THE HEALTHCARE SCIENCE LEADERSHIP JOURNAL

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Editorial Board

In this issue

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EDITORIAL

Welcome to this issue of the Journal at a time when health services in the UK continue to be under intense pressure. Staff shortages, extensive waiting lists and the fall-out from a continuing pandemic are just three of many problems being faced by the NHS. Focused government action to address long standing issues is lacking, and uncertainty is growing in national and international economic, political, social and public health arenas. Effective leadership has never been more essential – for patients, services and staff. We hope you find ideas and inspiration in this edition to help you develop your own services and careers.

Many healthcare scientists pass on knowledge and understanding that helps their colleagues do a better job. **Elaine Cloutman-Green** explores the potential of shared learning as a route to aid service improvement. She describes a regular event she has set up to build networks and develop cross-fertilisation across traditional boundaries. **Stephen Gandy** talks about his personal journey to lead a national training scheme and what needed to be adapted to cope with pandemic lockdowns. Like many unplanned events, this has given rise to fresh ideas and approaches that have enhanced the value of this scheme.

An important part of leadership is the ability to empathise with and care for those around us. **Jo Horne** summarises her journey into compassionate leadership and stresses the importance of self-care and developing an understanding of others. **Robert Farley** identifies similar themes when looking at inclusive leadership from an LGBTQ+ perspective, uncovering fresh perspectives on what this can feel like and why values and integrity matter.

The way in which healthcare scientists deliver care is critical to the experience of patients and contributes to the success of their treatments. **Naomi Chambers** and **Jeremy Taylor** summarise the results of a research study listening to patient and carer stories to analyse what will best improve patient care. They have recognised five factors that make a vital difference in addressing systemic shortfalls identified by the Care Quality Commission. This framework provides healthcare scientists and others with a way to focus service improvement efforts. **Amy Read** also uses a patient story to highlight the threats from antibiotic resistant bacteria and illustrate the power of narrative in initiating wider social and behavioural change. She discusses the value of both social movement and top-down techniques in improving healthcare.

The final three articles provide more personal perspectives on topical issues. **Sarah Smith** provides an overview of her career path from laboratory bench to Healthcare Science Professional lead, including the challenges she faced at different key transitions. Her experiences show the value of being open to new opportunities and input from others whilst pursuing your own interests and passions. **Berne Ferry** provides an update on leadership training within the National School. **Jane Tovey** describes her experiences leading a professional body through the height of the pandemic.

Finally. I would like to thank **Shelley Heard** for her insights, ideas, hard work and encouragement in getting the Journal up and running and jointly editing it for its first year. Shelley has now stepped down as editor for personal reasons but we are pleased she is staying on the Editorial Board. We also thank **Jo Young** for her contributions to the Board since its inception.

Please continue to contact the Journal with your ideas and offers of contributions. Accounts of your personal experiences, research results, opinion pieces and project reports may contain just what someone else needs to provide encouragement and inspiration for their future career. Send your enquiries and comments to admin@ahcs.ac.uk.

FROM SCIENTIST TO EDUCATOR: UNLOCKING OUR POTENTIAL

I have always been interested in learning and in how education and information support change. But are we healthcare scientists optimising its use?

I am in my 40s, so my own education was delivered largely by subject experts sitting at the front of lecture theatres, giving out knowledge. After I became a specialist in Infection Prevention and Control I found myself having to teach people who were experts in their own field and in their patients' treatment.

I soon realised that the formal approach to knowledge transfer that I was familiar with was not the best way to teach and learn in a healthcare setting. I was failing to engage and use the knowledge and expertise of my audience. They could help me put Infection Prevention and Control into a context that would improve both their practice and my own. I became more than a little obsessed with finding out how I could change educational practice for our mutual benefit.

Change Starts with You

The first thing that we can do as learners and leaders is to examine and reflect on our own practice. In 2013, I undertook what was seen by colleagues as a bold step and enrolled on a Post Graduate Certificate in Teaching and Learning in Higher and Professional Education. I found the first six months of the course to be really difficult. I recently found an old Facebook post of mine from the time which said, "My god it's filled with touchy feely nonsense. I may struggle." As a scientist, it took me a while to adjust to writing essays that used feelings and qualitative data to express opinions. However, after those first months, I had a revelation.

My own experience as a student was based on the ability to regurgitate facts. My insight was that I could move from this

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'showing' learning to the creation of 'shared' learning. This means working collaboratively with learners to bring together the information that we each held individually. We could therefore develop new approaches and re-contextualise our shared knowledge, thereby changing practice in a way that worked for each individual and, in the healthcare setting, eventually improved patient outcomes. Since then I have been passionate about this approach.

One of the main changes that I made was to stop designing my teaching activities and presentations to simply present a series of facts aimed at recall. Instead, I used Bloom's Taxonomy to guide lesson planning, in order to encourage a deeper learning aimed at reaching a minimum of the Application level in each session.

Bloom's Taxonomy (Krathwohl 2002) [1]:

1. Knowledge –ability to observe, recall and name
2. Comprehension –understanding, demonstrating, summarising
3. Application – able to use and apply in practice, experimenting
4. Analysis – identifying patterns, organising ideas, generalising
5. Synthesis – able to combine different approaches to create new ideas
6. Evaluation – assessing, comparing, appraising, making judgements

What does any of this have to do with Healthcare Science?

Completing this course made an incredible impact on me. Through my blossoming interest in education and the connections made, I encountered the Education team of my NHS Trust. As a Healthcare Scientist I had never come across this group before. We had our own education leads within pathology and my supervisors did not interact with the trust's team at all. As far as I knew they ran generic courses but had no real relevance to my professional practice. It was only as I developed my interest in educational theory and met this wonderful team that it struck me - Healthcare Scientists were all educators, we just didn't realise it!

Every Healthcare Scientist who I have ever met teaches others – whether providing on the job training, delivering university lectures or going out into the world and undertaking public engagement. However, we generally forget to pin the label 'educator' on ourselves and consequently do not reflect on how much we do, how well we do it, or access the support that is available to help us improve. The language and theories of education can also make engagement difficult for those from a traditional scientific background. I strongly believe that we need a route for Healthcare Scientists to improve their education skills and teaching delivery. On this premise, the Healthcare Science Education Conference (HCSEd) was launched in 2017.

Leading for Change

HCSEd was born following the successful completion of my PGCert and my being inspired to share my newfound knowledge. It came at a serendipitous time, as I was also stepping up to become Joint Trust Lead Healthcare Scientist at Great Ormond Street Hospital, creating capacity for me to find funding for and lead such a project.

HCSEd is now a national annual one-day conference with around 150 attendees. The morning contains didactic lectures on the Knowledge part of Bloom's Taxonomy. In the afternoon, we use that knowledge and undertake workshops to enable us to move to Application, Analysis and Synthesis. A key part of the learning comes from connecting with others and having discussions that encourage cross fertilisation. HCSEd encourages attendees to build networks that can support them throughout their careers.

Whether we recognise it or not, most Healthcare Scientists act as educators through their practice. By recognising this amazing skill set, our profession can harness and develop its skills, not only for our own benefit but also for that of the entire healthcare system. This will maximise our impact, enhance our practice and improve patient outcomes.

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'STEPPING UP' TO LEAD A NATIONAL TRAINING SCHEME (WHEN THE PANDEMIC STRUCK)

Stephen Gandy *leads MR Physics at NHS Tayside and the Scottish Medical Physics and Clinical Engineering Training Scheme*

Introduction

In late 2019, the head of Medical Physics and Clinical Engineering at NHS Tayside (David Sutton) announced his plan to retire. One of his roles was to lead the Scottish Medical Physics and Clinical Engineering Training Scheme (SMPCETS) and a successor was needed. I had worked alongside David and his predecessor since 2008 as NHS Tayside Coordinator for the Scheme and, having served this apprenticeship, felt the time was right to 'step up' and offer my services as the new national Lead. With David's retirement on the horizon, we prepared a handover plan starting in January 2020. I was to fulfil the role of Scheme Lead under his guidance for 12 months before taking over fully at the end of the year. However, not everything went to plan! This article provides a brief account of my experiences and of some new training initiatives.

