

THE HEALTHCARE SCIENCE LEADERSHIP JOURNAL

SPRING 2021

BRENDAN COOPER

ON WHAT LEADERSHIP REALLY MEANS

ARTHI ANAND

**DIVERSITY BARRIERS TO LEADERSHIP
IN HEALTHCARE SCIENCE**

BASIT ABDUL

GOES GLOBAL WITH CLINICAL ENGINEERING

RUTH THOMSEN'S

UNUSUAL PATHWAY TO LEADERSHIP

FIONA O'NEILL

**ON EMERGING LEADERSHIP ROLES IN CLINICAL
RESEARCH**

KEITH ISON

SHARES HIS GO-TO GURU

ANNA STEC AND JACK STANCEL-LEWIS

**ON WHAT HEALTHCARE SCIENCE FELLOWS CAN
DO**

GEOFF LESTER

REFLECTS ON LESSONS FROM DISASTER

SUE NASH AND KEVIN WYKE

GET FIRED UP WITH ACTION LEARNING

NEWS

FROM THE ACADEMY AND THE SCHOOL

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In this issue

3 Welcome

From the four UK Healthcare Science leads

4 Editorial

Keith Ison and Shelley Heard

5 Brendan Cooper

AHCS Leadership – a President's perspective

6 Arthi Anand

Diversity barriers to leadership in healthcare science

7 Berne Ferry

News from the National School of Healthcare Science

8 Jack Stancel-Lewis

Leading through Co-production and Action Learning

10 Sue Nash & Kevin Wyke

Action Learning - a leadership tool you might not have experienced yet

12 Anna Stec

Antimicrobial stewardship – an innovative approach

14 Basit Abdul

Global Clinical Engineering Day 2020 – how the UK made an impact

17 Ruth Thomsen

Serendipity and happenstance

18 Fiona O'Neill

The evolution of new healthcare science roles

19 Keith Ison

Classics corner – *Managing Oneself* by Peter Drucker

20 Geoff Lester

Learning from disaster

21 Janet Monkman

View from the Academy for Healthcare Science

22 News Round up



The Healthcare Science Leadership Journal is published electronically by the Academy for Healthcare Science. The first two editions will appear in April and November of 2021, and the Journal will be published quarterly from the beginning of 2022. Contributions relating to leadership in healthcare science are welcomed and more guidance for contributors is provided on page 16.

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WELCOME FROM THE FOUR UK HEALTHCARE SCIENCE LEADS



“ The Chief Scientific Officer for England, her Deputy and the Office of the CSO welcome the launch of the new *Healthcare Science Leadership Journal*. We hope that it will provide the opportunity to raise the profile of leaders in healthcare science and showcase the excellent

work they do in directing and delivering high quality innovative services across the health and care system. As the NHS recovers and responds to the pandemic, we will need scientific leaders who can lead transformational change, form partnerships outside of health and create cross functional teams, to ensure that scientific and technological advances deliver better outcomes for patients and our populations in the UK and around the world.

Dame Professor Sue Hill
Chief Scientific Officer
England



“ Mature and confident healthcare science is key to transforming medical care, as scientific and technological innovation is introduced into clinical practice. It follows that those working in healthcare science have a critical role to play, taking on additional and advanced roles and ensuring

dissemination of innovative multidisciplinary practice across multiple settings.

In this context, there has never been a greater need for clear leadership across the many different domains of professional practice within healthcare science. It is a particularly opportune time to launch a new journal with a focus on leadership. I wish the journal and its editors every success and look forward to a positive and real impact across the UK.

Professor Ian Young
Chief Scientific Adviser
Department of Health
Northern Ireland



“ The healthcare science workforce in Wales has demonstrated great skill, resilience and expertise in its COVID-19 pandemic response. Harnessing and releasing the leadership potential of this workforce will be crucial to delivering the highest standards of patient care as we re-establish full

services and drive improvements in healthcare delivery.

The Journal supports this ambition. It provides a platform to highlight and showcase leadership developments, and to promote good practice in the healthcare science community. It will inspire, support and encourage individuals to advance or embark upon their own personal leadership pathways.

There has never been a more pertinent time to launch a leadership initiative for this professional group. This exciting development is hugely welcomed, and I look forward to Wales' engagement and future contributions.

Dr Delia Ripley
Deputy Chief Scientific Advisor (Health)
Welsh Government



“ I am pleased to see a leadership journal for healthcare science which captures and disseminates examples of good professional leadership. Effective clinical leadership is essential in ensuring a high quality health care system that consistently provides safe and

efficient care.

It is becoming increasingly critical that our profession embraces the ideals of leadership, to empower and release the potential of each and every individual.

A leadership journal for Healthcare Science will provide our workforce with a platform to ensure their contribution to all elements of leadership is showcased. I am certain that our healthcare scientists will use this opportunity to develop collaborations and embrace collective leadership models to increase the visibility of this critical workforce.

Catherine Ross
Chief Healthcare Science Officer
Scottish Government

EDITORIAL

The purpose of the Journal is to encourage an interest in leadership amongst those in healthcare science by showcasing examples of how leadership in healthcare science can influence and support excellent patient care.

Welcome to this first edition of the Healthcare Science Leadership Journal, a journal supported by the Academy for Healthcare Science (AHCS) and championed by its Professional Bodies Council. The Journal provides a high-level strategic discussion forum on healthcare policy, scientific leadership and horizon-scanning of issues that may affect the whole of the healthcare science workforce.

There has never been a better time to launch an on-line journal, supporting and encouraging leadership across all professional groups in the healthcare science community. Leadership is recognised increasingly as being vital in shaping new ways of delivering health and healthcare. NHS plans^{1,2} acknowledge the value of healthcare science in supporting new ways of working across scientific, clinical and system-wide contexts.

Effective and imaginative leadership at all career stages will be essential as those in healthcare science engage with significant change and help to create a health service for the 21st century. Dame Professor Sue Hill, the Chief Scientific Officer (CSO) in NHS England, has said that the values and community spirit she grew up with shaped her as a leader. The Journal will celebrate the diversity of insights and approaches each person working in healthcare science contributes to its development.

The ways in which those in healthcare science have responded to the COVID-19 pandemic provide ample evidence that, when given encouragement, support and freedom to act, this diverse workforce demonstrates the imagination, ability and drive to rapidly overcome problems and take on new challenges. Of longer-term significance in their response, is the way that many in the profession have shown an increasing confidence in taking the lead in challenging situations, and in stepping beyond existing boundaries in the interests of patient and public care. This confidence partly comes from a growing interest in leadership development across healthcare science professional groups, encouraged by the work of various bodies including the AHCS³ as well as from the stories and role models that those in healthcare science increasingly see in professional body and NHS communications.

Our aim is that this Journal will provide an essential part of the leadership journey for the healthcare science profession. We want it to provide an open and cross-professional platform that complements and extends the reach of work being done by professional groups within the AHCS. To that end, we will publish a mixture of papers, reports, articles, commentary and information that together inform and inspire those in healthcare science to take up the mantle of leadership, wherever they work and

whatever activities they undertake.

One element of the Journal's intended content will be examples of leadership development work carried out within healthcare science. We are delighted that this first edition showcases several projects undertaken as part of the Practical Skills for Education Training and Leadership (PSEL) programme and look forward to further contributions that highlight ways in which those in healthcare science are leading and supporting changes in healthcare. We would encourage individuals to write up what they have learned from taking on leadership roles to share practice and opportunities with the healthcare science community and submit them to the Journal for consideration.

Two other important elements of health and social care are connected to the Academy which will be reflected in the Journal's pages. One area is patient safety: this edition has news of links between the Academy and the *Patient Safety First* organisation, which will provide a powerful resource to help professional bodies and individuals build safety considerations and patient perspectives into their work. The other area is research: The Academy includes under its umbrella *Clinical Research Practitioners*, who bring a wealth of experience in the practical issues of undertaking patient-centred research which can help other professional bodies in creating and implementing effective and sensitive research projects and protocols.

We look forward to receiving your contributions and suggestions as the Journal develops. We anticipate that the Journal will fill a unique role in the life of those in healthcare science and clinical research practitioners by providing a source of learning and inspiration that enables them to grow in leadership confidence, benefit patients and the public and improve the quality and satisfaction they find in their working lives.

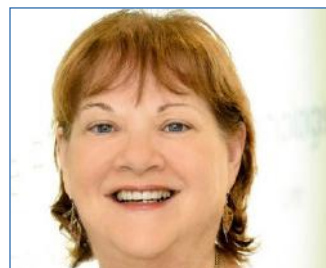
Keith Ison and Shelley Heard

Co-editors, The Healthcare Science Leadership Journal

¹The NHS Long Term Plan, NHS England, January 2019.

²WE ARE THE NHS: People Plan 2020/21 – action for us all, NHS England, July 2020.

³The Academy supports 2 important new leadership awards - The AHCS Award for Inspiring the Healthcare Science Workforce of the Future and The AHCS Award for Outstanding Achievement by a Clinical Research Practitioner, recognising the importance of leadership initiatives in these groups.



AHCS LEADERSHIP – A PRESIDENT’S PERSPECTIVE

Brendan Cooper, AHCS President writes: A great deal has been written about leadership in general. This Journal will be of specific relevance to those in healthcare science. I have selected some quotations that illustrate this.

Leadership is abundant in the healthcare sciences as there are many examples of leading teams: professional bodies, scientific specialities, and whole clinical services are good examples. Healthcare scientists demonstrate leadership through the significant amounts of training, teaching and mentoring required as part of establishing and developing scientists in new and exciting fields of healthcare science.

Healthcare science actually lends itself to being a prime area for leadership opportunities. Examples include research teams, project leaders, heads of service and the problem solving exhibited across the 53-plus professions delivering 80% of NHS diagnostics every day. Sometimes we may not recognise just how crucial that leadership is, but what does it actually entail?

