb opportunity to take their career to the next level. They do have to commit to a certain amount of work in their own time but the trust currently provides educational and financial support while also employing the learners as band threes. Those who want to top up their foundation degree to a full BSc can do additional self-funded modules at the end of the course.

The trust set up the scheme because it wanted to offer a progression route that its band threes could access. But it has also benefited in terms of workforce planning – it knows in advance how many paramedics are likely to be available. With a staff turnover of 5 to 6 per cent, it has a largely static staff base, reflecting both the geography of the area and the fact that it is well regarded as an employer.

The trust continues to offer development pathways, dependent on workforce planning, and is looking at pathways to support different levels of staff in the future. ●

ANDREW VINCENT ON DISTRIBUTED LEADERSHIP

IN ASSOCIATION WITH MEDICADEMY

Leadership has to change and so does leadership development. Both are deeply flawed and we are seeing the consequences of those flaws in the collective state of healthcare services across the country. Services are where they are primarily because of an absence of strategic direction in alignment with healthcare's direction of travel and/or through a failure to mobilise the people to implement that strategic direction.

This encompasses the two primary elements of leadership – direction and people – making it difficult to conclude anything other than our approach to leadership is failing. The commonest reaction to this failure is not to re-examine our leadership approach but to tighten management control – at best symptomatic treatment of a complex disease. Historically, this mattered less, with the worst organisational failures attracting the highest levels of bailout and support, a security blanket that disappears with increasing austerity.

In a system without explicit hierarchical control but full of complexity and interrelationships, we have to accept that the right strategic direction comes from the collective wisdom of many brains, equipped with a much deeper understanding of this system, and not from one heroic leader. This consensus-based approach is vital to the implementation of any strategy in a system

'People only believe if they have been meaningfully involved'

where the power of passive resistance trumps the degree of explicit authority carried by leaders. In effect, people only engage if they believe it's right and they only believe if they have been meaningfully involved.

I am describing a model of distributed leadership; collective responsibility for understanding the problem, devising a solution and accepting collective accountability for how that turns out. The role of the leader is one of behavioural catalyst, ensuring that key issues are surfaced and the right people are at the table, each with the right mindset. Autocratically induced compliance, through elaborate control regimes, is small comfort in failure arising from poor strategic choices.

The successful leader today recognises that humility is a strength, that wisdom emerges collectively, not individually, and compliance without wisdom is akin to being able to move a trust towards a cliff edge in fog. It will take more than a singular, myopic but heroic leader to find a safe path and a very different approach to leadership development to create the sort of catalysts every service and trust is going to need to survive a fog full of precipices.

Andrew Vincent is chief executive of Medicademy
www.medicademy.co.uk

LEADERSHIP

NO MORE HEROES ANY MORE

The senior managers of the future will be 'catalysts' for change, handing autonomy down the line

The NHS is in a period of unprecedented change where organisations will require leadership and new skills to find their way through a maelstrom. But it is having to do this at a time of financial stringency which will affect its ability to invest in the skills it will need.

The NHS is often said to be facing a perfect storm of increasing demand and static funding and is having to do so at a time when organisations also need to respond to external forces such as provider competition, the need to promote themselves and the imperative for individual services to reform profitability and performance. Underlying all of this is the challenge of operating in a new environment where trusts can be dissolved or put into administration – as has happened to South London Healthcare Trust.

These challenges shake the conviction among many managers that the NHS can survive by continuing to operate as it has in the past. Leading organisations through this to a more secure future is possibly everyone's greatest challenge – and is likely to require a very different style of leadership.

Andrew Vincent, chief executive at training company Medicademy, suggests that trusts need to think more like a holding company – an umbrella organisation with individual services operating as distinct businesses with greater autonomy to run themselves, identify key issues and devise their own solutions. This requires a more distributed style of leadership.

It's a view shared by Steven Allder, consultant neurologist and assistant medical director at Plymouth Hospitals Trust who has led several transformation projects in his own trust. "It's my conviction that healthcare will only survive if it transforms itself," he says. "It is possible to do that but we are going to need to develop a bunch of clinical leaders that recognise this and have the skills to do it. And we are starting from a low base."

Few trusts currently have these skills embedded at the service level, hampering adoption of this model. If they buy them in, people from the commercial world frequently find themselves defeated by working within the very different NHS culture, where explicit control rarely exists.

Distributed leadership requires a broader base of leaders to work collectively, to define problems and reach consensus on solutions. The NHS has tended to concentrate on smaller numbers of senior leaders, rather than building leadership capacity throughout the organisation. The concept of a heroic leader pulling the organisation out of crisis has prevailed. However, the reality of tomorrow's health service is that organisations will face such complexity that no one leader will be able to do this.

"We promote the idea of leader as catalyst rather than ruler," says Mr Vincent. 'The leader is someone who surfaces understanding of the core issues and then enables devolution of responsibility and freedom to operate to capable, coal-face leaders."

Jane Adams, head of organisational development and learning at Bolton Foundation Trust, says: "There is a requirement to review leadership skills and knowledge to meet the challenges of a rapidly changing healthcare landscape. We are always looking to develop our leaders and support them to lead effectively in this period of mass reform. We actively seek out more innovative and tailored approaches to leadership development to enable us to do this."

Do existing NHS leaders really understand what this means? Mr Vincent suggests this is beginning to happen.