Background

SMPCETS trainees complete a 3½ year STP-equivalence programme which is funded by NHS Education for Scotland (NES). In summary, this involves:

- Year 1 is a full time MSc in Medical Physics or Clinical Engineering
- Year 2 is a Foundation Year of ten-week hospital-based rotations, after which a specialism subject is agreed
- Year 3 and part of Year 4 provides 18 months of training in a trainee's chosen area, including a 3-6 month innovation project. This gives trainees the opportunity to develop experience in innovative research and development
- Towards the end of the programme each trainee is invited to submit a portfolio of equivalence to the Academy for Healthcare Science
- Subject to successful review and oral examination, trainees are awarded a Certificate of Equivalence enabling them to register as a Healthcare Scientist in Medical Physics or Clinical Engineering with the Health and Care Professions Council

Scheme administration follows a (relatively) consistent annual cycle:

- January-April: advertising and recruitment of new trainees
- February-March: Academy for Healthcare Science (AHCS) equivalence assessments
- July-September: workforce planning activity
- September-October: participation in NES annual Quality Assurance (QA)
- October: midway QA assessments for Foundation Year trainees
- November: annual trainee symposium
- Regular Steering Committee meetings (typically January, May/June and November)

Handing over during a pandemic

The hand-over programme progressed smoothly during January and February 2020. Plans were put in place to advertise for a new intake of trainees. Then we were hit by the coronavirus pandemic. This required some very rapid decision making. All communications were switched to Video Conferencing (VC) as soon as possible. With the support of NES, interviews for the new intake went ahead via VC slightly later than planned but the process was completed without too many difficulties, and trainees were appointed. All existing trainees worked from home during the initial lockdown (March-May 2020) and so wherever possible theoretical work was prioritised for this period. The only exercise to be relatively unaffected was AHCS equivalence assessments. These were held virtually on the 'GoToMeeting' platform, with training assessors and supervisors who were familiar with the use of VC facilities.

For the rest of 2020, virtual meetings were the order of the day. A series of Scheme Steering Committee meetings were held using MS Teams. The October 2020 end of Foundation-Year Quality Assurance (QA) exercise was switched to 'GoToMeeting' with the help of NES. In response to a request for feedback,

trainees described the use of VC for this QA exercise as being quite challenging. However, the event was considered largely successful in the circumstances. It also provided a more realistic 'rehearsal' for trainees ahead of their virtual equivalence assessments.

After David's retirement in January 2021 it was time for me to go solo as Scheme Lead. Using the term 'solo' is a something of a misnomer, as the SMPCETS is strongly supported by a National Consortium comprising all training centres, along with national oversight from NES and essential input from the Steering Committee. The collegiate nature of the scheme remains one of its greatest assets.

Key decisions and learning

What key decisions were required over the initial 12 months? We had to react very quickly to new ways of working in response to Covid-19, including taking several initiatives to ensure that trainees were supported appropriately. A month of additional funding was requested and approved by NES for all trainees, to help offset lockdown delays. Additionally, the requirements for innovation projects were relaxed slightly so that trainees were able to summarise their work in abstract form and deliver a presentation at the annual trainee symposium, rather than having to provide a full-length written report. Trainees were also invited to look back on their training experience by preparing an 'Individual Reflection of Readiness to Practice (IRRP)' statement, to be included as part of their AHCS equivalence portfolio evidence. This gave an opportunity for each trainee to focus on a final period of reflection, identifying which elements of training had gone particularly well and those that might benefit from further on-going post-registration support. The IRRP process has now been operational for two years and feedback from trainee cohorts has been extremely positive.

> **"It is important that we maintain a listening ear and support one another collectively as we recover from the pandemic."**

A big side-effect of Covid-19 has been the potential impact on mental health. The SMPCETS has kept fully engaged with its trainee network to identify any wellbeing concerns. It is important that we maintain a listening ear and support one another collectively as we recover from the pandemic. Following discussion with our External Training Advisor, I encouraged the adoption of regular three-monthly 'coffee break' meetings between trainees and their training coordinators at all training centres. These informal meetings have enabled trainees to discuss any aspect of their training or personal wellbeing as they journey through the scheme.

Another initiative tackled recently was to help our trainees understand the updated 2021 version of the Good Scientific Practice (GSP) guide. A very useful webinar was hosted by the AHCS where trainees had the opportunity to learn more and ask questions about the latest guidance. Wider training support has also been extended to include supervisors on the scheme, and the SMPCETS held an inaugural 'Train the Trainer' event earlier this year. This ensured that everyone involved in delivering training had an opportunity to refresh and optimise their supervisory skills.

The scheme will continue to evolve as we seek to maintain the highest quality training and education. Since the beginning of 2021 we have held two 'virtual' open days, with over 100 delegates at each event, and two successful annual trainee symposia hosted by colleagues in Glasgow. I have also spent time learning how to create web-pages and have set up our training scheme website www.smpcets.scot.nhs.uk which provides information about the scheme and acts as an access point to key documents.

There is a developing need to set up 'hybrid' approaches to training, where trainees are provided with experience in more than one specialism. Two examples where this could be useful are Radiotherapy and MRI, for radiotherapy planning; and Nuclear Medicine and Radiation Protection, for patient and staff dosimetry. Care will clearly be required to ensure that such training continues to satisfy GSP requirements as well as maintaining equivalence to the STP scheme. However, as workforce requirements evolve through the development of new methods and technologies, our training approaches will need to do the same.

In summary, I feel that my first year as SMPCETS Scheme Lead has gone reasonably smoothly. Where difficulties were encountered I received excellent support from colleagues, training coordinators, NES and our External Training Advisor. I am very grateful for their ongoing support.

One key learning element for me from the role is to justify decisions clearly, so that everybody understands how they have been made. Careful thought and communication of a clear rationale at the outset helps to keep everybody well informed and reduces the need for follow-up clarification work.

A final note

In my younger years, my father used to encourage me personally with the phrase 'Halfords Shop Window' - relating to the retailer famed for filling their shop window to 'bursting point' as a way of attracting potential customers. To me, the phrase 'Halfords Shop Window' is a simple metaphor for, 'Show them your very best'. I do like it as a personal reminder to give of my best and it is immensely satisfying when I see our trainees stepping up to do the same.

LEADING WITH COMPASSION IN HEALTHCARE SCIENCE

There is a sign in the hallway above the stairs in my home that reads, 'Dream until your dreams come true'. It has been there since I moved in, which was around the same time that my clinical histopathology career started taking shape. Ten years later I became one of the first people in the UK to gain the Royal College of Pathologists / Institute of Biomedical Science reporting qualification in gastrointestinal histopathology, and began working as a Consultant Healthcare Scientist. I would occasionally look at the sign to remind me of my dream to be part of the histopathology consultant team. Since completing my training, it has been an absolute privilege to undertake this role and it has been one of the biggest achievements of my career. However, there were also many challenges and barriers, which have taken years to overcome. As one of the first UK scientists to gain a consultant post in histopathology, I have had to work hard to prove my worth. Making extra efforts like this can weigh heavily on anyone – no matter how resilient and driven we might be.

The pandemic made me reflect on my career and start to think about how I want the second half of my working life to be. Reflection led me to seek self-improvement, partly to cope with the anxiety and stress that the pandemic was causing me and those around me.

In 2021, I decided to move away from front line clinical histopathology, where I had worked for almost 25 years. I started a new role in healthcare science education with the National School of Healthcare Science. I soon met many people with similar values to my own and I am embracing the career change, working collaboratively across systems and organisations with a wide range of partners. I continue to have the opportunity to understand myself and others better, so I can become a more rounded leader.

I believe that a fundamental aspect of effective leadership is compassion for yourself and others. Compassionate leadership starts with beginning to understand and explore your own personality and leadership styles. It was no surprise to me to find out that I have a reflective and introverted personality and transformational leadership style. Learning about our own style gives us better insight into what we bring to a team and, just as importantly, what others bring that we might not.

We know that good teams contain people with various strengths and weaknesses. To succeed, we must develop and use networks to give a voice and seat at the table to everyone irrespective of our differences, whether these be a protected characteristic or our professional background. There is a decreasing tolerance for outdated autocratic and hierarchical leadership structures and organisational practices, and understanding different styles helps team members complement each other rather than cause conflict. It is true that one person's weakness is another person's strength. Once I understood this, I began to feel more comfortable with my own style.

I am fortunate to work with a brilliant mentor, and I think that finding a mentor is one of the most self-compassionate and positive actions we can undertake. My mentor has never told me what to do but instead has asked enough challenging questions to help me work things out for myself, to the point where I can then take effective action.

For me, self-compassion has also been about realising and valuing my worth. This is surprising given everything that I have achieved, but my internal critic and external criticism can undermine my sense of worth, especially when working under significant pressure. This feeling can be exacerbated by a sense that where I have got to might not actually represent the dream I originally had.

Being self-compassionate involves aligning my daily professional life with my personal values, making those choices that fulfil and drive me the most. This helps build my confidence to know when it is time to make the next leap into the unknown. We always have the freedom to make new decisions, even when we think otherwise.