“Leadership means making people feel good” Jean Chretien, 1934

This doesn't mean being a “people pleaser”, but it should mean bringing out the best in people to deliver the strategic vision that you, as a leader, have decided to pursue. Leadership requires people to do things in a way where they want to say “yes”, where they share your vision and where they want to have ownership of what is being proposed. Leadership is about bringing engagement with people, turning their negatives into positives. It means pulling people together and ensuring their ingenuity and shared ownership delivers that vision.

In setting up a diagnostic service, procuring new ideas/equipment, developing new tests, services or patient pathways - we involve aspects of leadership. Sometimes we are successful, but occasionally we can fail badly – often during stressful

times. Leadership is more of an art than a science, with interpretation, light and dark, detailed and broad-brush strokes – all creating a leadership style. However, it is a fine balance:

“The challenge of leadership is to be strong, but not rude; be kind, but not weak; be bold, but not bully; be thoughtful, but not lazy; be humble, but not timid; be proud, but not arrogant; have humour, but without folly.”

Jim Rohn

COVID19 has provided many examples of great leadership by healthcare scientists, both within our professions and also when interacting with other healthcare colleagues. Heads of service who rolled up their sleeves and supported wards or ITU; laboratory leads who devised and set up PCR and other tests/assays to detect the virus over weekends; clinical engineers who procured and set up ventilators and other equipment at short notice and over long hours, day and night. Further examples include staff who delivered care outside their normal realm of service, monitoring acute treatment, supporting colleagues or comforting patients and speaking with relatives on the phone. Leadership can take many forms and isn't limited to the top grades of staff - it's possible to demonstrate leadership across the whole of the healthcare science workforce.

Equally, we have seen some poor examples of leadership during the pandemic. The national debacles of the Test & Trace App; the dithering over lockdown; stopping lockdown too soon; the breaking of lockdown by celebrities and national leaders. In examining poor leadership, we can often see the pathways to good practice.

“All of the great leaders have had one characteristic in common: it was the willingness to confront unequivocally the major anxiety of their people in their time. This, and not much else, is the essence of leadership.”

John Kenneth Galbraith, 2017

Our recent “major anxiety” has been the COVID19 pandemic which has been both a challenge and an opportunity for leadership. From a personal perspective, as a Consultant Clinical Scientist in respiratory physiology and President of the AHCS, my clinical world had become punctuated with lots of professional commitments, writing papers and applications, but mainly time spent reporting diagnostics and delivering out-patient clinic services and being scientific advisor to the service.

Once the third wave hit hard, I was immediately repurposed from out-patient duties and began directly supporting the newly established Respiratory Support Unit on the ward, where we supported nurses and physiotherapists delivering Continuous Positive Airway Pressure and oxygen to COVID19 patients. This work required extended hours - nights, weekends, etc – to ensure optimal patient care.

Sometimes leadership means rolling your sleeves up, pushing your normal roles aside, delivering some basic duties and demonstrating humility. Leading from the front and working alongside your colleagues encourages them to raise their game. Someone once described management as pushing a weight up the hill, but actually, leadership is *pulling* the weight up the hill. Healthcare science has more than “pulled its weight” in this pandemic.

This Journal will hopefully provide the inspiration to encourage more great leaders in healthcare science. That next leader can be you!

**Brendan Cooper, FERS,
President of the AHCS**



DIVERSITY BARRIERS TO LEADERSHIP IN HEALTHCARE SCIENCE: "YOU CAN'T BE WHAT YOU CAN'T SEE."



Arthi Anand describes the barriers to leadership diversity and suggests some solutions. She is Consultant Clinical Scientist in Histocompatibility and Immunogenetics, North West London Pathology and BAME Ambassador, Imperial College Healthcare NHS Trust.

The healthcare science workforce is more diverse than ever. However, there has been limited progress towards increasing diversity in healthcare science leadership. There may be many underlying causes of this, but the most important question is: what can be done to bring individuals from more diverse backgrounds into leadership positions?

On a personal note, while being an Asian woman has never been an overt barrier in my career in healthcare science, I have not always felt empowered to stand out and speak and have hesitated to voice opinions in case my perspective is not seen as relevant. I also often find it necessary to downplay aspects of my cultural identity in order to assimilate myself more effectively into organisational networks and pursue career aspirations.

Background

Multiple organisations, including the NHS, have seen the benefits of having more diverse leadership teams¹. Yet the NHS, one of the most diverse public sector workforces, recognises it still has a long way to go to address workplace inequalities². People from ethnic minority backgrounds are still under-represented in senior positions³ and experiences of BAME (Black, Asian and Minority Ethnic) staff, whilst mixed, continues to show significant differences in their ability to access promotion and leadership opportunities⁴. For a diverse workforce to flourish and aspire to take up leadership positions, organisations need to focus on initiatives to enhance inclusion - the degree to which employees are embraced and enabled to make meaningful contributions⁵.

Identifying barriers

A poll of 5 BAME colleagues, all middle managers with aspirations to senior leadership positions, indicated they see that the greatest barriers to advancing their careers involve *Access, Sponsorship, and Opportunities*.

Access

Research shows that many employees from a BAME background have impoverished social capital and limited access to informal sources of information, career-

related assistance or guidance from senior colleagues. Unconscious bias and discrimination can also block the progress of talented BAME staff and may undermine equal access to promotions, projects, senior leaders and secondments. This limits the aspirations and potential success of BAME staff⁶. Having visible and accessible role models in senior positions to act as vocal allies, provide access to networks, and promote a culture of belonging, is a 'quick win' in creating a diverse leadership pipeline.

Moving from mentorship to sponsorship

While mentors provide guidance, sponsorship opens doors. It is a formal relationship focused on advancing the protégé. Leaders should intentionally develop processes that go beyond their familiar circles to offer leadership development opportunities, including secondments and special projects, to a broader, diverse group that is representative of the workforce.

Creating opportunities for leadership experiences

Creating leadership experience opportunities: *Reverse Mentoring* is a tactical step senior leaders can take to increase their visibility to talented BAME staff and benefit from the diverse perspectives this group brings. This involves a senior leader being mentored by a more junior colleague who, from a diversity and inclusion perspective, is different from them in some way and therefore brings alternative career experiences⁷.

Master classes are another way to increase BAME staff understanding of senior leadership roles. So are "lunch days" where senior BAME leaders meet and greet BAME staff and openly share their experiences, including challenges faced as a BAME leader. These events can also support leadership opportunities across a more diverse workforce.

Championing diversification in healthcare science leadership is crucial to shaping policies that take account of the needs and perspectives of diverse users of the NHS. It will improve patient and staff experiences and address health inequalities. As the NHS faces workforce shortfalls and responds to changing patient need, there is a clear and urgent imperative to focus on strategies that draw leadership from across its diverse pool of talent.

'Experiencing bias, discrimination or inequality, is not a choice. Tackling it is. Each member of staff, at every level, has an active role to play making the NHS a more inclusive environment. It is the responsibility of the majority, not the minority, to make this change happen.'³

1. Workforce race equality: Case studies of good practice from non-NHS employers. NHS England/NHS Improvement, August 2017.

2. NHS Workforce Race Equality Standard: 2019 Data Analysis Report for NHS Trusts. NHS England, February 2020.

3. Workforce race inequalities and inclusion in NHS providers. The King's Fund, July 2020.

4. Increasing black and minority ethnic representation at senior levels across the NHS, 2019.

5. Briefing for NHS Boards on the NHS Workforce Race Equality: NHS workforce race equality delivers better care, outcomes and performance. NHS England, October 2015.

6. Addressing the barriers to BAME employee career progression to the top. Chartered Institute of Personnel and Development, December 2017.

7. Factsheet: What is Reverse Mentoring? Business in the Community, 2018.

NEWS FROM THE NATIONAL SCHOOL OF HEALTHCARE SCIENCE



Berne Ferry, FRCPath, Head of the National School of Healthcare Science (NSHCS) in Health Education England (HEE), brings us news from the School.

This regular feature will enable all those in education and healthcare science to have their voice heard as NHS scientists move towards taking their essential place in leading scientifically based medical care.

The NSHCS in HEE oversees the training quality and/or is involved in several HCS training programmes including the Accredited Scientific Practice Programme (ASP), Practitioner Training Programme (PTP), Scientist Training Programme (STP), Higher Specialist Scientist Training (HSST) as well as various apprenticeship, credentialling, and flexible short courses for scientists and other healthcare professionals. In all these programmes, the NSHCS tries as far as possible to ensure that an awareness of leadership is rooted appropriately into the curricula.

The creation of this journal is welcomed by the NSHCS and HEE and it will be of value to all healthcare scientists whether in formal training or working in practice. On Induction day for STP and HSST trainees, I tell trainees: "We know by virtue of the fact you are in these training programmes that you are excellent scientists, committed to the NHS and developing your specialist scientific skills to the highest standard for patients. But what you may not know is that an equally important chunk of your training will be to develop and then use your communication and leadership skills throughout your careers".

When I go on to say: "These soft skills are as important and in certain situations may be even more important than your scientific skills", they generally look at me with a mixture of horror and disbelief. However, to prove my point, here are examples of comments we regularly receive – unsolicited - from HSST graduates of the Postgraduate Diploma (PGDip) in Leadership and Management from the Manchester Alliance Business School in the University of Manchester.

"Becoming aware of the multitude of skills and competences that are actually needed to successfully lead a scientific department was easily the most interesting and surprisingly fulfilling part of my HSST journey".

"The NHS recognises that Heads of Scientific departments require comprehensive management and leadership skills and I know that I gained these through the PGDip within HSST".

We recognise, as do other contributors, that it is only by instilling leadership awareness, providing leadership experience and equipping healthcare scientists with the right leadership skills that those working in healthcare science will be enabled and emboldened to claim a central place as crucial leaders within the NHS.

