Delivering Nurse Education within the Greater Manchester Combined Authority- Challenges and Opportunities for Ensuring Clinical Leadership Development for Student Nurses

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Within this paper we offer some personal perspectives about delivering nurse education within the University of Salford, a University situated within the Greater Manchester region, reporting on both challenges and opportunities for ensuring clinical leadership development of its student nurses.

The Greater Manchester Combined Authority

"*Greater Manchester Combined Authority (GMCA) is one of the country's most successful city-regions. Home to more than 2.7 million people and with an economy bigger than that of Wales or Northern Ireland. The GMCA is made up of the ten Greater Manchester councils and Mayor, Andy Burnham who work with other local services, businesses, communities and other partners to improve the city-region. The ten councils (Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan) have worked together voluntarily for many years on issues that affect everyone in the region, like transport, regeneration, and attracting investment*" (GMCA 2108).

The Greater Manchester Strategy sets out a collective vision to make Greater Manchester one of the best places in the world and has 10 key priority areas:

1. Children starting school ready to learn
2. Young people equipped for life
3. Good jobs, with opportunities for people to progress and develop
4. A thriving and productive economy in all parts of Greater Manchester
5. World-class connectivity that keeps Greater Manchester moving
6. Safe, decent and affordable housing
7. A green city-region and a high quality culture and leisure offer for all
8. Safer and stronger communities
9. Healthy lives, with quality care available for those that need it
10. An age-friendly Greater Manchester

In terms of GMCA and health and social care, Greater Manchester has signed a devolution agreement with the Government to take charge of health and social care spending and decisions in the city region. The Greater Manchester Health and Social Care Partnership is overseeing devolution and taking charge of the £6 billion health and social care budget. The rationale for this is to implement its vision to deliver the greatest and fastest possible improvement to the health and wellbeing of the 2.8m people of Greater Manchester (GMCA 2018). This would be achieved through radically transforming and building a clinical and financial sustainable model of health and social care. Since the signing of the agreement in 2015 Greater Manchester has seen changes to the way that care is delivered and this has included the transformation of large hospitals and NHS Trusts into even larger organisations. Examples include the setting up of The Northern Care Alliance NHS Group and Manchester University NHS Foundation Trust (MFT). It is not yet known the added value of these larger organisations on

patient care delivery and impact on services with robust evaluations required to seek patient and other key stakeholder's viewpoints.

What is clear however, is the synergy between the healthy population and delivering on the 10 key priority areas set out in the Greater Manchester Strategy. For example recognised is the correlation between providing good jobs, with opportunities for people to progress and develop with promoting safer and stronger communities. Tackling ill health in isolation from wider environmental and sociological detriments such as unemployment and poor housing is fast becoming an outdated concept.

Interestingly, the September Centre for Advancement Inter-professional Education (CAIPE)Forum was hosted by the University of Salford with presentations provided by John Rouse, Chief Operating Officer Greater Manchester Health and Social Care Partnership who shared his perspectives of the challenges and opportunities of the Greater Manchester Health and Social Care Partnership. What became clear is the need for innovative approaches to healthcare workforce development that supports the GMCA vision for making Greater Manchester one of the best places in the world and to improve health and wellbeing of its population. For John, key is early intervention and prevention, the need to transform community based care and provide support at work within neighbourhoods. Inter-professional education is paramount, but without losing the focus of what each professional group brings to excellent patient care delivery. For those universities who provide nurse education, clear is the need to demonstrate what works (educational outcomes) when delivering all aspects of its nurse education. Higher education institutions (HEIs) collaborating with practice partners to research/evaluate and disseminate good practice around nurse education is therefore essential.

The pledge to deliver on its vision to provide the greatest and fastest possible improvement to the health and wellbeing of the 2.8m people of Greater Manchester comes at a time of the withdrawal of student bursaries, with school of nursing nationwide reporting on a decrease in undergraduate nursing applications. In place of the bursary the Department of Health has made funding available to support an extra 10,000 Student Nurses, Midwives and Allied Health Professionals by 2020 (DH 09/08/17). Middleton (2017) reports on Andy Burnham, Mayor Greater Manchester "*radical plan in Greater Manchester that anyone who comes through the city as a health professional, if they commit to Greater Manchester NHS for five years, we will commit to pay them for their tuition f*ees."