Over the last few years, I have become more interested in issues around equality, diversity, inclusivity, and well-being. Like many people, my interest comes from my own lived experience. I have sometimes felt excluded because I was 'different', whether that be in relation to my professional background or my reflective and introverted personality. I now understand that I have a Highly Sensitive Person (HSP) personality type, which means that I think and feel more deeply than others do in response to certain situations. This also means that I am effective at listening to and supporting others as they seek to work through challenges and achieve their own goals and dreams. I realise that what I was often told was my weakness is in fact my superpower!

I have also learnt to recognise and manage anxiety and stress. I think this is important for us all, especially

during challenging times. We can do this by creating a personal 'stress signature' where we identify emotional, behavioural, and physical signs of anxiety and stress. We can then create a personal toolkit to maintain our wellness, containing whatever works for us, whether it be exercise or a mindful practice such as yoga. Looking after ourselves means we stay well and support others better.

Compassionate leaders should always strive to learn. Each of us goes through different challenges and experiences, and consequently we cannot fully understand another person's situation. We all demonstrate bias, which can relate to race, sex, family circumstances or professional background. We never know what stress another person is carrying, their 'invisible backpack', but as leaders we do have a responsibility to actively listen, understand and act, if and when asked. I believe that good leaders do the right thing when nobody is looking, are quiet allies, and fulfil their commitments. This creates trust and psychological safety, which is important when developing professional relationships. It especially matters when we are in a position of hierarchical power, because we speak from a platform. We have a responsibility to use our influence and power for positive change. This includes creating an inclusive workplace, supporting those who need our help by providing them with psychological safety, and reducing our own and others' biases wherever possible.

The last two years have seen unprecedented change for many of us. I have realised that I was wrong about my dream. I had thought my career was about gaining a qualification and finding a specific role. In fact, it is about aligning my life and work with my values to find my true purpose. I have learned and gained so much over the last few years, and I look forward to seeing what my professional future holds next. Whatever it is, I plan to do it with compassion towards myself and for those I support. I encourage you to do the same.

Dr Jo Horne

Training Programme Director and Midlands Dean for Healthcare Science at the National School of Healthcare Science, and Lead Practice Educator for the Southern Counties Pathology network

INCLUSIVE LEADERSHIP IN HEALTHCARE SCIENCE: WHY DOES IT MATTER AND WHAT CAN I DO AS AN INDIVIDUAL? AN LGBTQ+ PERSPECTIVE

In her article ***"Diversity Barriers to Leadership in Healthcare Science: 'you can't be what you can't see'"*** Arthi Anand explains beautifully the need for visible, diverse leadership in Healthcare Science and presents sound practical methods for developing this [1]. The approaches that Anand describes sit primarily at an organisational level. This article focuses instead on inclusive leadership from the point of view of an individual: specifically, based on the experiences, mistakes and personal reflections of a member of the LGBTQ+ community. The challenges faced by LGBTQ+ leaders in providing visible leadership will be considered in a subsequent article.

In order to provide inclusive leadership, it is necessary first to understand why you need diversity. As Ruth Hunt, former CEO of Stonewall, points out:[2] 'if you don't understand why diversity matters to you then you are unlikely to succeed in generating an inclusive workforce'. Clearly, there are powerful moral reasons to increase diversity. There are also practical ones that are of considerable importance in Healthcare Science [3], such as improved workforce supply and the positive effect diverse teams have on innovation and performance.

The powerful impact of visible diversity on minority groups is explained by Ruth Hunt when she says that people look to work in organisations where they feel they will fit [2]. Arthi Anand in her article describes the personal consequences for her as a BAME person of not fully fitting into the workplace: 'I also found it necessary to downplay aspects of my cultural identity...' [1]. Remove the word 'cultural' and you have a sentence that also describes the experience of many LGBTQ+ employees.

The second step to understanding inclusive leadership is to understand what is meant by the term 'leader'. Its definition varies with context and is often confused with 'management' or associated with specific roles: we often talk of preparing people for 'leadership' roles.

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In my own experience, leadership is about empowering and enabling others to perform to the best of their abilities within a set of constraints. I also see leadership as being more of a strategic function, whereas management tends to be more operational. It is not necessary to be in a formal leadership role to be a leader, as true leadership is not about authority, control or power. The only way to gain respect is to earn it and, once earned, it can be lost very quickly. In other words: anyone can be a leader at any time.

The third step to inclusive leadership lies at a personal level and is arguably the hardest, to develop a deep understanding of yourself. I am not quite sure what experience cis-straight people have of doing this but I can say that the majority of LGBTQ+ people at some point in their life have had to question themselves at the most fundamental level, as part of understanding their own identity. As I have no point of reference for this, I cannot say whether this makes it easier or harder to develop self-understanding for LGBTQ+ people than cis-straight people but I do know that self-reflection is key.

For a surprising proportion of my own life, my self-understanding was extremely limited. I understood that I was different, but did not know why or have any words to express that difference. It was clear that this difference was bad, shameful and not something that should ever be spoken to a soul. Once I did understand myself and realised that there were other people like me and that I had no reason to be ashamed, despite the general consensus at the time, it enabled me to be very clear about my values and what mattered to me as an individual. It will probably come as no surprise that equity, kindness, inclusion and integrity come high up my list.

However, when it comes to leadership, it is not sufficient just to identify values. You have to live them and apply them consistently. Do otherwise and any credibility that you might have disappears in an instant. The problem is that you will be directly and repeatedly challenged on your values, and sometimes the right or fair thing to do is neither what you want to do nor what other people want you to do. Hence, a good dose of resilience can be useful.

Another part of developing an understanding of yourself is to have a good understanding of your strengths, weaknesses and skills. Our skills and strengths develop through life and through experience. This is where a diverse leadership group can prove advantageous, as people develop different skill sets from common experiences.

An anecdotal example of the development of differential skills was used in a leadership programme for LGBTQ+ leaders. It highlighted their ability to read a room. Now, I did not really know that this was a skill. I thought it was something everybody did but apparently there are whole books written about it. Why should LGBTQ+ people have better room-reading capabilities than the general population? The answer is that they have developed this skill out of necessity. When they walk into a group of people, they need to know whether or not they are in an accepting and safe environment. Consequently, they have learnt to rapidly sense the mood of those around them.

Having identified your values, strengths and weaknesses, the next step is to look at your biases and make sure that you can recognise when they are active, both in yourself as well as in others. This can be hard to do objectively but there are tools such as the Harvard University Project Implicit tool which can help you identify your own biases [4].

Many forms of human bias have been identified but some are particularly relevant in a leadership context [5]:

- Affinity bias, the natural tendency to engage with people who are similar to us;
- Confirmation bias, the tendency to consider only evidence that confirms our beliefs about our own social identity; and
- Perception bias, where assumptions and stereotypes about a given social group obstruct objective judgement of that group.

The final step, and perhaps hardest of all, is to identify your privileges and be prepared to use them to help others who may not be so advantaged. When I undertook this exercise on myself I started with the obvious privileges – I am white, male and cis-gendered. However, I was surprised at how many more I could identify and

benefit from. For example, I have educational privilege in that I have degrees enabling me to work as a Healthcare Scientist. This means I have a salary, somewhere to live and, most of all, the benefits obtained simply by having an address. And I am indebted to other people for many of the advantages that I have gained.

The above steps are not a recipe for inclusive leadership but are topics which I continue to find useful. I revisit them surprisingly often. What I think the above steps show, however, is that self-reflection is absolutely critical to developing the skill set you need to be an inclusive leader. It is important to recognise too that there will be occasions when you just get it wrong. Again, reflection is key and, in my experience, these are the occasions when you are able to gain a better insight into yourself.

Glossary

LGBTQ+: Lesbian, gay, bisexual, transgender, queer or questioning, and the whole spectrum of queer identities. For a more detailed definition of LGBTQ+ terms, see for example: https://ok2bme.ca/resources/kids-teens/what-does-lgbtq-mean/

Cis-: Refers to a person whose gender identity and sex assigned at birth are the same. The word cisgender is the antonym of transgender.

Straight: Having an attraction, either sexual or romantic, to a gender other than one's own.

BAME: Of a person, that they identify as being of Black, Asian or Minority Ethnic heritage. This term emphasises certain ethnic minority groups (Asian and black) and exclude others (mixed, other and white ethnic minority groups). This and the term BME can also mask disparities between different ethnic groups. In March 2021 the Commission on Race and Ethnic Disparities recommended that the government stop using the term BAME and instead refer to individual ethnic minority groups.