In our STP and HSST programmes we continually try to ensure that leadership is embedded and its importance is highlighted in the curricula. I discussed how the highly successful and valued PGDip in Leadership and Management is a major component of the HSST programme. Likewise, in our STP programme, we are developing and will introduce in Autumn 2021 a new leadership programme for STP trainees. This is the Leading through Education for Excellent Patient care (LEEP) programme.

This new programme recognises that the role of the scientist as leader within the context of the future multidisciplinary team has never been more important. With the advent of new technology in the NHS, scientists will be driving and leading their own scientific specialties; but within a multi-professional team, they will need to be capable of working confidently and supportively to inspire their colleagues and build patient trust. To achieve this, healthcare scientists must be both literate and experienced in leadership so that they can function well across hierarchical and organisational boundaries. The LEEP programme delivers a multi-faceted approach to leadership across four modules which include developing each scientist as an individual, developing networks and developing system knowledge.

In future editions, I hope to be able to keep you updated on the progress of developing our LEEP faculty, rolling out the programme to STP trainees and as our LEEP programme matures, exploring how we can expand the learning to scientists outside the STP programme. So, watch this space.

I look forward very much to reading this first edition and to witnessing what will be its undoubted positive influence on our scientific community in the NHS.

LEADING THROUGH CO-PRODUCTION AND ACTION LEARNING



Jack Stancel-Lewis, audiologist, describes how his leadership skills have developed through his Healthcare Science Fellowship, the Practical Skills for Education and Leadership Programme, action learning and mentoring

Stepping out of full-time clinical practice as an audiologist and straight into a Healthcare Science Fellowship was daunting at first. Moving from a structured day based on a series of patient appointments to one that lacked clear and immediate deliverables made it difficult for me to judge how well I was doing. At times I caught myself longing for the repetitive nature of my previous role, something I had wrestled so hard to move away from. Yet the benefits of “sticking” with that uncertainty have been instrumental in my development.

The Practical Skills for Education and Leadership (PSEL) programme was the first activity I took part in during my London Region NHSE/I Healthcare Science Fellowship. PSEL was a real opportunity to explore and identify new processes and viewpoints. It advocates taking ownership of the healthcare scientist professional identity, builds leadership and educational skills and prepares you to advocate for all 53 healthcare science professions. This programme supports you to become a leader, educator and thinker.

My Fellowship project was aimed at improving access to sensory health for patients across London. It was aided by a number of frameworks and methodologies that I was exposed to during the PSEL programme. What I learned on the programme helped me to plan what I was going to do and to reshape my year as other opportunities emerged.

We know that poor sensory health and unsupported sensory loss impact negatively on an individual’s cognitive, psychological, emotional and physical wellbeing. Studies highlight an association between hearing loss and dementia, and it is thought that the risk increases when two or more senses are impacted¹. Some more recent reports suggest wearing hearing aids may slow the rate of cognitive decline². It is reported that 50% of people in care homes have vision impairment and up to 90% of older care home residents have a hearing loss. On top of this, many problems are undiagnosed and hearing aids are often unused or left in disrepair³.

The Sensory Health Passport is aimed at tackling some of these issues by improving the sensory health of residents in care homes. It was developed in a co-produced, solution driven manner through a collaboration between

charities, community nurses, optometrists, GPs and staff and residents in long-term care facilities. It provides a way to systematically record a resident’s sensory needs and acts as an aide-memoir for care home staff. It also appoints champions in each home who take ownership of sensory health and disseminate awareness of good communication skills.

The Fellowship and PSEL helped develop my thinking on what constitutes high quality patient care and how the system can influence this, which in turn helped me identify some of the barriers that prevent this happening. The PSEL programme opened my eyes to think outside traditional professional boundaries and helped me see how the community workforce could be used to meet unmet health needs in the population.



Co-production - Working with people who have lived experience

After successfully implementing and piloting the Sensory Health Passport, we evaluated the development process using semi-structured interviews and thematic analysis to gain insights into participants’ viewpoints and experiences. We also developed and implemented a comprehensive framework for internal and external communications about the project that included presenting at conferences, senior NHS leadership team meetings and award nominations to gain greater exposure. This was facilitated by creating an ‘elevator pitch’, a short explanation of who you are and why what you are doing is important. This process really helps you grab the attention of the listener, engaging them and leaving them wanting to find out more. This gave me the confidence to interact and work with people I may have previously found intimidating, and it challenged me to share my ideas as opposed to being overly concerned that I might get something wrong. It was vital that we

1. Brenowitz, W.D., et al., Multiple Sensory Impairment Is Associated With Increased Risk of Dementia Among Black and White Older Adults. *J Gerontol A Biol Sci Med Sci*, 2019. 74(6): p. 890-896.

2. Bucholz, M., et al., Association of the use of hearing aids with the conversion from mild cognitive impairment to dementia and progression of dementia: A longitudinal retrospective study. *Alzheimer's & Dementia: Translational Research & Clinical Interventions*, 2021. 7(1): p. e12122.

3 Echallier, M., A World of Silence The case for tackling hearing loss in care homes. 2012, Action On Hearing Loss.

did not just stop at proof of concept; broader adoption of the quality improvement project was key. We engaged with local authorities, using appreciative inquiry and gap analysis during a workshop with clinical commissioners to point out good practice and show how our initiative would fill gaps in the service. Focusing on positives and highlighting current good practice helped to get people onside, and people were then more open to try and solve the remaining problems.

Participating in other initiatives has helped me expand my learning. I have been privileged to be part of the [Hearing Birdsong](#) project, which brings together art, design and science to facilitate behaviour change in people who may have hearing loss. This initiative opened up my thinking and exposed me to patient participatory design methods. These included co-production and patient-public involvement to help develop and redesign services and interventions that add value from the bottom up, utilising individuals who are experts through experience. Stakeholder engagement of this nature requires people management and leadership skills to ensure everyone works towards the same goal in a non-hierarchical manner. Joint decision making has been key, alongside taking ownership, anticipating and managing risks and resolving issues. Involving patients in the design and implementation of services really does result in improved outcomes and interventions that better meet user needs.

Action Learning Sets (ALS) have been another important part of my development. These groups aim to help you find solutions to problems you may be facing at work or in your personal life and were first introduced to me during the PSEL programme. ALS activity is based on the premise that you are the best person to solve the problems you face. The group and facilitator ask open, coaching style questions to help you work through a problem and identify ways forward. Taking time to understand how and why things happen is key to personal development; this

“ I have been privileged to be part of the Hearing Birdsong project, which brings together art, design and science to facilitate behaviour change in people who may have hearing loss. ”

process breaks down many barriers and provides space to think and reflect. I was able to bring challenges to the group and the outcomes really helped me have difficult conversations with team members, follow up issues with senior leaders and enable better engagement. Personally,

ALS helped me think about the direction of my project and how and where I wanted to progress to next. These processes ultimately result in better decision making and therefore indirectly or directly influence outcomes for patients. Improved decision-making has translated into other areas of my life, supporting career planning, negotiating skills and relationship building.



Healthcare Science Fellows Action Learning Set

Mentorship can also help you grow and become more confident in your decision making, especially when exploring new tasks and engaging at a senior level. Mentorship provides a basis for long-term relationships that guide your development and mentors can often provide targeted support and advice. A mentor can guide you through different aspects of your professional career and help you network and learn from others. Having a mentor has positively impacted the way I think and engage with my work. Coming from a technical background, I can get enmeshed in detail and my mentor has helped me think more strategically and at a higher level when necessary.

Finally, culture is key. Having a leader who is compassionate and inclusive, who genuinely cares about your well-being and opinion whilst valuing your input, results in motivated team members and team players. I have been fortunate to be part of a multidisciplinary healthcare science team, formed of engineers, physiologists, physicists and biomedical scientists. Collaboration has been invaluable and has progressed my learning by giving insights into how others think. This team offered a support network during my Fellowship, allowing me to lean on and learn from others who may have a better understanding or other valuable perspectives. Honesty, confidentiality and non-judgemental ground rules are the basis all teams should be built on. The space to ask questions and explore ideas really does lead to better care for patients.

ACTION LEARNING – A LEADERSHIP DEVELOPMENT TOOL YOU MIGHT NOT HAVE EXPERIENCED YET!



Sue Nash and Kevin Wyke tell us about the power and potential of Action Learning Sets and invite us to give them a go.

Action Learning Sets (ALS) are viewed as an essential element in developing excellence in individuals and teams around the world and consequently form an integral part of many NHS leadership development programmes. Our experience of facilitating ALS for healthcare scientists over the last five years suggests that, despite its widespread adoption in the leadership, learning and development world, ALS have rarely been a part of healthcare scientists' development and are still viewed as a novel approach. We believe that this is a missed opportunity as our experience indicates that ALS have had a positive impact on the development of healthcare scientists.

What is Action Learning?

Action Learning is a "continuous process of learning and reflection, supported by colleagues, with an intention of getting things done"¹ that uses the task/workplace issue as the vehicle for learning.

ALS are a form of group coaching that provides a safe space to learn from our actions through reflection, facilitated by questions posed by set members. This leads to the potential for gaining valuable insights in order to set the foundation for changes in behaviour and actions in the future.

The pioneer of Action Learning, Reg Revans, started developing the approach while studying astrophysics at Cambridge and later refined it. Revans described action learning in terms of a Learning Equation:

$$L = P + Q$$

where Learning is the acquisition of Programmed knowledge AND Questioning insight.

Revans believed that the key to improving performance of systems and individuals lay not with experts but with the practitioners themselves reflecting on, and learning from their actions. He stated that, 'any system that is to learn, whether an individual manager or a national cabinet, must regularly receive and interpret inputs about its own outputs.'²

Weinstein³ extended the Learning Equation to reflect Action Learning principles of action (A) and reflection (R).

$$L = P + Q + R + A$$

The Action Learning Set

At the heart of action learning is the set which usually consists of small group of 6-8 willing and voluntary participants who are committed to work with each other on each other's work issues.

