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CHSS
University of Kent

Centre for Health Services Studies

CHaL
Children's Hospices across London

A Learning and Development Strategy for Children's Hospices across London

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Material from this report may be used only with acknowledgement to the authors and the CHaL Learning and Development Group. Hospices that attended the group are:

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A Learning and Development Strategy for Children's Hospices across London

April 2011

1 Introduction

This document sets out a learning and development strategy for Children's Hospices across London, referred to throughout this document as CHaL. It is the culmination of a four month project, with funds awarded to CHaL by the Department of Health as part of a range of projects to support the development of children's hospice services across the UK. The funds enabled CHaL to commission academics from the Centre for Health Service Studies (CHSS) at the University of Kent from November 2010 until March 2011 to undertake the work in partnership with CHaL Learning and Development Group (LaD) (see appendix 1 for membership).

This project lays the foundation for the development of a sustainable and unified approach to learning and development by bringing together policy, practice and evidence, and interfacing with regulatory requirements that have recently been strengthened for hospices and that are inspected by the Care Quality Commission (CQC). It commences with CHaL's vision for learning and development, follows with project description and methods, and summarises the initial scoping conducted to underpin the strategy. The subsequent analytical and conceptual development of the strategy is described, alongside a rational for aligning thinking with the CQC essential standards that are inspected. The project had a unique opportunity to link in to a set of three national workshops for hospices arranged by Children's Hospices UK (CHUK) and working with CQC that served to act as a consultation forum; this process is described.

Throughout the project a number of key issues were articulated, captured and formed into a set of key strategic principles that the CHaL LaD Group will now use as the basis for an Operational Plan for the children's hospice services that work in London and form the membership of CHaL. It is hoped that, whilst London has some unique opportunities, these might be useful for other children's hospice services throughout the UK, not least because of comments made at the national workshops that have been incorporated. These principles, plus the vision that follows, are key to understanding the scope of this document, and the more detailed sections that follow, plus the appendices, supply the evidence.

Key strategic principles

CHaL will:

➤ **Implement an organisational culture that has the proposed learning and development strategy at its centre a) because it is good practice and b) because it provides a link to regulatory requirements in a way that will ensure that hospice services meet those (recently enhanced) regulatory requirements. This includes developing the workforce by supporting and motivating all employees and volunteers to become life-long adult learners, and developing a common and embedded implementation of staff appraisal**

➤ **Develop consensus about evidence-based approaches to learning that make visible the specialism of children and young people's palliative care. This includes developing and agreeing core competencies and mandatory training common to all CHaL members. In addition, shared programmes for induction and skills development will be designed, and learning pathways for specific roles across organisations will be created.**

➤ **Develop a teaching and learning evaluation framework for common use. This will include determining broad learning objectives to be measured against stakeholder focused outcomes and the construction of valid and reliable tools applicable to all learning environments.**

➤ **Produce a business plan to take advantage of the opportunities offered by economies of scale and encourage effective and efficient use of resources for learning. This includes taking advantage of the geographical proximity of CHaL members, the potential for shared procurement and the possibility for developing education services that can be marketed across London to other providers.**

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2   Vision for Learning and Development

Since the earliest discussions between the children's hospices in London that have led to the formation of CHaL and the vision of moving from independence to interdependence, the theme of learning and development has been key. This is particularly the case because of the geographical and strategic opportunities presented by being the children's hospices that serve children, young people and families across the capital.

This led to agreement to establish a project that would develop a "Training and Education strategy including a core training pathway that encompasses mandatory and required training, competencies pertaining to palliative care (e.g. medicines management) and other training that the hospices have in common. A strategic approach can also include student placements across a variety of settings (not just within children's hospices), staff rotation and other training opportunities". Whilst the project as it has developed has not necessarily addressed all these specific matters the outcome opens the way to any number of possibilities.

It has also been suggested, and subsequently embraced, that this is a learning and development strategy in order to emphasise that people should take responsibility for learning (rather than simply being taught) and can take that responsibility given the right opportunities. The graphic below illustrates the key components of how members visualise the learning and development strategy.

The four dimensions are interrelated and signify that the strategy should project an approach that **unifies** and **shares** current good practice and **evidence** in how it **develops the workforce** and enhances the skills base**.** It is important that the core work of hospices, how they care for and support children with complex needs and their families, is rendered more **visible**, not only **internal** to the hospice movement, but **externally** to other current and potential stakeholders and publics. This will promote a better understanding of hospice philosophy and activity, and improve multi-agency connections. While the project is concerned with forming a strategy for CHaL, there are aspirations for the project outcome to have wider applicability; therefore the work has been undertaken with the opportunities for **national transferability** in mind.

3   Background to the Project

Those responsible for learning and development within the children's hospices across London (CHaL) have been meeting as a group and have identified the need for a shared strategy that makes stronger links between policy and practice. The general feeling was that there has been too much duplication of effort and resources, and the project seeks to change this, with the formation of a transferable training function emanating from CHaL that might ultimately sell training to other services.

The specific aims of the project were to:

- Consider policy and practice that has been established for children's palliative care.
- Audit current policy and practice at the children's hospices in London.
- Identify good practice and gaps across London.
- Report back to the CHaL learning and development group with initial ideas and possible proposals.
- Establish a consultation event that will give a broad range of people, including users, the opportunity to comment.
- Write the first draft of a learning and development strategy by the end of March 2011 that the group will use to underpin its future work.

The work CHSS has carried out fell into three main activities; reviewing relevant literature, surveying current practice, and combining these into a learning and development strategy. Literature searches were made of the key policy documents and the legal requirements relating to children's hospices. A substantial part of the literature searching was to find research evidence on best practice in training, by reviewing current training approaches, philosophies, motivations and learning cultures, and including how people are encouraged to take responsibility for their own training; planning and evaluation.

The survey of current practice at six children's hospices was to build on existing work (for example from Little Havens, part of the project group though not formally in CHaL) and seek to identify and compare good practice examples. The focus was on ascertaining existing learning and development strategies, what courses are provided and to whom, how training is organised and delivered, how learning needs are identified and competencies assessed, and perceptions of their respective organisational learning cultures.

3.1 Literature review

The review was to provide a critical overview of published literature and identify indicators of good practice for guiding and underpinning the learning and development strategy.
An initial web-based search was made for the years 2000-2010 drawing on a variety health-related search engines), and relevant websites such as the Department of Health, Care Quality Commission (CQC), Health Service Executive, Skills for Health, Children's Hospices UK, and Association for Children's Palliative Care (ACT). Key words used were firstly 'children's hospice' as a lead, then 'hospice' and 'palliative care'. When little was found directly related to hospice care, a more generic search was made, including books on aspects of training and learning. Material from the wider search is included where it is deemed relevant and transferable.

There are a number of documents on this subject that have been published or are in preparation since the review was completed, which the CHaL Learning and Development Group will need to take into consideration in future strategic planning. This includes the ACT/RCGP/Skills for Health document 'Working with Children' which looks at ways of developing the multi-agency workforce to support children with life-limiting and life-threatening conditions.

The key emerging themes from the literature review are given here and a fuller version is given in appendix 2.

3.1.1 Policy, guidelines and legislation

- Only a few relevant policy/guideline documents were found for workforce development in palliative and/or hospice care that addressed training. These include

    NICE (2005) Improving Outcomes in Children and Young People with Cancer[1]

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[1] National Institute for Clinical Excellence (2005) Improving Outcomes in Children and Young People with Cancer. London: NICE

Palliative care services for children and young people in England: an Independent Review for the Secretary of State for Health[2]

(ACT) and CHUK (2009) Right People, Right Place, Right Time[3]

- With reference to legislation, the Health Service Executive sets out workforce training regulations with respect to capability and competence, and the management of health and safety at work. This should include manual handling injury risks and prevention, and fire training. It is the employer's duty to determine what the training needs of their employees are. There are no specific requirements for hospices and lack of clarity.

- The Care Quality Commission has published guidance based on all the relevant legislation for compliance of organisations providing health and social care, and CQC's Essential standards of quality and safety document gives the outcomes that CQC inspectors look for in hospices.

3.1.2 Current training approaches

- Interprofessional approaches seem to be effective in enhancing organisational cohesiveness and values, and centralising training around practice improves understanding of respective staff roles within the hospice.
- Different teaching and learning methods have been shown to be effective in the hospice environment. These include role play, in-depth skill building workshops, interactive lectures, small group facilitation, trigger videos with interactive participant discussions and self-learning modules.
- Other effective styles of learning include mentorship, clinical supervision, reflection (key in hospice and palliative care), work-based learning, self-directed learning (SDL) (the internet and computer-based tools have widened the accessibility, scope and appeal of SDL), and e-learning.
- Competencies have been shown to be important for standardising tasks across agencies. There are a range of tools available, some of which are directly related to children with complex needs (Coventry and Warwickshire) and others that are more broad in their application (Skills for Health). CHUK and GOSH have a range of guidelines on caring for children with complex needs.

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[2] Craft A & Killen S (2007) Palliative care services for children and young people in England: an Independent Review for the Secretary of State for Health. London: Department of Health
[3] Association for Children's Palliative Care (ACT) & Children's Hospices UK (CHUK) (2009) Right People, Right Place, Right Time. London: ACT/CHUK.

3.1.3 Philosophies underpinning training

- Only a small number of articles indicated an underpinning philosophy to training and these were interprofessional and collaborative courses in hospice and palliative care. They focused on promoting multiprofessional working and an holistic approach to patient and family care, one that revolved around the concept of the patient and family directing their own care.

3.1.4 Motivation and learning cultures

- An important factor here relates to the organisation. Those that create positive learning environments also motivate staff to be life-long learners. This can be done through the use of key leadership roles, change-management approaches, and having team-based learning structures that prioritise learning, empower change, and involve staff.
- Organisations can promote a positive learning culture by addressing pressure of work, reducing feelings of apathy in staff and creating forward thinking environments. Good practice in supporting staff is connected to a positive sharing and learning culture.

3.1.5 Planning and evaluation of training

- A crucial element in planning is the skill needed, which should be obtained through qualified professional trainers, and corporate training programmes. Expertise should be evident in presentation skills, curriculum design, group process skills, educational psychology and organisational development.
- With evaluation, there are different evaluation models that have been used in palliative and hospice care using formative and summative approaches - Bailey & Littlechild (2001)[4] and Phillip (1997)[5]. Evaluation focuses on the goals of learning and the extent to which they have been met, but methods of evaluation depend on the aims and outcome of the course, and there is not a single approved method.

3.1.6 Summary

There were a range of studies addressing good practice that have the potential to provide evidence to underpin the development of a shared strategy. Of particular importance are interprofessional approaches, mentorship and clinical supervision, and establishing a positive organisational learning culture. It must be noted however that the studies were in

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[4] Bailey, D. and R. Littlechild (2001). Devising the evaluation strategy for a mental health programme. Evaluation 7(3): 351-368.

[5] Phillips, J. (1997). Handbook of Training Evaluation and Measurement Methods. Houston, TX: Gulf-Publishing Company.

general quite few although collectively amounted to a small body of evidence, particularly with respect to current training approaches.

3.2 Current practice

From visiting the six members of CHaL and Little Havens in Essex, it was clear that they had advanced the organisation of staff training and learning in different ways according to available time and skills, and as a result there would be benefits from more systematic sharing of what had been done. The following summarises current practice, and the full version appears in Appendix 3.

3.2.1 Learning and development strategy documents

Hospices differed in the extent to which they had developed their own learning and development strategy documents. Some had none, while others ranged from having short documents or diagrams to having more fully described strategies. A template has been put together combining the best of these and incorporating web-based advice for the voluntary sector (see appendix 4 'Learning and development strategy template').

3.2.2 Identifying what training should be covered

There was general agreement that it was a major task to establish precisely what training was required of staff. As well as keeping up to date with legislation such as fire, safety, food preparation, basic life support and infection control, hospices were affected by changes in the inspection regime that left them uncertain about how they would be assessed and where they could get unambiguous information to help them.

One hospice had spent a considerable amount of time identifying the mandatory and other important topics for training and shared their work with others. A set of detailed spreadsheets had been developed which showed training topics and the reason for including them, such as legislation, CQC or organisational requirements. The spreadsheets showed how long the courses were, who delivered them, how often they were run and how often staff needed repeat or refresher training. Spreadsheets also matched the appropriate level of training with specific staff groups and indicated where a higher level of training was required for more senior staff. This was a clear example of good practice that was informally being shared.

3.2.3 Organisation and delivery of training

The CHaL group of hospices differed in terms of where responsibility for training lay and the number of full or part-time staff supporting education. The responsibility was sometimes

taken by Human Resources, sometimes the lead person was non-clinical, but more usually there was a clinical lead training person.

Hospices organised their own training sessions, some during an annual shutdown period, and others through planned events spread throughout the year. They had developed their own induction programmes for new staff and had established links with people or organisations that delivered the training. Some had built up reciprocal arrangements with hospitals or universities to provide places on courses, and these operated on an informal basis.

Hospices employed a wide range of learning approaches to suit the staff group and the subject (internal and external trainers, interactive sessions, occasional use of on-line, CD and DVD resources). Clinical staff were learning through supervision, observation and mentoring, and undertook self-directed learning followed by assessment. Hospices wanted training to be delivered to a consistent standard, and some hospices stressed how important it was to train the trainers. From a low starting point, CHaL hospices wanted and expected to make more use of e-learning tools.

Each hospice was broadly happy with the training they organised, but small organisations did not all have sufficient space to accommodate the training sessions. With small staff numbers, it was only feasible for most hospices to run an induction programme once a year. The CHaL group did not seem to share training courses or expenses. Some felt that the distance to travel was a deterrent to sharing, and some saw in-house training as an opportunity to reinforce organisational vision and values and strengthen the way staff work together. In general there was no over-riding reason for not working together more, and some suggested that training of new personnel could be run across the London children's hospices.

3.2.4   Measuring competencies and assessing skills

Competencies established elsewhere for both clinical and non-clinical tasks were used in various ways by the CHaL group. Some of the nationally developed competencies were seen as quite generic (e.g. Skills for Health, Skills for Care, the Royal College of Nursing). Other more specific clinical competencies were used, but had limited transferability, such as the Coventry & Warwick framework for care of children and young people with complex health needs. One or two used Great Ormond Street Hospital clinical guidelines. Issues were that these frameworks were too cumbersome to use or did not cater for the specialised work of children and young people's palliative care.

Some CHaL members had developed their own methods in terms of how they described, taught and assessed staff competencies. A few had written their own versions of

competencies and some had also written supporting training and assessment material, such as workbooks and pro-forma for keeping training records.

3.2.5 Staff appraisals and training plans

Hospices were quite similar in having appraisal processes in place. All hospices had annual staff appraisals and these fed into identifying and planning staff training needs. However the success of the processes varied and some said that assessing staff competencies was difficult to do. All hospices had budgets allocated for staff training.

Linked to the appraisal process was the issue of maintaining training databases and ensuring staff were up to date and safe to practice. It was important to record staff's skills, training attended, whether standards were achieved, when updates are required, and to plan future training needs. For several hospices, a good database had not been set up, and for those that had one there were issues of ownership and accessibility.

3.2.6 Learning culture and best practice

Hospices varied in how well the culture of learning was adopted by all staff. Some believed there was a poor training culture among managers, or an organisational reluctance to change. Some hospices were trying to instigate good practice, such as all staff having to undergo training whatever their seniority, and having systematic evaluation of training and assessment of the subsequent impact on individual staff performance. Hospices were generally keen to follow evidence based practice, both in terms of the care given and the kinds of training to deliver it.

3.2.7 Summary

A range of good practice examples were identified within CHaL for learning and development. There was recognition and a will that skills and resources needed to be shared in order to capitalise upon the individual strengths of each organisation, and to overcome the tensions associated with the need to develop a competent workforce and the available assets to carry this out. For the learning and development strategy therefore, this scoping exercise indicates where the opportunities for consensus lie in terms of identifying common patterns of how training is organised and delivered, how skills deficits are identified and assessed, and how best to promote good practice and a strong organisational culture.

4   Analytical and Conceptual Development of the Strategy

The next step was to decide how this information could best be analysed and represented in order to gain a clear picture of how a comprehensive, evidence-based and shared strategy could be achieved. This project was taking place against the backdrop of new requirements for hospices to be inspected by CQC. The discussions within the project group saw the connection between meeting the new standards and developing an appropriate learning and development strategy that had synergy with those requirements. It became apparent that organising the information through the CQC essential standards was the most fitting way forward.

