

THE HEALTHCARE SCIENCE LEADERSHIP JOURNAL

Winter 2024

BASIT ABDUL

**DRIVING CHANGE: ADVANCING
EQUALITY, DIVERSITY AND INCLUSION
IN HEALTHCARE SCIENCE**

SARAH PITT

**MASTERING THE SPOTLIGHT:
REFLECTIONS ON MEDIA ENGAGEMENT
AND COMMUNICATION**

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THE BENEFITS OF QUALIFYING
IN ADVANCED PRACTICE**



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THE HEALTHCARE SCIENCE LEADERSHIP JOURNAL

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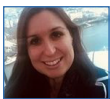
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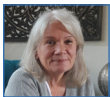
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EDITORIAL

Our Winter Edition of the AHCS Leadership Journal showcases pioneering initiatives aligned with Good Scientific Practice (GSP) (AHCS, 2021). We focus on the significance of leadership and communication in driving innovation and enhancing patient care. You will find the collaborative efforts of our leaders shaping healthcare science, highlighting innovation, resilience, and leadership across the profession.

Effectively embedding Equality, Diversity, and Inclusion (EDI) in all we do, is a must and a priority. Basit Abdul introduces a blueprint, the Healthcare Science EDI Programme, led by NHS England and the Academy for Healthcare Science. This initiative addresses systemic disparities through a structured framework, fostering a diverse workforce essential for innovation and effective problem-solving. Through total inclusion, the programme aims to enhance patient care, equity and health outcomes, benefiting individuals and the wider healthcare system.

Sarah Pitt illustrates the transformative power of professional communication in healthcare science. She has become a prominent advocate, participating in over 800 radio and 100 television interviews since the COVID-19 pandemic began. Her efforts not only raise public awareness and understanding of healthcare science but also inspire our future scientists. Recognising the critical role of accessible communication, she introduces a media fellowship scheme to train scientists in effective public engagement. Alongside this, Emma Walker's job planning pilot project demonstrates the value of scientific leadership in enhancing professional identity, recognition, and career fulfilment in an evolving healthcare landscape.

Gemma Jones, a neurophysiologist and a serving member of UNISON, reflects on her role of advocacy, representation, and workforce cohesion, particularly during industrial action. Her insights highlight the power of collective voices in driving positive change and navigating complex challenges.

The Clinical Research Practitioner (CRP) profession is now part of the AHCS register. CRPs are instrumental in the support and delivery of clinical trials. Ibiyemi Sadare advocates for developing leadership competencies among CRPs, stressing the importance of adaptability and digital skills. Her initiatives promote collaboration and professional growth, aligning with the continuous professional development (CPD) and reflective practice as endorsed by Health and Care Professions Council (HCPC).

Philip Cosgriff and Joanne Andrew share experiences of leadership and resilience, emphasising the value of mentorship, networking, and lifelong learning in navigating healthcare science's complexities. Their journeys highlight

the importance of balance and adaptability, offering a roadmap for aspiring leaders to thrive in our demanding profession.

Advanced Practice pathways present exciting opportunities for healthcare scientists. Sandra Iles explores how Advanced Practice qualifications in histology equip biomedical scientists with leadership and specialist skills. This pathway addresses rising diagnostic demands, supports departmental needs, and facilitates multidisciplinary collaboration. Completion of this qualification enhances confidence, mentorship capabilities, and research opportunities, contributing to professional and departmental growth.

Behind the Scenes: Shaping the Journal's Future

The editorial team and board have been actively developing a new strategy for the Journal. It aims to enhance engagement with diverse readerships, elevate content value, improve design, and address existing subject gaps. Stakeholder input from every healthcare science specialty, the professional bodies, higher education institutions, and NHS England will be key to the Journals success. In the coming year, the team intends to engage with all stakeholders to refine, finalise and implement the strategy.

A Farewell to Visionary Leadership

As December 2024 approaches, we bid farewell to Keith Ison, who stepped down early this year, as Editor of the Healthcare Science Leadership Journal. Since its launch in 2021, Keith's visionary leadership has guided the publication of 7 issues and over 66 articles, solidifying the Journal's role in advancing healthcare science leadership. His commitment to supporting the editorial transition ensured a super-smooth handover. We extend our heartfelt gratitude to Keith for his exceptional contributions and wish him continued success in future endeavours.

Usman Lula & Jonathan Flannery



Jonathan Flannery



Usman Lula

DRIVING CHANGE: ADVANCING EQUALITY, DIVERSITY AND INCLUSION IN HEALTHCARE SCIENCE

Diversity and inclusion are more than mere statistics. To draw an analogy with a pantry filled with multiple ingredients, diversity's true value is realised only when varied perspectives are actively employed to create something meaningful.

This article summarises progress with the Healthcare Science Equality Diversity and Inclusion (EDI) Programme 2023/24, a collaboration between the NHS England Chief Scientific Officer and the Academy for Healthcare Science (AHCS). The programme seeks to address critical challenges and gaps in EDI across the healthcare science workforce by increasing awareness of EDI, developing a national healthcare science EDI strategy and creating an implementation framework and practical resources.

Background

The NHS Constitution¹ commits to harnessing multiple perspectives to enrich the NHS's mission. It embodies the understanding that a diverse workforce, sensitive to the nuances of different patient needs and experiences, is better equipped to deliver care that is equitable, safe and effective. This ultimately leads to improved health outcomes across all communities.

