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# Embedding Consumer Culture in Health and Social Care Education – a University Office’s Perspective

## Summary

The National Health Service is changing – and this change is radical. It will no longer be a monolith dictating what services it offers. It is starting to take seriously the views of its consumers: the patients, service users and carers. Darzi talks of ‘High Quality Care for All’. The Prime Minister’s Commission says that nurses must pledge to give high quality care to all.

The NHS is starting to put the patient experience at the centre of everything it does and its regulators are asking for evidence. This process may yet prove to be one of the NHS’ greatest challenges. Understanding the consumer viewpoint is essential in ensuring compassion in nurses. This paper will consider what the university sector can do to embed the consumer culture within the education of health and social care professionals. It will look at the challenges of involvement and culture change, highlighting the key points to address in the early and middle stages of involvement from a University office’s perspective. Whilst explaining where consumers have been involved and how their input is starting to make a difference. Examples will be drawn from teaching, assessment and selection of students.

The paper opens with background information and the case for involvement, methodology and challenges. The findings cover the academic perspective, the case for a development worker and their role. The results of the paper describe what is needed in a development office to support effective service user and carer involvement on health and social care courses in Higher Education. The article concludes by saying that there is much more work that needs to be done in this field to embed the work of a development office, but that early steps have been promising.

### Key words:

Service user	Carer	Higher Education	Health
Social care	Professional	Development	Embed
Compassion	Patient		

## INTRODUCTION

The National Health Service (NHS) is changing – and this change is radical. It will no longer be a monolith dictating what services it offers. It is starting to take seriously the views of its consumers: the patients, service users and carers. Professor The Lord Darzi, in his summary of the report ‘High Quality Care for all’ (DH 2008b) describes, ‘AN NHS that gives patients and the public more information and choice, works in partnership with and has high quality care at its heart.’ The Prime Minister’s Commission on the Future of Nursing and Midwifery in England (PMC, 2010) has as pledge one, ‘Nurses and midwives must declare their commitment to society and service users in a pledge to give high quality care to all.

The NHS is starting to put the patient experience at the centre of everything it does. Its regulators are asking for evidence from Trusts to show they are really doing this. This process may yet prove to be one of the NHS’ greatest challenges, with many staff still entrenched with the old ways of doing things. Examples from patient’s surveys and press stories across the UK show that car parking on hospital sites is a serious concern for many patients (The NHS Confederation, 2009).

At a recent hospital visit, I noticed how a car park was under capacity until after 1:30pm. By 2pm there was absolute chaos as visitors arrived en masse for the 2-4pm visiting slot. The standardisation of visiting may well make sense from the clinical end of care; with doctor's rounds and meal times out of the way before visitors descend – yet it makes no sense at all for the car parking resource. Trusts need to consider if alternatives such as 'park and ride' schemes can help to ease this capacity. Likewise a relative recently attended a clinic where everyone was given a 9am appointment. It was close on noon when she was seen. An administrator told her that it simplified the clinic and ensured that it finished on time. Yet three hours of unnecessary waiting can hardly be regarded as patient care. Presumably the clinic times were for the benefit of staff not patients.

Understanding the consumer viewpoint is essential in ensuring compassion (Davidson, 2009). Press stories continue to show that compassion may be getting lost as health professionals need more technical skills. Madeleine Brindley (Brindley, 2010) asks in the Western Mail are nurses 'Too posh to wash?' Whereas the Department for Health (Lister, 2009) hopes that, 'All new nursing graduates must have the knowledge skills and attitudes to nurse with care and compassion.' The Nursing Times (Nursing Times, 2010) quotes Sue Bernhauser, Chair of the Council of Deans says, 'We expect a lot of nurses on qualification. Other professions like Law don't expect graduates to fir the floor running.'

This paper will consider what the university sector can do to embed the consumer culture within the education of health and social care professionals. It will look at the challenges of involvement and culture change. It will highlight what the author's believe to be the key points to address in the early and middle stages of involvement. It will explain where consumers have been involved and how their input is starting to make a difference. Examples will be drawn from teaching, assessment and selection of students.