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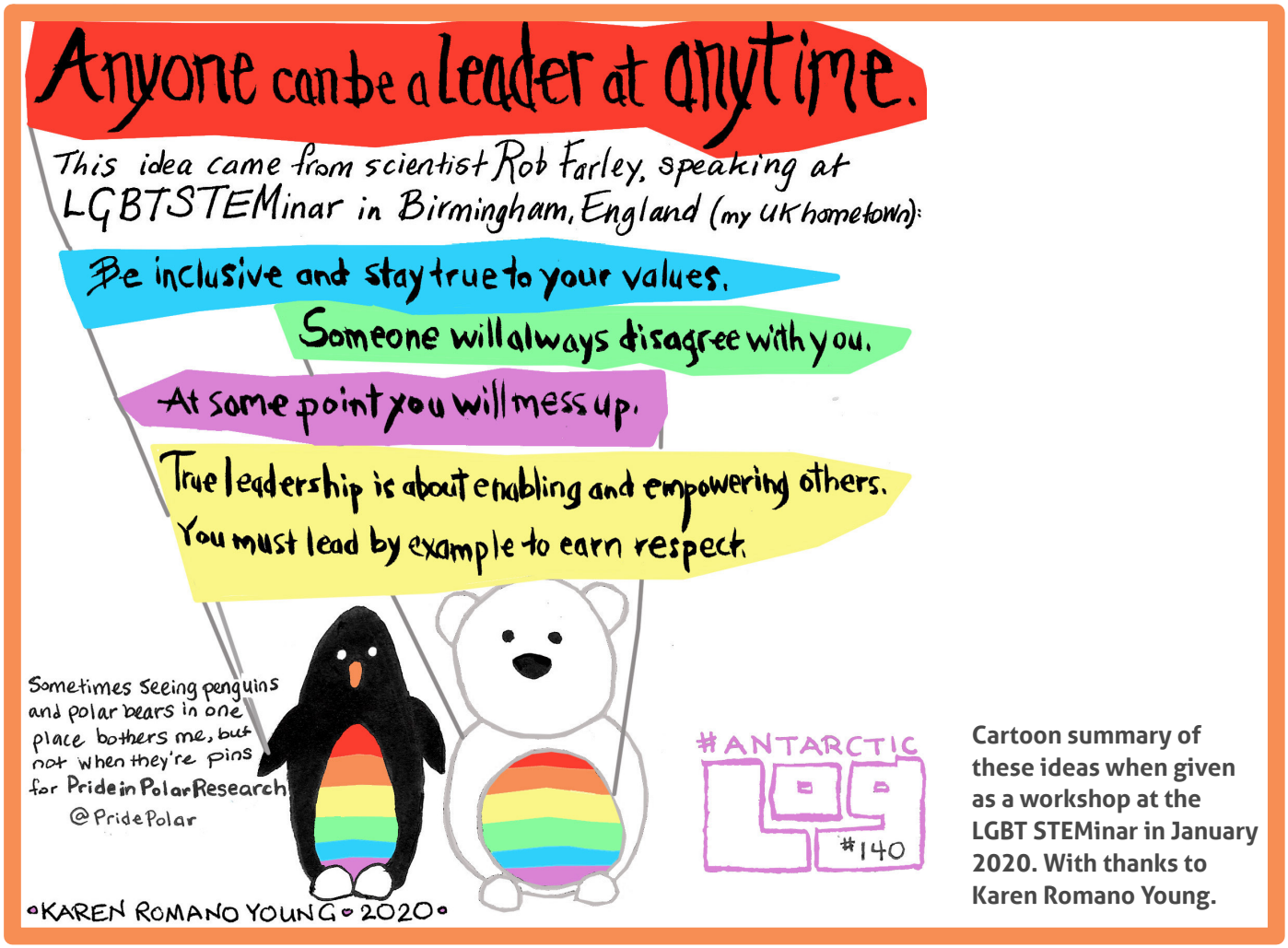

Cartoon summary of these ideas when given as a workshop at the LGBT STEMinar in January 2020. With thanks to Karen Romano Young.

LEADERSHIP FOR ORGANISING CARE AROUND PATIENTS: NAOMI CHAMBERS AND JEREMY TAYLOR HIGHLIGHT ISSUES FOR HEALTHCARE SCIENTISTS IN THE CONTEXT OF CURRENT CHALLENGES FACING THE NHS

Introduction

"The NHS belongs to the people... It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most." [1]

The arrival of Covid-19 in March 2020 was a 'stop' moment for the NHS, and particularly for healthcare scientists. The service had to pivot immediately – to prevent hospitals being overwhelmed by seriously ill and dying patients, implement large scale testing and sequencing as well as galvanise the biggest ever vaccination programme. This pandemic has been an opportunity for the 'creative destruction' [2] of arcane systems and processes. This unfreezing of the old ways of doing things [3] offers a policy window [4] to imagine the reorganisation of healthcare around patients.

We draw from a recently published book [5] that uses a series of patient stories to find out what matters to patients and explore how the gap between rhetoric and reality can be closed. Our findings show there is more to be done to meet the aspirations of the NHS Constitution. Five clear themes emerge from these stories: the importance of kindness, attentiveness, empowerment, and professional and organisational competence. These add to our knowledge about how leadership can enable patient-centred care.

How well does the NHS perform in relation to patient-centred care?

The creation of the NHS in 1948 was such an important advance in social welfare that it has taken decades for a progressive critique to gather force. Healthcare provision expanded and became more technocratic as Britain moved away from its post-war austerity. There was growing discontent with both medical paternalism and bureaucratic indifference to people's rights.[6]

There are a number of ways to frame patient-centred care. These include understanding and acting on what matters to patients; seeing the whole person; respecting patient autonomy; having an inclusive rights-based approach; and being customer focussed.

Official data and assessments paint a mixed picture of how far these characteristics are reflected in healthcare practice. The Care Quality Commission (CQC) considers most care to be of good quality but also highlights a number of continuing concerns:

- The poorer quality of urgent and emergency care in comparison with planned interventions
- The need for care to be delivered in a more joined-up way
- The fragility of adult social care provision
- The struggles of the poorest services to make any improvement
- Significant gaps in access to good quality care, especially for mental health
- Persistent inequalities in some aspects of care [7]

These deficiencies partly reflect financial pressures and workforce shortages within the NHS. However, leadership and management also play a part. As the CQC has noted, services that improve tend to have leaders who are visible and accountable to staff, promote an open and positive organisational culture and engage effectively with others to provide joined up care.

The charge is that the NHS remains stuck at best on the middle ("tokenism") rungs of Arnstein's ladder of participation, depicted in Figure 1 below.[8]

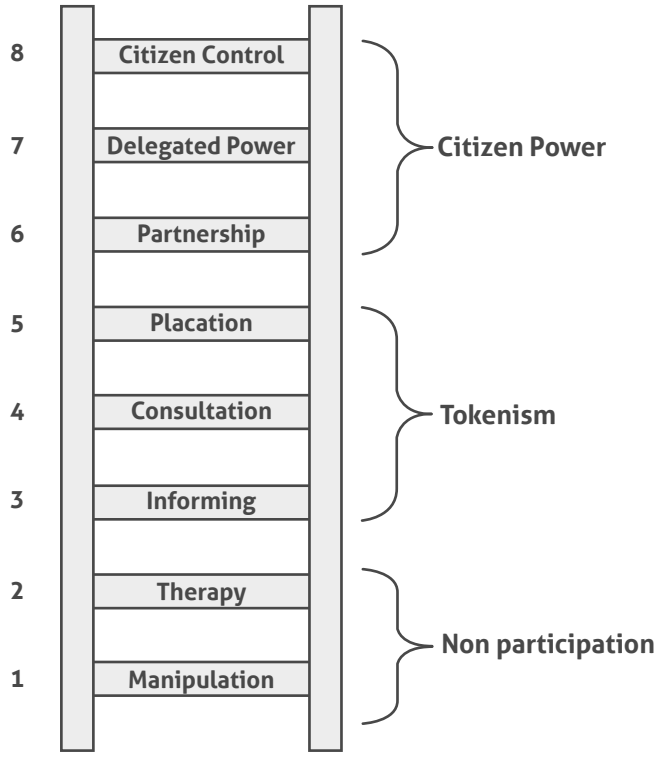

Figure 1: Arnstein's ladder of participation (1969)

Given this state of affairs, two overarching questions present themselves. What matters to patients about how their care is organised? And what can they teach policy makers about how to reframe the NHS? Hearing from patients about what already works well for them, and how things can be done differently, struck us as the most suitable approach to begin to address these questions.