The essential standards of quality and safety consist of 28 regulations (and associated outcomes) in the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010. CQC inspections focus on the 16 essential standards from Part 4 of the Health & Social Care Act, because they relate most directly to quality and safety.

Looking for relevant guidance on the CQC site and choosing service type as 'Hospice Services' (HPS) http://www.cqc.org.uk/guidanceforprofessionals.cfm, leads to guidance on outcomes considered of relevance to Hospices. It gives a list of 14 outcomes, these exclude Outcome 5: Meeting nutritional needs and Outcome 13: Staffing. It was however decided to include these outcomes as they are relevant to learning and development.

In addition, the group considered it of equal importance to focus on competencies as a way of identifying the skills needed to meet these standards. This seemed appropriate due to the difficulties with identifying suitable competencies within the CHaL scoping exercise, and the desire to see the development of a 'transferable' skill set that could be recognised, deployed and shared across the hospices and the construction of core competencies.

The focus of the analysis thus became to link the information from the CHaL scoping exercise, group discussion and the literature to discreet headings. The table (see Table 1 p15.) is the result of the analysis; the researchers conducted the first analysis and this was subsequently discussed and refined at a project meeting on 17th March 2011. Leading with CQC Outcomes, the table has the following sections:

- ***Competency resources.*** This includes those in use within CHaL (Coventry and Warwickshire framework, Great Ormond Street Hospital guidelines), and those identified as potentially useful from the Skills for Health website. With the latter, approximately 20 competency areas were identified and these all contain more than 50 separate competencies. It was recognised that it may not be feasible to adopt all in their entirety, but that some broad indicators that are applicable to caring for children with complex needs may be useful.

- ***Suggested training resources.*** This section matches identified training courses with the CQC outcomes and competency resources. These include courses currently available from CHaL and through independent sources (either e-learning or bespoke on-site courses found via the internet).

- ***Health and Social Care Act Regulation No.*** This section links the relevant regulation to the matrix, enabling the easy identification of which regulations are being addressed.

- ***Other legislation in CQC standard.*** This identifies other policies and legal requirements that underpin the standards and outcomes and should prompt the development of courses. For example Outcome 2: 'Consent to care and treatment' is linked to a number of Mental Capacity and Mental Health Acts and should form the backdrop to learning in this area.

It is recommended that this table will become a shared resource that is regularly updated, dynamic and will evolve over time according to the learning and development requirements of the hospice workforce.

5   Consultation and Validation of the Approach

An original aim of this project was to include some form of consultation in order to ensure validity, relevance and completeness of approach, and to explore the potential for national buy-in. Concurrent to the development of the strategy and during March 2011, CHUK was conducting three national workshops for hospices through an initiative funded by the Department of Health. The purpose of the workshops was to promote a better understanding of the regulations, and CQC compliance and inspection processes as they affect hospices. This was carried out through the provision of information and practical guidance, and offering an opportunity for questions and discussion. A CQC representative attended each workshop as the key speaker.

Negotiations took place with the workshop leads which resulted in recognition of the importance of including a learning and development perspective. In all three workshops, the project was given an hour to present findings to date and discuss the table with the participants (see appendix 5 for programme details).

The workshops took place in Birmingham, Chorley and London and approximately 60 people attended. Participant representation was evident across all regions in England, and those attending included senior managers and directors of Care Services as well as other relevant staff. In all areas, feedback was very positive about the approach and there was general agreement from participants that, by combining and identifying learning and development

needs alongside CQC outcomes, the table represented a valuable resource and a useful way forward. There was also agreement that the approach had relevance across both children and adult hospices, and was seemingly generalisable across different settings and regions. Therefore from this consultation it can be concluded that the approach has validity and potential national transferability.

Importantly, CQC representatives also endorsed the approach and felt it could significantly contribute towards the Provider Compliance Assessment form in demonstrating what had been done to meet outcomes. A recommendation was to include additional evidence, such as why training was needed, how and what gaps had been identified, and an evaluation of the courses from the participants attending.

In addition to the general feedback above, the following points summarise other commentary from these sessions, some of which link to comments made in the CHaL scoping exercise:

- Many hospices are already working to the CQC essential standards and outcomes so welcome the additional ideas of adapting a learning and development to this framework.
- Some hospices are building collaborative links with stakeholders involved in education to gain a wider consensus of what should be taught.
- It was seen as important to use this exercise to demonstrate to hospice Boards that training courses and workforce development are essential when linked to regulatory requirements in this way.
- Skill development in hospice staff must include assessing training needs of specific groups such as management and leadership deficits, and identifying the most appropriate training.
- Competencies are important but can be too rigid and not reflect the softer interactive work of hospices or the ethos of palliative care, therefore there needs to be some flexibility in how they are adopted. It was noted that the Coventry and Warwickshire competency framework is now an e-learning resource and has been adapted to make it less cumbersome.
- There is widespread confusion about mandatory training with respect to what should be done and how often. It is not clear what is acceptable.
- Due to the nature of hospice work (i.e. dealing with children and young people with complex needs), many hospices now conduct themselves or buy in bespoke training.
- There were a number of suggestions for training courses that have been included into the table; examples include levels of communication skills, specific bespoke bereavement training and change management.

In developing the key strategic principles for CHaL, these points have been considered by the CHaL LaD group whose members are grateful for the contributions that have been made by those consulted.

TABLE 1: Analytical Table: CQC essential standards, Competencies and Training

CQC Outcomes relating to the 16 essential standards have been linked to information generated from this study - to CHaL group's core competencies, to identified courses within CHaL and the wider consultation at the CQC workshops during March 2011, and from information obtained through the literature review. Also included are sections that link the work to requirements within the Health and Social Care Act, and to other relevant current policy. The entries are colour coded:

Competencies: Core competencies as agreed at a CHaL group meeting on 13 Jan 10 and 17th March 2011 with those present
                                        and competencies developed elsewhere and used by one or more hospices in the CHal group (eg GOSH)

                                        Competencies identified in 'Skills for Health' as relevant to children with complex needs – these are listed
                                        under their general titles within which contain a list of performance criteria.

                                        Competencies identified from the literature review – these are listed from studies.

Training courses: Courses supplied by CHaL Hospices to this study, some suggested in a survey of all Children's Hospices in the UK, and those
                                        obtained through the consultation exercise

                                        Courses from Skills for Health

                                        Courses identified from the literature review, either from websites or from descriptive published accounts or evaluated
                                        studies (nb CIEH refers to a qualification from the Chartered Institute of Environmental Health)

All CQC standards and legislative requirements accurate at Feb 2011, and will need updating from time to time.

CQC Outcome	Competency Resources	Suggested Training Resources	HSC Act reg no	Other legislation in CQC standard
1 Respecting and involving people who use services	**CS1** Communication with children and young people, and those involved in their care. **CS19** Develop relationships with children and young people. **GEN85** Support individuals with communication and interaction difficulties.	Communication Skills (all levels of the organisation). Sage & Thyme: Is a standard communication model. User participation tool kit CHUK. Diversity toolkit CHUK. Makaton.	17	
		Managing behaviour/Violence & Aggression. Tutorcare: Challenging Behaviour Course. Team Teach: positive handling techniques.		
		Confidentiality. Tutorcare: Confidentiality Awareness Course.		
	CS26 Share an adverse prognosis about children and young people with their families. Post-death care (within CHaL).	Bereavement/ grief and loss. Bespoke training from the Child Bereavement Charity. Lansdell & Beech (2010) Three day course for end of life. Mackenzie & MacCallam (2009) Bereavement work. Mannix et al (2006) Interdisciplinary training in cognitive behavioural techniques. Tutorcare: Palliative and Bereavement Awareness course. ELCA Skills for Health.		
		Siblings and extended family members.		
	CS3 Work with children and young people to assess their health and well-being.			
	CS13 Implement interventions with children and young people, and those			

CQC Outcome	Competency Resources	Suggested Training Resources	HSC Act reg no	Other legislation in CQC standard
	involved in their care.			
	CS14 Evaluate interventions with children and young people and those involved in their care.			
	HSC315 Work with children and young people with additional requirements to meet their personal support needs.			
2 Consent to care and treatment		Mental Capacity Act training – Help the Hospice website www.helpthe hospices.org.uk Train the Trainer Mental Capacity Act.	18	Mental Capacity Act 2005, Mental Health Act 1983, Children's Act 1989
4 Care and welfare of people who use services	Respiratory care competence. Ventilation competence.	Basic life support (different levels) CPR/ Resuscitation/ anaphylactic shock. Paediatric Basic Life Support and Paediatric Advanced Life Support (Resuscitation Council). CHUK toolkit for long term ventilation. GOSH clinical guidelines.	9	Health & Social Care Act 2008, National Patient Safety Agency (NPSA safety alerts), Refocussing the Care Programme Approach guidance 2008
		Medical Gases.		
		Moving and handling (various levels).		
	Central VADs/lines (within CHaL).	IV Skills. Blood transfusion. Syringe driver management. McKinley on-line syringe driver training programme. GOSH clinical guidelines. Skills for Health: Infusion Devices e-learning.		

CQC Outcome	Competency Resources	Suggested Training Resources	HSC Act reg no	Other legislation in CQC standard
	Seizure management (within CHaL).	Specific conditions (SMA, HIV, brain tumours, epilepsy). GOSH clinical guidelines.		
	Symptom management. CS25 Recognise and manage adverse signs and symptoms in babies, children and young people.	Pain relief. Rainbow's guide – Basic symptom control. ELCA Introduction to symptom management. Jessie's fund music therapy. GOSH clinical guidelines.		
		Tissue viability. Glamorgan pressure ulcer risk assessment tool		
		Play.		
	CS3 Work with children and young people to assess their health and well-being.			
	CS5 Develop individualised care plans with children and young people.			
	CS8 Assess the effectiveness of individualised care plans in meeting the health and well-being needs of children and young people.			
	CS22 Support children and young people to cope with changes to their health and well-being.			
	CS14 Evaluate interventions with children and young people and those involved in their care.			
	CS10 Prepare a discharge plan with children and young people and those involved in their care.			
	CS30 Provide advice and information to children and young people and those			

CQC Outcome	Competency Resources	Suggested Training Resources	HSC Act reg no	Other legislation in CQC standard
	involved in their care on how to manage their own condition.			
	HSC316 Support the needs of children and young people with additional requirements.			
	PT28 Promote the engagement of children and adolescents in family and systemic therapy.			
	Cooper et al (2010) 14 competencies for spiritual care workers.			
5 Meeting nutritional needs	Enteral feeding competence.	GOSH clinical guidelines. Local training from hospitals/reps. Safe oral feeding.	14	Food Safety Act 1990
	CS24 Contribute towards meeting the nutritional needs of babies, children and young people.			
6 Co-operating with other providers	**CS4** Plan interdisciplinary assessment of the health and well-being of young people. **CS10** Prepare a discharge plan with children and young people and those involved in their care.	Transition. Assessment and discharge.	24	Civil Contingencies Act 2004, Data Protection Act 1998
	CS23 Work with others to improve healthcare services for children and young people.	Information governance training.		
	Egan & Abbott's (2002) interdisciplinary hospice training model *the Patient/Family Value Directed Model of Care* lists 16 competencies.	Working in a team.		

CQC Outcome	Competency Resources	Suggested Training Resources	HSC Act reg no	Other legislation in CQC standard
7 Safeguarding people who use services from abuse	**CS17** Ensure systems and procedures for safeguarding children and young people are implemented. **CS18** Recognise and respond to possible abuse of children and young people.	Safeguarding (children and adults). NSPCC on-line course and other resources for running courses. Local Child Safeguarding Board. SAFE Network. Mental Capacity Act training. Tutorcare: Safeguarding vulnerable children and adults. Train the Trainer (Adelphi Associates)	11	'Government and local guidance', Deprivation of Civil Liberty Safeguards, Mental Capacity Act 2005, Children Act 2004, Public Interest Disclosure Act 1998, Mental Health Act 2005 and 1983 Code of Practice
8 Cleanliness and infection control	Infection control (within CHaL).	Infection Control (various levels, clinical and non-clinical). Local Infection control specialists. Tutorcare: Infection Control Awareness Course. Skills for Health: Infection Control e-learning.	12	CQC Reg 12 'Code of Practice for health and adult social care on the prevention and control of infections and related guidance'
		Food hygiene (basic, level 2, level 3). Tutorcare: Food safety levels 1-4.		
9 Management of medicines	Medicines management. **CS27** Administer medication to babies and children.	CHUK Medicines management toolkit. NMC Medicines management Tutorcare: Medication Awareness Course.	13	Mental Capacity Act 2005, Mental Health Act 1983, Medicines Act 1968, Misuse of Drugs Act 1971, Safer Management of Controlled Drugs Regulations 2006, 'relevant … memoranda and professional guidance' from RPSGB and other relevant bodies NMC Standards for Administration of Medication
		Control of Substances Hazardous to Health (COSHH) (full course and refresher). Tutorcare: Award in the Principles of COSHH		

CQC Outcome	Competency Resources	Suggested Training Resources	HSC Act reg no	Other legislation in CQC standard
		Level 2 (CIEH) ; COSHH Awareness Course. Skills for Health: BOC Medical Gases e-learning		
10 Safety and suitability of premises		Fire Safety Mandatory training.	15	Health & Safety at Work Act 1974, Regulatory Reform (Fire, Safety) Order 2005, Disability Discrimination Act 1995, Health Regulations 2002
		Health & Safety Mandatory training.		
		First Aid.		
		Moving and handling Mandatory training. Cold room toolkit.		
11 Safety, availability and suitability of equipment			16	Medical Devices Regulations 2002(a)
		Medical devices alerts (MHRA).		
12 Requirements relating to workers (relates to recruitment, checking qualifications)		Performance management.	21	Schedule 3 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Safeguarding Vulnerable Groups Act 2006. Also appropriate registration and CRB checks.
13 Staffing (relates to sufficient numbers)		Shift co-ordination training.	22	
14 Supporting workers (covers learning, supervision)		Performance management. Management and leadership development. Change management.	23	Appropriate registration and Children's Workforce Development Council Induction standards
		Corporate induction.		
		Equality & Diversity.		

CQC Outcome	Competency Resources	Suggested Training Resources	HSC Act reg no	Other legislation in CQC standard
		Diversity toolkit. Tutorcare: Equality and Diversity Awareness Course. Skills for Health: Respect for People – Equality and Diversity e-learning.		
		Dignity at work (bullying and harassment).		
		Conflict resolution.		
		Clinical supervision. Girling et al (2009) Practice model of supervision. Chilvers & Ramsey (2009) Group reflective clinical supervision programme. Mentorship updates (MIPS). Egan & Abbott 2002 Formal peer mentorship. Baverstock (2006) Mentorship 'debrief' approach. Schonwetter (2006) One-on-One Paired Mentoring Programme. **Reflection:** Bailey & Graham (2007) guided reflective practice. Taylor et al (2008) Reflection and action research. Morgen et al (2006) 'Virtual' reflection through e-learning. Siebert et al (2009) Critical reflection learning groups. **Motivation:** Egan & Abbott (2002) & Williams (2010) Developing an organisational culture of learning.		