Simultaneously, to address qualified nurse vacancies In Greater Manchester hospitals, Executive Nurses have requested that its local HEIs increase its numbers of student nurses in training. The implications of this increase of which fifty percent of the educational programme is delivered from within the clinical learning environment (NMC 2008) and of whom student nurses are supported by an increasingly overstretched mentor (Leigh and Roberts 2017) could potentially lead to the perfect storm.

The Nursing and Midwifery Council are currently reviewing its standards for pre- registration nurse education. Leigh and Roberts (2017) critique of the draft standards concluded that central to the proposed standards is the fundamental requirement for partnerships between HEIs and healthcare organizations to provide the practice based learning for the student nurse. This is a welcome clarification, however in a system that is already struggling to cope with student numbers forces a re-think of how high quality clinical placements are structured and clinical leadership development is secured.

Equipping Greater Manchester nursing students with exemplary clinical leadership skills is reliant on the practical component of their educational programme taking place in a supportive clinical environment in which these new nurse leaders can flourish. Firmly embedding clinical leadership development within undergraduate nursing programmes ensures that our Greater Manchester nursing workforce have the right leadership knowledge, skills and behaviours required to make sound clinical, non-clinical decisions that will empower nurses and strengthen nursing in decades to come.

In Greater Manchester robust systems such as the Greater Manchester Practice Education Group are in place whereby the four HEIs who provide pre-registration nurse education work in partnership with its practice partner organisations to standardise policies and procedures and to collaborate on areas of common interest or concern such as clinical leadership development, practice learning and mentorship. Examples of projects delivered by the group include the development and evaluation of a unique practice allocation model in support of high quality student placements (Leigh et al. 2014). The four HEIs are University of Salford, Manchester Metropolitan University, University of Manchester, and University of Bolton.

As a Greater Manchester Practice Education Group we applied problem solving techniques to identify our underlying challenges and subsequent opportunities associated with delivering nurse education that would operationalise the GMCA vision to contribute towards delivering the greatest and fastest possible improvement to the health and wellbeing of its population. Challenges related to delivering on Health Education England Quality Strategy 2016-2020 and Quality Framework for promoting high quality placements and clinical leadership development. An issue identified was the variable support in clinical practice for undergraduate student nurses of whom were not consistently encouraged to take ownership of their clinical leadership development learning needs. The current model adopted is the traditional mentorship model. Challenges already identified are those associated with the need to increase the number of nurses across Greater Manchester and this accelerated the necessity to seek opportunities to change both the current placement and clinical leadership development model. Healthcare organisations in Greater Manchester have already implemented the Trainee Nurse Associate programme with the University of Salford planning to commence its apprenticeship programme commencing September 2018. The Trainee Nurse Associate Role offers a route for those nursing assistants who want to progress in their careers to become a registered nurse (NMC 2017).

The Greater Manchester Practice Education Group explored alternative support models and this included the University of East Anglia's Collaborative Learning in Practice (CLiP) placement model recommended by Willis in The Shape of Caring Report (2015).

Following attendance of a study day facilitated by East Anglia and attending site visits to Lancashire Teaching Hospitals NHS Foundation Trust who have successfully implemented the model on a small number of selected clinical placement areas the group reflected that the model whilst providing student support and peer mentoring did not adequately develop students clinical leadership skills, qualities and behaviours. Importantly, there seems to be no robust evaluation or evidence base for the CliP model; evidence was often anecdotal.

The Greater Manchester Practice Education Group have therefore created the Greater Manchester Clinical Leadership Coaching Education Model (GM Synergy) that takes the original CLiP™ model further with emphasis on clinical leadership and organisational partnerships. We have gained assurances from East Anglia University CLiP team that we can adapt the model.