Storytelling draws on lay wisdom to generate new understandings. While in contemporary culture we often associate story with entertainment, it has always served other purposes. Lugmayr and colleagues discuss the concept of 'serious storytelling' in which the power of narrative, by conveying experience and triggering emotional responses, is used to achieve socially important goals.[9] The Victorian physician, Osler, was an early enthusiast for hearing the patient story: "Just listen to your patient, he [sic] is telling you the diagnosis".[10] It is now considered good practice to start board meetings in NHS organisations with a patient's story in order to keep discussion grounded in what matters at the front line.

For our book we sourced 25 stories from people with experiences of the NHS in England from as wide a range of backgrounds as possible. We used a variant of the biographic narrative method [11] to encourage people to tell us their story in their own way, which was often 'from the beginning', with only minimal prompts.

Findings

The stories surface key themes: the importance to patients of continuity of care, openness in learning from mistakes, actively managing expectations, communicating complex information and the mental toll of long-term physical conditions. Recurrent themes also included discrimination and variation in the quality of patient experiences of care. We present below a selection of examples of findings based on these core themes. Note that all names have been changed.

In maternity services, continuity of care was confirmed by Cathy as really important, especially in the antenatal period:

'....All my midwife appointments before I had my son were excellent because I saw the same person every single time. And having talked to a lot of other people about that, they saw a different midwife every single time. I felt like I had a real bond with the midwife, she made me feel very comfortable...during my pregnancy I lost one of the twins...I was therefore very anxious about the process and she was fantastic at reassuring me the whole way through...' [Cathy]

Unfortunately, Cathy acquired sepsis during childbirth. It was missed at first and diagnosed late, and there was a further delay in heeding her preference for an epidural. To make matters worse, the epidural then did not work and had to be reinserted four times. But in terms of openness when things go wrong, Cathy was heartened by the subsequent behaviour of the anaesthetist:

'....The next time the anaesthetist was on shift, she came in to find me on the postnatal ward and asked if we could go through what went wrong...She'd been feeling absolutely dreadful about it... it was good to know that she was using my experience to reflect on current practice and learn what could have been done differently...' [ibid].

When there are delays during the course of diagnosis and treatment, actively managing expectations emerges as another important theme. Eileen's teenage son Finbar had scoliosis:

'...The care has been good....it's just the long wait...and to see him in pain...for the initial appointment with the paediatrician, I had to contact them about three or four times because they didn't have any appointments...I [also] did chase quite a few times for the results of his X-ray and I'm chasing now to find out where he is on the operating list...' [Eileen]

Absorbing complex information can be hard. Jonathan's son, Dan, was admitted to hospital during the Covid-19 pandemic with a life threatening bacterial infection:

' ...It was quite a bewildering and anxious time...there's an awful lot of information to absorb...They were very good at doing their best to convey lots about what they thought was happening but it was very difficult to make sense of.... there was almost too much...' [Jonathan]

The mental toll of long-term physical conditions came across strongly. Katie has had Type 1 diabetes for 25 years which has affected her ability to work and she has suffered a range of difficult and painful complications. Like Cathy, Katie valued the continuity of care, in this instance as given by her general practice, but as she puts it:

'....Because of everything that I've got wrong with me I get very depressed....a few years ago I was actually sent to see a psychiatrist and he was very, very good...and I really wished I could go back, to be honest....I'm not going to get better. But just having somebody to talk to...' [Katie]

Examples of racist attitudes were not uncommon. Rabiya

CONT...

cares for her mum, who has early onset dementia. As a Muslim Asian woman, Rabiya related multiple experiences of discrimination:

'...It was very difficult to get a diagnosis...it took two years... first, all the tests were done in English and it was, well, you can't translate for your mum because you are a relative...it took ages to organise a translator...Eventually we found a consultant who was willing to take us a little bit seriously... our GP was not willing to listen to me and I had to bypass him...I feel like I am fighting the system all the time...' [Rabiya]

Lucy has suffered from severe mental ill health from her teenage days. Even as a healthcare professional herself, she has not always found it easy to get the right care:

'...Since the late 1990s to the present, I've been under the care of a psychiatrist....I've been very fortunate in that... I know there are lots of people like me who would only have seen a GP so I am really lucky.....I negotiated the [specialist] treatment myself.....there's this stupid delusion that somehow everybody gets the same care, and they don't...' [Lucy]

And then Lucy found herself hospitalised with sepsis, which was diagnosed straight away in A&E. But the only bed they could find for her was on an older persons' ward:

'... When we went up there, the person hadn't left their bed and I was left sitting in a chair with no headrest for two hours.... the ward was just awful. It was dirty and they were not very nice people.... they would come and get you out of bed in the morning and make you sit next to the bed until they remade the bed, which was like two hours, and I was really ill and it was horrible. Anyway, after a week, they needed that bed, so they moved me to another ward....and that was completely different. That was run and organised like a ward when I was a medical student. It had a sister who came round to check if everything was alright, and in the morning they said, would you like us to refresh your bed, and they did, and I was able to get out and get straight back in. People came and did everything at the right time...' [ibid]

Discussion

The general tenor of these stories is consistent with the picture painted by the CQC. Whilst most care is good, poor experiences arise from difficulties in access to care, uncoordinated services, people having to 'chase' to get the care they need, problems with information and communication and variation in the quality of care on offer. This study confirms that there is a way to go before we can say that the guiding principles of the NHS Constitution are being consistently upheld.

From immersion in these stories and thematic text analysis, we identified five dimensions of care that support not just patient-centred care but also care organised around the patient. These dimensions are: kindness, attentiveness, empowerment, professional competence and organisational competence. These are depicted as five pillars in Figure 2 below, emphasising that all five are needed to create a firm foundation for quality healthcare.

The first theme is kindness. In the stories, professionals demonstrated kindness when they believed their patients, were generous with their time, rang them at home, conveyed warmth and refused to give up on them. They understood the impact of delays and mistakes in diagnoses. By contrast, casual instances of unkindness and thoughtlessness were very hurtful.

The second theme is attentiveness. This requires listening and observing closely, focussing on the person as well as on their illness. It might include keeping an open mind

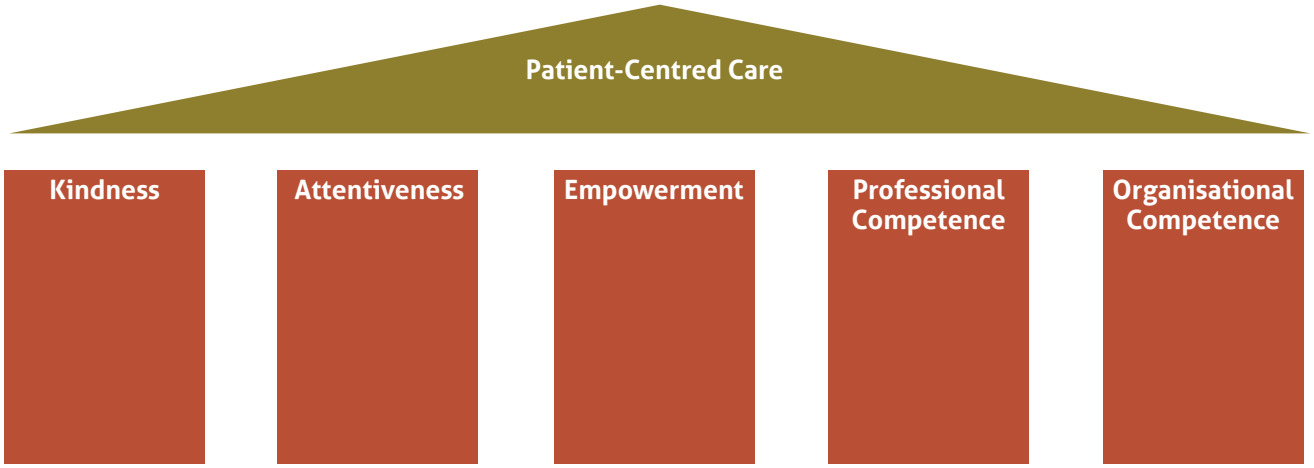

Figure 2 Proposed framework for well organised care around patients (Chambers & Taylor, 2021)

about diagnosis. Patient narratives indicate the importance of picking up on cues as to whether patients would prefer a relaxed or a more formal style of communication and when there might be dissent amongst family members.

The third theme is empowerment. There is often a power imbalance between the professional and the patient. A key determinant of this is asymmetry of information. The clinician has technical knowledge, expertise and practical experience that the patient cannot match. On the other hand, the patient has expertise and knowledge about their life and about living with particular conditions. So, who is the actual expert here?