CQC Outcome	Competency Resources	Suggested Training Resources	HSC Act reg no	Other legislation in CQC standard
		Baverstock's (2006) Staff support. **Evaluation of training:** Bailey & Littlechild (2001) & Phillip (1997) Models of evaluation.		
		Managing volunteers.		
		Driving/minibus training.		
		IT skills.		
		Project planning.		
		Time management.		
		Values, vision, core purpose.		
	Becker (2007) Core competencies for palliative care educators.	Palliative care. **E-learning:** DH and the National End of Life Care Programme. Nottingham University paediatric palliative care course (e learning module). Cardiff University 2 programmes for multi-professionals; a post grad diploma or an MSc in palliative care. Skills for Health: Palliative care awareness courses e-learning.		
		Professional boundaries. Bunniss & Kelly (2008) Teaching teams to cope with change. Egan & Abbott (2002) Patient - Family Value Directed Model of Care (interprofessional training). Bellamy et al (2006) and Carroll & Lawton (2006) Case studies as an interprofessional learning tool. **E-learning:** Pack (2010) Good practice in on-		

CQC Outcome	Competency Resources	Suggested Training Resources	HSC Act reg no	Other legislation in CQC standard
		line collaborative learning. Miers et al (2007) Good practice in e-learning interprofessionally.		
		Lone working. Suzi Lamplugh Trust (various courses).		
		For registered nurses: MSc Advanced Practice (Children's Palliative Care) University of Dundee. Birmingham City University- modules for children's palliative care. King's College London BSc/MSc in Children's Palliative Care.		
		Work-based learning: Williams (2010) Best practice in work-based learning (eg facilitation). Manley et al (2009) Developing an organisation-wide learning philosophy for work-based learning.		
		Self-directed learning: O'Shea (2003) Best practice in self-directed learning. **E-Learning:** Sanders and Langoise (2006) Use of discussion boards. Childs et al (2005) Good practice in e-learning. Skills for Health – essential training courses via e-learning.		
		Skills Passport.		
16 Assessing and monitoring the quality of service provision	**CS8** Assess the effectiveness of individualised care plans in meeting the health and well-being needs of children and young people	Assessing clinical risk. Record keeping.	10	Refers to Regn 19 (Complaints) and 20 (Records)

CQC Outcome	Competency Resources	Suggested Training Resources	HSC Act reg no	Other legislation in CQC standard
		Risk management.		
		Ethics and decision making.		
	CS23 Work with others to improve healthcare services for children and young people.	Clinical audit. User involvement training.		
	PHP10 Collect and link data and information about the health and well-being and related needs of a defined population.	IT skills training and managing databases. CHUK Quality Assurance toolkit 'Are we getting it right?'		
17 Complaints		Handling complaints. Incident reporting.	19	
21 Records	**CS4** Plan interdisciplinary assessment of the health and well-being of young people.	Record-keeping. IT skills training. Tutorcare: Observation Skills for Carers Course; Communication and Record Keeping Course.	20	Freedom of Information Act 2000, Data Protection Act 1998, Department of Health's Records Management NHS Code of Practice (Part 2). And 'other professional bodies standards where applicable' NMC Standards for Record Keeping
		Information governance/ Caldecott/ data protection.		
	CS5 Develop individualised care plans with children and young people. **CS8** Assess the effectiveness of individualised care plans in meeting the health and well-being needs of children and young people.	Medical record keeping.		

APPENDICES

APPENDIX 1: CHaL Learning and Development Group plus others who have participated in and informed the project

CHaL

Rachel Black   Head of Clinical Education and Development, Demelza Hospice Care for Children

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Rebecca Matthewman   Education & Training Co-ordinator, EllenorLions Hospices

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Other hospices

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APPENDIX 2: Literature Review

Introduction

This report provides an account of the first phase of the Learning and Development Strategy Project funded by the Department of Health, which took place between November 2010 and March 2011. The overall aim of the project was to develop a shared learning and development strategy for Children's Hospices across London (CHaL), in recognition of the need to build on existing good practice, to gain consensus about the way forward for education and to identify how resources could be shared more effectively.

The first phase of the project consisted of a literature review, described in section 1 of this report, and a scoping of existing learning and development practice within CHaL, set out in section 2.

Section 1: Literature Review

1   Introduction and Method

The purpose of this review was to provide a critical overview of published literature in key areas, in order to identify indicators of good practice for guiding and underpinning the learning and development strategy.

The key themes included: Policy, guidelines and legislation

Current training approaches

Philosophies underpinning training

Motivation and learning cultures

Planning and evaluation of training

The review will commence with an account of the method used and search strategy, followed by the findings which are presented within the key themes above with relevant subthemes. The review will conclude with a summary of indicators for good practice derived from the literature.

An initial web-based search was made for the years 2000-2010 drawing on PubMed, Google Scholar and the University of Kent Academic Search Complete. The latter contains full text for over 5500 academic, social sciences, humanities, general science, education and multi-

cultural journals. Academic Search Complete cross references with ScienceDirect, Ingenta, Medline, Cinahl and many other health-related search engines.

As the search progressed, specific websites were targeted in a more focused search. These included the Department of Health, Care Quality Commission (CQC), NHS Employers, Health Service Executive, Next Step Careers Advice, Skills for Health, Skills for Care, Childrens' Hospices UK, Association for Childrens' Palliative Care (ACT), Royal College of Nursing, Universities/independent providers with palliative care training courses, Nursing and Midwifery Council. Where initial web screening did not reveal the required information, organisations were phoned directly.

A combination of the main topic areas were entered as key words, in combination firstly using 'children's hospice' as a lead, then 'hospice' and 'palliative care'. For some areas, such as learning cultures, philosophies and planning and evaluation of training, a more generic search was made as little was found directly related to hospice care. In addition, a search was made under specific key terms such as 'e-learning', 'skills passports', and 'NVQ training'. Alongside the web-based search, books were a source of information for aspects such as planning and evaluating training, self-directed learning and organisational cultures.

There were not many policy documents or articles found specifically relating to children's hospices or palliative care and education and training within the scope of this search. More were found that related to palliative care for adults. However, there were relevant and transferable data that could be included from this latter area, and the more generic literature on philosophies, planning and evaluation of training. Interprofessional training and education appeared to be prominent among the small range of palliative care articles, and was therefore presented as a subtheme.

There were a large number of hits from medical and nursing journals such as Journal of Palliative Medicine, Palliative Medicine, Medical Training, International Journal of Palliative Nursing, British Journal of Nursing, and Journal of Advanced Nursing among others. This has meant that the sample has a bias towards these two professional groups. A smaller amount of articles relate to pharmacists, social workers, physiotherapists, volunteers, and support workers.

2   Literature Review

As the main focus of this project is children's hospices, the literature review findings have been presented into a hierarchy of relevance, focusing primarily on policy, guidelines and studies from the UK with a hospice connection, followed by palliative care approaches and studies from overseas. Some studies investigating medical education were also included as they had some relevant information. This hierarchy has resulted in the reporting of studies that are small but informative and useful to consider as potential strategies to investigate or test further within pilot studies. This topic area in general did not reveal many studies that had strong evidence of effectiveness, and reported processes rather than outcomes.

The review commences with a summary of the most relevant policy, guidelines and legislation, and follows with a critical review of the published literature according to the main themes.

2.1   Relevant Policy, Guidelines and Legislation

2.1.1   Policy and guidelines

A small number of documents were found that related to a lesser or greater extent to training and education or workforce development in the area of palliative and/or hospice care. These policy documents offered a combination of guidance, recommendations, 'Best Practice', and evidence.

National Institute for Clinical Excellence (NICE)(2005) Improving Outcomes in Children and Young People with Cancer.

The purpose of this guidance is to provide recommendations on service provision for children and young people with malignant disease, based on the best available evidence. It is primarily for commissioners of services, but has equal relevance for service providers. There is particular attention to workforce skills and the need for trained specialist staff across all disciplines, able to work with children and young people with cancer. The guidelines state that training plans should be included in workforce development strategies by cancer networks to ensure the provision of a sustainable service. The document highlights that specific attention is required to address the shortage of allied health professional expertise in this area.

The publication recognises that services can only be sustained and developed if there are adequate numbers of appropriately trained staff, and highlights the importance of support to counter the emotionally draining nature of this specialty. It identifies the difficulties

recruiting and retaining medical paediatric specialists such as radiologists and pathologists, nurses and clinical psychologists.

Examples of specific areas for staff training and education include recognition of symptoms and appropriate investigation and referral (primary care); the prescription and administration of chemotherapy; management of central venous access devices; pain management; rehabilitation approaches; blood product support; and communication skills.

NICE recommend that the relevant national bodies should advise on what training is required for all staff groups and that all staff should be trained and competent to undertake specific tasks and address the specific care needs of patients and families. They should also undertake relevant CPD to maintain their competence and stay abreast of scientific and technological advances. In addition, there should be access for nurses and other healthcare professionals to appropriate post-qualification specialist education in the care of children and young people with cancer. The document sets out cost implications which are helpful to commissioners, but these are CPD costs and are based on the development of specialist skills at treatment centres that treat children, and may not relate to costs of training staff in the hospice setting.

Although useful, this focus is on cancer care and therefore workforce development concentrates on specialist education. This may be less relevant to hospice care of children and young people as cases involve different and more complex conditions.

Palliative care services for children and young people in England: an Independent Review for the Secretary of State for Health (Craft and Killen 2007)

This independent review found there are enormous deficits in service provision and overlap between children with disabilities and complex health needs and those requiring palliative care. Services for these groups of children need to be planned together. With respect to education to support the development of services, there also needs to be greater recognition of palliative care

as a specialism along with an appropriate workforce strategy. This is to ensure children have access to appropriate specialist services but also better access to general services. The review recommends that:

- there is a formal recognition by the Royal College of Paediatrics and Child Health (RCPCH) and the Postgraduate Medical Education and Training Board (PMETB) of children's palliative care as a sub-specialty of paediatrics;

- the RCPCH and Royal College of General Practitioners (RCGP) should ensure that basic competencies in children's palliative care services are part of generic training for all paediatricians and GPs;
- the Royal College of Nursing (RCN) should lead work on developing a career pathway for nurses specialising in palliative care for children and young people;
- the DH should lead the development of a workforce strategy, including the development of training in palliative care for those working with children and young people

This review is a precursor of DH document 'Better Care Better Lives 2008.

Department of Health (2008) Better Care: Better Lives

The document provides 'Best Practice' guidance and sets the future direction for children's palliative care services. It is a call to action to all those engaged in providing services – commissioners, service providers, voluntary sector partners – to improve data sources, to develop better needs assessments and support regimes, to tackle inequalities and encourage the delivery of care in the most appropriate setting, so improving the experiences of children and young people and their families. It states that every child and young person with a life-limiting or life-threatening condition will have equitable access to high-quality, family-centred, sustainable care and support, with services provided in a setting of choice, according to the child and family's wishes.

There are a number of key guidelines that focus on close partnership working between health and social care, education and the voluntary sector that is responsive to and respectful of the diverse needs of children and their families, and built around a philosophy of 'children first' rather than relying on diagnostic labels. There is also an emphasis on a seamless transition of care between primary, secondary and tertiary healthcare settings.

With regard to training, planning and developing an effective workforce is identified as one of eight goals, but only in general statements like workforce should be 'appropriately skilled, experienced and confident'. Other guidelines are equally vague and stipulate that services should provide 'access to responsive care and support from staff skilled in children's palliative care management'.

Association for Childrens' Palliative Care (ACT) and Childrens' Hospices UK (2009) Right People, Right Place, Right Time.

This document sets out practice guidance for workforce development addressing the palliative care needs for children and young people. It describes itself as a 'tool' that recognises the complex mix of services required by these children and their families and the need for a workforce to become life-long learners with a range of skills and competencies. The document introduces a Skills Pathway that offers a four-tiered approach called the

Learning Cone, which encourages an incremental growth in expertise through different spheres of practice – basic to expert. Benefits of this approach include its flexibility in when and how the pathway can be accessed, accreditation for prior learning, work-place learning, and four 'core' learning areas which are interlinked. These areas are communication skills, assessment skills, complex care management and role development, and are seen as essential for children's' palliative care skill and knowledge acquisition. In addition, the tool sets out key recommendations not only to individuals but to service providers in general and commissioners regarding workforce development.

To a large extent, this document is relevant as it makes more explicit the skills that are needed through the learning outcomes set out in the four core learning areas. However, despite the emphasis on complex care management, it does not seem to address the unique requirements of hospice staff in terms of continuity of care, dealing with children with physical skills that are slowly deteriorating, and managing parents and families over time. It also focuses on professional training and does not consider the institutional training requirements and the needs of different staff groups, which is relevant for more integrated institutions such as hospices. It also does not identify or blend in mandatory or other specific training course or levels. As a tool however, the document is a step forward in its focus on children and young people and the training required to meet their palliative care needs.

The Children's Hospice UK (2007) Guidelines for best practice in a children's hospice service (2007).

This contains quite general statements about providing safe environment, quality care, family-centred, etc, and does not address training specifically. ACT has developed some best practice prompts for care in the last days of life in the Education and Practice area of its website.

Children's Hospices UK (2004) Quality Assurance in Children's Hospices

This is the CHUK the QA tool and covers six key aspects of the hospice's role asking for judgements to be made on specific focus questions, for example whether there are sufficient staff to give each child individual attention.

National Council for Voluntary Organisations (NCVO) (2010) People Count Third Sector Benchmarking

This document supports good practice for Human Resources, and includes sections on learning and development. The NCVO have also published 'Third Sector Skills Research 2008' showing evidence of skills gaps in the voluntary sector workforce.

Some material, such as NIHCE's 'Education strategy to support implementation of NICE guidance' was more concerned with evidence-based healthcare decisions, and gave little help when developing a training and education strategy.

2.1.2 Legislation: Mandatory training requirements

Obtaining clear information about what sorts of training was mandatory or statutory for healthcare organisations in terms of legislative requirements did require considerable investigation. A number of websites were explored and several contacts made by telephone where followed up where information was not clear. Below is a summary of this investigation.

The NHSE website provided some initial definitions:

Statutory Training is training that a Trust is legally required to provide as defined in law or where a statutory body has instructed an organisation to provide training on the basis of the legislation.

Mandatory Training is a training requirement that has been determined by a Trust (i.e. in Policy). Mandatory training is concerned with minimum risk, providing assurance against policies, and ensuring a Trust meets external standards.

Statutory and mandatory training have to be completed regardless of an individual's post or ability.

The most relevant information was obtained from the Health Service Executive, which provides guidance for what the training requirements regulations are for organisations. It has not produced a specific document detailing all the training requirements applicable to staff working in hospices. Enquiries to the email helpline about hospices revealed that what training is required will depend upon the nature of the work and the roles performed and is not something set out in law by job title. Therefore, it is the employer's duty to determine what the training needs of their employees are, and there are some regulations that guide this decision-making. It would appear that there are regulations however in relation to the employee's capabilities and competence, and the management of Health and Safety at Work Regulations, which include manual handling, first aid and the care of harmful substances.

Capabilities and competence

Regulation 13 of the Management of Health and Safety at Work Regulations 1999 is concerned with an employee's general capabilities and training. The legislation states:

1) Every employer shall, in entrusting tasks to his employees, take into account their capabilities as regards health and safety.

(2) Every employer shall ensure that his employees are provided with adequate health and safety training -

      (a) on their being recruited into the employer's undertaking; and

      (b) on their being exposed to new or increased risks because of -

            (i) their being transferred or given a change of responsibilities within the employer's undertaking,

            (ii) the introduction of new work equipment into or a change respecting work equipment already in use within the employer's undertaking,

            (iii) the introduction of new technology into the employer's undertaking, or

            (iv) the introduction of a new system of work into or a change respecting a system of work already in use within the employer's undertaking.

(3) The training referred to in paragraph (2) shall -

      (a) be repeated periodically where appropriate;

      (b) be adapted to take account of any new or changed risks to the health and safety of the employees concerned; and

      (c) take place during working hours.

The accompanying Approved Code of Practice (ACOP) 13 and Guidance goes onto explain:

      When allocating work to employees, employers should ensure that the demands of the job do not exceed the employees' ability to carry out the work without risk to themselves or others. Employers should take account of the employees' capabilities and the level of their training, knowledge and experience. Managers should be aware of relevant legislation and should be competent to manage health and safety effectively. Employers should review their employees' capabilities to carry out their work, as necessary. If additional training, including refresher training, is needed, it should be provided.

With respect to competence, Guidance 13 states that

      The risk assessment and subsequent reviews of the risk assessment will help determine the level of training and competence needed for each type of work. Competence is the ability to do the work required to the necessary standard. All employees, including senior management, should receive relevant training. This may

need to include basic skills training, specific on-the-job training and training in health and safety or emergency procedures. There may be a need for further training eg about specific risks, required by other legislation. (Reference: L21, Management of health and safety at work, ISBN 9780717624881)

Management of Health and Safety at Work

Section 2 of the Health and Safety at Work Act 1974 and regulations 10 and 13 of the Management of Health and Safety at Work Regulations 1999 require employers to provide their employees with health and safety information and training. This should be supplemented as necessary with more specific information and training on manual handling injury risks and prevention, and fire training as part of the steps to reduce risk required by regulation 4(1)(b)(ii) of the Regulations.