But, on the ground, awareness of what needs to change – and what this means for

Crossing the divide: clinicians are going to have to learn to lead in the new NHS

leadership within organisations – can be more limited. Dr Allder suggests: "Many people in the system are clueless about what to do. And, it can be very hard for leaders to step back and devolve power: they can become defensive and stymie change, sometimes not even recognising that they are doing this.

"But once you start engaging with what patients really need and the gap between what they have and what they need, then it becomes blindingly obvious that your clinical teams have to change. No one is going to change unless you engage with them and they believe in it. By asking why is change needed and what needs to change, the answer to how it happens becomes clearer – and clarity is what people are seeking."

Mr Vincent sees engagement and buy-in of clinical leaders as being crucial. "Without true engagement, senior clinicians can block change using the 'not in the patients' best interests, get out of jail free card' but challenged to create acceptable solutions that fully consider the complexity, they demonstrate tremendous capacity for solving immensely complex problems," he says.

'Clinicians will make just about anything happen as long as they believe it is right. That belief comes from fully understanding the problem and genuinely owning it'

"Clinicians will make just about anything happen as long as they believe it is right," he says. "That belief comes from fully understanding the problem and genuinely owning it.

"Often that means understanding an issue for themselves and deciding what needs to be done in their own service, rather than simply being told what to do. Understanding the impact of current and emerging reform is a crucial part of this that is frequently lacking amongst clinicians."

But what does this mean for training and development within trusts? Dr Allder points out: "At the end of the day we know the NHS is cutting and scrimping in every corner and training and development are often seen as soft targets."

With increased demands from mandatory training and revalidation, few organisations will have the cash to fund all the training they would like or genuinely need. Mr Vincent suggests the solution is not to

ALAMY

restrict training to the few, or to offer inadequate depth, but to look at better ways of delivering it. And, he adds, it needs to reflect the necessity for a collective approach to solving complex problems.

"The traditional point-in-time course approach is increasingly unaffordable in sufficient volume," he says. "It does not adequately address the need to evolve continuously and learn as you face each new emergent challenge. It's in these moments that you need people with the right understanding and skills or reform falters."

Ms Adams concludes: "Trusts require an approach that has flexibility of access which also appeals to a range of learning styles. This can be done through a range of learning options, which are practical and fast-paced and include face to face sessions, e-learning, and coaching. Effective, collaborative learning by clinicians and managers together is essential for the survival of trusts."

Medicademy offers a membership backbone which services subscribe to on a "fixed fee" basis, allowing every member of staff to access e-learning and online lectures on demand, individually or collectively, as well as traditional in-house training when required.

Mr Vincent adds: "We also provide, as part of this approach, each service with their own unique learning and collaboration website so that they can marry discussing, agreeing and managing reform integrated with the learning they need to achieve it. It also recognises that everyone has a different baseline and needs, something that the traditional approach has never overcome."

Medicademy has been working with Bolton on leadership development. Ms Adams says: "We initially worked with Mr Vincent on the leadership imperative and the evolving healthcare landscape. The first groups through were consultants and medical leaders. This was so successful that we now use the sessions for our managers too. I think this more flexible Medicademy approach could shape not only our consultant learning for the future, but also management development in general."

'You end up in the position of South London – knowing what to do but failing to catalyse consensus and action, leading to disaster'

Louise Hardy, head of organisation development for South Devon and Torbay clinical commissioning group, an area renowned for commissioner-provider collaboration and provider integration, is currently considering just how to support leaders across the health economy to learn and reform together.

Ms Hardy says: "Enhancing a common understanding and capability amongst clinical leaders across our healthcare community will significantly unblock system reform." Commenting on the Medicademy approach, she adds: "The concept of a collaborative environment that allows groups to work together across boundaries and learn [the same things] as they go is really exciting."

This cross-boundary necessity is recognised by commissioners and providers in Oxfordshire, wrestling with delayed transfer of care across the full health and social care spectrum. Adopting the Medicademy approach, Paul Brennan, chief operating officer for Oxford University Hospitals Trust, comments: "Although it's early days in our transformation programme, we fully recognise the complexity of the challenge, the massive learning need it highlights and the importance of physically disconnected groups working together."

For many organisations, time is not on their side. Mr Vincent and many others point out that many trusts are already in severe and growing financial difficulty. Dr Allder suggests that the NHS has failed to have the sort of "bottom line" which precipitates change in other organisations – commercial firms would go bust but the NHS finds a fudge. "Healthcare systems have been bumbling along for 60 years so transforming them was always going to need something radical. This means the reality of the situation doesn't always bite home and people fail to act swiftly enough or sufficiently."

Some would say that South London Healthcare Trust's experience is changing this perspective. But many remain naive about the extent of future challenges while others recognise them but don't know what to do or how to do it. South London identified clinical and financial problems and, while it improved quality, it did not manage to tackle its financial deficit which ultimately led to special administration. The Rotherham Foundation Trust identified an imperative – redistribute certain care into community settings – but failed to build consensus around what and how: now it expects to shed 750 posts by 2015.

"This highlights the severe consequence of failing to gain consensus, which is directly linked to your leadership approach," says Mr Vincent. "You end up in the position of South London or Rotherham – knowing what to do but failing to catalyse consensus and action, leading to disaster.

"Our future approach to development has to be completely consistent with this reality and provide for a very different approach to leading services over timescales that feel frighteningly short." ●