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## REFLECTIVE PIECE

# Whose Responsibility Is It to Develop and Extend Practice Education Beyond Professional Training?

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## Abstract

Practice education has historically focused on the development of learners' skills in the pre-qualification period. This article argues that generic skills exist which could be extended to the development of skills in other qualified professional staff and in direct care staff who may lack professional qualifications. It points to the crucial link between education, supervision and governance and notes the absence of much good practice. It argues that commissioners of services may need to be educated in the contribution these skills can make to high-quality health and social care provision.

**Keywords:** practice education, governance, supervision, inter-professional working

Historically, practice-based education has focused on the development of the individuals' skills to enable them to gain professional qualification. Alsop & Ryan (1996) define practice education as "that special part of a professional educational programme in which students gain 'hands-on' experience of working with clients under the supervision of a qualified practitioner" (p4). Practice education is a core element of all educational programmes that prepare health care and social care professionals for academic award and registration to practice (Mulholland *et al.* 2005). However, National Health Service Education for Scotland (NES) considers a broader application to learning of the practice education model "... practice based learning standards could apply to any learner undertaking structured learning in a practice environment including support workers, as well as pre/post-registration students, returnees to practice, or AHPs (Allied Health Professionals) undertaking a period of adaptation to allow registration with the Health Professions Council (HPC)" (NHS 2010, p10).

Research has demonstrated a growing evidence base linked to practice education (e.g. Cross *et al.* 2006, Sellars & Clouder 2011). Increased attention is being paid to developing the quality of practice education provision and the poor preparation for the practice educator role that was reported in studies in the 1990s has been transformed through widespread educational preparation for the role (HCPC 2012a) and the provision of Practice Education Facilitators (Mulholland *et al.* 2005). As a result individual practice educators are

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increasingly competent and confident in their abilities, and are able to draw on explicit models of education and clear training strategies – for example, the Continuous Improvement Model for NHS Allied Health Professions described in NHS (2011).

I consider there to be strong similarities between practice education and supervision and this article argues that these practices, whose purposes are ultimately associated with clinical governance, can and should be extended to a variety of practice settings in health and social care. A useful definition of supervision is provided by Milne (2007), who suggests that “clinical supervision is the formal provision, by approved supervisors, of a relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of colleague/s. The main methods that supervisors use are corrective feedback on the supervisee’s performance, teaching, and collaborative goal-setting. It therefore differs from related activities, such as mentoring and coaching, by incorporating an evaluative component. Clinical supervision’s objectives are ‘normative’ (e.g. quality control), ‘restorative’ (e.g. encourage emotional processing) and ‘formative’ (e.g. maintaining and facilitating supervisees’ competence, capability and general effectiveness)” (Milne 2007, p437).

Many members of the health and social care professions work indirectly with their clients, in the sense that their professional contribution is conveyed through carers, family members and, commonly, other less qualified or unqualified staff with a direct caring role – often called *direct care* staff (e.g. Rich 1992, Lillywhite & Haines 2010). One result of this style of working that can remain implicit and unacknowledged is that professionals are involved in developing the expertise of their colleagues. The professional demonstrates, asks or directs other staff to work in a particular way to carry through the therapeutic intervention. This work will often involve developing the knowledge and skills of the other member of staff, and subsequently that person may be reliant for advice and support on the professional because no one else in the work setting possesses comparable knowledge and experience (Morrison 2006). This idea of helping others to work in different ways is consistent with clinical supervision, although this has traditionally been seen as an activity between members of the same profession. However, it is also consistent with the increasing attention paid to inter-professional working and learning and there is a body of evidence supporting inter-professional supervision (Clouder & Sellars 2004, Johnson 2011).

At the heart of many models of practice education and clinical supervision is an emphasis on learning being aided by reflection on existing practice (Clouder & Sellars 2004, Mann *et al.* 2009). The ability to reflect as a generic quality is applicable to a range of forms of practice education whether the recipient (supervisee) is a trainee, a peer, or a member of a different profession. I would argue that this *genericism* extends to the requirements of the practice educator/supervisor to skilfully provide clear evaluative feedback on the learner’s performance, although the actual power of the evaluation will vary according to the context. Evaluation should be present – albeit in different forms – whether it relates to the more formative assessment of a trainee seeking qualification and entry into a profession or to a member of a peer supervision group. The absence of critical feedback and evaluative commentary can undermine the value of practice education and supervision through what has been termed “*the tyranny of niceness*” (Sommers 2005). This proposed generic core to practice education and supervision processes overrides other variations in practice. For example, in Clinical Psychology there is an interesting discussion of whether it is more effective to use specific forms of supervision allied to and derived from a particular psychological model (for example, cognitive behaviour therapy) rather than more generic forms of supervision (Green 2012). There are also different organisational models of practice education that can be employed, including peer assisted collaborative learning models, 1:2, split and shared models (NHS 2007). In addition, as I have suggested above, it is common practice for professionals in health and social care to deliver their work

through other members of staff, and for there to be a generic core to practice education and supervision.