Core components of the set are:

1. A Committed Group or Set who

- meet for at least 4 sessions at 4-6 weekly intervals
- support and challenge each other in thinking through the issues, agreeing actions and learning from the effects of that action.

2. Real Issues

Each individual brings a work-related issue that:

- has resisted being resolved and on which they want to, and have the authority to act
- is something they want help with

3. A Set Facilitator

- focuses on the group and action learning process.

The Action Learning Process

Set meetings are run as a series of structured conversations (see diagram). Each set member has an opportunity to share their issue (not always in the same session) and each conversation encourages fresh perspectives and a commitment to action. Action is key. Reg Revans said that "...there can be no learning without action, and no action without learning."



The above may be best seen as a virtual spiral where the learning is built on by bringing back planned actions to the ALS and reflecting on what went well and areas for further development. Key to the reflections is to not only identify actions, but to reframe our mental models and subsequently change our behaviours.

Benefits and outcomes

Some of the key benefits of Action Learning identified by Reg Revans are:

- helping to solve complex, urgent problems
- instrumental to developing leaders and teams
- creation of a learning culture

In addition, Leonard and Marquardt in their review⁴ elicited that ALS also:

- are particularly effective in developing collaborative/shared leadership skills
- improve the ability to develop integrative, win/win solutions in conflict situations
- improve coaching skills.

The benefit of developing coaching skills has been described as being helpful in the workplace by set participants where they work within their own teams. This demonstrates the multiplier effect as identified by Reg Revans. The benefits from participation are not only experienced by the set participant but there is a significant benefit when the learning and the skills are used back in the workplace – a ripple effect. In the 21st century, in the face of much change and much disruption, leaders cannot be expected to be able to provide all the answers and as Revans described, it is often the practitioners who can provide the solutions. This requires that the manager or leader acts as coach.⁵

We have been involved in introducing action learning to healthcare scientists mainly through the development programme, Practical Skills in Education and Leadership (PSEL). We have also worked with groups such as the healthcare science regional leads and Healthcare Science Fellows as well as other professional groups across the NHS. Feedback from the sets that we have facilitated reflect the above outcomes and also indicate key benefits with regards to managing in times of change, problem solving, increased confidence and wellbeing. Some feedback is shown below in the participants own words:

"Action Learning Sets occurred during times of great change and upheaval within the service. I would arrive often feeling overwhelmed by the issues connected with trying to effect change. ALS offered the opportunity to 'empty the bucket', but also to be challenged on my thinking and approaches. As a result, I have been able to keep issues in perspective and to deal more effectively with the conflict that can accompany managing change."

BM, Service Manager

Although not without its challenges, those participants and sets that kept going during the 2020 COVID pandemic reported feeling positive about the support from their colleagues and the positive impact on their mental wellbeing.

"Useful in a variety of ways: helping tackle problems at hand, learn better about other members of the team, in fact therapy too. During some events we talked about challenges in terms of managing time during lockdown and working from home, I think that was very useful for all of us."

BA, Healthcare Science Fellow

Problem solving

"Action learning has given me the tools and skills to challenge and resolve historical, entrenched issues within my role and workplace. I am able to better consider and implement means of resolution and remain focused on an issue, whilst being more open to exploring routes and ideas for resolution."

ALS participant

"Action learning sets have been an excellent development opportunity for me. The sessions improved my problem solving and leadership capacity. I was able to get the clarity about what I need to do to overcome the issues faced during my project. And it gave me greater adaptability as I was able to set up actions for myself I needed to lead me in the right direction."

AS, Healthcare Science Fellow

Reflection as a way forward

"I have valued the chance to reflect on my leadership practice with colleagues in a neutral setting. It has been essential to have protected time, since this has enabled me to focus on the issues, rather than the issues having to compete with a host of other pressures. The Action Learning Set has given me a variety of insights, both through exploring the issues I brought, and through exploring the issues brought by others. I have been impressed by the power of open questioning in the group, as a means to explore things that challenge us in our work and I was particularly enlightened exploring the assumed motives for the actions we take, which when unpacked are not what they seem."

KS, Lecturer/practitioner

In its simplest terms action learning is "...about taking action from learning and learning from action." It is a powerful developmental tool ideally suited to learning from complex challenges and could form part of every healthcare scientist's learning experience, particularly as they develop as leaders.

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1. McGill and Beaty, (2001) *Action Learning: A Guide for Professional, Management & Educational Development (2nd edn)*, London: Kogan Page.

2. Revans, R (1998) *The ABC of Action Learning, (2nd edn)* London: Lemos and Crane.

3. Weinstein K, (1999) *Action Learning A Practical Guide (2nd edn)*, Aldershot: Gower.

4. Leonard and Marquardt, (2010) *The evidence for the effectiveness of action learning, Action Learning: Research and Practice Vol 7, No. 2 121-136.*

5. Barra and Scoular, (2019) *The Leader as Coach: How to unleash innovation, energy and commitment. Harvard Business Review, November-December 2019. Available at: <https://hbr.org/2019/11/the-leader-as-coach>*

ANTIMICROBIAL STEWARDSHIP – AN INNOVATIVE APPROACH



Anna Stec, a registered healthcare scientist with over 5 years' experience in clinical engineering, used her Healthcare Science Fellowship to lead, design and deliver a service discouraging unnecessary antibiotic prescription.

Up until autumn 2020 I was working at the United Lincolnshire Hospitals NHS Trust in Lincoln, where I was responsible for managing the medical equipment lifecycle (Fig.1). A big part of my job was around testing, evaluating and selection of medical equipment as part of the organisation's procurement projects. My favourite aspects of the job were that I could constantly expand my knowledge of different types of technology and patient treatments and that I could work with variety of clinical and non-clinical teams across the Trust.

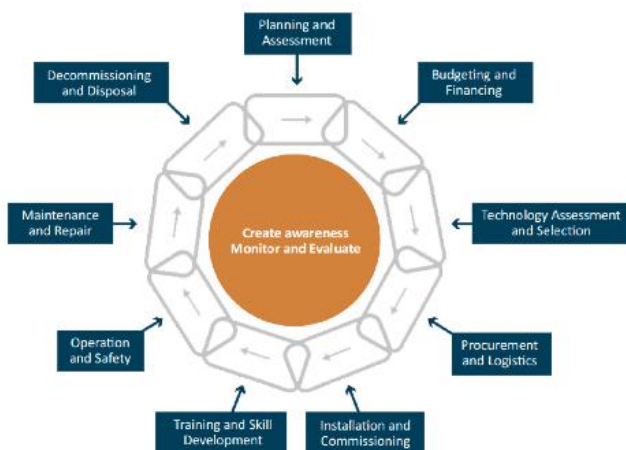


Figure 1. Medical Equipment Management Lifecycle

But I always look for opportunities to challenge myself. So, I was definitely excited when I was successful in my application for a Healthcare Scientist Fellowship with the Scientific Director's team at NHS England and Improvement (NHS E/I). As part of my fellowship project, I was asked to lead, design and deliver a service that:

- contributes to Antimicrobial Stewardship (AMS) by limiting unnecessary antibiotic prescription
- uses Point of Care Testing (POCT) technology to provide faster diagnostic results with faster therapeutic intervention
- is delivered in community pharmacies to support better access to patient care.

Antimicrobial resistance (AMR) is a natural process where microbes evolve to become resistant to the effect of drugs (Prestinaci, 2015)¹. Nevertheless, it presents a threat because the improper and excessive

administration of antibiotics has led to many antibiotics now being ineffective against common infections. In addition, there have been a very limited number of new antibiotics developed since 1980 to replace those which have become ineffective due to the development of drug resistance (Silver, 2011)². If antibiotics lose their effectiveness, key medical procedures (e.g. gut surgery, caesarean sections, chemotherapy) could become too dangerous to perform. AMR is one of the most serious global public health threats in this century.

POCT devices provide fast and reliable results that aid in disease screening, diagnosis and patient monitoring³. Although in the UK 80% of all antibiotics are prescribed in primary care, it is believed that at least 20% of these prescriptions are inappropriate⁴. Community pharmacists therefore can have a crucial role in addressing poor prescribing practices by tapping into existing patterns of care-seeking behaviours and by improving early diagnosis and treatment.

I could not have asked for a better project! I was able to use my scientific knowledge and project management experience but in a completely new setting. I had never led on a project of this complexity and as I didn't necessarily understand all the parts of the wider NHS system, I had very good opportunity to learn a lot. I started by attending a 'Practical Skills for Professional Education and Leadership in Healthcare Science' (PSEL) course supported by the Academy for Healthcare Science. It equipped me with theories, models and methods essential for leaders in the NHS. I found out that my personality type is Extraverted, Intuitive, Feeling, Perceiving (ENFP) which is also one of the least common types amongst engineers. Nevertheless, the course helped me use this to my advantage. Being different is what makes us special. We just need to find an environment where we will be given a chance to shine. And my strength lies in an ability to communicate science through accessible language which facilitates an understanding of medical technology whatever the audience's background. The course helped me to write my "elevator pitch". As part of the programme I was able to practice my influencing and negotiation skills. But most importantly it left me with the confidence and belief that I do have the skills and unique personality that will enable me to succeed as a leader in the NHS.

And so, on 15 July 2019 I packed my suitcase and my big hopes with me, got on a train in Lincoln and arrived at the office of the NHS E/I in London to begin my exciting 12-month venture. The first step into designing the service was to establish my stakeholder group. I believe that my enthusiasm for this project and my ability to learn quickly were the key skills that helped me get a group of very busy experts to commit their time to this work. But since they were representing different parts of the system, they

often had different priorities and interests. I had to get my head around all of their agendas very quickly - it often felt as if we were speaking different languages native to our professional backgrounds of medical technology, academia, pathology, pharmacy, commissioning, data analysis, finance etc. My goal was to facilitate discussion in this multi-disciplinary group, while creating a plan for the project which would satisfy all the stakeholders.