Another important dimension of the power dynamic is that many people's experiences of ill health and of care are overlaid with bias, stigma and exclusion as a result of their condition, ethnicity, age or other characteristics. Some of our stories touch on these issues and the intersections between these areas of discrimination.

The fourth theme is professional competence. It is clear from these stories that perceptions of competence are highly important for patients and link to the other themes of patient centricity. Delays in diagnosis are distressing for patients for obvious reasons, whereas patients can be surprisingly forgiving of errors made in good faith. A common theme of some of the stories was the feeling of not being listened to when the patient knew that something was wrong.

The final theme is organisational competence. The first four themes are very much to do with the personal values, behaviours and skills of individual healthcare professionals. Individual caregivers, however, work in organisations and systems of care. The extent to which their kindness, attentiveness and other qualities can cut through and make a difference is influenced by the efficiency, accessibility and responsiveness of the wider system. These stories frequently tell of examples where the patient, or their carer, needed instead to 'work the system' to coordinate the care required.

Conclusion

The proposed framework, with its five dimensions of care organised and centred around patients, is drawn from textual analysis of these 25 stories. The framework goes further than the current discourse around patient-centred care by suggesting that, as well as kindness, compassion, attentiveness and empowerment, patients also expect the system to attend to issues of professional and organisation competence.

We would argue, therefore, that there is sufficient material here to create a call to action for leadership policy and practices to focus more on organising care around patients. Paradoxically, current circumstances under which the NHS is stretched as never before present a unique moment in which this issue could be tackled. The formal establishment of Integrated Care Systems (ICSs) in July 2022 provides a readymade governance vehicle. There is a realisation that the service can no longer improve by simply doing more and faster, with ever more burnt out staff. Osler's injunction to listen to the patient, because they are telling you the diagnosis, still holds true.

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A CALL TO ACTION – A REVIEW OF THE CONTRIBUTION OF PUBLIC NARRATIVE AND SOCIAL MOVEMENTS FOR HEALTHCARE SCIENTISTS IN THE NHS

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A Call to Action

A young, fit and healthy female fell, damaging her ankle and sustaining a nasty cut to her leg. A few days later the injury worsened and she began to feel unwell, with the area around the cut becoming swollen and painful. She was prescribed a course of oral antibiotics by her GP and her wound was tested for infection. Her leg did not improve on first line of antibiotics and tests showed her leg was infected with methicillin resistant Staphylococcus aureus (MRSA). This superbug is resistant to several commonly used antibiotics. The patient was admitted to hospital, had her wound cleaned in theatre and started a second intravenous course of different antibiotics. Whilst receiving this round of treatment, a further infection emerged and she had to have a third course of antibiotics. In total, it took six weeks for this patient to recover and for the infection to be eradicated.

The patient commented that she had no idea that a 'simple' infection could affect her quality of life so much, preventing her from carrying on her normal life as well as leaving her feeling tired and unwell. She never thought infections could be so significant. She went on to question – "What if the antibiotics had not worked? What if there had been no antibiotics at all?" These are frightening thoughts.

The spread of antibiotic resistance has given rise to 'superbugs' such as MRSA. These bacteria are difficult or impossible to treat with existing drugs and a rise in resistance has depleted our armoury. We are falling further behind in the fight against serious infections such as pneumonia and TB. Without effective antibiotics, we cannot support patients receiving chemotherapy who are susceptible to infections. Without antibiotics, routine surgical procedures such as organ transplants and caesarean sections would carry an increased risk. Without antibiotics. more than three million surgical operations and cancer treatments a year could become life threatening.[1]

Antibiotic resistance is a global problem. It does not respect borders, cultures, gender or wealth. It is everyone's problem, both complex and multifaceted. One crucial action we can take is to raise public awareness and understanding. Patients must be encouraged to change behaviours, including taking antibiotics as prescribed. We must support clinicians to stop unnecessary, inappropriate and 'just in case' prescribing of antibiotics. These steps can slow antibiotic resistance.

I want my children to grow up in a world where they have access to antibiotics that cure common and life-threatening infections. My 'call to action' is to get individuals involved in the national Antibiotic Guardian (AG) Campaign in order to help keep antibiotics effective and life-saving (www.antibioticguardian.com). This campaign aims to generate collective action. It invites the public, students and educators, farmers, and the veterinary and medical communities to become Antibiotic Guardians and act now to slow the spread of antibiotic resistance. This ongoing campaign seeks to build sustainable behaviour change through education and invites individuals to commit to deliver a pledge. Over 150,000 people have signed up and the total continues to grow. Pledges can either be selected from a list of pre-written commitments or crafted individually. They aim to deliver appropriate and maintainable actions within different groups (see Table1). Where could you start? Will you visit the website and educate yourself about antibiotic resistance? Will you prepare your own pledge? What will you do to stop antibiotic resistance?

Table 1 Examples of pre-written pledges
(adapted from the Antibiotic Guardian website accessed 21/02/2022)

For adults and families
• For infections that our bodies are good at fighting off on their own, like coughs, colds, sore throats, and flu, I pledge to try treating the symptoms for five days before going to a GP
• It is vital that we prevent antibiotics from getting into the environment. I pledge to always take any unused antibiotics to my pharmacy for safe disposal
• If the NHS offers me a flu vaccination, I pledge to accept
• Sing the ABC song when washing our hands with soap

and water. Washing hands properly (for at least 30 seconds), especially before eating, is the single best way to prevent the spread of infections and keep your family healthy

- If anyone in my family is prescribed antibiotics, I will ensure that they are taken exactly as prescribed and never shared with others

Public Narrative and Social Movements

The preceding public narrative on tackling antibiotic resistance is an example of a 'call to action' designed to initiate a social movement for change. Public narratives can be a powerful leadership tool for capturing attention and motivating others to join a collective action. Storytelling has been widely used in organisations to elicit moral and emotional responses. Stories can make complex topics easier to understand and bring the message to a wider audience. Public narratives tend to hit harder and leave a longer lasting impression than managerial approaches quoting statistics, data and evidence.

The construction of public narratives is an exercise in leadership, motivating others to join in our shared action. Public narratives involve the story of self, the story of us and the story of now (see Figure 1). In addition, public narratives must be strategic stories laying out clearly the action that must be taken and what goals are to be achieved.

Figure 1. The story of self, the story of us and the story of now based on the work of Marshall Ganz [2]

Social movements are made up of individuals working together towards a common goal. They have driven transformational change throughout history. Well-known social movements include Black Lives Matter, the American Civil Rights movement and UK Occupy. Within the NHS several social movements have been highly successful, such as the campaigns around COVID vaccination and #Hellomynameis.

Social movement theory has evolved over time. Paradigms have come in and out of favour but common themes link the different theoretical stances. It is now accepted that no one factor precipitates collaborative mobilisation but that it comes from an amalgamation of emotional, cultural and structural factors that inspire and motivate collective action.[3] Bate et al list six groups of factors that contribute to an individual joining a movement (Table 2). The closer individuals' meanings, values, identity and lived experience align with those of the movement the more receptive they will be to change and to join, invest emotional energy and participate in a collective action.

Table 2. Summary of six factors that explain why an individual may join a movement (adapted from Bate et al 2004)

Factor	Summary
Rational	• Logical • Reasonable thing to do • Self-interest
Emotional	• Strong, positive emotions • Commitment-based • Affiliation • Caring
Social and Normative	• Widely shared values • Shared aims • Social networks, collective identity • Narrative fidelity
Behavioural	• What people 'do' inside the movement • Participation in movement-related activities - enactment • Reinforcing shared values, beliefs, emotional commitments
Organisational	• Dedicated roles, leadership, co-ordination • Financial, time, and human resources • Safe spaces to express hopes and worries

Application to the NHS

It has been proposed that existing NHS quality improvement approaches would be substantially developed and extended if they incorporated elements of social movement theory, to help draw additional energy, passion, and support from stakeholders.[4]

Existing 'top-down' improvement strategies rely on planned, incremental change programmes striving to 'motivate' individuals and 'sell' the change. In contrast, social mobilisation engages and empowers individuals to facilitate 'bottom up' change. This has the potential to achieve wider and deeper outcomes and participation in service improvements by tapping into unrealised potential at all organisational levels, from the hospital floor right up to the board room. A summary of the differences between these two approaches is shown in Table 3.[5]

Looking again at the example of antibiotic resistance, it is clear that organisational mandates and government strategies to tackle the problem can get some traction. However, social mobilisation and collective action could achieve more extensive behavioural change. A practical application of the public narrative outlined above would be to present on the topic at a Trust board meeting, encouraging the board to make individual public pledges to reduce antibiotic resistance while also urging other stakeholder groups to make and act on further pledges.