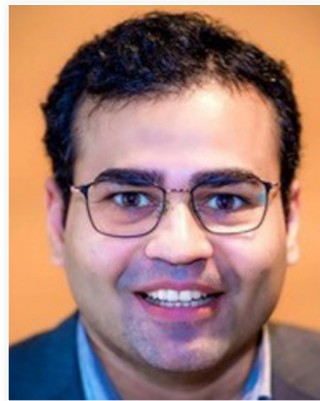
NHS England also published an EDI Improvement Plan in 2023². This sets out six high level actions that organisations should be taking to realise the benefits that come from greater equality, diversity and inclusion across its workforce.

Previous research has identified significant disparities and barriers related to EDI within healthcare science. These include underrepresentation of certain demographics such as ethnic minorities and individuals with disabilities, and a lack of progression for individuals from protected groups into senior roles. A number of surveys were conducted as part of the programme and they revealed that around 30% of healthcare science staff felt uncomfortable sharing information about their mental health, gender identity, ethnicity, disability, or other protected characteristics.

Programme development

The above insights helped to establish the programme and steer the development of a robust strategy and framework for EDI in HCS. This needs to align with NHS goals and address wider concerns regarding the wellbeing and equitable development of all NHS staff.

A variety of engagement activities were used to gather



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insights from stakeholders across the healthcare science landscape. These included:

- Meetings with Regional Healthcare Science leads
- Input from healthcare science professional bodies (PBs) through the Academy's Professional Bodies Council (PBC)
- Workshops with Scientist Training Programme trainees
- Presentations at and feedback from conferences and meetings
- Digital surveys of a pool of 91 HCS professionals who volunteered to assist the programme.

The first digital survey asked contributors, "Why is EDI important to you and what change you would like to see or bring about?" This provided a rich data set that was full of personal insights from passionate healthcare scientists wanting to make a positive impact. An analysis of the resulting 5,000 words generated 12 strategic themes and multiple actions for the implementation framework.

Professional Bodies were invited to take part in a survey with 24 questions, designed to understand the current state of EDI. Results indicated a varied approach across different PBs, with a significant number still planning for or yet to establish a formalised EDI policy.

There is also considerable scope to

improve data collection on protected characteristics. This survey produced a further eight themes.

In total 27 themes were generated through engagement activities. These were presented to the HCS EDI Oversight Committee, co-chaired by the Deputy CSO (Chief Scientific Officer) and the CEO (Chief Executive Officer) of the Academy. This committee provides the programme with governance and direction and has a diverse panel of 16 members

“ Why is EDI is important to you and what change you would like to see or bring about?,,

representing NHS Employers, the NHS Confederation, the National School of Healthcare Science, HCS EDI champions, Regional HCS Leads and a service user.

Strategy Content

The HCS EDI Strategy is built upon four foundational pillars (figure 1). Each one contributes vital insights and direction. The first pillar is previous research carried out in 2022, which summarised its survey results into 31 EDI recommendations. The second pillar is data on healthcare scientists taken from the NHS Electronic Staff Record and the survey of Professional Bodies. The third is the 27 themes that emerged from stakeholder engagement events. The final pillar is to align the Strategy with the guiding principles and objectives set out in the NHS England EDI Improvement Plan².

All 27 engagement themes and all 31 recommendations from previous research were analysed and aligned with the NHS EDI Improvement plan, under the guidance of the HCS EDI Oversight Committee. This identified three areas to focus on (figure 2):

- 1 Evidence driven EDI insights.
- 2 Diverse & Inclusive Recruitment and Retention.
- 3 Embedding Inclusion in Daily Practice.

Together these elements create a comprehensive, data-informed, community-engaged and historically-grounded Strategy. Each key area is further delineated into discrete ambitions, each with detailed actions for its implementation.

The expectation is that as these key focus areas are realised the HCS workforce will become more diverse, inclusive and empowered. The aim is to create a sense of belonging amongst staff that enhances patient care and reduces health inequalities.

Framework and Toolkit

The strategy is supported by a comprehensive implementation framework that articulates how its recommendations will be implemented and monitored. This framework outlines how the strategy will be brought to life and identifies key players and stakeholders. The accompanying toolkit will include