With regards to First Aid training there is nothing under health and safety law that details every staff member must be trained in first aid. The employer must assess what first aid provision is appropriate for their organisation in order to ensure adequate provision is in place for employees whilst they are at work.

There may be a requirement for the Control of Substances Hazardous to Health (COSHH) training if employees are working with these substances. With regard to training, the Control of Substances Hazardous to Health Regulations 2002 states that every employer who undertakes work which is liable to expose an employee to a substance hazardous to health shall provide that employee with suitable and sufficient information, instruction and training. Reference: L5, General COSHH ACOP, Carcinogens ACOP and Biological Agents ACOP (Fifth edition), ISBN 9780717629817

Implementing Guidelines

Investigations also focused on how these regulations were being operationalised, and there did not seem to be any connectedness or common interpretation between organisations. It would appear that organisations are interpreting the guidelines according to individual requirements.
- The Care Quality Commission (CQC) expects providers to ensure that all applicable mandatory training and accompanying regulation is adhered to. CQC do not however provide guidance on which mandatory training needs to be completed or indicate how often mandatory training should be carried out.
- At the NHS Employers website (www.nhsemployers.org) modules were found that form part of the Statutory and Mandatory Programme and include fire safety

awareness, health and safety awareness (eg food safety, infection control) and manual handling.

- A national training organisation called 'Tutorcare' offers a range of courses to the NHS that it labels 'mandatory' and include fire safety, infection control, health and safety, manual handling, first aid and safeguarding vulnerable adults/children.

2.2   Current Training Approaches

This section is separated into four main areas, which are further sub-divided into relevant themes

    2.2.1   Interprofessional training and education
-      o   Case studies as an interprofessional learning tool

    2.2.2   Single staff group training approaches
- o   Nurses and care staff
- o   Professions allied to medicine
- o   Doctors and medical students

    2.2.3   Skills and Competencies
- o   National vocational training

    2.2.4   Teaching and learning styles
- o   General techniques
- o   Mentorship
- o   Clinical supervision
- o   Reflection
- o   Work-based learning
- o   Self-directed learning
- o   E-learning
- o   Skills passports

2.2.1   Interprofessional Training and Education

Because of the need to develop the skills necessary to enable future health professionals to function effectively within a team, there has been an increasing emphasis on interprofessional education in both campus-based and practice settings (Barr 2002; Stew 2005). Particularly within children's hospices, there is a need for close collaboration between all staff involved and the importance of creating a multi-disciplinary learning approach that facilitates mutual appreciation of roles, expectations and skills to enhance patient outcomes is becoming evident (Egan & Abbot 2002). Despite its appeal, evidence of the effectiveness of this approach does remain elusive (Reeves et al 2009) and publications would in the main appear to be restricted to accounts of individual practice initiatives; these

are however of interest as potentially useful strategies and do have positive learning outcomes.

Egan & Abbott (2002) for example describe a team training model for new hospice employees entitled *Patient/Family Value Directed Model of Care* developed in the US. The primary goal of this training is to help new employees become competent, comfortable and efficient in providing end-of-life care, in recognition of the fact that educational needs are different to other settings, less about 'cure' or the disease process. It is directed at all health and social care professionals, as well as chaplains and volunteers and seeks to transform how end of life is experienced by patients and relatives. The model includes an interdisciplinary team-based mentor programme and consists of five main interrelated dimensions, designed to support optimal quality of life closure and based on Cassell's (1991) theory of personhood. These dimensions include the physical, functional, interpersonal, well-being and transcendental.

The training develops the skill of role blending using an interdimensional approach and uses an interesting field and team approach to learning to integrate a new employee into the hospice. The authors argue that the most effective method is one that is individualised to each new employee and reinforces the value of the interdisciplinary team, supported by peer mentors. While some people learn best by 'doing', others are more responsive to observation. Thus once this is established, learning styles are matched to activities and this purports to promote comfort, longevity and stability in the working environment. New employees can for example mirror the experience of hospice patients and their families by sharing the care process from beginning to end with varying degree of engagement. This model provides a full description of competencies, learning cultures, philosophies underpinning training, and planning and evaluation which will be outlined in the relevant sections below.

With a focus on psychosocial care, Lansdell & Beech (2010) developed, conducted and evaluated a three day programme for all hospice staff with the aim of increasing confidence of staff to deliver effective psychosocial interventions. The programme covered aspects such as psychosocial assessment, attachment and loss, end-of-life conversations, empathy, the family dynamic, measurement of psychosocial outcomes, and professional boundaries. The results indicated that attendance on the course increased health professionals' understanding and confidence in providing psychosocial care in the hospice setting. Peer support was important and an unanticipated benefit was enhanced team working within clinical teams and across hospice services through gaining a better understanding of interdisciplinary roles. This was a small study (nine participants) but its findings support other work on the benefits of interdisciplinary training and the focus on more difficult aspects of hospice care.

Continuing with psychosocial care, an in-service training programme was developed by Mackenzie & MacCallam (2009) to meet the needs of an NHS palliative care service for children and young people, specifically focused on bereavement work. A training day was held every six months for all staff members including nursing, psychology and management that allowed them to share and support each other's practice and to consider how best practice could be promoted. Content included aspects such as models of bereavement; identifying factors that are needed for a first bereavement visit to go well; developing and documenting 'end of life' plans; developing skills and strategies in bereavement work; and helping staff to feel less helpless and cope with emotion. Also included were talks from parents and other professionals, such as a coroner, funeral director and tissue co-ordinator. Participant evaluations indicated that the aims of the training days were being met, and improvements and positive outcomes were noted in the workplace. The authors conclude that ongoing training and support as well as clinical supervision are essential to maintain good practice in palliative and bereavement care.

Focusing more now on psychological interventions, Mannix et al (2006) developed and tested interdisciplinary training in cognitive behavioural techniques (CBT) for 20 palliative care practitioners (nurses, occupational therapists and social workers). This was delivered as 12 days' teaching plus skills-building supervision over a six month period. The course was developed on the basis that emotional distress is a common symptom of advanced and terminal illness, and is frequently encountered among patients and their family/carers by staff working in palliative care. It has been shown that CBT is an effective psychological treatment for depression, anxiety and panic in patients with physical health problems, with a reduction in psychological morbidity and enhancement of coping skills (Greer et al 1992).

Mannix 2003 suggested that people with advanced and end-stage illness and their families can benefit from CBT. Previous research into delivering CBT to cancer patients has relied on referral to an expert cognitive therapist. This may not be desirable or practicable for very ill people with small energy reserves and a limited capacity for new therapeutic relationships, and adds considerably to the cost of delivering care. The study demonstrated that palliative care practitioners can be trained in CBT skills by a simple and brief training course and supportive, skills-building supervision to a national standard level. Supervision is necessary to ensure maintenance of skills and confidence to use them.

This next example looks at the importance of relational learning within teams with respect to change. Bunniss & Kelly (2008) studied the collective learning and change process within primary care teams in order to better understand how health care teams (general medical practice, pharmacy and dentistry) learn together and cope with change. The results indicated that informal collective learning is a powerful team coping mechanism that develops through experiential,

evolving and implicit learning processes. These processes are predominantly relational in that they rely on the extent to which team members know and understand one another as people.

The authors argue that as health care develops, it will become increasingly important to consider how to support the internal learning processes of care teams as they navigate complex organisational changes and the shared learning experiences that characterise those changes. Those who support learning and development within the NHS should therefore focus on how relational processes, as well as educational content, contribute to a team's collective learning capability and the quality of care its members provide.

Case studies as an interprofessional learning tool

Bellamy et al (2006) identified the way a hospice team and their community colleagues took a different approach to the case-review process, aimed at enhancing professional development and palliative care practices by fostering multiprofessional relationships.

Case reviews or studies are a traditionally recognised teaching and learning strategy; they have been used in medical training and are now used widely by other disciplines including nursing (Tomey 2003). Case reviews involve the retrospective analysis of a patient care episode. This may be a review of the whole episode or focused on a particular aspect of the care. If well constructed and facilitated, case reviews/studies can stimulate critical thinking through the analysis and interpretation of the presented data (Tomey 2003). They can generate discussion and the sharing of ideas and best practice among the group members. There is also the potential to address the theory practice gap (McSherry and Proctor-Childs 2001).

Bellamy et al describe a different perspective of the case review process, using it as a proactive learning tool. The case reviews run once a month and dates are held in an environment that promotes learning by minimising interruptions. With a view to encouraging a multiprofessional culture, the hospice employs an independent facilitator with a psychotherapy background to manage the case-review process. The facilitator's role is to employ strategies in the group which facilitate learning by, for example, maintaining confidentiality, boundaries, building trust, encouraging open and honest discussion and promoting critical thinking. The presentation of the cases alternates between the community team and the hospice team. A key aspect of the facilitator's role is to pay attention to aspects of care that may have been missed. An example of this would be to encourage reflection on the family dynamics of a case and its challenges. It takes time and continuity for a group to build trust and this can be impacted by a changing membership.

An audit of the process highlighted how this forum assisted in the development of mutual trust and respect among teams. The formal evaluation has shown evidence of improved

communication and challenged thinking in relation to changing practice. The results of this experience could be considered in other areas where multiprofessional teamwork is essential.

Case study approaches have also been tested within the primary care setting in Scotland by Carroll & Lawton (2006). The overall aim of the project was to provide multi-professional access to a palliative care evidence-based and patient-focused education programme through the use of short (90-minute) learning events built around case studies. This short duration was in recognition of the time pressures of staff. After one year the course had attracted over 1,000 attendees and had increased knowledge levels for a wide range of palliative care issues. This style would appear to be relevant.

2.2.2 Single staff group training approaches

Nurses and care staff

Nurses and care staff would appear to be a major focus for Palliative care training courses, of which there are established qualifications available via Universities and through other sources. There is not a recorded qualification within the Nursing and Midwifery Council for palliative or hospice care and it would appear that universities have led the way in terms of training requirements in this area. Examples of available courses are given below, some courses are specifically for children's palliative care and others contain optional modules specific to this population group. As entry requirements, most require post-registration experience of a year for undergraduate courses and a first level degree plus two years experience for postgraduate courses:

- Advanced Certificate in Palliative Care (University of Lancaster)
- Post graduate certificate, diploma and/or MSc Palliative Care (Canterbury Christ Church University (CCCU), University of Kent, Oxford Brookes)
- Advanced Diploma, Graduate certificate and/or BSc or BA(Hons) Palliative Care (CCCU, University of Sheffield, Birmingham City University- this has modules for children's palliative care,)
- MSc Advanced Practice (Children's Palliative Care) (University of Dundee)
- Graduate Certificate in Paediatric Intensive care (University of Anglia)

Outside of the university setting, Tutorcare is an example of a company that provides a number of care courses for health care staff that meet Common Induction Standards, and Health and Safety Executive as well as CQC requirements. This particular company provides workplace training for mandatory requirements for all staff as well as awareness courses in a number of subjects and can also develop bespoke courses to meet the needs of

institutions. Examples of courses that would suit children's hospices may include palliative and bereavement awareness courses, safeguarding vulnerable children, and paediatric first aid, but the latter is more connected to nurseries, schools and other children's day care.

There are examples of specific training courses within the published literature that have been evaluated. Focusing on health care assistants, Dowding &Homer (2000) developed a teaching programme to support the learning of palliative care principles for those working in nursing homes. Topics included 'What is palliative care?', 'How can you help patients with pain?', 'Needs of the dying patient', 'I don't know what to say', and 'Answering awkward questions'. Despite being enrolled on National Vocational Qualification courses (see below for more detail of NVQs), the programme revealed that health care assistants had several emotional and vocational training needs that were not being met in this area.

Professions allied to medicine

With respect to other health care staff, some studies indicated the value of incorporating palliative care modules or specific practice exposure in undergraduate studies for various disciplines. Pereira & Murzyn (2001) for example developed and evaluated a semester course entitled 'The Pain Module' for pharmacy students in their final year of undergraduate training in the US. The aim was to generate opportunities for skill and attitude development, including those related to the management of cancer-related pain. The course included visits by students to patients in hospices. The evaluation indicated that the course improved understanding and increased students' exposure to experts in the field, but some students were uncomfortable with the aspects of the training. A small study by Morris & Leonard (2007) investigated physiotherapy students' experiences of palliative care placements. The benefits of interprofessional team approaches were again evident; students were exposed to a more diverse range of team members than in other practice settings, including clinical psychologists, counsellors, art therapists, music therapists and chaplains. As a result students felt they had an increased understanding of the contribution made by the many different health professionals who were involved in a patient's care pathway.

Doctors and medical students

There were many publications reviewing palliative medical training for medical students and doctors, mostly from the US. This includes a hospice-based elective to learn comfort with dying patients in undergraduate medical education by training them as volunteers (Skunkwiler et al 2005); a competency-based hospice and palliative care outcomes programme for medical sub-specialists (Morrison et al 2007); spirituality training for palliative care fellows (Marr et al 2007); a Nordic specialist course in palliative care based on

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the UK palliative medical curriculum (Haugen & Vejlgaard 2008); and the development of a palliative care course that involved both classroom and web-based learning for rural-based family medicine residents. This study assessed the impact of the course on palliative care-related competencies (Pereira et al 2008).

Continuing with doctors, a UK study by Amery and Lapwood (2004) explored the educational needs of children's hospice doctors in England using a descriptive quantitative and qualitative survey and the use of educational diaries. The authors approached all children's hospices in England and recruited a sample of 55 hospice doctors. The results from self-rated competencies and diaries indicated that respondents would most value support, education and training in the management of emergencies, symptoms and physical disease, as well communication skills, team-working skills, and personal coping strategies. There was however a disparity between educational needs as derived from self-rated competencies and from diary keeping, suggesting that children's hospice doctors may not be fully aware of their own educational, support and training needs.

Also in the UK, doctors are supported by Great Ormond Street Hospital through Service Level Agreements. In addition, the Association of Paediatric Palliative Care is developing training and in Cardiff University there is a post-graduate paediatric programme.

2.2.3   Skills and Competencies

Competence is defined as the quality of being adequately or well qualified physically and intellectually (wordnetweb.princeton.edu/perl/webwn). In the health care setting, the NMC Code of professional conduct: standards for conduct, performance and ethics (2004) states that:

"to practice competently, you must possess the knowledge skills and abilities required for lawful safe and effective practice without direct supervision. You must acknowledge the limits of your professional competence and only undertake practice and accept responsibilities for those activities in which you are competent."

There is a large range of practical tools and frameworks used in training and assessing staff in healthcare, which can be immensely detailed and includes:

- elements of care,
- care pathways,
- occupational standards,
- competences,
- tools for assessment, training and monitoring.

Standards of care and necessary skills relating specifically to care of children have been covered under the heading of policy and guidance, whereas this section covers classifications of skills and competences that can be applied in a variety of care settings. However it has been narrowed down to what is most relevant to staff in children's' hospices – either through recommendation, or where it can be used to identify elements of care that imply certain skill levels and competences, that lead to appropriate choices of training.

The Association of Children's Palliative Care (ACT) provides a link to the Coventry &Warwickshire Children and Young People's Teaching Framework. The Coventry and Warwickshire's Children's and Young People's Teaching and Assessment Framework (on the ACT website) contains 23 competences and was developed by nurses as a teaching and assessment tool for teaching support workers and junior nurses to look after children with complex needs. It includes competencies on ventilation, enteral feeding, catherisation, oxygen saturation monitoring etc. Competences from this framework have additional resources such as workbooks and teaching packs.

 Both ACT and CHUK provide a link to Rainbow Children's Hospice guidelines 'Basic Symptom control in Paediatric Palliative Care' (2008). ACT also describes several 'Care pathways' and an accompanying 'Service Self Assessment Tool'. Great Ormond Street Hospital (GOSH) provides clinical information and guidelines, such as 'Naso-gastric tube management' and 'Tracheostomy care'.

Other materials may provide excellent resources even though they are not specific to caring for sick children. The NHS Knowledge and Skills Framework (KSF) is a good model in terms of its structure and level of detail. It is likely to contain dimensions that are applicable to children's hospices.

Another comprehensive resource is 'Skills for Health' (http://www.skillsforhealth.org.uk/) with many tools for developing a skilled workforce, such as the Nursing Workforce Planning Tool. This site is endorsed by the CQC. The website also links to the National Occupational Standards, within which there are 155 standards under the heading 'Health & Social Care', 28 standards for 'Children's Services', and 2 standards for 'Supportive & Palliative Care'. The latter are couched in very general terms.