Table 3 'Top-down' and social movement approaches to change

'Top-down' approach	Social movement approach
• Planned centrally led programme of change programme • Incorporates milestones and goals • 'Motivating' people • Driven by an appeal to 'what's in it for me' • Involves 'overcoming resistance' • Change involves leaders and followers. Change is done 'to' people or 'with' them • Driven by formal systems and processes	• Change is about releasing energy and is self- directed • 'Moving' people • There may well be personal costs involved • Insists change needs opposition –it is a friend and not an enemy of change • Individuals change themselves and each other on a peer-to-peer basis • Driven by informal systems

Evaluating the usefulness of social movements in healthcare

Integrating social movement principles into the NHS could encourage change to occur in a grassroots and sustainable way, engaging the energy, passion and support of NHS workers and the public. As exciting as this approach seems, there are limitations.

Most notably, these ideas cannot be used as an everyday method of driving change within healthcare. It would be exhausting to frame every proposed development with a public narrative, then to seek out and recruit others with aligned values and experience to the cause. That said, it is a great tool to have in the arsenal to use in more challenging and complex situations.

Social movements can also be self-organised, unpredictable and move in an uncontrolled direction. The NHS is more likely to be comfortable with 'orchestrated social movement', where managers and policymakers work together with clinicians and frontline workers to utilise its tools in order to gain engagement, tap into individual passions and energies, and encourage people to take responsibility for change.

Many healthcare science roles incorporate both professional action and managerial responsibility. Healthcare scientists are ideally placed therefore to empower and motivate others, and to lead sustained collective action and improvement within the NHS. They are also well positioned to modify and moderate 'top-down' change ideas into an appropriate narrative that aligns others with the proposed improvement. Good leadership and framing from clinical leads can convert peers and help to create a critical mass of support for sustained change.

Public narratives are powerful framing tools that have much to contribute to organisational change. I feel that 'storytelling' is a powerful tool to help healthcare scientists reach others with similar values and beliefs. Motivating change by targeting values that others feel strongly about makes an improvement seem more appealing and less like yet another task being added to an already busy workload.

Through my research and reading for this article, I have concluded that existing 'top down' approaches and social movement principles do not have to be mutually exclusive. It does not have to be one or the other. There is potential to harness both techniques to achieve NHS improvements. I also believe that social movement principles 'add value' and can help NHS leaders propagate a movement mentality that will expedite long term NHS change.

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MY CAREER PATH: FROM LABORATORY TO HEALTHCARE SCIENCE PROFESSIONAL LEAD

Sarah Smith, *Healthcare Science Professional Lead NHS Lothian and Scottish Government Professional Advisor (Workforce and Education)*

I began my leadership journey as a Trainee Medical Laboratory Scientific Officer at the Scottish National Blood Transfusion Service (SNBTS). After early experiences with out of hours shift rotas and learning from my peers I moved into a specialist role set up by SNBTS and Diagnostics Scotland, as the very first East of Scotland Procurement Co-Ordinator. This post involved persuading Scottish donors to give some of their blood to create reagents used in testing both patient and donor blood groups. I had to set up a targeted donor recruitment programme, and in doing this learned much about leadership and management from the experienced team working around me. The Procurement Coordinator role also provided my first steps into training delivery. I spent many months travelling around the East of Scotland holding information sessions and meeting many of the donors I had recruited into the programme. As a result of this experience I decided to enrol for the Specialist Transfusion development programme, which had a dedicated module on leadership.

> **“ Working between two roles is difficult, especially when trying to prioritise ”**

I thoroughly enjoyed the training element of my role and began to explore other local training opportunities within SNBTS. My colleagues encouraged me to become a mentor and I began to work with and shadow training officers. I mentored trainees as they developed their registration portfolios. This cemented my career direction, particularly when a new opportunity came along to apply for a Laboratory Training Manager post in the NHS Lothian health board.

I look back on my first year as a Training Manager with mixed feelings. It was extremely challenging to be working in a role that was so much bigger than my previous ones. I had to learn rapidly how my new organisation functioned and faced situations completely new to me. However, I found support and direction to help me through these challenges both from my peers and through the local leadership and management training programmes offered within the Board.

Throughout my years working with laboratories, I have undertaken several training qualifications and completed an MSc. I was strongly supported to develop my leadership skills and this has enabled me to think out of the box and move into more strategic roles. My leadership style is one of inclusivity – I encourage my team to challenge themselves, provide them with opportunities and mentor them to ensure that they are ready for their next role.

Shortly after I started with NHS Lothian in 2007, the Scottish Government published ‘Safe, Accurate and Effective – An action plan for Healthcare Science.’ One of its recommendations was to develop Board-specific Healthcare Science (HCS) Education and Development Leads. In 2009 I successfully applied for one of these positions with NHS Education for Scotland, covering both NHS Lothian & NHS Borders. This 18-month part-time secondment was pivotal in changing the direction of my career. Working across two NHS Boards challenged me in new ways. I worked further on my existing leadership skills in areas such as collaboration and negotiation, and also developed new ones –with listening becoming a key focus!

During my first secondment I joined the local area HCS forum and, with others, became a champion in promoting HCS professions, leading on and participating in multiple conferences and events. These activities consolidated my leadership skills and boosted my confidence. In 2011, I became vice chair of the forum leading on the life sciences.

In 2016, I took over as Chair of the local area HCS forum. I was also successful in getting a second secondment as HCS Professional Lead, a new role for NHS Lothian and one of only three established in Scotland. This became permanent in 2018. The last five years has been a rapid personal leadership journey for me!

...CONT

I held this secondment in conjunction with my substantive post as Laboratory Training Manager, and flexed my time between the two. Working between two roles is difficult, especially when trying to prioritise your workload while operating at two different levels. I did struggle with this when I first came into post and was grateful to be offered executive coaching sessions through which I learned more about myself and how I react in various situations. Coaching was something that I had never encountered before but it provided me with a set of tools that I frequently return to, especially in times of self-doubt when "Imposter Syndrome" strikes. I would recommend coaching to anyone who has a strong desire to grow and learn.

Due to the various posts that I have held over the years, I have become a point of contact for many individuals who have a strong desire to develop themselves within the HCS community. I welcome this and ensure that these individuals are supported, mentored, and encouraged along whatever route they wish to follow. Developing a network of like-minded people is pivotal in raising awareness of HCS, ensuring that we have a constant stream of Healthcare Scientists who want to take the next step in their leadership journey.

In September 2021 I gave up the Laboratory Training Manager role to accept a secondment with the Scottish Government as Professional Advisor (Workforce and Education). I now juggle my time between fulfilling my government role and being a HCS Professional Lead. Although there is much more alignment between my current roles, at the time of writing I am only a few months in and beginning to realise I am on yet another leadership journey.

Reflecting on my career to date, I realise that I have taken up training and employment opportunities whenever they presented themselves. However, alongside this I have met and worked with key individuals who encouraged and motivated me to go further. In Healthcare Science leadership training is critical to any role but I have found it comes in many guises: not just through courses and programmes but via input from your peers and colleagues as well.

REFLECTIONS ON LEADING A PROFESSIONAL BODY THROUGH THE PANDEMIC

Which Professional Body are you involved with?

The Institute of Medical Illustrators (IMI). Originally founded in 1968, it is the professional body of choice for every medical illustrator and the leading such body in Europe. IMI represents clinical photographers, graphics designers, medical artists and videographers working in and supporting those who work in the healthcare team, to benefit patients and clients.

When did you become a member?

I have spent my whole career in the NHS, working mostly for University Hospitals Birmingham. I joined IMI early on when I was running a single-handed unit, and greatly valued the opportunities it gave me to talk to fellow professionals across the UK. At my first conference I met a huge variety of people providing similar services throughout the UK as well as Europe, the USA and Australia. Many have stayed friends for life. Before I went, I could not have believed that anyone could possibly find enough to talk about for three days solid – morning, noon and night. But we did and still do!

What has your involvement been?

I have held several roles within the Institute. I am passionate about what I do and believe strongly that the more you put into something, the more you get out. So I encourage other members to volunteer time and energy into supporting IMI. What they achieve also enhances their CV.

What happened when the pandemic arrived?

At the beginning of 2020, having only been in the Chairman's role for a few short months, I sent out messages encouraging all our members to use the IMI's network of contacts to help get them through the challenging weeks and months ahead.

Clinical photographers found themselves at the forefront of the tele-dermatology revolution, videographers were thrust into an avalanche of new work as training went completely online, and graphic designers were overwhelmed with the creation of Covid-related material of all kinds. Everything was changing rapidly and needed quick turnrounds.

Was it difficult?