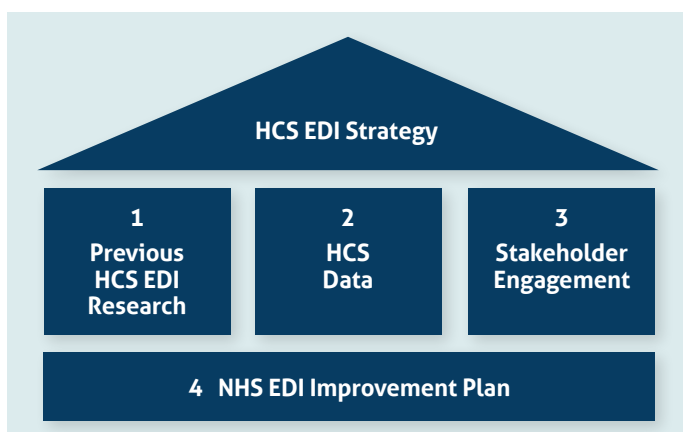


Figure 1: Foundational Pillars of the HCS EDI Strategy

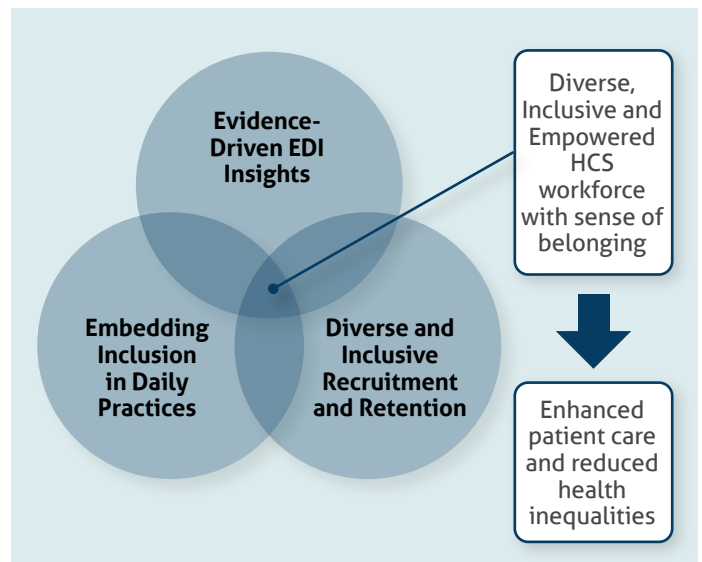


Figure 2: Key areas of focus

practical resources for frontline staff and managers, and sets out mechanisms for measuring progress. Another analysis of a Toolkit survey generated a further seven themes.

Recommendations

The Oversight Committee recommends retaining both the Committee itself and the pool of voluntary healthcare scientist contributors to support implementation of the strategy. It is also advocating for the establishment of a permanent full-time EDI and well-being lead role within the office of the Chief Scientific Officer for England, to oversee and be responsible for implementation of both Strategy and Framework.

Conclusion

The Healthcare Science EDI Programme represents a significant step towards fostering a more inclusive and equitable healthcare science community. Through collaborative efforts and stakeholder engagement, the programme has developed a robust strategy and framework to address EDI challenges and healthcare inequalities.

Collective responsibility and sustained commitment across Healthcare Science will be essential in realising the objectives of the programme. It is also vital to creating a workforce that is truly diverse, inclusive, and empowered. The strategy will be published in due course.

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MASTERING THE SPOTLIGHT: REFLECTIONS ON MEDIA ENGAGEMENT AND COMMUNICATION

Although I now work in an academic role as a Principal Lecturer at the University of Brighton, I usually introduce myself as a Biomedical Scientist. This reflection is an account of how I have tried to present healthcare scientists' work to wider audiences through engagement with the media.

During the summer of 2019, the *Mail Online* published a piece about my research with snails^{1,2}. I had worked with my husband and other colleagues to demonstrate that mucus from garden snails had an antibiotic effect against *Pseudomonas aeruginosa*. It was a nice story involving a bit of marital disharmony – my husband is an invertebrate biologist, so I took issue with his initial experimental techniques and the 'yuk' factor of snail slime. I happily contributed to written press articles but was extremely reluctant to do oral interviews. Talking about my work felt like showing off and I didn't think anyone would be interested in anything I had to say. The editor of my professional magazine, *Biomedical Scientist*, finally twisted my arm and in mid-December 2019, I did a carefully planned, pre-recorded podcast session. I was expecting to go back into the laboratory and not to have to interact with external people very much again.

However, a few weeks later the pandemic came along. I helped to write a short piece about coronaviruses for the Institute of Biomedical Science website³ which led to a request for an interview. And so, on 25th January 2020, I did my first ever live radio interview to BBC Radio Scotland. Via my mobile phone I explained what we knew about this new virus and how it compared to other coronaviruses. I was incredibly nervous and remember shaking during the call, but found I was able to answer the questions and came across reasonably well. As I have found with trying many new things professionally, I thought I could do it again but needed to reflect on how I could improve. I had been on a media training day organised by the IBMS in the autumn of 2018 and I tried to remember the points I had learned then.

We all know how the story of the 'novel coronavirus' unfolded. My reflections were obviously effective, because engaging with the media soon became a normal part of my working day. I tried to keep up with scientific developments, government guidelines and comments made by expert researchers, as I thought it was important that the general listener/viewer should have a fairly consistent public health message. I also began to realise that my general background in virology and



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my experience in diagnostics were assets which allowed me to bring a different perspective to medical doctors and professors of epidemiology. During the initial months of the pandemic lockdown I honed my skills inadvertently by talking to my mother every evening. We talked about the latest news on the COVID-19 virus. So when I was asked to comment on the same topics for radio or TV I had already practiced

explaining key technical points without using jargon – on my Mum!

Because I had a fulltime job at the university I was not able to help my local NHS diagnostic virology department by working shifts in the laboratory, so I came to view media interviews as my contribution to the COVID-19 pandemic response.

While others were carrying out testing I was explaining how the tests worked. I referred to "my colleagues working in hospital laboratories" whenever the opportunity presented itself. I also found myself working closely with the IBMS communications team and the then President, Allan Wilson, who had also been at my media training workshop. I think we can both say that we put the skills we learned that day to good use!

“ I happily contributed to written press articles but was extremely reluctant to do oral interviews.,,”

I have now done more than 800 radio and over 100 TV interviews in the UK and other countries including Canada, Turkey and India. Not all of them have been about COVID-19. Journalists have become alert to various aspects of infectious diseases since the pandemic, including transmission, testing and vaccination, and I am delighted that I am asked to comment on a wide variety of infections. Two examples are the 2022 global Mpox outbreak⁴ and the problem of *Escherichia coli* in salad leaves seen in the UK in 2024⁵.