The big lesson for me was realising that demonstrating vulnerability and humility were important features of being a good leader. I was the youngest person on this project and initially I assumed that I had to show my confidence and have answers to all of the questions all of the time. But I very quickly learnt how wrong I was - my team and the stakeholders were truly supportive and nurturing, trying to contribute from the start. And while I was driving the work with passion and all my energy, I also felt confident that I could rely on my team to co-produce this project which was touching on multiple agendas at local, regional and national levels (Fig.2). Our vision and passion for the work resulted in mutual respect and a real excitement for this project.

in specialist areas, we designed a project incorporating the different aspects of the service.

Working Differently – HCS and Pharmacists

Evidence of Co-production



- ✓ Fully-attended multi-disciplinary stakeholder meetings (20 members)
- ✓ Developed 8 Working Groups



Figure 3. Co-design and co-delivery of the service

Each working group had a team manager who reported progress at weekly meetings. As team manager for the Technology Selection working group. I had pleasure in working with the Chief Scientific Officer (CSO) team who were advising on the quality and safety standards for the POCT.

In March 2020, two weeks before the trial was due to live in over 45 pharmacies, the project was put on hold due to the pandemic. However, the lessons learnt, and the experience gained in establishing this project has enabled me to continue contributing to innovation and patient care improvement, and to champion leadership activities amongst healthcare scientists. The project was a finalist of the 2020 Advancing Healthcare Awards for Innovation in Healthcare which was both a gratifying recognition for our work and an encouragement for other healthcare scientists considering leading on innovation in patient care.

Immersing myself in the new experience of working within the team of pharmacists, advocating about the global issue of AMR, navigating through the complexities of commissioning, and being in a position to persuade and motivate people that I admire has been the most fulfilling role in my career. I grew as a person, developed as a professional and challenged myself like never before.

Scientists are brilliant problem solvers and are genuinely interested in the world around them. They make caring and compassionate leaders. If you have an improvement idea or want to challenge yourself by leading on a project, please do! It takes each of us to make a difference for all of us.

Working differently – HCS and Pharmacists

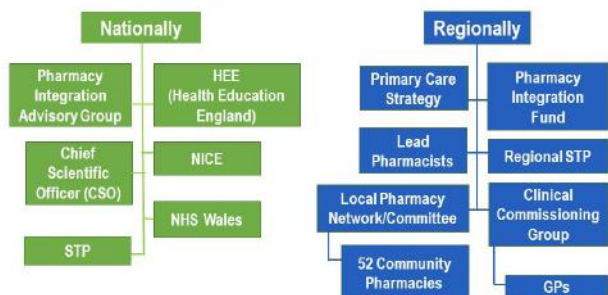


Figure 2. Unique collaboration across the system - at local, regional and national levels

And so, I set out to undertake a literature review and to liaise with other pharmacy pilots in search of ideas of a service using POCT technology. The 'Sore Throat Test and Treat' (STTT) service came up as one of the best options for a potential pilot. I reached out to a researcher in Wales who has developed a similar service there. I proposed a collaboration as an opportunity to generate and collect data which will be comparable and will feed into the future evaluations.

The STTT service was agreed and approved with the stakeholders. To ensure delivery of a service well integrated within the current system, I established 8 working groups (Fig.3). With the support of a project manager and experts

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3. Point-of-care testing in primary care in the Netherlands. Management of patient safety related aspects. National Institute for Public Health and Environment. (2012).
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GLOBAL CLINICAL ENGINEERING DAY 2020 – HOW THE UK MADE AN IMPACT

Global Clinical Engineering Day is a worldwide celebration of the value clinical engineers add to healthcare. Basit Abdul, healthcare scientist in Clinical Engineering, tells us how, for its contribution in October 2020, the UK decided to highlight the essential work done by this group in responding to the COVID-19 pandemic.

The global nature of the event provided an opportunity for clinical engineers in the UK to:

- **inform** people more widely about UK clinical engineering and how it helps patient care
- document and **recognise** how much the clinical engineering community has been doing to help tackle the pandemic
- **share** new ideas for innovation, research, training, and ways of working
- help **attract** future generations from diverse backgrounds into the profession.

Here we reflect on the process followed in the UK to develop and deliver its contribution. It outlines the approach taken and the leadership model which underpins it, evaluates the success of the outcome and makes recommendations for future events.

Background

Clinical engineering (CE) is both a healthcare science specialism¹ and a field within the wider discipline of biomedical engineering². Clinical engineers design, evaluate, regulate, maintain and manage medical devices, and train others on their safe use in healthcare settings³. Their work underpins almost every patient pathway and contributes to diagnosis, monitoring, treatment, recovery and rehabilitation.

The first Global Clinical Engineering Day, celebrated in 2016, was organised under the umbrella of the International Federation for Medical and Biological Engineering (IFMBE) and supported by the World Health Organisation (WHO). The UK's first international contributions in 2017⁴ and 2018⁵ were videos, each presenting a series of individual professional talks. These videos were telecasted by IFMBE via a web channel and have been watched 340 and 261 times, respectively. This is an extremely low viewing rate. No video was produced in 2019, leaving it to CE departments in the UK to hold open days for hospital staff and the public and otherwise locally showcase their work.

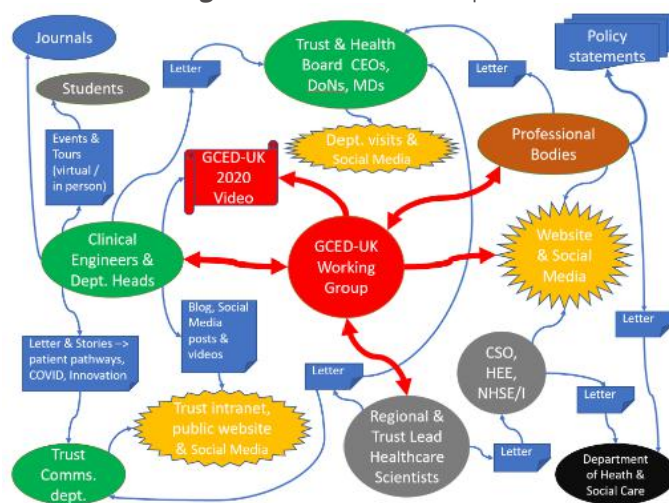
Due to COVID-19 restrictions and the enormous workload pressures on clinical engineering departments after February 2020, it was thought unlikely that

widespread in-person events could be organised for Global CE Day in October that year. By May 2020 clinical engineering networks were therefore identifying the need for an innovative way to communicate their message safely to all healthcare workers and the public.

How was the UK's contribution developed?

Underlying principles: The Healthcare Leadership Model⁶ was broadly adhered throughout the project. Its various dimensions are highlighted in bold where they are referred to in the following text. A second helpful framework was provided by the NHS People Plan (2020/21)⁷ which sets out what people in the NHS can expect from their leaders and from each other. It focuses on working together to foster a culture of inclusion and belonging, including taking action to train and look after the NHS workforce and to develop new ways of working to improve patient care.

Initial organisation: An initial informal meeting was organised 15 weeks ahead of the event with the aim of **Inspiring a Shared Purpose**, by helping clinical engineers appreciate why a celebration should be held and how it could align with the NHS People Plan. This successful meeting led to the formation of a UK Working Group of 13 members which provisionally decided to focus the 2020 theme on COVID-19 related activity. An invitation email was then sent to 78 stakeholders including clinical engineers, professional bodies and Health Education England, to understand their availability and preferred level of engagement. Relevant email distribution lists were compiled, based on their responses. The establishment of honest, appropriate, and timely communication, via the initial meeting and ongoing email correspondence, aided in **Sharing the Vision** and helped stakeholders



1. NHS England, What is healthcare science? Available at: <https://www.england.nhs.uk/healthcare-science/what/> (Accessed: 14/02/2021).
2. IPeM, Biomedical Engineers, Available at: <https://www.ipem.ac.uk/CareersJobs/Whatdoourmembersdo/BiomedicalEngineering.aspx> (Accessed: 14/02/2021).
3. Human resources for medical devices, the role of biomedical engineers. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.
4. The UK's contribution to the second Global Clinical Engineering Day - 21 October 2017, Available at: <https://youtu.be/uUrgEAOLXZs> (Accessed: 14/02/2021).
5. Global Clinical Engineering Day 2018 - Contribution from the UK, Available at: <https://youtu.be/UFZ9HPQcOY> (Accessed: 14/02/2021).
6. NHS Leadership Academy (2013), The Healthcare Leadership Model, version 1.0, Leeds: NHS Leadership Academy.
7. We are the NHS: People Plan 2020/21 – action for us all, Available at: <https://www.england.nhs.uk/ournhspople/> (Accessed: 14/02/2021).

appreciate how their work was contributing to the aims of the project. Following stakeholder feedback, the Working Group decided to create a video with content presenting the excellent work done by clinical engineers to support the national response to COVID-19, and to accompany this with an extensive communications strategy.

The Working Group agreed that this opportunity to showcase the UK clinical engineering profession nationally and internationally was too important to not be done well.

Team Engagement was achieved by issuing an open call for COVID-19 clinical engineering stories, followed up by regular Working Group planning meetings, email 'in touch' updates to all contacts and prompt responses to feedback, suggestions and agreed actions. An internet cloud-based shared folder supported effective data sharing and increased productivity.

Creating an impact: An experienced healthcare scientist on the Higher Specialist Scientist Training scheme performed a thematic analysis to **Evaluate** all the COVID-19 stories received. This work both helped the project and **Developed (individual) Capability** towards achieving their future qualification.