'Skills for Care' is similarly designed for broad use in helping social care employers to improve their workforce The section on Common Induction Standards (http://www.skillsforcare.org.uk/entry_to_social_care/common_induction_standards/common_induction_standards.aspx) is kept up to date, but lacks detail.

'Skills for the Third Sector' is working towards a national skills framework for the voluntary sector. They have also identified National Occupational Standards for the following three groups of staff: Trustees (2006), Fundraising (2008) and Managing volunteers (http://www.skills-thirdsector.org.uk/national_occupational_standards).

The Royal College of Nursing (RCN) has a learning zone with sections on clinical skills and on health and safety guidance and legislation. Material is not easy to find and is for members only. There is some material produced jointly by RCN and the Working in Partnership Programme (WIPP), but the example of competences for nurses in general practice may not be sufficiently relevant to hospice care.

Within the published literature, there are a number of examples of competency based models. Egan & Abbott's (2002) interdisciplinary hospice training model *the Patient/Family Value Directed Model of Care* includes a list of common competencies for continued learning. The authors have found them important for helping to communicate the responsibilities of the new employee in the learning process, and to help direct peer mentors in facilitating the process. They are also useful in standardising information and messages across agencies, especially for staff groups that employ flexible workers. The competencies consist of a list of 16 aspects; examples include 'outline the process of patient/family consultation, assessment, referral and admission', 'discuss grief and bereavement issues and services', and 'participate in a death and closure visit with an experienced hospice team member'.

Becker (2007) focuses on palliative care educators and outlines the conceptual thinking and development of core competencies for this group. It is suggested that the process of defining a common core of key skills, personal qualities and attributes that reflect the unique role of a palliative care educator can provide an indicator of the diversity and complexity of this role, which can be used by the educator and employer in job planning, review and professional development. Hitherto, roles have been poorly defined, variable internationally and not directly connected to the central training needs of staff or fair enumeration for the role. Becker outlines six main competency areas: knowledge; technical; cognitive/analytical; ethical/personal behavioural; affective; and intrapersonal. He states that the areas will need to be discussed and clarified more, and that some of the skills and attributes referred to are not unique to palliative care. Becker however argues that it is the collective range of these competencies, which when brought together, demonstrates the distinctive and unique nature of the palliative care educator and the totality of the role. This in turn is necessary to be competent for the training of staff working in palliative care areas.

Some publications were concerned with spirituality education within an interdisciplinary approach. Cooper et al (2010) for example describe a Canadian Community of Practice

process to develop an occupational analysis-based competency profile for the Professional Hospice Palliative Care Spiritual Care Provider. Such providers in Canada are drawn from a diversity of mandates, academic qualifications, and training backgrounds. Some possess advanced degrees, significant clinical training, and professional association certifications, while others possess fewer qualifications or credentials. Some have a faith-based mandate to provide care (eg ministers, priests, rabbis, imams, people in religious orders, or religiously authorised lay persons), while others may be multifaith counsellors. The evident lack of standardisation with respect to clinical and academic preparation and licensure for this work is a concern. It is argued that working in specialist hospice and palliative care teams and units requires specialised knowledge and skills.

A competency-based curriculum was developed based on a review of existing evidence and educational needs. This resulted in a total of 14 competency domains that included aspects such as identifying and understanding spiritual and religious history, resources and care needs; providing appropriate, culturally sensitive spiritual care; providing spiritual counselling; and collaborating as part of a multidisciplinary team. Although it has yet to be implemented, the authors conclude that the competency profile may be of international benefit for spiritual care providers intending to work in hospice and palliative care, their employers, and certifying bodies and in the production of curriculum for clinical training purposes.

National Vocational Qualifications

Aside from the literature indicating competencies specific to palliative and hospice care environments, National Vocational Qualifications (NVQs) are a progressive cross-discipline 'competence-based' qualification enabling participants to learn practical, work-related tasks designed to help develop skills and knowledge. NVQs are based on national standards for various occupations. New vocational qualifications have recently been introduced and placed on the Qualifications and Credit Framework. Some of these new qualifications will continue to be called NVQs, and NVQs will continue to be recognised by employers.
NVQs can be at levels 1 to 5 on the National Qualifications Framework and the Qualifications and Credit Framework. There is no maximum time limit to complete an NVQ; it is designed to be needs-led, however many learners take about one year to complete an NVQ at level 1 and 2, and around two years for an NVQ at level 3.

There are no courses specifically for hospice or palliative care. Childcare courses prepare participants for roles in nurseries and pre-school environments, and Health and Social Care courses are largely aimed at Care Assistants and Support Workers and develop skills in

communication, reporting, general competence in practice, health and safety, and protection of individuals.

Potential benefits of NVQs have been listed as improved skills, less skills shortages and more appropriate job-employee fit, however, there has been considerable and sustained criticism of NVQs from employers, employees and academics (McAdam & Crowe 2004). Criticisms include excessive bureaucracy, overly complex terminology and a lack of credibility of the competence concept. A large qualitative study conducted by McAdams & Crowe revealed that NVQ was seen as a training regime within the organisation and that there were no clear links to improved performance or employee morale. Moreover, there were contextual problems in applying the standards with respect to sufficient assessors and time within the care setting to ensure competencies were reached.

In addition to this, Swailes & Roodhouse (2003) investigated uptake of the higher NVQ levels (4/5), which are mostly connected to the professional qualifying routes. Research involving interviews and case studies showed that the most successful higher NVQs have generic application across a range of sectors or fill gaps where qualifications were not previously established. Their findings revealed however a number of barriers and constraints. Higher NVQs for example suffer from credibility problems and the variable delivery quality partly accounts for a tarnished image. Support for occupational standards is strong, but their design is not generally suited to higher qualifications and funding mechanisms disadvantage higher NVQs particularly in the university sector; NVQs are perceived to be relatively costly. McCrystal (2003) also notes that where NVQs have been integrated into colleges of further education, more work remains to improve the working relationships between colleges and employers at all levels of NVQ delivery.

2.2.4   Teaching and Learning Styles

General techniques

Different teaching and learning methods have been shown to be effective in the hospice environment including active classroom settings, small group facilitation, and self-learning modules (Ferrell & Coyle 2001). The latter is particularly useful for those hospice employees working flexible hours or part time. For their interdisciplinary training, Egan & Abbott (2002) used in-depth skill building workshops at part of their programmes. Repetition in learning is done in each of the defined skill areas through completion of competencies supported by the team mentors. Kang et al (2010) used interactive lectures and role play in their Korean hospice and palliative care training programme with effect. They also adopted learner-

centred methods such as the use of trigger videos with interactive participant discussions, as developed and evaluated by Stratos et al (2006).

Mentorship

Mentorship is a critical component of career development and has been found to be associated with a number of career benefits including early research productivity (Steiner et al 2002). Formal peer mentorship programmes can be an important part of any training programme and can significantly affect engagement in learning (Egan & Abbott 2002). Authors suggest that senior staff with at least two years experience who enjoy teaching and are expert practitioners are ideal mentors. For an interdisciplinary approach, it is suggested that mentoring should begin with directed learning activities, progress to shadowing and observation of all disciplines, then lead to case assignments.

Baverstock (2006) conducted a study to establish what staff support mechanisms are currently in place within 26 children's hospices in the UK looking specifically at 'individual' staff support including mentoring and 'team' staff support including the use of debriefs. Most hospices had a team debrief soon after a significant or traumatic event, usually facilitated or chaired by a bereavement counsellor, often with a senior member of the clinical team. The ethos of the debrief seemed to be all inclusive, inviting hospice staff, volunteers and external staff (teacher, GP, social worker) as appropriate. The structure involved a discussion of how things went, looking at the positives and also at different methods of dealing with things. It provided a chance to review and learn, and an opportunity for everyone in confidence to express their thoughts and feelings.

All hospices had access to a bereavement advisor or counsellor for staff support. This ranged from a support team of counsellor, social worker and/or chaplain to an outside counsellor available when needed for one to one or group work. Staff found this invaluable and believe it helps to discuss personal or work issues to strengthen own coping ability. In house training was also available for all staff working in every hospice along with opportunities to attend external courses. The in house training followed various themes: self-awareness 'caring for ourselves, the carers', coping skills and 'boundary sessions', communication skills, looking at loss and grief and bereavement skills.

Schonwetter (2006) describes advances in mentoring developed by the American Academy of Hospice and Palliative Medicine (AAPHM) College of Palliative Care. The primary goal of the College is to provide support for the development of leadership skills of junior, midlevel, and senior interdisciplinary palliative care professionals who will advance palliative care as an academic and clinical discipline through educational and research endeavours.

The College developed the One-on-One Paired Mentoring Program, which provided an opportunity for students, residents, fellows, junior faculty, and midcareer faculty to speak personally with a senior mentor. Recognising that many individuals do not have palliative care-related mentors at their home institution and that mentoring relationships are most productive over an extended time period, the College developed the Year-Long Mentoring Program, which provided an opportunity for physicians, nurses, social workers and their senior mentors from another institution to focus on professional development in clinical care, education, administration, and research through regular contact and in-person meetings. The program was designed to facilitate development of distance mentoring relationships by providing a modest honorarium for mentors and travel support for the mentor–mentee pair to meet in person.

Clinical supervision

Clinical supervision is described as a formal process of professional support and learning, which helps individual practitioners to develop knowledge and competence, assume responsibility for their own practice, encourage reflection and enhance safety of care in complex situations (DH 1993).

Despite the support for clinical supervision by organisations such as the Nursing and Midwifery Council, (NMC 2008), as well as the DH in successive policy documents (DH 1999, 2002, 2004), uptake has been patchy. The reasons for this appear mainly to relate to a lack of clarity of how clinical supervision is defined (Bush 2005, Shanley and Stevenson 2006), which may contribute to what Cottrell (2002) describes as 'suspicion, mutiny and tokenism' about the supervision process. However, the benefits of clinical supervision, such as the promotion of staff wellbeing and prevention of burnout, are widely documented (Begat and Severinsson 2006, Edwards et al 2006) and the practice has been shown to support staff effectively, which is particularly necessary in clinical specialties such as children's palliative care that place exceptional demands on nurses (Kilcullen 2007).

There is also a growing body of evidence to suggest that clinical supervision contributes to good and safe practice (Edwards et al 2005, Kilcullen 2007) through supported reflective practice and personal and professional development (Lilley et al 2007). Moreover, clinical supervision can reduce professional isolation, promote change in working practices, support professional development and improve care and teamwork (Bedward and Daniels 2005).

Girling et al (2009) describe how East Anglia's Children's Hospices implemented a form of clinical supervision over a two year period called practice supervision throughout its services. Crucial to the project was the employment of an expert external facilitator and

internal 'champions' who were responsible for driving the project forward on the ground. Nurses, managers, family support staff and senior care assistants were trained to become supervisors over four courses lasting two days. Despite initial staff concerns about the implementation, it has been successful and most staff now participate in practice supervision, either as supervisors or supervisees.

In addition, Chilvers & Ramsey (2009) describe the practicalities of setting up a group reflective clinical supervision programme for nurses, healthcare assistants, and community practitioners across three hospice sites. The philosophy of palliative care provision was to foster transparency in providing safe and effective care to patients, carers and families and clinical supervision was seen as an important mechanism to promote this across these nursing groups. The reflective group model is designed to examine critical incidences and draw meaning from clinical events. As with Girling et al, pivotal to the success of this initiative was the appointment of two key posts – the lead nurse for patient safety and an education and training co-ordinator – who drove the initiative through and acted as facilitators. Also, ten nurses were recruited to be trained as clinical supervisors and in order to get staff engaged in the idea, a course promoting awareness of clinical supervision was run by a lecturer from the local university. As a supplement to this, an information leaflet was placed within pay slips. Evaluation of the programme demonstrated some felt benefits by those who had attended but issues with attendance due to work pressures was an issue. In addition, there were insufficient clinical supervisors to cover all three hospices.

Reflection.

Health and social care education has a long established association with reflective learning as a way of developing post-qualifying professional practice. Reflective learning is also a key feature of self-regulatory learning, which is an essential aspect of life-long learning for today's National Health Service workforce. Recent literature and research on reflection emphasises its critical role in the field of hospice and palliative care. Reflection can occur in the midst of action or following the experience. Authors such as Farber (2002) state that reflection is what allows problems to be addressed and solved, and can lead to improved performance in situations characterised by complexity, uniqueness uncertainty, and value conflicts. Farber states that the need to find solutions to complex problems is typical not only of end-of-life practice but the design, implementation and evaluation of end-of-life education.

Hermsen et al (2005) add to this by stating that reflection on values seems to be particularly important in palliative care teams, as decision-making is more value-laden related to life, living, end-of-life decision-making, dying and how to manage it, and incorporating the differing views and values of patients, families and providers in the decision-making process.

In palliative care, the authors state that it is crucial that team members consciously reflect upon and communicate about decision-making, because making the right decisions is inherent to delivering good quality of care. Taking this further, Bailey & Graham (2007) describe the processes involved in introducing, facilitating and evaluating a project of guided reflective practice for a group of eight palliative care nurses. While literature has tended to concentrate on critical discussion relating to reflection, the authors assert that less attention has been directed towards the organisation and facilitation of reflective processes in practice. Group evaluation of the project highlighted the importance of the following themes: understanding the process of reflective practice; the value of keeping a reflective diary; guided group reflection and moving forward. The introduction of guided reflection for palliative care nurses afforded both the facilitators and the participants an opportunity to meet away from the clinical environment, and to work together, finding fresh insights to inform practice. The authors conclude that the valuing and promotion of reflective processes by an organisation arguably provides a fundamental strategy to support nurses in a quality palliative care setting.

Taylor et al (2008) undertook a project using a combination of reflection and action research. Eight experienced registered nurses identified their need to 'get it right under pressure' in their work in palliative care. Participants collaborated in generating and evaluating an action plan to enhance the likelihood of getting palliative nursing care right, under pressure, more often.

While learning using online methods and resources will be considered in more detail later, the potential benefits of reflection online have been investigated (Morgan et al 2006; Pack 2010). Morgen et al (2006) capitalised on the 'virtual community' approach to e-learning. They used a small-scale case study of reflective practice to investigate the experiences of 25 health and social care students who used Blackboard to reflect online. Findings suggest that participants developed more extensive reflective accounts than they had done previously when reflecting in traditional classroom environments. They reflected further, spent longer reflecting, self-managed their reflective learning and recognised significant learning achievements through reflection. Data did indicate varying levels of engagement in the online reflective process however, with not all learners achieving a deep level of critical analysis. Reasons for this in relation to online learning are explored in more depth later.

Work-based learning

With NHS budgets under increasing pressure, and challenges to the impact of classroom-based learning on patient outcomes, work-based learning is coming under increasing scrutiny as a potential solution.

There are many different definitions of work-based learning, but some of the key features are that the learning arises from the work itself (Clarke & Copeland 2003), is centred on the member of staff (Flanagan et al. 2000), uses experiential learning and critical reflection (Rhodes & Shiel 2007) in the creation of new knowledge. The learning should also be designed to meet the needs of the work place as well as the learner (Sobiechowska & Maisch 2006) so there is a strong organisational connection.

Evidence from higher education institutions suggests that work-based learning can improve professional practice, but in many cases it is perceived as little more than on-the-job training to perform tasks. There is very little evidence in the published literature of classroom-based learning making a difference to patient outcomes. Gijbels et al. (2010) carried out a systematic review of the literature published between 1990 and 2007 evaluating the impact of post-registration nursing and midwifery education on practice. They found that although the learners benefit from the acquisition of knowledge and skill, and a change in attitudes and perception, the returns related mainly to the personal and professional development of the learners involved, rather than practice development, organisational change or patient outcomes. Similarly McCormack et al. (2006) in a synthesis of the literature surrounding practice development found no evidence of more traditional education having any effect on the development of practice.

Williams (2010) conducted a literature review to critically examine the work-based learning literature and explored the implications of the findings for the development of work-based learning programmes. While the review focused on nurses, there are some important and transferable messages to other practitioners. It would appear from her review that work-based learning has the potential to change practice but its success is dependent on three main aspects concerning the empowerment of the practitioner, the managerial input, and the prevailing organisational culture of learning.