Yes. Every member struggled with their own professional and personal circumstances. Some departments were displaced, as accommodation was converted to make extra ward space. It was distressing as chairman to hear so many different stories and have only a limited ability to help.

During the pandemic, many commercial businesses faced challenging times and some did not survive. One of those

was IMI's web developer, who had created not only our site but hosted it as well. With very little notice, we moved webhosting to another supplier to provide a bit of stability while we went through the tender process to find a new provider.

How did the Institute change during the pandemic?

No-one knew how long it would last. We had to take the decision to cancel our planned annual conference and move activity on-line. As all regional meetings had been suspended, many Regional Reps worked hard to find alternative ways to provide localised training and information sharing, culminating in our first virtual conference. The Awards Lead and Education Team worked to ensure our annual awards competition could be judged anonymously online using teleconferencing from across the UK.

Members of Council and subgroups of our main committees were equally busy increasing readership and interest in our professional publications. We delivered a steady stream of news, through social media campaigns, and worked together to offer mentorship schemes, Healthcare Assistant training information, and careers packages. I was hugely proud to be chairing an organisation that continued to change and progress through such a challenging period.

What did your Council and Officers achieve?

There were so many areas that changed during the pandemic as each of our specialty groups worked to keep up with demand, introduce new ways of working or recover from unexpected challenges. Our Officers quickly set up video conferencing facilities, a particular challenge for those working from home or freelancing. They had to acquire technology that was up to the task and that meant researching (and purchasing) appropriate microphones and video equipment. They also had to become adept at using new types of software, installing and learning multiple video conferencing systems to speak with different users –all without the advice and support of an IT department.

Council masterminded our first virtual AGM, online awards ceremony and regular Council meetings, much of which

we will retain. This has reduced activity in our London office which means we will make longer term savings. And as a Council we decided to produce a commemorative badge for IMI members – a very small token of gratitude from the profession to recognise the resilience, energy and commitment of members over this extraordinary period. Much effort was also going on behind the scenes to make sure the Institute continued to function, upheld our professional standards and developed for the future.

Looking back over your term of office during the pandemic, what are your thoughts?

I did not come into the role with any preconceived ideas, merely with an awareness that I had huge shoes to fill both from the immediate past chair and for all those who had taken on the role before me. It has left me with a massive sense of pride in what we collectively managed to achieve with very limited resources and under 500 members, but with the same passion and resilience of so many others working in the healthcare environment.

We have seen the NHS transform as it embraces telemedicine and other innovations. This has brought wonderful opportunities to develop new services, that look likely to stay in place post pandemic. It is at times like this that our community comes alive with advice and support for each other.

Jane Tovey *is Medical Illustration Services Manager at University Hospitals Birmingham*

VIEW FROM THE NATIONAL SCHOOL OF HEALTHCARE SCIENCE

Leadership for Healthcare science is an area that is developing slowly but surely. I am really pleased to see the positive and informative article in this edition aimed at helping scientists develop patient centred care. One of the authors, Professor Naomi Chambers, is co-director of Leadership and Management in the Higher Specialist Healthcare Scientist Training (HSST) Programme. Her article is accompanied by an equally illuminating and personal slant on achieving change written by Amy Read, a first year HSST trainee.

Development of the HSST programme emerged from the vision of the Chief Scientific Officer, Dame Professor Sue Hill, and the Modernising Scientific Careers (MSC) team over ten years ago which designed and developed the academic and clinical HSST programme. When thinking about the skills and knowledge that a future senior NHS scientific workforce would require to deliver an excellent scientific service for patients, the MSC team had the foresight to acknowledge the fundamental importance of leadership skills for this group of senior scientists. It was understood that while obtaining high level skills in individual scientific disciplines was clearly necessary and important, so too would be the ability of these prospective consultant scientists to lead departments, negotiate at high levels in Trusts, inspire junior colleagues and to spearhead major regional and national initiatives in their fields.

The HSST programme development team looked beyond the scientific fields to the dynamic and flourishing field of Leadership and Management. This team understood that to be a good leader, it was necessary for scientists to understand and learn about leadership theories, types of leadership, negotiation and conflict resolution styles, and to understand and have the tools to implement such ideas and processes into their scientific working lives and departments. The understanding that these concepts could be taught not only academically but also through learning blended into the clinical work of HSST trainees led to the incorporation of the "PGDip" as a crucial part of the HSST/DClin Sci programme.

Professor Berne Ferry *is Dean for Healthcare Science and Head of the National School of Healthcare Science (NSHCS)*

I have heard personally from many HSST current and alumni scientists that the skills, knowledge and understanding of leadership that they acquired in undertaking the PGDip was unexpected but vital to transforming and freeing up their thinking – including of themselves as professionals. They found the course ideas challenging and thought provoking, and the results have enhanced their aspirations and provided a new positive dimension to their practice as scientists.

It was the success of the PgDIP in HSST that led us at the school in HEE to begin discussions with Prof Geeta Menon in HEE to help to deliver a leadership programme for STP. The NSHCS began to build the faculty for this programme during 2021. We hope to begin delivering this online introductory programme –**L**eading through **E**ducation to **E**xcellent **P**atient care (LEEP) – to the second year of the STP course later this year. Hopefully in the next report in this journal, I will be able to tell you about LEEP in more detail.

AHA AWARD WINNERS

2022 United Kingdom
Advancing healthcare awards
Allied health professionals & healthcare scientists

2021

Global Clinical Engineering Day Team, Basit Abdul and NHS Trusts in the UK

The team acted quickly to produce an excellent 'Global Clinical Engineering Day' video . This became the UK's contribution to an international celebraion, at a time where the profession was under pressure to deliver support to the pandemic response.

The approach taken, the number of organisations, and the quality of the output were all innovative, and stood out versus previous contributions from the UK. Many contributed, but Basit in particular had to drive this exercise forward and was crucial in making this happen. The feedback can be seen in the YouTube comments, but also in the discussion of the video across the regional and national clinical engineering networks that formed to coordinate pandemic response.

The video was a series of vignettes that can be split down and used for professional awareness, educational material and marketing. This was a deliberate and considerate decision by the team, and meant that Clinical Engineers across the country will be able to make use of the content for years to come. By featuring contributions across the country, it shows a breadth of perspectives that makes the content transferable. It was also designed to introduce lay audiences to the work of Clinical Engineers.

> "The judges thought this was a highly innovative initiative, which was wide reaching both inside and outside of his immediate field. Basit showed considerable leadership in developing the film and using the opportunity to raise the profile of clinical engineering within his own Trust and beyond."

Bamidele Farinre (left)

Basit Abdul (right)

2022

Bamidele Farinre, Scientific Advisor Lab Validation and Quality Assurance, UKHSA

In her role as the Chief Biomedical Scientist for Mobile Processing Units Vans (MPUV) commissioned by the Department of Health & Social Care, Bamidele competently built and managed over 100 staff teams of scientists, associate practitioners, and laboratory assistants within a 7-month period of commencing her role. She took responsibility for their continuous development including creating a safe working environment for her team to thrive. Bamidele set up detailed SOPs for COVID-19 LAMP- RT and processes for performance tests, trained her team of Scientists and Associates, as well as developing a comprehensive train the trainer programme. She established the competency assessment framework, led the implementation of the IT LIMS system, and established a KPI monitoring regime all within the MPUV project. Furthermore, Bamidele was instrumental in leading, designing, and implementing the June Almeida Laboratory based in the Franklin Wilkins Building, Waterloo, London as a collaborative project between Kings College London and Viapath Analytics LLP. She ensured that good laboratory processes and training were embedded throughout the project.

As a versatile scientist, Bamidele has featured on many platforms and her commitment to Biomedical Science is evidenced by nominations to several awards. She has authored several IBMS articles, the Pathologist Magazine, Inspiring the Future, and also featured in the Tara Binns case studies project with The WISE Campaign.

Bamidele is a member of the IBMS Virology Advisory Panel group that foresees the setting of Congress Scientific Programmes and updating the IBMS qualifications amongst other important roles. She is an IBMS CPD officer, Freedom to Speak Up Ambassador, WISE campaign role model for 'My Skills My Life', Mentor, British Science Association (BSA) Crest award Assessor, and Inspiring the Future STEM Ambassador. Addey and Stanhope school representative said, "I can sincerely say you made a difference to their lives which you may never see, and you should be congratulated for your selfless action."

> "Bami made us proud to be scientists. She comes across as a leader for the profession who is inspirational to other scientists. In the midst of a global pandemic, she set-up a mobile based testing system for Covid-19, facing enormous pressure and deadlines, but succeeded in doing this."


AHCS
Academy for Healthcare Science