This paper will explore both the challenges and benefits faced by a team at the University of Huddersfield in setting up a development office to support the involvement of service users and carers into health and social care courses. The paper opens with background information and the case for involvement, methodology and challenges. The findings cover the academic perspective, the case for a development worker and the development worker role. This includes administration, support, teaching and learning, networks, partnerships, research, enterprise and reputation. The paper will summarise the benefits of service user involvement, together with limitations. Finally conclusions are drawn. The limitations of the study are that this is article represents the views of the authors. The challenges in other universities and setting may be somewhat different. However the authors have shared some of their findings with Developers of Carer Involvement in Education (DUCIE) a national network of development workers and found many similarities in issues. To aid readability, throughout this paper the generic term 'service user' will be used to cover consumers, patients, service users and carers.

## **BACKGROUND**

The faculty of Human and Health Sciences at the University of Huddersfield supports a wide range of courses for health and social care professionals. These include four branches of nursing, midwifery, podiatry, physiotherapy, social work, psychology and politics. With over 5000 students across three campuses, the faculty supports the University's strap line 'inspiring tomorrow's professionals.' The University is proud to be part of a West Yorkshire wide Centre of Excellence in

Teaching and Learning known as Assessment and Learning in Practice Settings. It is a collaborative programme between five Higher Education Institutions: the Universities of Bradford, Huddersfield, Leeds (lead), Leeds Metropolitan and York St John with the aim to ensure that students graduating from courses in health and social care are fully equipped to perform confidently and competently at the start of their professional careers so improving standards of care (<http://www.alps-cetl.ac.uk>). The programme has a specific aim to enhance the role of service user involvement. A network has been established across West Yorkshire where all the staff members engaged in this type of work has been able to meet, share learning, undertake research and disseminate their findings. Assessment and Learning in Practice Settings funding has supported a two day a week secondment at the University of Huddersfield for an Academic Lead for service user involvement.

### **The Case for Involvement**

There is growing recognition that there is a need for service user involvement in health and social care education, this has arisen out of health policy and legislation related to consumer focused, user driven services (DH 1999, 2000, 2001, 2005 2008a). This includes enforcement of section 242 (1B) of the NHS Act 2006 which places a duty for service user involvement in service planning, change and operation (DH 2008a). Lord Darzi's NHS Next Stage Review (DH 2008b) calls for developments in how to involve users of services. Professional Regulatory and Statutory Bodies require evidence of service user involvement in health and social care education (GSCC 2005, NMC 2010). The Department of Health Education Commissioning for Quality document includes guidance on user involvement in the design and delivery of education supporting the healthcare workforce (DH 2009).

Several Universities have involvement strategies and have developed their own guidelines.. Whilst, this work has been mainly in the field of mental health and social work (Duffy 2006, Levin 2004, NHS Trent SHA 2005, Tew et al 2004) it is relevant to other areas of health and social care education. The Developers of Carer Involvement in Education network has recently published guidelines and recommendations on staffing frameworks to support involvement in Higher Education Institutes (DUCIE 2009). This said, the national interpretation of the need and allocation of resources to support involvement varies enormously across the sector. The University of Central Lancashire has a World Class leading involvement team known as COMENSUS; with involvement embedded across courses and a well resourced team of service users supported by professional staff. At the other end of the spectrum, many universities have limited or no involvement. At Huddersfield the aim was to provide some infrastructure to support involvement.

### **Challenges**

Our aims and objectives were to embed involvement into health and social care courses . Originally involvement was carried out in pockets by a small group of enthusiasts primarily in the fields of mental health and social work. The rationale for having an academic lead was to have an individual with credibility and responsibility for putting in place the structures and processes necessary for involvement. This was combined with understanding how to overcome the organisational barriers to involvement, ensuring there was more scope for involvement across the Faculty with inter-professional working and learning. Fortunately with initial funding from the Centre of Excellence a part time academic lead post was funded. As a starting point, existing links with partner universities were strengthened in order to share ideas and develop a community of practice. This resulted in a strong network of staff that provided a supportive, enabling,

environment - difficult to achieve when working in isolation. This, however, highlighted that for involvement to become truly embedded there needs to be a shift in the representation of service users. Therefore a scoping exercise was undertaken looking at the areas for engagement with service users; those who had already participated were working but not yet as equal partners. Initially the academic was only able to 'skim the surface', setting up an infrastructure and supporting a few initiatives. In order to create standards, guidelines for involvement and a remuneration policy were developed and implemented. A service user and carer forum from existing contacts was established and a contact database set up.