Another consequence of the raised media profile of diagnostic laboratory scientists is the appropriate use of our professional title of biomedical scientists in news stories⁶.

Over the last four years I have become confident in communicating with people outside healthcare science about our work. I feel even more strongly that we need our voice to be heard. We should be contributing to strategic decision making within healthcare, highlighting our roles among policy makers and explaining our work to general audiences. The last of these is important in two key ways. First is to help patients understand tests and procedures better, so that they can prepare well and feel less anxious about interacting with healthcare scientists. The second is to encourage bright young people with an interest in science to consider a career in healthcare science. In 2022, I was selected for an Association of British Science Writers Fellowship⁷. I spent the summer of 2023 working with

journalists at BBC Future in Television Centre, West London and produced a number of articles⁸. As part of that placement I found out that journalists can get access to press releases in advance so that they can prepare articles about them. I worked with the IBMS communications team to sign up for one of these schemes so that we can identify items with a clinical diagnostic laboratory angle and include comments from expert IBMS members.

I also encourage colleagues who have links to a university or other institution that subscribes to *The Conversation*⁹ to write short articles for that website. It is an excellent way of explaining healthcare science to wider audiences. The editors are really helpful in guiding the use of suitable language (fairly informal, no jargon) and pieces are sometimes taken up by national and international media sites.

My reflection on my experiences on media engagement is that healthcare scientists can and should do this. As an expert in your field, you are well placed to explain your work and its value to a variety of audiences outside of your department. In early 2020 I was very uncertain about doing this but once I understood what was required I became more comfortable with appearing on radio or television. I am still nervous and prepare as thoroughly as I can for all appearances but am glad I took the opportunity to tell the world about microorganisms and my profession.

“ I feel even more strongly that we need our voice to be heard.,,”

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ENABLING SUCCESS: IMPLEMENTING HEALTHCARE SCIENCE JOB PLANNING IN THE NHS

Within the context of the National Health Service (NHS) a job plan is an annually agreed prospective description of an employee’s duties and responsibilities, outlining how their time is spent on direct clinical care and other supporting professional activities.

Job planning can therefore be viewed as an element of human resource management, and more specifically as a high-performance workforce practice aimed at enhancing employee engagement and performance. Job planning has been a contractual requirement for medical consultants working within the NHS since 2003 and has only more recently started to be applied to the non-medical workforce. This article describes a job planning pilot project conducted at Imperial College Healthcare to introduce healthcare scientist job planning for the first time.

Project Rationale

The key driver for this project was the publication of a number of strategy and policy documents by NHS England and NHS Improvement (NHSE&I)^{1,2}. Job planning has been advocated for allied health professionals (AHPs) since 2017 and a best practice guideline was issued in 2019 stating that all AHPs should have job plans in place³. More recently e-job planning has been proposed for all clinical professionals working in the NHS, which would include healthcare scientists⁴. Furthermore



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the NHS Long Term Plan made the commitment that by 2021 NHS Improvement would support NHS hospital trusts to deploy electronic rosters or e-job plans.

Figure 1: Driving and opposing forces for the job planning project, identified by applying Lewin’s force field analysis.