The stories told were diverse in source and content, but it was thought important to deliver a coherent and high-quality narrative, for maximum effect. Therefore, the Working Group decided to make a professional documentary-style video hosted by a seasoned TV presenter. An overall story board for the video was co-developed from the thematic analysis, with the chosen presenter helping to make well-judged decisions and **Connecting** the Working Group with an experienced production company. Working Group members also used their personal and professional connections to reach out to appropriate senior leaders in the health sector to ask them to participate in the video and to help prepare suitable material for wider communications. The figure summarises established links and actions required by various stakeholders. The timings and frequencies for issuing letters, emails and social media posts were specified in a communications strategy document: for example, letters were to be sent at least 4 weeks in advance of the event followed by a two-week reminder, and weekly social media posts were to be made starting one month prior to the event.

Supporting activity: The project was **Led with Care** by providing participants in the video with the flexibility to choose in-person or virtual interviews at a time of their preference, and by providing a variety of resources as listed in the table. A well-reasoned paper was presented

to secure funding for the project, ensuring **Holding to Account**, and a climate of high expectations was set by championing an ambitious mindset for the project. This included reaching out to the Cabinet Office and the Chief Executive of NHS England/NHS Improvement. Regular **Evaluation of Information** was carried out along government guidelines to help ensure success of the project, looking at relevant policies, production requirements and available resources including funding and time.

Communication Resource	Recipients
Letter signed by presidents of IPEM, IMechE and IET ⁸	For CEOs of NHS Trusts & Health Boards across the UK
Template email, virtual meeting background and email signature banners	For Clinical Engineering Leads and network members. Available on IPEM website ⁹
Logo, Poster ¹⁰ and teaser videos, #GlobalCEDay, Eventbrite (237 registrations) & LinkedIn event (619 attendees) and YouTube premier	For all stakeholders to share in print or digital format, to create awareness and generate interest
Guide to making a video using a smartphone ¹¹	For video contributors

Results

The video: Thirty-one clinical engineers and senior leaders at NHS England/NHS Improvement took part in the final video, which was just over an hour long. The National Performance Advisory Group classed it as, 'lasting testament of the valuable input clinical engineering makes every day'¹². The video not only highlighted contributions made by clinical engineers in responding to COVID-19 but also shared views from those receiving their services including a critical care nurse, the Medical Director for NHS England (London) and the Deputy Chief Scientific Officer at the Department of Health and Social Care.

Its presentation: More than 600 people watched the live premier on 21 October 2020 and many engaged via YouTube chat. It received widespread recognition from the clinical engineering community world-wide, through the IFMBE platform, and from the WHO. Comments included:

'... an excellent work. Very professional. Well done and well-coordinated. A work that seems to be done by BBC. Congratulations', and 'I'm really amazed to see the work UK did. Just amazed'.

It has been watched 3,754 times within four months.

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8. Institute of Physics and Engineering in Medicine, Institution of Mechanical Engineers, Institution of Engineering and Technology (2020) Joint Letter to CEOs, Available at: <https://twitter.com/ipemnews/status/1311689939093000192> (Accessed: 14/02/2021).

9. GCED-UK Working Group (2020) Global Clinical Engineering Day, Available at: <https://www.ipem.ac.uk/AboutIPEM/PublicEngagement/GlobalClinicalEngineeringDay.aspx> (Accessed: 14/02/2021).

10. Basit Abdul (2020) Global Clinical Engineering 2020 poster, Available at: https://twitter.com/Basit_HCS/status/1311363525143650311 (Accessed: 14/02/2021).

11. Basit Abdul (2020) Tips on recording professional video with a smartphone, Available at: https://twitter.com/Basit_HCS/status/1308752918850437122z (Accessed: 14/02/2021).

12. NPAG (2020) NHPAG Clinical Engineering Groups, Available at: <https://www.linkedin.com/feed/update/urn:li:share:6740593856099745792/> (Accessed: 14/02/2021).

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Audience gender distribution is around 42% female and 58% male, and the most frequent viewer age group is 35-44 years (34%) followed by those of 25-34 years (30%), 45-54 years (23%) and 55-64 years (13%).

Social Media Reach: The social media campaign was an integral part of the project. Without it such success would have been impossible. It raised awareness and created momentum. The hashtag **#GlobalCEDay** was used around 740 times by multiple stakeholders, predominantly clinical engineers showcasing their stories and presenting at local events set up for Global CE Day. Several text-based, pictorial and video posts were shared (64 Tweets, 35 LinkedIn posts and 16 Facebook posts). These initiatives were combined, liked and reshared 1,888 times. This generated a total reach/impression/watch number of over 65,000, including impressions on YouTube.

The Deputy Chief Scientific Officer (England) declared the whole event as: 'a phenomenal achievement that has made an enormous impact on raising awareness of the vital work clinical engineers undertake, on a daily basis, that often goes unrecognised. As a consequence, many of our clinical engineers have been invited into their Trust Boards to talk about their work and have received personal thanks and encouragement from senior leaders.'

Discussion

- The quantity and complexity of medical devices used by health professionals is increasing exponentially, as is the need for clinical engineering support. The UK should not

wait until it is too late but should promote and grow our own highly skilled clinical engineers as set out in the NHS People Plan. Celebratory events such as this, carried out on a regular basis, are a key component of a long-term strategy to achieve this.

- A major success of this project was securing funding in a very short timeframe. Obtaining such substantive funding for an investment celebrating and promoting the profession is a landmark in UK clinical engineering history.
- Of the many challenges faced throughout the project, two were particularly critical: the availability of volunteering time, and funding. Work on projects such as this should start at least four to five months ahead of their delivery date, and regular funding should be allocated annually by major stakeholders.
- Expectations from both the national and international CE community are very high for the UK's 2021 contribution to Global CE Day. Some high impact areas of clinical engineering that could provide themes for future events are research and development, and near-patient roles.
- Trailblazing has been done well this year but momentum must not be lost. Continued further engagement is required with health professionals and senior leaders in Government and the NHS to build on what has been achieved.

ADVICE TO CONTRIBUTORS

The AHCS welcomes article submissions relating to leadership in healthcare science. The aims of the Journal are to provide an open and cross-professional forum that supports strategic discussion of healthcare policy, scientific leadership and horizon-scanning of issues that may affect the whole of the healthcare science workforce. It will publish a mixture of papers, reports, articles, commentary and information to inform and inspire those in healthcare science to develop and exercise effective leadership, irrespective of what they do, where they work and what their responsibilities are.

Full guidelines for authors are available on the Academy for Healthcare Science website at:

<https://www.ahcs.ac.uk/news-events/events/advice-to-contributors/>



SERENDIPITY AND HAPPENSTANCE



**Ruth Thomsen,
Audiologist and Scientific
Director for NHS England
(London), answers our
questions about her career
pathway**

What was your earliest leadership experience?

My first job was picking and sorting fruit on a farm in Scotland, where I grew up. In my first summer, I was asked to supervise and help other children. I was eleven.

What attracted you into audiology?

At 19 I came to London after dropping out of science 'A' levels. I needed a job and saw an advert for a trainee audiology technician at St Mary Abbott Hospital in Kensington. The work looked interesting – and you got paid while you trained! I loved it and came into contact with healthcare scientists working in other areas such as cardiology, perfusion, neurosciences and respiratory function. It was a great start.

Where did you go after your training?

Initially I worked as a basic grade technician at the same hospital. I took on extra responsibility, including training other audiologists and setting up a hearing service in the community. I went on a travel fellowship to see how domiciliary visits were managed in the USA. I was promoted to Chief Audiologist at 24 and helped move the service to Charing Cross Hospital, whilst fighting to keep a hearing aid service on the St Mary Abbott site. I'm pleased to say it's still there.

What made you want to do more?

By age 27 I knew I didn't want to be a service manager and wondered what to do next. An opportunity came up to spend a year in Africa with an audiology charity, delivering services and supporting local clinics. I learnt so much, including how to get through checkpoints without paying bribes or getting shot (keep calm and be respectful).

What happened after that?

In 1995 I went to work for a hearing aid manufacturer in Denmark. They were launching their first digital hearing aids. I trained lead audiologists from around the world in digital technology. I worked with highly skilled people from many cultures and backgrounds. The company was very different to the NHS – paperless and non-hierarchical. Job titles were irrelevant, it was what you did that mattered. I returned to the UK as a part-time lecturer in audiology, later expanding this into a full-time role by taking on clinical work in Imperial Healthcare. I also got involved

in education and training with my professional body. I helped set up regional networks, then became President of the British Academy of Audiology just as Modernising Scientific Careers was being developed. I was encouraged by the CSO Office to apply for a NHS National Clinical Fellowship and was one of three healthcare scientists accepted for the year-long leadership programme, alongside doctors and other health professionals. Its Masters-level mix of academic and experiential learning was the first time I had been on a university course. Afterwards I was seconded to the CSO office two days a week, to work on the 'any qualified provider' programme in audiology. My current post was advertised just as I was thinking of making a change. Its wide remit attracted me, as did my passion for the NHS. The job advert called for a PhD or equivalent level of qualification, so I had to show how my experiences had prepared me to operate at this level.

What are you leading on at the moment?

I recently gave up my weekly clinical day to lead a national project improving hearing services for people with learning disabilities and with autism. This initiative puts patients and their families at the centre. It's like the COVID vaccine project– we are designing, delivering, testing and collecting evidence on new ways of doing things, all at the same time. I am also continuing to work with the Academy and HEE on funding and delivering mid-career leadership training to healthcare scientists through the Practical Skills in Education Training and Leadership (PESL) programme and an Advanced PESL course. And I've just got £4m to spend setting up leadership training in pathology!

What has your leadership journey felt like?

A series of adventures. I never had a career plan. I am a great believer in serendipity and happenstance. It has been challenging and difficult at times, but I've loved it. I've had great support and encouragement from inspiring leaders at every stage of my journey, including my family, supervisors, peers and children!

What gives you the greatest satisfaction from being involved in leadership?