To what degree should professionals be responsible for ensuring the quality of others' practice in these situations of 'working through others'? Guidance can be sought from the Health and Care Professions Council (HCPC) which regulates most health and social care professions in the UK. The Standards of Conduct, Performance and Ethics states: "you must effectively supervise tasks that you have asked others to carry out" (HCPC 2012b, section 2.8). For members of my own profession, the Standards of Proficiency state that practitioner psychologists must "be able to demonstrate effective and appropriate skills in communicating information, advice instruction and professional opinion to colleagues, service users, their relatives and carers" (HCPC 2012c, sec 1b3) and "be able to implement interventions and care plans through and with other professionals..." (HCPC 2012c, section 2b4). The presence and content of these guidelines indicate significant support from regulatory bodies for professionals extending their practice education role to members of other professions and to staff who lack professional training.

However, experience suggests that practice can be rather different, and that in particular the structure in services may not be conducive to extending governance in this way. As a clinician who works regularly with other care staff from a range of service providers I have noticed the following: a low level of staff skills training and development; an absence of time for staff to meet and discuss their work together – even where a consistent approach is paramount; and a lack of anything that could be considered to approach practice education or supervision. Sadly, the space for these activities is not commissioned or factored into staff costs and overall service balance sheets (e.g. DOH 2013, section 2.19). It is difficult for practice education to flourish in a working environment of this nature and it would be important to identify the minimal level of managerial and staff support to enable reflective practice education to thrive.

I strongly believe that the commissioning process must acknowledge that staff training and development, practice education and supervision are critical to high quality care. It is of great concern that services are commissioned that fail to incorporate relevant research and evidence-based practice because time is not factored in to give them the attention they deserve (see DOH 2013, section 4.20). Existing care services can appear to ignore the crucial role that practice education can play in determining the quality of care. Careful reading of the inquiry reports into two of the most recent care scandals in the UK, at the Mid-Staffordshire NHS Trust (Francis 2013) and the Winterbourne View Hospital (DOH 2013), suggests that supervision was either not undertaken, or practised in a form unrecognisable in terms of the creative, reflective and accountable form that defines high-quality and effective practice. For example, the Care Quality Commission (CQC) reports that at Winterbourne View "the registered provider failed in their responsibilities by not providing the appropriate training and supervision to staff, which would be required to enable them to deliver care and treatment to the people who use the service" (CQC 2011, p5). Furthermore, "people who used this service did not have their needs met by competent staff. Supportive structures for staff, such as supervision... were lacking, causing concern for the ongoing safety of people who reside at this location" (ibid, p7; see also DOH 2013, section 5.2). These inquiries suggest that presence and integration into services of high quality supervision and practice education are critically important to ensuring good practice and care.

This brief article has sought to make the case for practice educators to play a greater and broader role within health and social care services to improve practice and achieve better outcomes for service users. Evidence is available and models that can be utilised exist. An important issue concerns the commissioners of services and their understanding of the value of practice education. Consideration of the two recent UK inquiries into service

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failures does not inspire optimism about the commissioners' understanding of what establishes and maintains high-quality care. Practice educators might consider how to inform those commissioning services of both the importance to governance of ongoing regular practice education/supervision and their expertise in enabling this. In doing so, practice educators might also consider developing a more explicit model for their role in external services that would specify how this is delivered. It might be useful to draw on the experience of inter-professional supervision, and to consider the experience of practice educators in providing leadership to services. Practice educators might wish to consider whether they need to develop skills in leadership and service development to ensure that their contribution is acknowledged and valued.

A final point concerns assertiveness. Practice educators may need to reassess their contribution and develop confidence in articulating the crucial role in governance that practice education and supervision can play. Thought needs to be given to how this professional experience and knowledge can inform those planning and commissioning human services.

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