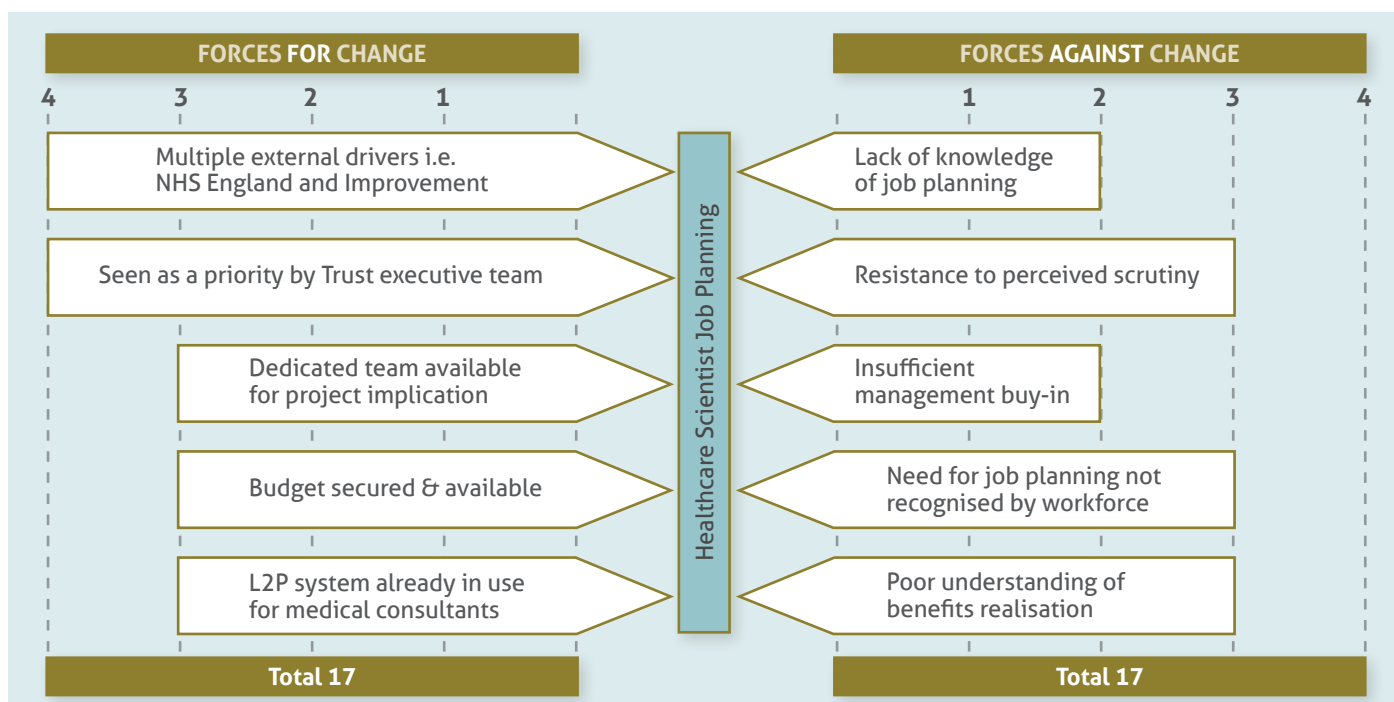
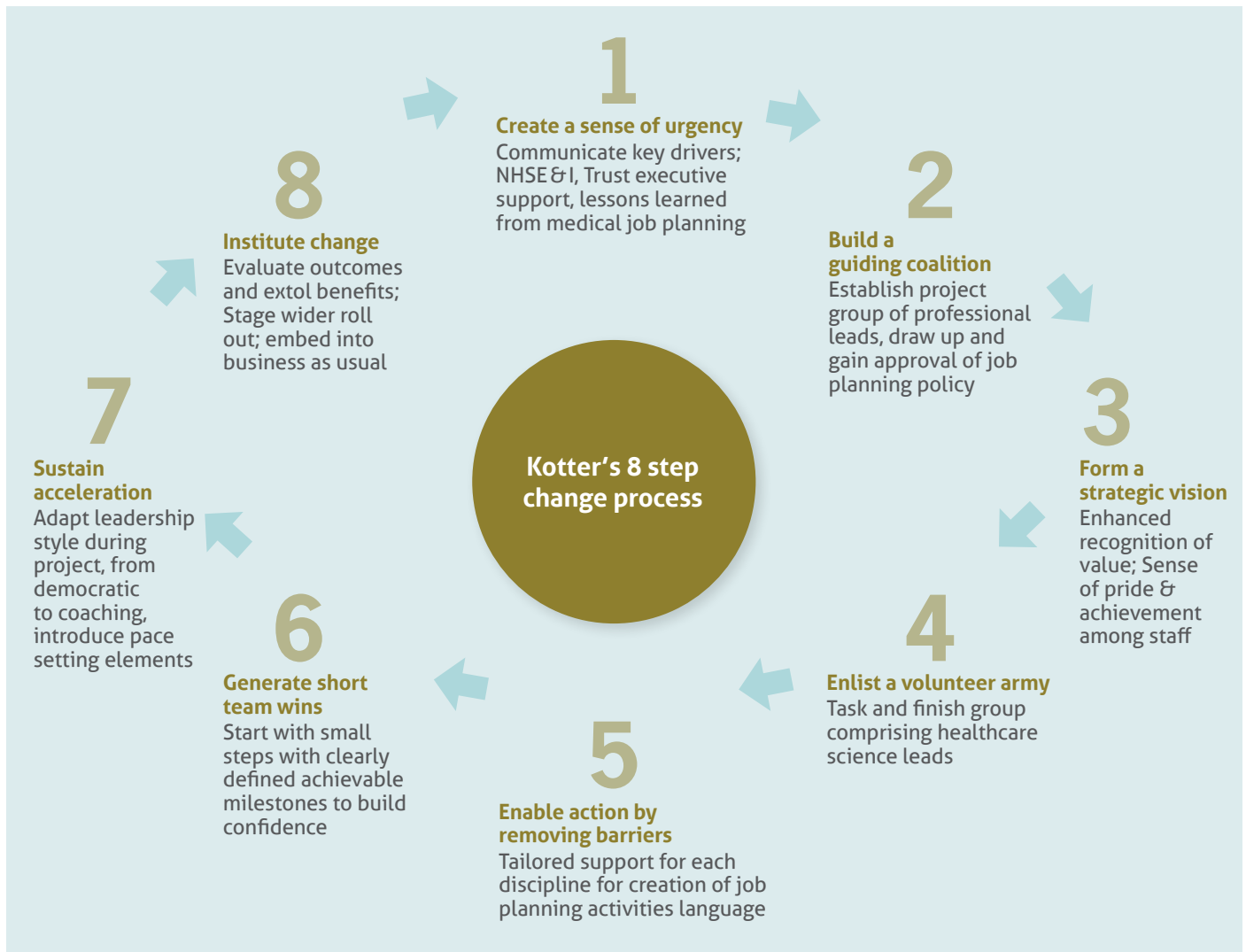


Figure 2: Kotter's 8 step change process model as applied to the job planning project.



In response to these drivers, Imperial College Healthcare executives determined that a non-medical job planning policy should be created and implemented. The creation of this policy supported the following Trust strategic objectives:

- To achieve excellent patient experience and outcomes, delivered with compassion
- To educate and engage skilled and diverse people committed to continual learning and improvement
- To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

A multi-professional project team was convened to formulate and implement the policy. It comprised the Trust's Lead Healthcare Scientist, Chief AHP, Chief Pharmacist and Deputy Director of Nursing. The executive level project sponsor was the Trust Chief Nurse. A policy document was co-authored by the project team following extensive discussion amongst a wide range of stakeholders within the Trust. As the Trust's Lead Healthcare

Scientist, the author was responsible for determining both the strategy and approach to job planning that would be taken with the healthcare scientist workforce.