There is that poignant moment in a leadership group or action learning set where suddenly there is silence. You can almost hear people thinking; and then change happens. It's that moment when people move things on themselves.

What has been your most encouraging moment?

Most recently? A showcase event when our Healthcare Science Fellows in London gave five-minute presentations. The Chief Executive and Medical Director of NHS London were blown away by it.

1. *Mining Hidden Gems: a report on PSEL. NHS Leadership Academy/Academy for Healthcare Science, 2018.*

2. See for example: <https://marcr.net/marcr-for-career-professionals/career-theory/career-theories-and-theorists/planned-happenstance-theory-krumboltz-levin/> (Accessed 28/2/2021).

THE EVOLUTION OF NEW HEALTHCARE SCIENCE ROLES - CLINICAL RESEARCH PRACTITIONERS AND THEIR JOURNEY TO RECOGNITION



**Fiona O'Neill,
The Academy's Head of
Registration Services for Clinical
Research Practitioners, shows
how this important new role has
emerged and charts the road to
registration**

The fight against COVID-19 and the incredible effort to develop vaccines and treatments to limit the impact of the pandemic has put the spotlight on the role of research like never before. After many years of trying to explain why I am passionate about clinical research and my role in supporting the development of the research workforce, finally my friends and family understand. The future would indeed be looking bleak without the dedication and expertise of all those who have contributed to the research effort over the last year.

Here I am focusing on a particular section of the research workforce: Clinical Research Practitioners or CRPs for short. As key members of front-line research delivery teams, CRPs are crucial to making research happen in health and social care settings. The journey to develop the professional identity of this group, including a continuing and productive association with the healthcare science profession, illustrates the importance of leadership and a strategic approach to supporting the development of new roles through innovation and collaboration.

Clinical Research Practitioners are an essential part of the research delivery workforce. They work in patient facing roles, performing tasks including receiving consent, monitoring, and recording trial related information, always working to required ethical standards. The role has developed over the last 15 years in response to the policy drive to integrate research activity into health and social care, enabled greatly by the research infrastructure put in place by the National Institute for Health Research (NIHR).

The expansion in the CRP workforce happened gradually, often driven by local workforce considerations rather than a planned approach. In urban areas, particularly in London, where it was not productive to rely on recruiting research nurses, supporting the development of a research practitioner career pathway provided an effective way to diversify the workforce. CRPs bring a variety of skills and attributes that complement those of their clinical colleagues. They are usually graduates, and a significant number also have masters level qualifications. In addition, CRPs often bring industry or other research related experience, and are motivated to make a difference by working in front-line research roles with patients and healthy volunteers.

As funders of the research delivery workforce, the NIHR Clinical Research Network committed to investing

in the development of the CRP workforce at national level. This has proved to be a fairly long and interesting journey. Policy documents focus on the need for flexibility and innovation in the NHS workforce but in reality, the established statutory regulated professions often dominate thinking. This is no different in research, where attention is focused on the investigators leading research teams and the more established clinical research nursing workforce. Yet the evolution of CRP roles illustrates the importance of having strategic oversight of the workforce so that trends and best practices at local level can be shared and influence strategy at national level.

One of the biggest challenges at the start of the journey was to find ways of connecting and engaging with CRPs and to start to build the community. Influenced by the literature and evidence around Communities of Practice, one of the first steps was to reach out to people working in CRP roles and invite them to a series of events that helped to define the community and build a coalition of interest for this work. These early developments helped to build a shared understanding of the role and a common language. These events also provided opportunities for CRP leaders to emerge from the community who will play a vital role in supporting continuing work.

The second major influence came from the guidance and partnership working provided by the Academy for Healthcare Science¹. The vision of the Academy is to speak with One Voice for the Healthcare Science workforce, enhancing its recognition, reputation and regulation. This focus on visibility, contribution and voice chimes with the ambitions of CRPs. Furthermore, the Academy's experience in establishing accredited voluntary registers has provided a much needed route map.

The Academy launched initially a Directory for CRPs in the autumn of 2018, and this helped to build the community of practice, providing a platform for engagement and consultation. An agreement was also reached to start the process of establishing an Accredited Register for CRPs as part of the Academy's Professional Standards Authority (PSA) Accredited Register. The process of meeting standards set by the PSA for approval of the register played a pivotal role in development of the CRP Scope of Practice, Standards of Proficiency and associated requirements for entry. Using the principles of 'right-touch' regulation at the heart of the PSA accredited registers programme also made sure that patient safety and assessment of the level of risk informed the approach.

After a period of piloting, the new register for CRPs will be launched in the spring. We have over 700 members in the Directory and indications are that interest in and support for joining the register is high. Our experience suggests that the journey to regulation provided a valuable

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1. <https://nihr.ahcs.ac.uk/>

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route map to enable the development of innovative new roles in ways that put patient safety at the centre. The opportunity to join the healthcare science workforce through partnership with the Academy also provided the leadership and expertise required to put aspirations and ambitions into a concrete plan of action.

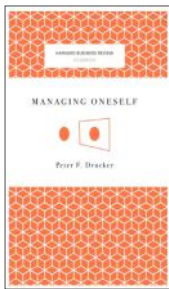
Opening up new career paths to graduates looking for satisfying and productive work in the NHS makes a lot of sense in the current economic climate and against a background of continuing and acute nursing shortages. Enabling a more diverse workforce to flourish will ensure that the research delivery workforce continues to support the UK's strong research base into the future.

I hope that our continuing journey to establish the role

and career pathway of Clinical Research Practitioners will contribute to a much-needed evidence base about how to develop new roles within the NHS workforce. The productive partnership with the Academy and the opportunity to join the Healthcare Science family illustrates the value of collaboration and shared learning.

As we move forward with the optimism that science has given us all, we should celebrate the commitment and expertise of all those involved in the national research effort. From a place of relative invisibility CRPs are now firmly on the map. As we get ready to launch the register and the first Academy awards for CRPs, we look forward to saying thank-you and celebrating these next steps on the road to recognition.

CLASSICS CORNER – MANAGING ONESELF BY PETER DRUCKER



Keith Ison reflects on the messages from a classic publication which helped him throughout his career.

“Most people think they know what they are good at. They are usually wrong.” So begins the first section of Peter Drucker’s classic monograph on the importance of understanding yourself. His view is that to unlock your potential and make a lasting difference you need to know what your strengths are.

There is nothing new about this, of course. “Know thyself” is an ancient proverb cropping up in various forms everywhere from ancient Greek temples to Imperial China. Drucker’s short book focuses this exhortation into several key questions to help his readers develop their strengths and use them appropriately – what helps us perform, how we work best with others, and where our values lie.

“Successful careers are not planned. They develop because people are prepared for opportunities because they know their strengths, their method of work, and their values.”

Originally published in Harvard Business Review in 1999, the title comes from the now commonly-held belief that it is not the job of employing organisations to take responsibility for their workers’ lifetime careers, but that this should be left to individuals to manage themselves. The paper

seeks to provide ideas to help people navigate their own unique journey, based on the author’s long career and extensive experience in management and leadership .

The monograph avoids discussing theories of leadership and management. Its wisdom is practical, built on a deeper tradition of the importance of self-understanding in developing empathy and tolerance for the benefit of ourselves and others. It is clearly and sparingly written, with simple yet profound insights and cogent examples.

Its content reflects the time in which it was written, but it has dated surprisingly well. For example, there is a short section on the importance of good manners to getting things done that would be worded differently if it was to be written now. However, the truths it contains remain unaltered and are explored again later when looking at how we take responsibility for relationships and working with others.

Towards the end of the paper the author addresses two questions: “What should I contribute to?” and, “How do I make the greatest contribution to what needs to be done?” Its advice on reaching an answer to each is as applicable to introducing a scientific development as it is to taking forward a personal interest in climate change. The paper finishes by considering the importance of developing new or parallel interests in one’s career.

One of the great strengths of this paper is that its content remains relevant irrespective of your career stage and the context of what you are doing. I re-read part or all of it every year and always come away with good ideas and helpful advice. I recommend it to you .

“ Successful careers are not planned. They develop because people are prepared for opportunities because they know their strengths, their method of work, and their values. ”

1. Peter Drucker was an Austrian writer, teacher and management consultant who advised individuals, corporations, governments and public service institutions. He died in 2005.

LEARNING FROM DISASTER



Geoff Lester,
AHCS Non-Executive Director,
comments on a recent King's Fund
article about recovery from disasters
other than COVID and what health
services can learn from them

The Covid-19 pandemic has thrown previously unseen scientists, doctors, and public health specialists into the public gaze on a daily basis. Expert scientific leaders are in the media explaining complex concepts and techniques such as viral genomes, RNA, patient ventilation, prevalence of infections, sensitivity/specificity of tests, efficacy of vaccines and epidemiology. It has been a landmark in popular science education!

The scale and speed of the science and its delivery has progressed rapidly, encouraged by skilled scientific and technical leadership. Most of this feverish activity has been focused on the "immediate response", even if we are now a year into the pandemic. The King's Fund, an authoritative source of evidence-based comment on health policy, has produced an on-line, long-read article¹ that takes a wider look at the prospects for successful personal, local, national, and international long-term recovery from the impacts of this event. Using evidence from those involved in multiple disasters over the last 20 years, including 9/11, Hurricane Katrina, Grenfell Tower, earthquakes, the Manchester Arena, and the SARS outbreak, the authors analyse features that influence two things: how those communities affected have journeyed towards recovery; and how systems have attempted to build greater resilience against future disasters. Their focus is primarily on the repair of individuals and their communities rather than on physical and environmental details. 'Community' is used in the widest sense: it could be your work team, your institution, your family and friends, your locality, or your nation.

Although most examples cited in the paper are acute traumatic events with physical damage to people and property, all have taken a long time to recover from and have had significant emotional impact. Hence the authors' observations of long-term effects and subsequent recovery contain very pertinent lessons for today's health system leaders.