With respect firstly to the practitioner, learning how to learn and critical reflection are key features. For effective work-based learning, staff need to take control of their own learning, receive support to critically reflect on their practice and be empowered to make changes to that practice. In order to change practice, practitioners that are closest to the actual care delivery should also be enabled to create knowledge and lead change in the workplace using frameworks that fit all grades of staff. Rhodes and Shiel (2007) describe a possible approach to this, basing their ideas around individually negotiated work-based change projects which are designed to benefit both the learner and their employing organisation.

The importance of facilitation cannot be over-emphasised. Without support to question practice there is a danger that nothing will change as learners struggle to move from

established practice (Siebert et al 2009). The advantages of a facilitative approach include building upon individual experiences, treating people as adults and developing critical thinking and creativity (Reece & Walker 2003). In related areas such as practice development and getting evidence into practice, facilitation has been shown to be a key factor for success (Rycroft-Malone et al 2004, McCormack et al 2006). It is reasonable to assume therefore that effective facilitation is a key factor in enabling successful work-based learning. Facilitation is a complex skill however, and facilitators need to be properly prepared for work-based learning (Manley et al 2009). There is potential for work-based learning to develop as a collective activity, even when the topic for learning is negotiated individually (Choy 2009). Amongst other collaborative learning activities, colleagues can assist each other's learning by participating together in facilitated critical reflection such as learning groups (Siebert et al 2009) and clinical supervision (Jenkins 2007).

From the manager's perspective, the manager has been found to have a great impact on a learner's ability to implement change as a result of new learning (Currie et al. 2007). Learning will require the manager to be actively involved in working with the individual practitioners to help them select and implement appropriate projects (Finn et al. 2010). This will mean changing position from being both the planner and driver of change, to becoming more facilitative – supporting the staff themselves to take on that role.

With reference to organisations, Manley et al (2009) identify an organisation-wide learning philosophy and a supportive organisation-wide infrastructure as the two enabling factors for the successful implementation of work-based learning. Organisations therefore need to be proactive in demonstrating that they value work-based learning and the expertise that is developed through that learning, as much as they value traditional learning. This could be achieved by ensuring adequate allocation of resources such as time, and also skilled facilitators to support learning in practice.

Self-directed learning

Self-directed learning (SDL) has a long history and stems from the seminal work of Tough (1979). It based on the principles of adult education and relates to the individual's intentional efforts to take the initiative to learn, gain knowledge and skills to produce some change in themselves. SDL is seen as connected to and facilitating lifelong learning (Miflin et al 2000) and continuous professional development (Greveson & Spencer 2005). While some consider SDL to be a prerequisite to lifelong learning, others describe SDL as having a reciprocal relationship (Candy 1991). Specifically SDL is seen as the principle activity in the independent pursuit of learning, while the goal of lifelong learning is to equip people with the skills and competencies to continue their own self-education beyond formal schooling.

SDL has been used widely in healthcare training. O'Shea (2003) undertook a review of the literature relating to SDL and its use in nurse education. She concludes that there are many benefits including increased confidence, autonomy, motivation and preparation for life-long learning. O'Shea adds that the literature implies that self-directed styles seem to appeal more to mature 'learners' who are more ready to learn. In general, acquiring the necessary skills is dependent upon preferences and a variety of teaching methods should be used.

However, evidence suggests that students and teachers have different perspectives about the concept which can lead to conflicting learning outcomes. Greveson & Spencer (2005) stress that it is critical that educators understand concepts underlining educational approaches and initiatives in order to evaluate whether they will be effective. Candy (1991) has suggested that there are several distinct ways of viewing self-directed learning based on varying educational philosophies (ideological to instrumental) which may have different implications for practice in different settings.

The context of learning must also be considered. Self-directedness has been seen by some as a relatively stable characteristic or measureable personal attribute, but Greveson & Spencer argue that the ability and motivation to be self-directed varies with the context of learning. The subject matter, the social, cultural and educational setting, past experience and study skills all influence the extent to which self-directedness is possible or likely.
However, Hiemstra writing in 2003 makes the connection between SDL and the internet. He argues that the presence of virtual information sources will make SDL approaches to teaching and learning a default norm, rather than the exception in adult education. Following on from this, the rise of distance learning to accommodate and include a broader range of new learners means that more learning will take place outside of the traditional educational environment. Certainly, on-line sources have expanded in recent years as Hiemstra predicted, and this is taken forward in the next section.

E-learning

'E-learning' has been gathering momentum as web-based access becomes more widespread. This has been driven forward by successive government policies aimed at promoting e-learning as a central strategic delivery mechanism through which to produce a highly skilled workforce (eg DfES 2005). It comprises all forms of electronically supported learning and teaching. The information and communication systems, whether networked or not, serve as specific media to implement the learning process. The term is used to reference out-of-classroom and in-classroom educational experiences via technology, even as advances continue in regard to devices and curriculum (Tavangarian et al 2004).

In recent years, e-learning has become a high profile approach for pre-registration health students and for continuing professional development needs of healthcare staff, both uni-professionally (Blake 2009; Brunaro & Lamont 2010) and using an interprofessional approach (Luke et al 2009; Pack 2010). These latter authors have highlighted the increasing use of online collaborative learning for healthcare continuing professional development.

E-learning resources for staff working specifically in end-of-life care have recently been launched in an attempt to improve access to training in the sector (Community Care 2010). The training, commissioned by the Department of Health and the National End of Life Care Programme, will eventually offer more than 100 sessions, covering assessment, advanced care planning, communication skills and symptom management. The programme fulfils one of the government's commitments under the July 2008 end-of-life care strategy and will be free once care staff have been registered. The National Council for Palliative Care support the notion that end-of-life care training should be mandatory for all care staff, but point out that access to training must be assured.

A literature review concerning health care professional usage of e-learning was conducted by Sanders and Langoise (2006). They revealed that discussion boards are the most frequently used method. Most studies note that there are low levels of participation, problems with the computer-based technology and differences in user expectations. Several small studies describe positive experiences by participants, with learning and change in practice, and self-reported reduction in professional isolation. It is suggested that further developments in the use of online collaborative learning should be based on the needs of users and that the importance of the healthcare context is recognised.

Despite e-learning's high profile and seemingly high uptake, it is not straightforward and very often raises many issues. Research suggests a number of key issues and questions that need to be considered. E-learning for example may be more effective used in addition to with traditional class-room based learning. The level of personal support required through e-tutors, has been frequently underestimated and cannot replace face-to-face contact. There is a need to consider the role of current and future trainers, and what information, communication and technology infrastructure is required to support e-learning.

Childs et al (2005) conducted a systematic review to identify the barriers to e-learning for health professionals and students. The project also established possible solutions or success criteria to overcome these barriers. Fifty-seven references were suitable for analysis. This review was supplemented by a questionnaire survey of learners and an interview study of learning providers to ensure that data identified from the literature were grounded in reality.

Several barriers were identified and the main ones included costs, poorly designed packages, inadequate technology, lack of skills, the need for face-to-face teaching, the time intensive nature of e-learning, and computer anxiety. With respect to solutions, the authors indicated that issues such as standardisation of materials, funding, integration of e-learning into the curriculum, blended teaching, user-friendly packages, access to technology and skills training were important to overcoming the problems. The authors argue that librarians can play an important role in e-learning through providing support and support materials, teaching information skills, and managing and providing access to online information resources.

Several different approaches to e-learning are evident in the literature. Miers et al (2007) for example implemented and evaluated an interprofessional module through online discussion boards with health and social care students in a faculty in the UK. The module assessment encouraged engagement with technology and with group members through peer review. An evaluation of student experience of the module gathered data from 48 students participating in 10 online groups. Many students were apprehensive about the technology and there were different views about the advantages and disadvantages of online learning. Students interacted in a supportive manner and group leadership was seen as associated with maintaining motivation to complete work on time. Students reported benefiting from the peer review process but were uncomfortable with critiquing each other's work. Sensitivity about group process may have inhibited the level of critical debate. Nevertheless the module brought together students from different professions and different sites. Examples of sharing professional knowledge demonstrated successful interprofessional collaboration online.

With a focus more on the individual, Skills for Health (**www.skillsforhealth.org.uk**) has capitalised upon the drive for e-learning. Licensed by the **UK Commission for Employment and Skills (UKCES)**, Skills for Health labels itself as a Sector Skills Council for all health employers; NHS, independent and third sector and is driven by skills and workforce needs. Its purpose is to provide solutions and tools to help improve productivity and quality and support organisations to plan and manage workforce development and change. It also sees itself as an authoritative 'champion' to represent employers' views.

Skills for Health has developed a number of essential training courses, seemingly addressing a number of barriers outlines by Childs et al (2005). Their local out-reach support service also purports to assist organisations in constructing and implementing an e-learning strategy. Skills for Health have a Core Learning Unit that offers e-learning and face-to-face programmes for healthcare staff, thus adopting mixed approaches known to be preferred. The courses are popular and already widely used by healthcare and education providers. Last year, 482 UK organisations accessed the courses, with over 200,000 individual learners.

Authors of the website are keen to extol its benefits (albeit in the absence of solid evidence) and assert that it is an effective, flexible, easily accessible and popular way to deliver mandatory training requirements (Fire Safety Awareness, Health and Safety Awareness, and Manual Handling), minimises retraining as staff move between jobs or organisations, and reduces costs as short e-learning modules can be done anytime, such as in between other duties. The managed learning environment system allows organisations to track what training has taken place, monitor the progress of their learners, and evaluate the impact of the training.

Continuing with specific websites, some practical guidance aimed at palliative care professionals is provided by Smyth (2010), who critically reviewed study skills websites to aid continuous professional development. He concluded that the Open University site provided the clearest and most comprehensive content for SDL (www.open.ac.uk/skillsforstudy/), with clear, accessible, informative and user-friendly instructions. Topics include how to get the most out of tutorial support, developing confidence, improving writing and reading skills, revision techniques and reflective thought.

Accompanying these practical examples are other papers that offer strategies to help learners to evaluate internet resources. Experts are fairly consistent in suggesting that Web pages be evaluated through the lens of the same five criteria: *authority, accuracy, currency, objectivity*, and *coverage* (Rager 2003). The criterion of *authority* refers to investigating the credibility of the author or creator of the Web page. The author's credentials, institutional affiliation, educational background, and qualifications for writing on a particular subject should be assessed.

Verifying the *accuracy* of the information is accomplished by establishing its compatibility with other sources. It is recommended that citations be verified if possible and that even simple things such as spelling, grammatical, and typographical errors should be noted. They may be indicative of a lack of quality in regard to the information itself. Web sites should include information on when they were created and when they were last updated. This information is used to determine the *currency* of the information or how up to date it is.

In assessing *objectivity*, the fourth criterion, the challenge is to distinguish fact from opinion or propaganda. The purpose of the Web site and the source of the information are critical in uncovering potential bias. Verifying facts in other sources is also helpful in this regard. Determining if the information is provided as a public service and if it is free of advertising is also critical. The last criterion suggests that sites should be evaluated regarding *coverage*. By exploring multiple sources on the same topic, it is possible to identify a variety of viewpoints

and to distinguish those sites that cover the topic extensively as opposed to those which provide superficial or minimal information. Rager concludes that examining a site with these five criteria in mind is a good starting place for determining information quality.

Skills Passport

A Skills Passport is a portable, online record of an individual's career history, current skills and training. The information in a Skills Passport can be independently verified and includes an individual's education, qualifications, competencies, employment history, training record and objectives. It is seen as particularly good for identifying individual and organisational training and education needs. The use of the skills passport is not new and has been used in Australia for a number of years for training apprentices (Youth Studies 1996) and discussed in the context of teacher training (Times Ed sup 1995). However, it has been recently introduced in for training workers in nuclear plants in t he UK (Nuclear future 2010) and is being rolled out within nursing (Nursing Management 2010).

In the field of nursing, the initial concept emerged from a series of national stakeholder events and was included as an action in 'Modernising Nursing Careers' (Department of Health 2006). Skills for Health developed a skills passport and a pilot phase was run with the nursing profession which was deemed successful after two independent evaluations (Skills for Health 2010 a&b). The concept of the Skills Passport is that it will be a hosted, on line repository for an individual's employment record, skills, competencies, achievements, qualifications, training and posts held. It will provide an electronic record that is searchable and can be issued by the different stakeholders involved, whether those are within NHS establishments, non NHS health sectors, training organisations or indeed individuals. One of the key benefits is that being an electronic, centrally located passport, it is easily portable between posts and potentially across sectors. The Skills Passport covers the NHS and independent sector, permanent, contract temporary and volunteer workers, clinical and non-clinical staff across all four UK countries.

There would appear to be many perceived and potential benefits of Skills Passport to the employer and the individual. **For the employer for example it** reduces duplication of training, reduces the time and costs of hiring (e.g. less need for staff cover and pre-employment administration), provides visibility over the skills and abilities of the entire workforce, and allows easy identification of mandatory and other training needs and subsequent targeting of training to those that need it most. **For the individual it provides a** single verified and portable career record from education to retirement, facilitates mobility and flexibility across the sector, and provides easy identification of training needs.

2.3　Philosophies Underpinning Training

The Department of Health (2008) workforce policy document 'The NHS Next Stage Review' sets out a number of principles for future workforce education based on a philosophy for the NHS that delivers high quality for all and gives staff the freedom to focus on quality. Achieving this will require the NHS to provide the best possible education and training for future generations and to ensure that existing staff get the support they need to continuously improve their skills.

The approach to roles, education and career pathways are based on six main principles:

1　*Focused on quality*: Quality-focused means being clear about the roles of professionals and then ensuring structured training and career pathways that offer the appropriate breadth and depth of knowledge and experience. Furthermore, they must support working with partners, such as social care.

2　*Patient centred*: The skills for understanding and responding to the needs of individual patients and supporting them to manage their health in a manner that is respectful of diversity and difference must be incorporated into education and training programmes and clinical practice.

3　*Clinically driven*: The active engagement of clinicians in the development and delivery of workforce planning, education and training is essential to delivering high quality care and improve patient pathways. The visions in each region show the level of ambition the NHS has for changing services for the better.

4　*Flexible*: Healthcare is constantly in a state of development and change with increasing emphasis on health promotion, well-being and disease prevention and shifting patterns of care. The approach both recognises the need to build in flexibility and reflects the importance of continuous professional development (CPD) and life-long learning.

5　*Valuing people*: This means designing education, training and career pathways that are sensitive to trainees' personal needs, and that acknowledge the dedication of those entering healthcare professions.

6　*Promoting life-long learning*: Staff in all roles and settings need opportunities to continuously update the skills and techniques that are relevant to delivering high quality care through, for example, work-based learning, distance and e-learning, and further education.

Bellamy et al (2006) have developed their interprofessional collaborative case-review process upon palliative care philosophy, which promotes multiprofessional working and a holistic approach to patient and family care. It is seen as a way to bring colleagues together in an environment that enables communication and encourages the development of best practice.

Egan & Abbott's (2002) hospice philosophy guided their interdisciplinary training model, *the Patient/Family Value Directed Model of Care*. The philosophy revolves around the concept of the patient and family directing their own care and the model is founded on the following principles:

1   Dying is a unique personal experience
2   People experience the last phase of their lives through many interrelated dimensions
3   The last phase of life provides continued opportunity for positive growth and development in the face of suffering.

Work-based learning is based on the philosophical stance that learners are adult learners and are therefore self-directed, autonomous and self-motivated (Sobiechowska & Maisch 2007).

2.4   Motivation and Learning Cultures

Egan & Abbott (2002) argue that hospices have inherent problems establishing a culture of learning and motivation to learn, as programmes have often evolved from medical training and can be overly focused on the core skills of specific disciplines, primarily nurses. The challenge to prepare all disciplines is evident; however they argue that for those hospices wishing to develop their staff through a joint interdisciplinary route, their interdimensional approach to team training provides a way forward. The authors state that an initial step is to critically evaluate the organisation's culture to see if it supports interdisciplinary training, this is best done initially by reviewing team structure to see if it supports team functioning. Practices such as care planning, care management responsibilities, documentation systems and the cultural language can be reviewed for their collaborative nature. In addition, the training resources and processes can be assessed, looking at whether all disciplines get the same attention.

Egan & Abbott (2002) used a formal peer mentorship approach in their interdisciplinary approach and argue that it can significantly affect motivation and retention of staff. When well established and supported, they can serve as professional growth opportunities, giving long-term employees value and recognition. In addition, a strong interdisciplinary model of peer mentorship can strengthen organisational culture and enhance the role-blending needed for effective hospice care.