Although progress was being made, there was still a danger of 'tokenism' with service user involvement, but sometimes uncertainty as to their role. The pool of service users already known by the university was limited, and without resources for a serious recruitment campaign, would remain so. Whilst it is acknowledged that diversity of representation is not always possible, the repeated involvement of a small number of individuals can narrow perspectives. Moreover, there was the danger of inequalities of opportunity with some students having continued exposure to service users throughout their courses, and others virtually none. To maintain and enhance our reputation it was important that this was not allowed to happen.

It quickly became apparent that the workload generated by this involvement initiative could not be effectively covered by the part-time academic and that if the university was serious about driving this area of work forward then a full time development worker role was essential. A business case was therefore presented to the senior management team strongly supported by the Associate Dean for Learning and Teaching that led to agreement for the monitoring of a development worker post.

## **Methodology**

The methodology used is first person reporting as the paper is intended as a case study. No ethical approvals were gained for writing this paper.

## **FINDINGS**

### **Findings – The Academic Perspective**

The author took on the academic lead secondment as it was a specific area of interest. A literature review of service users' involvement in healthcare education had already been completed as part of her MSc in Health Professional Education (Rhodes 2006). This review identified some evidence that service user involvement enhances students' ability to demonstrate empathetic understanding, an individual approach and an appreciation of good communication skills. These findings are supported by following studies (Repper & Breeze 2007; Rush 2008). The qualities identified are of paramount importance in health and social care practitioners and link in with the acknowledgement of the importance of compassion in healthcare (Davidson & Williams 2009). Following the appointment of the academic lead progress was rapid, with the level of involvement increasing in some areas primarily due to connections made with academics who already had an interest in this field. The first student evaluations of involvement experiences were positive with statements about how meaningful and memorable the input from service users had been. In 2009, when the Nursing and Midwifery Council carried out quality assurance monitoring (NMC 2009) at the university it commended our strategy for service user involvement, which was seen to be

making an outstanding contribution towards student learning. This gave a boost to all the staff and service users involved, and affirmed the importance of this work to the management team.

Opportunities for involvement are varied from course design and delivery; input into recruitment and selection of students for courses, teaching, assessing and committee representation. However, it soon became apparent that there was a serious time commitment to support and prepare both service users and academics for involvement. Whilst there were enthusiasts; there were also the sceptics. Some academics could not see the value of involvement, did not support the payment of service users and considered involvement just another fad. This highlighted the need for research and a value evaluation of involvement activities.

Working with service users can at times be challenging. Many get involved to have the chance to make a difference to others and their experience of services. However this is sometimes driven by their own poor experience of care, so may not always be positive. It can be complex enough for staff who work inside organisational culture to understand how to affect change. This is compounded for the service user who can have difficulty understanding what can and cannot be influenced and achieved. The service users need to be offered guidance, support and sometimes advocacy in what they can achieve in order to see the valuable contribution that they have to offer. University bureaucracy often comes with systems and processes that can make simple tasks like cash payment for expenses overly complex. However, our links with partner universities confirmed that we were not the only university struggling with this. The network of other positive, like minded individuals, striving to made involvement work provided the impetus, momentum and support to keep going. However, the real tensions in the role were due to the complexities many 21<sup>st</sup> Century part-time workers find in the competing demands on time to fulfil all wider work role obligations particularly in jobs with multiple responsibilities..