The article first presents general emotional responses people have at different stages of a "disaster"². Two early messages are that this process takes a long time, and that it does not follow a clear linear pathway. Recovery takes a decade or more, with periods of rapid progress and multiple setbacks. The time taken by individuals or particular communities to recover can vary enormously, and some never regain their original level of function.

Evidence suggests leaders should treat four key areas

as priorities:

- give attention to mental health and well-being. Assess levels of need in the community and work to meet these.
- recognise differences in the pace of recovery. Make sure individuals or communities that are recovering more slowly do not get left behind.
- make collaboration work. It pays dividends for future resilience.
- prioritise workforce wellbeing. This is especially important for the health and care community on which the rest of the population needs to rely, especially during the early phases of a disaster.

On mental health and wellbeing, the paper observes that very few care providers will seek help for themselves. Simply making it available is not enough. This is not about formal referral to mental health services. It is about awareness and informal support, being sensitive to people's needs and providing opportunities for those involved to come together to share their experiences. Leadership means taking the first key steps in recognising and answering the need, a need which may persist for much longer than might be expected.

Disasters exacerbate existing inequalities. Ensuring (your) community and colleagues are not left behind means encouraging less visible groups, as many in healthcare science regard themselves, to engage with those in system leadership positions. "Getting up close and personal" to understand hidden issues tends to result in more successful disaster recovery and, importantly for the future, improves resilience.

Collaboration in these circumstances – forging a new common purpose when each component is itself challenged – is difficult but potentially very rewarding. It requires trusted and respected leaders to take on the role of system "connectors".

A crucial lesson for those in healthcare science is to pay attention to the wellbeing of themselves and their colleagues. Individuals are, at the same time, both victims of the disaster and also looked to by society to provide the support it needs. Pressures from this pandemic will be enduring, as the system struggles to recover from growing waiting lists and the consequences of treatment delays. The overall impact is therefore likely to be much longer lasting than might be expected. For example, after the Japanese earthquake of 2011, sickness absence remained high for 18 months and stress-related depression in nurses lasted at least four years. It was also observed that all staff groups are affected, irrespective of role or degree of patient contact. The message to leaders is to be ready for this and show patience, whilst acknowledging that usual methods of staff support are not enough. Organisations should think now about the risks their staff are experiencing and find out how properly to support them.

1. <https://features.kingsfund.org.uk/2021/02/covid-19-recovery-resilience-health-care/> Accessed 10/3/21.

2. Disaster phases: see <https://www.samhsa.gov/dtac/recovering-disasters/phases-disaster> (Accessed 10/3/21).

VIEW FROM THE ACADEMY FOR HEALTHCARE SCIENCE



Janet Monkman, Chief Executive, Academy for Healthcare Science, explains the importance of the Strategic Review of the Accredited Registers Programme¹ in terms of patient safety and workforce development

The AHCS Register was accredited by the Professional Standards Authority (PSA) soon after the Accredited Registers programme was introduced eight years ago. Accreditation of voluntary registers addressed the clear discrepancy in public protection between health and care occupations which were subject to statutory regulation, for example clinical scientists and biomedical scientists, and those groups which had no form of independent assurance whatsoever. The programme has provided a system of oversight for these vital areas of the wider health and care workforce, creating a benchmark for standards of practice, and strengthening public confidence in these professions as whole.

The Academy welcomes the PSA's Strategic Review of the Accredited Registers programme. It is an opportunity to focus on future priorities that provide the public and those working in health and care with the clarity they need.

Working towards and maintaining accreditation for eight years has been a major commitment for the Academy and for those who joined our register. It is crucial, therefore, that we take this opportunity now to ensure that the programme is as effective as it can be, and that it is fit for the future.

Perhaps it is also a great opportunity to explore how the programme can get better engagement and involvement from Regulators such as the Care Quality Commission (CQC), the NHS, employers and the public. The Review provides the opportunity for this, and I hope that these groups contribute their opinions and provide advice and evidence.

The Strategic Review of the Accredited Registers programme

The Register Programme has a great deal of unfulfilled potential in respect of its use by employers, especially the NHS. But for it to really have a significant impact on patient safety and workforce development, it must be integrated into the mainstream and fully utilised by the NHS and employers. Complete support and recognition from these institutions will give the Accredited Registers programme the opportunity to demonstrate added value to patients, the public, the NHS, employers and of course, registrants. Making accredited registers a requirement for employers using healthcare practitioners in unregulated roles will enable them to develop a sense of identity and of being appreciated. Unified standards and entry points onto accredited registers will be better understood, will

improve the level of patient care and create opportunities for all staff to be further developed and valued.

The public will also have more information than may currently be available about those in healthcare science looking after them. Whilst there is always a great deal of talk and media interest in doctors and nurses, much less is said about other groups in the workforce. Creating accredited registers for other professional groups is therefore likely to improve long term recruitment into the NHS and other areas of health and social care. The Accredited Registers programme also enables accountability by encouraging the ongoing use of standards to seek improvements in the quality of patient care.

In addition it will be helpful to see greater use of a single register for professions which currently have multiple registers covering a variety of professional groups, such as is the case in healthcare science. A proliferation of registers is confusing for the public and employers – leaving them with the burden of choice as to which register to use in relation to standards in a given profession. Accredited registers are supposed to make this process straightforward and self-explanatory. It also suggests greater divergence – if these professions are all meeting common standards, which are assessed through a similar process, then there is no need for duplication. Reducing duplication of governance systems will also be a means by which sustainability of the registers and costs to registrants can be addressed.

The AHCS welcomes the proposal for a tiered system within the Accredited Registers programme in the future. The current approach does not consider the varying levels of risk between different professions, and how some of these risks must be managed and mitigated through entirely different mechanisms. It is not as simple as statutory versus non-statutory regulation - some registers require measures such as licensing, while for others this would not be appropriate.

This change could enable a “right-touch” approach that is appropriate to the level and nature of risk. Healthcare scientists can pose a level of risk even without direct contact with patients, for example if a practitioner obtains inaccurate test results leading to a misdiagnosis. It is important to ensure that any changes to the programme, such as a tiered system, are embraced by employers and other stakeholders to avoid falling at the first hurdle.

The Strategic Review will give insight and hopefully direction for the way forward. There is no going back - there is simply too much at stake for the public, for patients, the workforce and for healthcare if we were to lose the system of oversight that accreditation brings. There is a breadth of unfulfilled potential that can be realised if it were seen to be something that works for all and is recognised by all – the public, the NHS, employers, and the Government.

1. <https://www.professionalstandards.org.uk/news-and-blog/latest-news/detail/2020/06/08/the-authority-announces-a-strategic-review-of-the-accredited-registers-programme>

NEWS ROUND UP

ACADEMY NEWS

The Academy for Healthcare Science is really pleased to facilitate this HCS Leadership Journal.

Click here <https://www.ahcs.ac.uk/news-events/news/> for further news and journal opportunities.

Contact us on admin@ahcs.ac.uk if you have any further queries about the Journal or the work of the Academy.

FUTURE TECHNOLOGY WEBINARS

IPEM and City, University of London are jointly running four public webinars in 2021 entitled STEM in Healthcare. These seminars aim to stimulate thinking by presenting cutting-edge STEM research and innovation in healthcare. Future topics include artificial intelligence and technology challenges. The next webinar is 'Cybersecurity in Healthcare' on Thursday June 17th at 11am.

<https://www.city.ac.uk/news-and-events/events/2021/06/webinar-series-stem-in-healthcare-cyber-security-in-healthcare>

MEDICAL DEVICE GUIDANCE

IPEM has produced a guidance document on good practice to follow when manufacturing and using medical devices (including software) within the same health institution. Its principles also apply to 'off label' use and non-medical devices. It will be updated as new UK guidance and legislation is issued. See:

<https://www.ipem.ac.uk/ScientificJournalsPublications/FreePublications.aspx>

SAVE THE DATE

Save the date for the Advancing Healthcare Awards for Allied Health Professionals and Healthcare Scientists. This is a virtual ceremony this year on the 21 May 2021. Everybody welcome.

#AHAwards



GLASGOW NEWS FEATURE ON THE PANDEMIC

Two healthcare science staff were featured in The Herald magazine in March 2021.

Lisa Miller, a clinical photographer, undertakes vital work capturing images for remote diagnosis and photographing staff and patients. One of her striking images appears in the National Portrait Gallery's on-line exhibit Hold Still which presents a collective portrait of the UK during the pandemic. Lisa's entry was one of 100 chosen from 31,000 submissions. See <https://www.nhsggc.org.uk/about-us/media-centre/news/2020/09/national-gallery-image/>

Ted Mullen was seconded from his job as head of medical equipment management in Glasgow to a role with the Scottish Government. He still helps to make sure there is enough equipment for patients



demographic planning. "So much good and innovative work has been done by a great team of dedicated staff", he said. "And I never dreamed of a change of career at my age". Ted has put his retirement plans on hold for a year to help out.

NEW DIRECTOR FOR NATIONAL INSTITUTE FOR HEALTH RESEARCH NETWORK



Anthea Mould is the new Director of Organisational Development and Learning for the National Institute for Health Research (NIHR) Clinical Research Network. After 15 years as a clinical pharmacist, Anthea held senior leadership roles in the NHS and pharmaceutical industry. She believes passionately that people are an organisation's most important resource. "We have the most amazing talent in the NIHR. Clinical Research Practitioners are critically important to high quality UK research and I'm excited to support the development of this profession."

CHIEF SCIENTIFIC OFFICER'S CLINICAL FELLOW SCHEME

Dame Sue Hill has announced that applications for the innovative Chief Scientific Officer's Clinical Fellow Scheme have now opened. With healthcare science at the forefront of the public's mind, Dame Sue says that this will help develop and inspire the next generation of healthcare science leaders.

Closing date 26 April 2021.