In her literature review and with a focus on nursing, Williams (2010) argues that organisations with strong learning cultures are characterized by non-hierarchical, team-based learning structures that prioritise learning, empower change, involve staff and are open to suggestion and innovation (McLaren et al 2008). Developing a learning culture has

the potential to increase the motivation and commitment of nurses. She reports that a staff survey carried out in England showed that staff motivation and commitment was linked to whether they felt able to develop to their full potential (Ipsos MORI 2008). The link between staff development and motivation has also been shown to make hospitals more attractive places to work (Stordeur et al. 2007) and there are current studies that demonstrate a positive relationship between critical thinking, autonomy, professional status, staff development and job satisfaction (Zurmehly 2008). Aiken and Patrician (2000) highlight the importance of autonomy, control over the practice setting, the nurse–doctor relationship and organisational support in the development of a culture that supports professional nursing practice, which in turn is felt to be essential in the development of a learning culture.

Williams (2010) states that a key component of a learning organisation is that staff participate at all levels. Girot and Richaby (2008) found that organisational support was the key difference between staff who did well in their learning as opposed to those who had difficulty. This means ensuring that learners do not work in a culture that accepts healthcare as dominated by medicine and task orientation (Moore 2007). In addition, organisations can promote settings conducive to a positive learning culture by addressing pressure of work, reducing feelings of apathy in staff and creating dynamite and forward thinking environments (Hardwick & Jordan 2002). Baverstock's (2006) study on staff support mechanisms also identified that good practice in supporting staff in a meaningful way is connected to a positive sharing and learning culture in the children's hospice setting.

Authors agree that organisations that create positive learning environments also generate and motivate staff to be life-long learners. This is purported to be an essential part of professional practice, and is defined as a continuous process of learning through study, experience, personal reflection and shared learning (NAfW 2000). Lifelong learning is seen as vital to the continuous personal and professional development of all staff (NAfW 2001), and the Knowledge and Skills framework specifies that organisations need to commit to learning and development, and to valuing workplace learning (DOH 2004). In addition to this, McClaren et al (2008) implemented a strategy to promote lifelong learning in the primary care workforce and concluded that the use of key leadership roles and change-management approaches had brought about early indications of positive transition in lifelong learning cultures.

O'Brien (2006) believes that people who are life-long learners are more committed, take more initiative, have a broader and deeper sense of responsibility in their work and learn faster. Although this could be seen to be advantageous to the organisation, he believes that

it is actually the personal fulfilment that it generates in the individual workers that is more important and that this is likely to make the difference to patients in the long term.

With a focus on motivation, Pelaccia et al (2009) looked at the impact of training periods on the motivation of health care students to learn. While the study took place in emergency departments, there are some transferable messages for practitioners and educators working in other stressful environments such as palliative care. The authors argue that motivation is one of the most important factors for learning and achievement. The perceived value of the task, perceptions of self-efficacy and beliefs about control of learning are the main determinants of motivation, and are highly influenced by the individual's personal history and especially by significant past experiences. The authors concluded that ideally, and in terms of increasing motivation, health care students should gain experiential learning in stressful environments before attending a corresponding academic course. During this period, tutors should provide appropriate supervision and feedback in order to support self-efficacy perception and learning control beliefs.

2.5 Planning and Evaluation of Training

2.5.1 Planning training

Egan & Abbott (2002) outline a series of considerations for the planning training in hospices. A crucial element is the skill needed for effective training, which should be obtained through qualified professional trainers, and corporate training programmes. Expertise should be evident in presentation skills, curriculum design, group process skills, educational psychology and organisational development. Goals of training should be linked to hospice goals and underpinned by philosophies that are understood by all disciplines. Additionally, as employees come with valid credentials, valuable training time should plan on focusing on how best to maximise their expertise within the context of the hospice and approach to care and not to repeat material that has previously been covered.

There should also be organisational readiness; learning can motivate staff to implement new practices and organisations should be prepared to support improvements. This will mean ensuring appropriate and realistic resources.

A study conducted by Ekblad et al (2000) in Sweden highlights the importance of considering cultural issues when planning training. The purpose of this study was to gather reflections about cultural issues among hospice staff after a 3-day seminar in multicultural end-of-life care, by using a qualitative focus groups method. The 19 participants (majority nurses) were divided into three groups, one per hospice unit. One of the study's main findings was that to better understand other cultures it is important to raise awareness about the staffs own culture and to pay attention to individual cultural sensitivities. The

findings from focus groups provide insight regarding the need for planning flexible training in cultural issues to match the needs of the staff at the hospice units studied.

Three main training themes emerged from the data:

1   Concrete information and examples of family patterns in different cultures, everyday living and traditions. Through knowledge of family patterns the staff may gain a better understanding of why patients and their relatives sometimes behave differently to those from the host culture.

2   Questions about life and death. How should, or how may, staff act in connection with the death of a patient? This may include for example the practical work involved in dealing with patients with different cultural backgrounds.

3   Knowledge about different religious and immigrant groups. It was seen as important to learn more about the religions and cultures such as
the Jewish culture and sects such as Jehovah's Witness.

The issues of relational aspects has been mentioned in an interprofessional study undertaken by Bunnis & Kelly (2008). Here, Browning & Solomon (2006) offer additional insights into the content planning of training for paediatric palliative care with respect to relational learning. They argue that the discrepancy between what is taught in formal educational settings and what is learned by practitioners in the informal flow of everyday practice has been called the hidden curriculum. The authors apply a well-documented range of concerns about the hidden curriculum and the erosion of professionalism in the area of paediatric palliative care education. The authors propose that educational initiatives must always be grounded in the charged existential space of relationships among children, families, and practitioners, because the learning that matters most occurs within these relationships. The authors urge for an educational approach, that puts relational learning in the forefront of educational strategies.

2.5.2   Evaluation of training

Although there is some disagreement about the terms surrounding evaluation, there are a number of approaches characterised by their intention of use, and Campbell (2007) provides a useful overview of these in relation to training in palliative and hospice care.

Campbell remarks that evaluation has two main purposes in the learning environment – formative and summative. Formative (process/implementation) can be directed towards assessing the extent to which an educational programme or training course is operating as it should. It assess quality assurance and the information can contribute towards immediate as well as long term change by informing educators of what is working and what is not. This type of evaluation is used most commonly to gather data on an ongoing basis and often

presents as satisfaction data or measurement of perceived skills and knowledge attained by learners. Summative or 'impact' evaluation focuses on learning outcomes, both explicit and implicit to the learning process, and in relation to the overall training course or educational programme (Scriven 1996; Bailey & Littlechild 2001). While both methods use research methods to gather data, they are more closely aligned to audit than research, although detailed summative evaluation may be more research-oriented in its approach.

Evaluation models

A number of models have summarised the different levels of evaluation that can be measured in relation to these two approaches. Bailey & Littlechild (2001) describe four levels which are seen as progressive and demonstrate not only complexity in achievement, but also 'distance' in terms of time and being able to attribute outcome to the input:

Level 1   examines immediate effects or 'reactions' of a programme for example satisfaction with the course. This would be seen as formative evaluation. Instruments include questionnaires, scaled response sheets, and nominal group techniques (Robson 2002)

Level 2   examines changes which may influence behaviour. This may include whether knowledge and skills have been gained and whether they have been sustained. This may be both formative and summative. Methods may include self-report pre- and post test questionnaires.

Level 3   examines whether there has been a change in behaviour or performance for the individual. Usually this is seen as summative evaluation. Instruments for both this level and level 4 may include interviews, observation and objective measures.

Level 4   examines the effects or results, intended or unintended of the training course or programme. This is also summative.

In addition to this, Phillips (1997) puts forward a framework specifically for hospice training which permits the evaluation of five different levels of learning. The author states that evaluation should be focused on the goals of learning and the extent to which they have been met, but looks beyond the immediate environment to assess the wider community impact that hospices may have:

1   Measuring evaluation: observation of level of interaction, involvement and knowledge gained, may involve pre-and post-test using questionnaires;

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2	Transfer of learning: evaluates how the new knowledge is being applied in practice, whether any peer support mechanisms are effective, and can use any competencies being completed;

3	Business results: measures the organisational impact through satisfaction surveys, the extent to which patient/family goals have been met, patterns in service complaints, financial health, staff turnover, fund raising;

4	Effect on community: refers to effects the hospice has on the wider community or other stakeholders through for example outreach services, collaboration with other agencies, ability to attract staff when vacancies arise or volunteers, whether hospice values are known and shared.

An evaluation of a course may include all or just some of the levels of evaluation. However, because the relationship between formative and summative is symbiotic (Campbell 2007), both are usually required. For example, formative evaluation will establish the reliability of a course through revealing whether it has been has been implemented as intended and is running efficiently (OERL 2005) and this be needed for there to be a valid assessment of outcome. Having a measurement for achievement framework based around prescriptive session outcomes will contain information, but instruments must account for individual, group or institutional factors, and measure of barriers or facilitators to achievement linked to programme design, content or resources.

An important issue for summative evaluation is that of sustainability and the long term effects education. It is vital to find out what has been learned and its impact on practice outside of the learning environment. This area of evaluation is methodologically difficult as there are many variables that may have an impact and these may not necessarily be attached to the educational experience, but again structured frameworks may facilitate a focused approach to information gathering. Chant et al 2002 and Ellis 2003 suggest content should be relate to the relevance of the programme to practice as well as factors in the practice environment.

Evaluation Methods

The aims and outcome of the programme or course will influence the methods used, but there is not a single approved method, and a variety are recommended (Bradley et al 2005) particularly multi-method approaches to explore more than one dimension. Certain educational interventions, such as study days, will generate mostly quantitative data, and other longer and more complex interventions will require additional exploratory approaches. For example, programme evaluations should obtain the perspectives of other stakeholders such as managers, colleagues who may have to backfill for practitioners on courses, and clients in receipt of care (Campbell 2007). This provides a wider picture of impact, not just based on performance of individuals. It is important not to underestimate

the time it takes to collect and analyse the data, and appropriate resources and skills should be put in place in advance of any evaluation.

3   Indicators of Good Practice from the Literature

3.1   Policy and legislation

- Four main policy/guideline documents were found that related workforce development in the area of palliative and/or hospice care.

  (NICE)(2005) Improving Outcomes in Children and Young People with Cancer is guidance and provides recommendations on service provision for children and young people with malignant disease. It has a focus on workforce development and offers some useful advice on skills development. It is however specialised to cancer care.

  Palliative care services for children and young people in England: an Independent Review for the Secretary of State for Health   (Craft and Killen 2007) identified the gaps and inconsistencies between service provision for disabled children, those with complex needs and palliative care. The review recommends a range of professional specialisms to increase competency when dealing with these children.

  DH (2008) Better Care, Better Lives recommends that every child and young person with a life-limiting or life-threatening condition will have access to high-quality, family-centred, sustainable care and support, with services provided in a setting of choice. It focuses on agency collaboration and seamless transition but has limited reference to training requirements.

  (ACT) and Childrens' Hospices UK (2009) Right People, Right Place, Right Time is more relevant and sets out practice guidance for workforce development for the palliative care needs of children and young people. It describes a Skills Pathway with a four-tiered approach called the Learning Cone, which encourages growth in expertise through different spheres of practice: communication skills, assessment skills, complex care management and role development.

  There are others, but they do not address training specifically and include the Children's Hospice UK (2007) Guidelines for best practice in a children's hospice service (2007); Children's Hospices UK (2004) Quality Assurance in Children's Hospices; and National Council for Voluntary Organisations (NCVO) (2010) People Count Third Sector Benchmarking.

- With reference to legislation, the HSE sets out workforce training regulations with respect to capability and competence, and the management of health and safety at work. This should include more specific information and training on manual handling injury risks and prevention, and fire training. it is the employer's duty to determine what the training needs of their employees are, and these regulations should guide this decision-making There is lack of clarity and consensus in how this is operationalised in practice and there are no specific requirements for hospices.

3.2   Current training approaches

- Regarding *interprofessional* approaches, training that brings together all or as many hospice personnel as possible seems to be effective in enhancing organisational cohesiveness and values. Egan & Abbott's (2002) interdisciplinary hospice training model *the Patient/Family Value Directed Model of Care* appears to be comprehensive in its approach.
- Centralising training around practice improves understanding of respective staff roles within the hospice, and enhances informal collective learning.
- Interprofessional team approaches to learning help professionals to deal with psychosocial aspects of care and bereavement work through the development of relationships. As well as increasing knowledge and confidence in this area, people learn to share issues of mutual concern and cope better.
- Clinical supervision, peer mentorship and reflection should be attached to practice related training.
- Using case studies as teaching tools can be a good mechanism for interprofessional learning.
- Regarding *single staff groups* for nurses, there are a wide variety of palliative care post-registration courses offered by many UK Universities, some of which offer specific modules on or post-graduate degrees in children's palliative care.
- Companies also offer workplace courses for health care staff on mandatory and a small range of palliative care awareness training that meet Common Induction Standards, and Health and Safety Executive as well as CQC requirements.
- Health care assistants may benefit from specific tailored palliative care training to help them deal with difficult situations and the needs of the dying patient, as emotional training needs are sometimes missed.
- Other pre-registration professional groups such as physios, doctors and pharmacists have benefitted from specific palliative care modules and competency training.

3.3   Competencies

- Competencies are used in a variety of situations and for different staff groups in hospice and palliative care and have been shown to be important for helping to communicate the responsibilities of a new employee in the learning process, and to help direct mentors or supervisors in facilitating the process.
- Competencies are useful in standardising information and messages across agencies, especially for staff groups that employ flexible workers.
- There are a range of tools available to increase skills and competencies, some of which are directly related to children with complex needs (Coventry and Warwickshire) and others which are more broad in their application (Skills for Health)
- CHUK and GOSH have a range of guidelines on caring for children with complex needs.

3.4   Teaching and learning styles

- Different teaching and learning methods have been shown to be effective in the hospice environment. These include role play, in-depth skill building workshops, interactive lectures, small group facilitation, trigger videos with interactive participant discussions and self-learning modules. In hospice settings, the use of external facilitation has been shown to be important to staff members.
- *Mentorship* is a critical component of career development and can significantly affect engagement in learning. Senior staff with at least two years experience who enjoy teaching and are expert practitioners are ideal mentors. Within children's hospices, inclusive team staff support mechanisms have been shown to be valued following traumatic events, using a bereavement advisor or counsellor. Individual support was also important in strengthening coping ability.
- *Clinical supervision* is important to help develop knowledge and competence, to promote staff wellbeing, prevent burnout, and encourage good and safe practice. It has been used in the hospice setting using an expert external facilitator and in a multi-disciplinary context.
- The role of *reflection* is key in hospice and palliative care and can lead to improved performance in situations characterised by complexity, uniqueness and uncertainty. Group and guided reflection with experienced facilitators has been shown to be valued, and on-line approaches can also be effective for individuals taking part.
- *Work-based learning* uses experiential learning and critical reflection to new knowledge. It has the potential to change practice; its success is dependent on the empowerment and facilitation of the practitioner to make practice changes, the

managerial input to ensure change happens, and the prevailing organisational culture of learning.

- *Self-directed learning* (SDL) is connected to lifelong learning and continuous professional development and can increase confidence, autonomy and motivation. A person's ability to learn in a self-directed way is dependent upon the subject matter, the social, cultural and educational setting, past experience and study skills. The Internet and computer-based tools have widened the accessibility, scope and appeal of SDL.

- *E-learning* has become a high profile approach for the training needs of healthcare staff, either singly or within on-line groups. There are a number of good practice suggestions in the literature; affordable, user-friendly packages as well as adequate access to resources and IT skills training must be assured; e-learning may be more effective used in addition to traditional class-room learning; and personal support through e-tutors is important. Skills for Health and the Open University websites provide a large number of relevant e-learning resources.

- A *Skills Passport* is a portable, online and verifiable record of an individual's career history, current skills and training**. It purported that benefits include a r**educed duplication of training, visibility of the skills and abilities of the entire workforce, and easy identification of mandatory and other training needs. Passports are currently being adopted in nursing with positive evaluations.