To achieve progress on involvement a partnership model needs to exist with representation from universities, the NHS, statutory and third sector organisations, local, regional and national links across health and social care economies. This requires the investment of time and resources. Pioneers in this field (Downe et al, 2007) have identified the need for authenticity in order for engagement to be successful. The recognition and understanding that effective service user engagement requires careful planning with support networks for service users and academics. Understanding that others had faced similar issues (Morris, 2009) was helpful in guiding our work. As understanding about engagement grew, so did the 'to do list' making it more complex to prioritise. Furthermore Townend (Townend et al. 2007) identified that improvements in practice come about by carefully planned, supported and evaluated involvement which reflected the priorities and wishes of those receiving the service.

The eventual appointment of the development worker has taken involvement to another level. Having someone who is able to immerse themselves in this field and concentrate their efforts on involvement has at least brought some structure to the chaos whilst further highlighting the enormity of the task. Whilst the university has shown a commitment to involvement and investment continues, the challenges faced under the current economic climate of funding cuts now poses the biggest threat to success. I am confident however that another year on the development office will deliver a first class service to service users, academics and most importantly students who are the future of health and social care.

## Employing a Development Worker

As with many institutions, employing new staff members takes time and has to be managed within available resources. There is often a significant time lag from idea inception to appointment which indeed was the case in this instance. Preparing a person specification and job description proved to be an iterative process. The author's view is that her experience of preparing job descriptions highlighted that job evaluation schemes work better for traditional functional roles, than newer multi-skilled roles. Development worker roles can vary considerably across the sector as the DUCIE guidelines (DUCIE, 2009) demonstrate. This can make it more difficult to match the job into job evaluation systems as such an array of skills are needed. Many universities go for the easy and cheaper option of classifying the post as an administrator. Yet in reality these posts often link across both the teaching and learning and research and enterprise agendas. Placing the post within the administrator framework could mean overlooking the range of inter-personal and social skills for working with the sometimes challenging needs and demands of service users and academics. Additionally, the development worker is likely to be the external face for the organisation and will work with senior managers in the NHS – so it has to be someone who is capable of this.

The job description for this post was largely based on the job description of an established development worker in a partner university based upon a lecturer pay scale. However, when matched to the job evaluation framework certain aspects were altered and the post was downgraded to administration and only approved for an 18 month initial period . This necessitated another re-write of the person specification and led to further delays. It is important that staff involved in the process do not lose sight of the eventual aim, which is to get the right person in post who is able to both lead and support the ongoing integration of service users in education.

Advertising the post, again presented challenges. A nursing or higher education journal may be the right place to recruit a professional, but may not be attract someone with personal experience of being service user. Additionally people new to the sector who have 'life skills' or have been a patient or carer themselves care may not connect with terms like 'service users' which tend to only be used in health and social care settings. It was important to find an outlet which would attract both service users and professionals for the post. Therefore the job was advertised on both the university website and job.ac.uk and attracted twelve applicants. With short listing completed the next task was organising and setting up interviews, which needed to take into consideration the specific, sometimes conflicting needs of candidates. The university strives to meet disability rights legislation, and trains its staff on meeting these needs. There was an acceptance that due to the nature of the job, it was highly likely that candidates may have additional requirements that would need to be accommodated at interview. What was not anticipated was that one person's additional requirement would direct conflict with another. This made it difficult to provide an environment that was acceptable and appropriate for all candidates.

The most successful element of the process was the composition of the panel, with an independent chair, a service user alongside two academics, one from health and one from social care which made the process highly inclusive. The development worker would be expected to work across health and social care professions and with service users and it was important that this was represented on the panel.. Whilst service user involvement on student selection was becoming more common, this was a first on a selection panel for staff. The process and format

was carefully planned in order to include all parties, this ensured that everything ran smoothly on the day. The time invested in preparation cannot be underestimated but clearly paid off with the panel's unanimous decision on who should be offered the post.

## **Costs**

The costs of setting up an office are not just about appointing people, funding an office base and a computer and telephone. If service users are to give up their time to contribute to education they often require payment or at least reimbursement of reasonable expenses. Finding budgets to support this activity is often difficult. Central budgets for this are often small. A more accountable model is to use the budgets of departments who are delivering the courses to pay for involvement. However this does lead to training more people in the bureaucracies of budgets. Short term funding for posts can have benefits to the organisation in terms of 'trying out' an idea. However this contrasts with staff on short term contracts who are looking for other jobs leading to a constant turnover of staff. This can lead to duplication, and re-learning, meaning that the service can be slow to develop and have an impact.