GM Synergy is based on the concept of coaching compared to mentoring and is applied to enhance the clinical leadership development (confidence, competence and performance of students for the benefit of quality nursing care) through the delivery of hands on nursing care. The coaching approach to practice learning adopts a stronger focus toward self-directed learning and personal responsibility for leadership learning. The leadership learning is student led, less focused on following the direction of the mentor and more focused on students taking responsibility in identifying their goals and objectives and working with the 'coach' offering guidance and critical challenge (Leigh et al. 2018).

Commencing September 2017 the four Greater Manchester HEIs have worked in collaboration with its practice partners to implement GM Synergy (phase 1) in thirteen practice placement areas spanning four NHS Trusts and a range of practice placement areas: adult acute and community settings and children's acute ward. The aim is to roll out the model further across Greater Manchester and discussions have taken place to adapt the model to the wider community, midwifery and mental health setting.

It is not the intention of this paper to evaluate GM Synergy and instead we report on lessons learned following the initial implementation, placing emphasis on strong leadership required to change culture and enhance patient care.

Applying Greater Manchester Practice Education Group expert knowledge around educational improvement and innovation we deliberately set out to apply the Five Practices of Exemplary Leadership (Kouzes and Posner 2012) to win the hearts and minds of those affected by what we were trying to achieve: model the way; inspire a shared vision; challenge the process; enable the others to act; and encourage the heart.

To Create and inspire our shared vision and model the way we developed an Inspirational Thought Leader Steering Group with inclusive membership drawn from HEI's and healthcare organisations from across Greater Manchester- including users and carers, advisors and students with experience of the Clip model. This group created the vison and provided the leadership to inspire others. Having a clear vision from outset was key and acted as the platform for us to work and this ensured that we kept on track and all moved in the same direction.

We communicated, consulted, engaged and challenged with the right people (those who influence and helped transform the student's clinical learning experience) in the right way, thus obtaining buy-in from the outset. We created a culture that welcomed challenge and for all involved to feel a sense of ownership with the new model. We were in a great starting position because of the overall GMCA agenda around transformation of health and society therefore meetings with executive nurses and Dean HEI's meant that we had buy- in from the top from the outset.

To inspire commitment to change for the benefit of improved patient experience and safety outcomes we took advantage of all the opportunities to resolve all the challenges that we faced and continued to face along the way. These included applying the current NMC standards (NMC 2008) for practice learning within a coaching as opposed to mentoring context. We have created an empowered learning environment in which we all do our best for the benefit of the patient and student experience. It has not been easy breaking the established and long standing mentoring traditions and we deliberately placed emphasis on sustainability of the model and this we have achieved through carefully preparing everyone involved and indeed the time and effort required to do this should not be underestimated.

As a nurse-led team we demonstrated that we care and were passionate about what we were trying to achieve (encourage the heart)

We have developed a robust evaluation strategy measuring the impact of the implementation of GM Synergy on student clinical leadership development and this evaluation sits within the University of Salford Educational Research and Scholarship Cluster. This cluster offers a vibrant community that engages academics in research that impacts teaching, learning and practice. We have also set up a research meeting that takes place before the Greater Manchester Practice Education Group where as a group we plan our evaluation strategies, making sure that we clearly demonstrate educational outcomes. Measuring the impact of GM Synergy from multiple stakeholder perspectives we are applying realist evaluation focussing on the on the following key areas:

1. Expected outcomes of an innovation, for example, enhanced clinical leadership development for undergraduate student nurses and preparedness for the coaching role by the range of practice educators

2. Mechanisms and processes by which expected outcomes are achieved and impact is realised, such as modes of student support and models of clinical leadership development, and ongoing models of support post project life cycle.

We have secured ethics approval so that we can explore those systems in place that make the model work in one clinical learning environment and not in others - think about the model within its unique circumstance and context.

Lessons learned so far is that providing clinical leadership development for undergraduate student nurses requires the support from educators drawn from clinical practice (qualified nurse), practice educators and academics from Higher Education Institutions. Development of the multi-personnel therefore reduces the single point of failure for student support and significantly increases the likelihood that GM Synergy is sustainable beyond this initial implementation phase.

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