3.5   Philosophies underpinning training

- Only a small number of articles indicated an underpinning philosophy to training and these were interprofessional and collaborative courses in hospice and palliative care. They focused on promoting multiprofessional working and an holistic approach to patient and family care, one that revolved around the concept of the patient and family directing their own care.

- More generically, the DoH (2008) sets out six principles for future workforce education based on a philosophy for the NHS that delivers high quality for all. These principles have a focus on quality, client-centredness, being clinically driven, valuing people, flexibility and the promotion of life-long learning.

3.6   Motivation and learning cultures

- An important factor in motivation and the learning relates to the organisation. Those that create positive learning environments also motivate staff to be life-long learners. This can be done through the use of key leadership roles, change-

management approaches, and having team-based learning structures that prioritise learning, empower change, and involve staff.

- Organisations can promote settings conducive to a positive learning culture by addressing pressure of work, reducing feelings of apathy in staff and creating dynamite and forward thinking environments.

- Good practice in supporting staff in a meaningful way is connected to a positive sharing and learning culture. Formal peer mentorship approaches can also affect motivation and retention of staff and they can serve as professional growth opportunities, giving employees value and recognition.

- Components of developing a learning culture for nurses include a focus on autonomy, control over the practice setting and the nurse–doctor relationship.

- The link between staff development and motivation has also been shown to make hospitals more attractive places to work with a positive relationship between critical thinking, autonomy, professional status, staff development and job satisfaction.

3.7   Planning and evaluation of training

- When *planning training*, a crucial element is the skill needed, which should be obtained through qualified professional trainers, and corporate training programmes. Expertise should be evident in presentation skills, curriculum design, group process skills, educational psychology and organisational development.

- Goals of training should be linked to hospice goals and underpinned by philosophies that are understood by all disciplines..

- Other issues when planning include organisational readiness, the inclusion of often neglected cultural issues, and grounding education in the existential space of relationships among children, families, and practitioners – 'relational' learning.

- With *evaluation*, there are different interpretations for the terms but two main approaches are evident – formative and summative. Formative looks at the extent to which a training course is operating as it should. Summative focuses on learning outcomes, both regarding the learning process, and to the overall training course. Both formative and summative approaches must be measured.

- There are different evaluation models that have been used in palliative and hospice care.
    - Bailey & Littlechild (2001) describe four levels which are seen as progressive and demonstrate complexity in achievement, and 'distance' in terms of time and being able to attribute outcome to the input.
    - Phillips (1997)'s hospice framework evaluates five different levels of learning. Evaluation focuses on the goals of learning and the extent to which they have

been met, and the framework looks beyond the immediate environment to assess the wider community impact that hospices may have.

- Methods of evaluation depend on the aims and outcome of the course. There is not a single approved method and a variety are recommended particularly multi-method (qualitative and quantitative) approaches to explore more than one dimension.

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APPENDIX 3: Current practice of learning and development for staff in Children's Hospices across London.

Introduction

An audit of current policy and practice was carried out for Children's Hospices across London to identify good practice and consider where there were opportunities for sharing and avoiding duplication of effort and resources.

The information described here on current practice was gathered at meetings of the Children's Hospices across London Education Group and from visits to six of the seven CHaL group of hospices plus Little Havens Children's Hospice in Essex between November 2010 and March 2011. Informants to the research were principally the education leads in each hospice, sometimes this was clinical staff, sometimes non-clinical staff, and sometimes both. Other staff contributed as available and as the education lead felt appropriate. The study coincided with the merger between Shooting Star and CHASE hospices, and due to changes in personnel and vacant posts, CHASE Hospice staff did not contribute directly.

At each visit, education leads and other staff were asked a set of questions on how they organised and ran training, whether they had a training strategy, if they had identified mandatory training needs, and how they assessed and appraised staff. They were also asked about clinical skills, how hospices had identified what clinical competencies care staff should have, and their appropriate education. Finally they were asked for general views, on good practice or examples of helpful tools and frameworks to support and staff development, and the threats to doing this well.

Types and sizes hospice

The children's hospices belonging to the London group visited plus Little Havens provided a range of services. Most provided day and inpatient services for children within the hospice buildings, whereas EllenorLions and Noah's Ark ran services supporting children in their own homes. Some children's hospices operated as separate entities, while others had some shared services or premises with partner hospices (both Little Havens and EllenorLions worked closely with a nearby adult hospice, and Demelza ran two distant sites for children one providing hospice and the other community services).

As a result there was wide variation between the hospices in the number of staff requiring training, in the size of the infrastructure organising it, and the space available to hold in-house training sessions. Training strategies for these hospices will need to accommodate around 50-90 paid staff in a hospice, or 20-30 paid staff where support is provided in

children's homes. In addition, each hospice has up to a dozen trustees who may be expected to take part in some of the training. (Hospices also have substantial numbers of volunteers and people involved in trading, but their training needs have so far been considered outside the scope of this work.)

Hospices did not all have sufficient space to accommodate the training sessions they needed to run. The CHaL group did not seem to share training courses or expenses. Some felt that the distance to travel was a deterrent to sharing, and some saw in-house training as an opportunity to reinforce organisational vision and values and strengthen the way staff work together. Apart from these points there was no over-riding reason for not working together more, and some suggested that training of new starters could be run across the London children's hospices.

Staff responsible for training

The pattern of responsibility for training clinical and non-clinical staff and topics was not consistent across hospices in terms of who took the lead and the amount of time available for education leads.

The contacts for this project tended to be a member of the clinical staff (for example a Practice Facilitator or Clinical Lead) who had responsibility for training in clinical skills. It was sometimes the case, especially for larger hospices, that there was also a Human Resources lead person with responsibility for training in non-clinical subject areas. These arrangements led to a reasonably clear division of responsibility, but of course required the staff to collaborate in the planning and organisation of training programmes, such as induction or annual training run during a shut-down period. In some hospices, responsibility for training fell mostly on one person, for example where a member of the clinical staff organised the whole range of training for all staff, or conversely a non-clinical lead took responsibility across all subjects and all staff for training.

The amount of time available for staff training varied enormously, from having a team of staff with dedicated time and facilities for training, to one or two staff combining responsibilities for training with delivering and supervising care. To some extent, staffing levels for training and development would be expected to vary given the differences in the size of hospices and the nature of services they provide, but there is still a need for clear lines of responsibility, that adequately cover both clinical and non-clinical training topics.

Education policies or strategies

Not all hospices had a written strategy for education and training. When they did these varied in scope and detail, and were in various stages of being drafted, completed or in need

of revision. The documents covered both the process of and the main subjects for training. For example, they might describe the training and development ethos of the organisation, the processes for staff appraisal and skills assessment, set out expected career progression, describe how training budgets are set, and how attendance is requested and approved. Regarding topics for training and course content, policy documents might describe the induction programme, identify mandatory training needs, core skills and clinical competencies, and indicate training topics applying to different categories of staff.

Some strategy and policy documents specified quality standards for training, for example in the skills they required in trainers, in making appropriate use of a variety of formats in which training material is delivered, and in measuring the impact of training. One strategy document incorporated a detailed action plan for the next two years.

Mandatory training and other training topics

Hospices consistently referred to a list of topics where they were expected to provide training to their staff, and they usually delivered these at annual in-house training programmes and induction courses. While hospices were clear that they must train their staff to meet a variety of legal and professional standards, when it came to identifying exactly what these are it represented a large amount of work for each hospice to do it for itself. The list of mandatory training included fire, food preparation, basic life support and infection control.

Staff training must cover the standards laid down by the Health & Safety Executive (HSE), by Health & Social Care legislation and standards set by the Care Quality Commission (CQC). In addition some training is required by NHS commissioners or decided by the hospices themselves. The difficulties hospices have are that the standards are not always clearly stated and that they can change over time. Hospices have realised that it is not necessary to train all staff in all subjects, for example not everyone needs the same level of training and frequency of re-training that a fire marshal receives. Therefore there is some discretion to be exercised in which staff groups require training, and at what level and how often it needs to be repeated.

CQC requirements had changed significantly over recent years, and had become less clear and prescriptive. Hospices are currently being inspected by the CQC against the same standards as independent hospitals and nursing homes, and recent experience with inspection had not helped clarify what was required of them.

Some hospices used spreadsheets to list the training that was required, sometimes elaborating these to say who dictated these standards, for which groups of staff, at what level and at what frequency the training should be provided. The most comprehensive work

on this had been done at Little Havens, and to some extent this had been shared. A section from one of the spreadsheets is given below to illustrate the detail being recorded.

Part of a spreadsheet used in planning training (with acknowledgements to Jackie Wiggins, Little Havens Children's Hospice).

Mandatory Courses	Frequency of Refresher/Updates (No. years)	Delivery Method	Type	Full Course Length (in hours)	Supplier/ Trainer	SMT		Executive Team	Lead Persons	Administration	Qualified Nurses	Nursing Assistants
						Non-Care	Care					
Appraisal Training for Staff	One off	Ins Led	Org	2	In-house	√	√	√		√	√	√
Appraisal Training for Managers	One off	Ins Led	Org	2	In-house	√	√	√	√			
Clinical Risk	One off	Ins Led	CQC	1½	In-house						√	√
Clinical Supervision for Supervisors	3	Ins Led	CQC	18	ARU				√			
Corporate Induction	One off	Ins Led	Org	32½		√	√	√		√	√	√
Core Performance Management Skills (includes Conflict Resolutions	As required	Ins Led	Org		External Suppliers	√	√	√	√			
Control of Substances Hazardous to Health (COSHH)	One off	Ins Led	Law / CQC	2	Datasound						√	√
Communication Skills	One off	Ins Led	Org / CQC	6½	Various						√	√
CPR (Resuscitation (BLS)) - Pae & Adult versions	1	Ins Led	CQC	3½						√	√	√
Basic Food Hygiene Awareness	3	Ins Led	Legal / CQC	2½	Food Hygiene Matters						√	√

Lists of the training topics they covered were supplied by most of the hospices visited, and the range was very similar.

Organisation of training

Hospices were running their own training, some of which was provided in-house. They had built up regular or reciprocal arrangements with external providers, which were mainly

private sector organisations, but also included hospitals and universities. Mandatory training was often bundled into sessions over a day or longer, for example annual and induction sessions might run over a week or two. Several hospices ran these during an annual shut-down period. Induction courses were run as frequently as possible, but for some hospices this was only once a year.

Hospices were at different stages in the development of databases for recording staff training. Some felt strongly that it was good practice for records to be kept and held centrally for all staff training, showing dates of training, if passed/failed, and when repeat training was due. There were some problems when records were not shared or when they were held centrally, such as issues of ownership and accessibility.

Styles of learning and development

The most usual form of training was instructor-led and delivered to groups. Interactive sessions were generally preferred especially for initial learning. On-line/CD/DVD courses were not used a great deal by this group of hospices, although it was used for repeat training, and there was the feeling that these methods would and should be used more.

A whole range of ways of learning were used for clinical staff and clinical competencies, such as mentoring, supervision and observation. Clinical staff were also much more likely to undertake self-directed learning followed by assessment.

Much of the learning was done in-house, but staff also attended courses run elsewhere. Hospices wanted training to be delivered to a consistent standard, and stressed the importance of training the trainer: having done the training was not sufficient to be able to pass the knowledge on, and trainers should be trained to teach and assess.

Competencies and assessment

We asked how the London Children's Hospices defined and measured staff competencies. Hospices tended to go to trusted organisations, and most mentioned the Coventry and Warwickshire Children and Young People's Teaching Framework. Some also mentioned Great Ormond Street Hospital (GOSH), Children's Hospice UK (CHUK), the NHS Knowledge and Skills Framework (KSF) and the Association for Children's Palliative Care (ACT) as being sources of guidelines, competencies and training material.

It was quite often the case that existing measures and standards were not found very useful, for example the Coventry and Warwickshire framework was described as being cumbersome to use, and other competencies not catering for the specialised work of children and young people's palliative care.

As the London Hospices did not generally find existing competencies suited them well, they had gone their own ways in terms of how they described, taught and assessed staff competencies. A few had written their own versions of competencies and were happy to share these. Some had also written supporting training and assessment material, such as workbooks and proforma for keeping training records, but found this was an extremely time-consuming job.

Staff appraisals

Hospices were quite similar in having appraisal processes in place. All hospices had annual staff appraisals and these fed into identifying and planning staff training needs. However the success of the processes varied and some said that assessing staff competencies was difficult to do. All hospices had budgets allocated for staff training.

Linked to the appraisal process was the issue of maintaining training databases and ensuring staff were up to date and safe to practice, and using databases to plan future training needs.

Culture of learning

There was some discussion on how a learning session helps to build teams and the organisational culture. Generally in-house courses and those involving a mix of staff groups were seen as enabling this, and some training had to be tailored to the individual hospice setting and could not be run across organisations. There was another view that running in-house course might undermine the consistency with which training is delivered, and that there were benefits to learning with people from different institutions.

Hospices varied in how well the culture of learning was adopted by all staff. Some believed there was a poor training culture among managers, or an organisational reluctance to change. Some hospices were trying to instigate good practice, such as all staff having to undergo training whatever their seniority, and having systematic evaluation of training and assessment of the subsequent impact on individual staff performance. Hospices were generally keen to follow evidence based practice, both in terms of the care given and the kinds of training to deliver it.

Summary points on current practice within CHaL

- From visiting six of the London Children's hospices and Little Havens in Essex, it was clear that they had advanced staff learning and development in different ways according to available time and skills. With limited capacity and different strengths, it seems clear that are benefits from sharing what they have done in a more systematic way.

- Establishing mandatory training is a major task and the detailed work from one hospice is an example of what can be shared, especially as hospices are essentially providing the same broad training to their staff.
- Induction courses are seen as the most likely starting point for shared training.
- It is possible to combine all of the current training topics, aspects of current practice, available training resources and good practice in learning, and to link these to external forces such as the CQC standards and legislative requirements (see Table 1 p15.).
- A shared strategy template can be set out encompassing the key elements of existing strategy documents (see Appendix 4). However, the detail in policy and strategy documents is often used to promote a hospice's values and visions and build a learning culture, and this will be a challenge if the needs of all hospices are to be accommodated in a single document.
- Hospices in the CHaL group are similar in that they do not make much use of competencies that have been developed elsewhere, but they have a shared vision of the topics they need to cover and are interested in sharing what individual members have written.
- With most hospices finding it difficult to measure performance, there could be benefits in working together on how skills deficits are identified and assessed.
- There is considerable consensus between the CHaL group in terms of their preferred styles of learning, wanting to foster a positive learning culture and follow best practice.

APPENDIX 4: Learning and Development strategy template

The template provides the shape of a learning and development strategy, and is based on the best of existing strategy documents within the CHaL group and advice from the National Council for Voluntary Organisations.   The following sections should be considered for inclusion when writing a training strategy for hospices:

- Document status, how reviewed and updated, how it links to other organisational policies

- Organisational vision, values, philosophy, culture relating to training

- External standards, legal/contractual and professional

- Who has responsibility for training and training budgets

- How training programmes are commissioned and delivered

- Quality of trainers

- Styles of learning

- Appraisal and assessment processes

- Career development and progression

- Personal portfolios

- Induction

- Mandatory training

- Core skills

- Competencies, workbooks

- Evaluating training

- Organisational records/database

APPENDIX 5: Programme at national workshops

Children's Hospices UK

CQC Essential Standards Compliance
Training and Education Strategy
Workshops
8th March 2011 – Drakes Court, Acorns, Birmingham
16th March 2011 – Derian House, Chorley
18th March 2011 – Finsbury Tower, CQC, London
Programme

10.00am	Registration and coffee
10.15am	Welcome and Introductions
10.30am	Background to the Department of Health projects
	-visit programme to all children's hospices services
	-update on the CQC Essential Standards project status
	-update on the Training and Development Strategy
11.15am	CQC's Essential Standards
	-overview of their purpose and how they are used
11.45pm	Tea and coffee break
12.00pm	CQC's Essential Standards (Continued)
	-overview of their purpose and how they are used
	-questions
1.00pm	Lunch
1.30pm	Training and Development Strategy
	-presentation, discussion and questions
2.40pm	Workshop session
	- group session to review provider compliance assessments
	- training and development requirements
	- discussion relating to examples of compliance
	- measurement and processes that need to be in place
3pm	Tea and coffee break
3.10 pm	Workshop session continued
3.35pm	Plenary and feedback
4.00pm	Close

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- o Addictive Behaviour
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