## **Findings - The Development Worker's Perspective**

As a development worker fairly new in post, these are some of my reflections. First and foremost was the feeling that there was a two year backlog to deal with. The post had taken a long time to appoint to. Whilst this had been going on, ideas had been generated which had not been implemented. This resulted in feeling 'thinly stretched' at first. However as the job had not been done previously there was much independence in the role to counter balance this. Access to funding was the next challenge. The world economic climate had changed in the previous two years, as whilst there was feeling that this work was important, finding funding sources has been achieved but is not always a straightforward issue. Another challenge was the lack of a team base. The role involves working across the faculty; as such the post works independently quite a lot, and doesn't fit into an existing team. This was resolved by the development worker becoming a de-facto member of the nursing team. However the strongest factor that I note from my early experience was that everybody expects a lot – no one less so than the service users who you work alongside. In particular, I felt a strong pull from supporting service users who effectively wanted full-time and social interactions, alongside a listening ear, with the demands that all organisations give to deliver results. It was apparent that whilst some systems were in place such as the payment policy, the implementation needed to be clarified. I had moved from another department in the university and found the new administration systems incredibly time consuming. There seemed to be lots of demands upon my time. My first priority was to make contact across the Faculty with academics. It was also about building partnerships. I quickly discovered others doing similar roles in the NHS, local government and third sector organisations. Our university, like many others in the sector is transforming to become more research intensive. To support this departments are encouraged to put in bids for external research and enterprise funding. Leading these bids is a key part of the role particularly as funders often require and even demand input from service users. It involves getting used to differing bidding formats for each bid and working with different collaborators depending upon the context . The service user forum proved more challenge than expected to organise. Previously the Faculty had an approach of inviting all service users in contact to the university to an open forum. Whilst this meant that people were able to participate informally, it led to difficulties in administration.

For my first forum event the venue was the only available room, which turned out to be quite small. The lack of a booking system for the forum, meant that we didn't know who and how many attendees to expect. However, attendance was high and included six wheelchair users. This created access and participation problems, as we adjusted the furniture in the room to allow better dialogue. The discussions in the meeting also, not unsurprisingly given the problems with the venue became sidelined into disabled access around the university. After the meeting, I felt very despondent. The purpose of the meeting was to discuss how we could improve student understanding of the service user perspective. Yet at the meeting none of the participants had mentioned students or learning, and I wasn't sure if the objectives of the university and the forum were compatible. The feeling that I had come away with was, that people wanted to be involved, but we had to provide better facilities and more structure to the meeting. Following on from this, I took corrective action. I ensured that the next meeting was in a more suitable venue with disabled ramps and plenty of space for wheelchair users. I asked people to let me know if they were coming so that I could book catering and car parking. I invited people to come and talk to the Forum about involvement so that real opportunities for involvement could be found and interest engaged. The second and subsequent meetings were much better though still posed challenges.

### **What does the development worker do?**

This development worker role involves managing service user involvement across the Faculty. The role can be broken down into the following activity areas: administration, support, teaching and learning, networks, partnerships, research, enterprise and building reputation.

**Administration** - the first step is developing effective processes for involvement and administration, or finding ways of utilising or adapting university processes. This involves organising events, conferences and fora. This will often involve chairing and planning meetings. It is likely that some service user will be disabled so access and inclusion need to be carefully considered. Many development workers produce websites to showcase work and provide links to other useful websites such as partner organisations of those who highlight the user voice. Normally there is a database which stores contact details of potential service users. Consideration has to be given to the customer relationship management part of this, making links between academics and service user, and understanding what each party can offer the other.