Consultant level job planning has been mandatory for the medical workforce in the NHS since 2003, with the launch of a refreshed medical consultant contract. The ethos of this process is that it ensures effective and efficient workforce deployment and optimises clinical capacity. Job planning can also facilitate the positive engagement, motivation and retention of the workforce. Retaining the medical consultant workforce is critical given that it takes 6-8 years of post-graduate training to qualify as a consultant at a cost of around £230,000.

Consultant Clinical Scientist training has a cost and time requirement similar to that of a medical consultant. Therefore, the most senior healthcare scientists at the Trust were selected for this job planning pilot because it was perceived that the most value and return on investment would be gained from creating job plans for this sector of the healthcare scientist workforce.

“The key driver for this project was the publication of a number of strategy and policy documents...”

Healthcare scientists who undertook job planning were experienced advanced practitioners, qualified to at least Masters Level and in senior roles at the Trust. The 30-strong cohort comprised Advanced Biomedical Scientists, Consultant Clinical Scientists and Trainee Consultant Clinical Scientists on the Higher Specialist Scientific Training programme (HSST) spanning 12 scientific disciplines across the life, physiological and physical sciences. Specific project objectives were to:

- 1 Establish a non-medical job-planning policy and gain organisational approval for its implementation.
- 2 Establish a task and finish group comprising healthcare scientist representatives to design the job-planning system.
- 3 Roll out job planning across the healthcare scientist Consultant Clinical Scientist, trainee Consultant Clinical Scientist (HSST) and advanced Biomedical Scientist practitioner workforces at the Trust.

Project Implementation

In formulating the project delivery, Lewin's force field analysis was utilised to evaluate the likelihood of success⁵. The outcome of this analysis is depicted in *Figure 1*. This analysis helped to design a process for change utilising Kotter's 8 step model⁶. The change process is depicted in *Figure 2*.

A project initiation meeting was convened with the healthcare science leads of each of the 12 scientific disciplines. In this meeting project drivers were explained, the benefits of job planning were presented and next steps were outlined. Initial ideas were captured on virtual post-its.

Meetings were subsequently convened with each discipline to create the bespoke job planning language needed for each speciality. An Excel template was created to support and capture the language needed for specific activities.

Each discipline was responsible for creating their own activities language but also had sight of other group's activity language as it was developed. Once a language had been created for each discipline it was built into the job planning system to enable bespoke job plans to be created for each healthcare scientist.

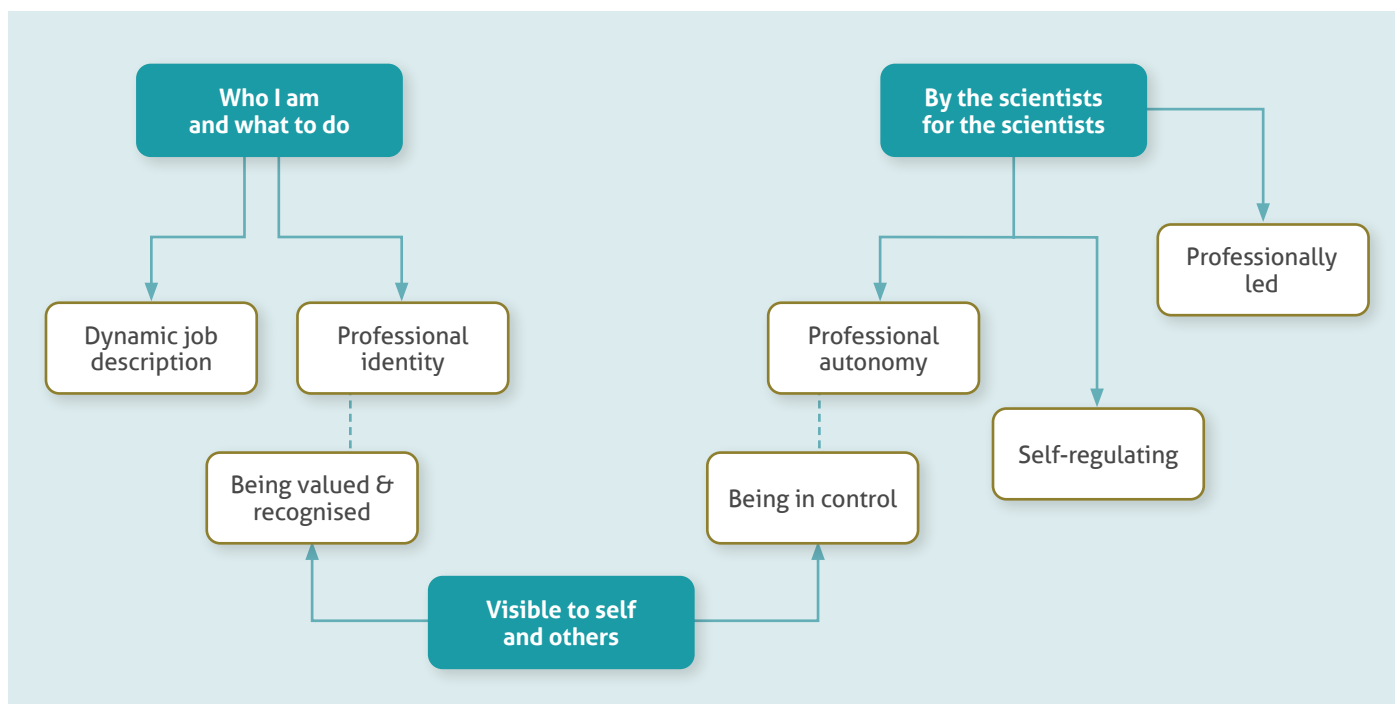
Training in the use of job planning software was provided to all areas.