**Support** - a key part of the role is about supporting the service user who effectively becomes part of your team. This can involve providing drop-in services or having an 'open door' policy. This can become a very time consuming part of the role, and involves induction training and de-briefing after events. Unfortunately there can also be scope for conflict resolution and being a mediator in any disputes or misunderstandings. Training and development needs to take place for academic colleagues on support for involvement.

**Teaching and Learning** - support to this area is one of the key components in involvement. This may involve preparing and de-briefing the service user on their involvement experience. It may involve work on new teaching and learning initiatives often piloting new approaches such as digital stories, multi-media resources and re-usable learning tools. Service users are involved in course development, where their views on essential qualities and needs of professionals are incorporated into course design. Involvement on courses can take place with service user representatives on course committees to ensure that courses are practical and relevant to the needs of all service users. Increasingly support to both internal and external validations ensures

that evidence is collected that involvement can make such a difference to student learning. By evaluating the impact and feedback from involvement activities, continuous improvements can take place.

**Networks** – the role involves working with staff from across the Faculty in all academic areas, building links into new areas. This can often be as an advisory service to academic colleagues, or working together on inter-disciplinary projects, such as ‘Mental Health; It’s everyone’s business’ (Balen, 2009). This was an inter-professional learning day where students attended workshops on a range of mental health issues presented as monologues and discussions, theatre, film clips and arts in facilitated discussions groups.

**Partnership** working is key, such as building and maintaining links with leads for Patient and Public Involvement and Practitioners in NHS, Local Government and third sector. Just as important are links to both the formal and informal service user groups locally and nationally. It is essential to take part in national networks such as DUCIE. This has the benefit of access to the latest knowledge and ideas as well as mutual support and encouragement from others.

**Research, Enterprise and Reputation Building** - in an ever competitive University sector leading and supporting cross faculty and university bids and projects and linking with funding agencies is imperative. Raising the profile of the university by presenting at external workshops and conferences about our work, and gaining academic credibility by publishing work in international peer reviewed journals is important. This may involve collaboratively working with service user on authoring work and peer –reviewing others work. High profile events such as the Public lecture series, press releases and public relations work help to showcase the university’s work. This is important to highlight the value of the role and seek management support for longevity in the role.

### **Benefits of Service User Involvement?**

In the modern world where there are always so many demands upon time and resources with finite budgets. The case for involvement has to be closely stated. Evidence is building that the involvement of service users in professional education has a positive impact and influence over student learning. See the findings from (Repper & Breeze 2007; Rush 2008) support the case for involvement. . However prioritise involvement is essential for progress to be made. Underlying the need for involvement are several factors. Firstly is the need to challenge and improve health and social care services. Much as the manufacturing industry has led on world class initiatives, the NHS is waking up to the fact that it is providing a service for its consumers. This does not mean as paying customers, rather as discerning clients with high standards. Patients want to be regarded as consumers where their needs, interests, dignity and respect are granted. There are strong drives to improve health and social care which have been previously referenced. Finally the main outcome, that as universities we have control over, is better students and graduates more able to serve a changing and developing health and social care sector.

I would like to conclude with my personal mission:

‘My mission is to ensure that that the voices of service users and carers are so embedded into health and social care education, that students upon graduation always consider the views of patients and carers as paramount. That they **have the courage** to challenge practice in themselves and in others that leads to poor patient care and every day they go to work with the desire to enhance the patient experience.

Research and evaluation of involvement is ongoing and it is essential that it continues to develop a body of evidence to substantiate its value.

### **Limitations**

The limitations of the study are that this article represents the views of the two authors – the academic lead and the development worker. The challenges in other universities and settings may be somewhat different. However, the authors have shared some of their findings with a national network of development workers known as DUCIE and found many similarities in issues.

### **CONCLUSION**

The article concludes that in order to bring about a shift in the culture of future health and social care services; making them more consumer driven and focused, as directed by policy; real investment in service user engagement in education is essential. This will only be achieved by embedding involvement in health and social care courses at all levels, this needs to be supported by an infrastructure that includes employment of specific individuals with a responsibility for engagement and involvement. We have made small steps but are confident that with continued resources we could take great strides and make a positive contribution to service improvement and the improved delivery of health and social care.

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