User training was given to healthcare scientists and manager training to the line managers who would be signing off completed job plans. These sessions were well attended with all users being successfully trained and able to access and use the system.

Each discipline then produced their job plans in conjunction with the performance development review period. Once

“The overall aim of this research was to identify what could be learnt from this pilot study...”

Figure 3: Thematic map of the research findings. Coloured boxes are major themes and white boxes are sub-themes. Arrows indicate hierarchical arrangements of each theme and sub-theme. Dotted lines indicate sub-themes that are related to each other.



created these job plans can then be reviewed and refined each year as part of the personal development review (PDR) process.

Evaluation and Impact

To evaluate the impact of the pilot project the author conducted a qualitative research study investigating the experiences of healthcare scientists undertaking job planning. The overall aim of this research was to identify what could be learnt from this pilot study of healthcare scientist job planning at Imperial College Healthcare NHS Trust to inform more widespread job planning of this workforce within the NHS.

Semi-structured qualitative interviews were conducted with twelve healthcare scientists who were undertaking job planning for the first time. The interviews sought to investigate the experiences of these scientists and their perceptions of the outcomes, benefits and challenges of job planning. A manual thematic analysis of interview transcripts was conducted using first stage in vivo and process coding and second stage pattern coding to identify codes, which were then grouped into categories and finally into overall themes.

Three main and seven sub-themes emerged from the thematic analysis. *Figure 3* shows how these were interrelated.

MAIN THEMES were:

- By scientists for scientists
- Visible to self and others
- Who I am and what I do

SUB THEMES were:

- Professional autonomy
- Professional identity
- Professionally led
- Self-regulated
- Being valued and recognised
- Being in control
- Dynamic job descriptions

These themes formed a map that provided insights into the experiences and outcomes for healthcare scientists undertaking job planning. They formed a set of guiding principles from which five key recommendations were drawn.

- 1 A partnership approach should be taken to enable scientists to be the architects of the process – by scientists for scientists.
- 2 Opportunities should be provided for healthcare scientists to work together on the process to articulate a clear picture of who they are and what they do.
- 3 The process must recognise healthcare science as a profession by allowing for professional autonomy and self-regulation.
- 4 The process can be used to increase the visibility of healthcare science and the perceived value of contributions made by healthcare scientists to healthcare.
- 5 Managers must embrace the opportunity that job planning provides to enhance roles and develop more fulfilling careers for healthcare scientists.

Conclusion

This research has begun to address an important gap in the research literature, with job planning itself and the healthcare scientist profession both being under-researched areas in the NHS.

In summary, the investigation has provided a valuable evidence base that can be used to inform the development of future policy and practice for healthcare scientist job planning within the NHS.

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LEADING TOGETHER: THE POWER OF UNION LEADERSHIP

I have worked in Neurophysiology at the Royal National Orthopaedic Hospital (RNOH) for 20 years. The majority of that time I've been a member of UNISON and Secretary of the RNOH UNISON Branch for more than 12 years. I joined UNISON's Scientific, Therapies and Technical (STAT) Committee as London's regional rep and now Chair that STAT Committee. As a result, I sit on UNISON's Health Service Group Executive, the decision-making body for Health in the Union.

All these lay leadership roles have defined duties and responsibilities, with additional aspects of work that are undefined. That's the same as any leadership role in healthcare or other organisations. Leaders must adapt and work positively in a changing environment, learning how to manage new situations. For example, I've recently taken part in Listening Events, aimed at improving staff experience. That was new but very worthwhile. Being the person whom staff choose to voice their concerns to is a privilege. It strengthens the relationship between unions and management at local level to achieve positive change. It shows staff the value of unions in the workplace and, for me personally, reinforces my role as a leader and a voice for staff. Enhancing staff experience is crucial, as high-quality patient care results from a motivated, cohesive workforce.

The value of trade union membership for leaders

Membership of and active engagement with trade union principles, union training and campaigns have provided me with skills that I believe would be valuable to enhance any leader's skill set. Importantly, understanding the holistic impact of decisions and the manner in which things are communicated are significant factors that, when not approached with care, can be destructive to trust and team morale.

When managers focus on behaviours and fairness staff can feel more engaged and supported in the workplace – be it improving department or organisational culture; providing deserved recognition; implementing reasonable adjustments for staff with disabilities; or ensuring equal access to flexible



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working opportunities. All these aspects are vital in retaining staff and the skills that they contribute to patient care.

Unions are for staff and managers

There are NHS Unions available for all staff. There are profession-specific unions, affiliated to professional bodies, that focus on issues affecting their profession while also being involved in wider discussions such as NHS pay. General Unions like UNISON work to influence all areas of healthcare because their members are found throughout the workforce. There is also a Union specifically for Healthcare Managers, Managers in Partnership.

It is worth taking the time to look at all the options available and assess what they have to offer. There is a lot of support for personal and professional development available through Unions that can easily go unnoticed.

Do I consider myself a leader to healthcare scientists whose professional body does not have a Union?

I see myself as an advocate for all roles but I always make sure that Healthcare Science is not forgotten in discussions that affect us as part of the wider workforce. However, I can only speak on behalf of the members I represent.

Matters of pay, terms and conditions for Agenda for Change

“ Leaders have to adapt and work positively in a changing environment, learning how to manage new situations. ”

staff are negotiated at the NHS Staff Council, between the Employer and recognised NHS Unions. Professional bodies without a formal union link do not have the ability to engage in the same way as Staff Council Unions.

Through my role on the STAT committee, I try to bring a Healthcare Science (HCS) perspective and consider how policy and proposals will affect HCS staff. Less high profile areas, including HCS, need to be considered as much as more well-known occupations and I feel that this is an important responsibility for me. The most valuable way to achieve awareness is to have members in HCS areas engaged with their Union and providing feedback. My role is to be a voice for the workforce but I do not claim to be an expert or a leader of the individuals themselves.

My approach is to empower members to improve their own circumstances as much as possible. Speaking for people may help them in the short term but helping others speak for themselves can create more lasting change. If members ask what they should do I help them understand the options available to them and possible consequences, and support them through the process.

Unions act on behalf of their members, but need them to be engaged in their workplace, as without active members in every discipline unions can be unaware of planned developments in a particular area. It is much better to know about issues beforehand, to influence and improve a proposal, than it is to unpick and change a bad plan once implemented.

Though I don't feel I am the leader, many members and staff do seek me out as an authority on some aspects of work life. Through my involvement in reviewing people policies and frequent involvement in supporting formal processes such as Sickness Absence and Resolution (Grievance), I can advise on the best way to manage difficult conversations and processes.

What is it like to lead Union members, including healthcare scientists, through times of industrial action and political unrest?

Union leadership becomes most visible during campaigns and disputes. This can be challenging as members are busy and can't always get away from their work to meet, plus the nature of a 24/7 service makes finding the right time to speak to everyone difficult. Despite social media and email, speaking face to face with members about the most important matters remains the best approach. Industrial action within the NHS is never taken easily and so a personal approach is needed to

build trust amongst members. This cannot be created by only holding virtual meetings or sending out emails.

Not everyone is as aware of the facts of a situation. Some are affected more than others and lots of members don't understand their true strength in standing together to bring about positive change.

Organising HCS members is difficult in organisations if there isn't an active rep from one of the HCS occupations. Those unfamiliar with HCS struggle to understand the nature and locations of our roles, how to reach us and what our concerns are.

The nature of HCS work as underpinning so much of patient care is a strength that we do not shout about enough in our workplaces, to get our voices heard as they should. There has long been a false sense that 'Professions' don't get involved in Industrial Action but recent widespread Industrial Action by doctors and nurses reminds us that that's not the case. Doctors within the British Medical Association have taken strike action rarely but significantly¹, and nurses have also been taking strike action for decades within general Unions such as UNISON and its predecessor COHSE². The significance of the recent Royal College of Nursing action was that they finally voted to do so too.

I started my Union role intending to be a voice for my department at a time of change. From there I became the source of help for individual members across the RNOH Branch. With experience, training and following the lead of excellent role models within the Union movement I have developed into a leader, an educator and advisor. I have brought more members into the Union, developed more reps and become a voice at national level. Members have elected me to do these things

on their behalf, and I'm very proud of that.

Leaders within organisations do not need to be managers. Successful leaders do not dictate but engage with others and meaningfully listen. Strong leaders bring people together, demonstrate the values that help an organization improve and develop and provide support to future leaders as they learn and progress.

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“ Unions act on behalf of their members, but need them to be engaged in their workplace... ”

BRIDGING THE GAP: TRANSFORMATIVE LEADERSHIP STRATEGIES TO EMPOWER CLINICAL RESEARCH PRACTITIONERS

Ibiyemi Sadare argues that taking account of different ideas and approaches can produce better outcomes and help get things done. Clinical Research Practitioners (CRPs) are central to clinical research. They link study sponsors and trial participants, often coordinating clinical trials from set up to completion. They identify and screen potential participants, provide information, take informed consent, coordinate Quality-of-Life Questionnaires and perform randomisation. Specific job titles differ within the UK¹ and include Clinical Trial Practitioner, Clinical Trial Coordinator, Research Assistant, and Research Coordinator. CRPs are part of the evolving healthcare process, ensuring trials achieve recruitment targets, contributing to patient care and supporting their employing organisation to deliver clinical trials¹.

This article explores personal insights and experiences on leadership practices that foster personal competency and good practice, in the context of CRPs. It highlights the importance of leadership to all professionals wanting to maintain their registration and deliver a high standard of practice.

Background

The Clinical Research Practitioner (CRP) role is evolving as technology advances and studies become more complex. CRPs must develop skills in real-time data entry, e-prescribing support, biological sample processing, digital recruitment and AI-based studies. Managing this complexity without proper professional development is challenging.

As the NHS becomes more innovative, with rapid changes in all aspects of healthcare practice, it is essential that the National Institute for Health and Care Research (NIHR) supports the development of CRPs in each organisation to become more competent professionals.

CRPs, like other healthcare workers, should possess adaptable skills that facilitate positive changes to practice. Professionalism



Ibiyemi Sadare is a Senior Clinical Trials Practitioner with over 20 years' experience in Cancer clinical trials recruitment and a CRP Engagement Lead in South London. She believes passionately in supporting CRPs' leadership development and in encouraging them to join the CRP register.

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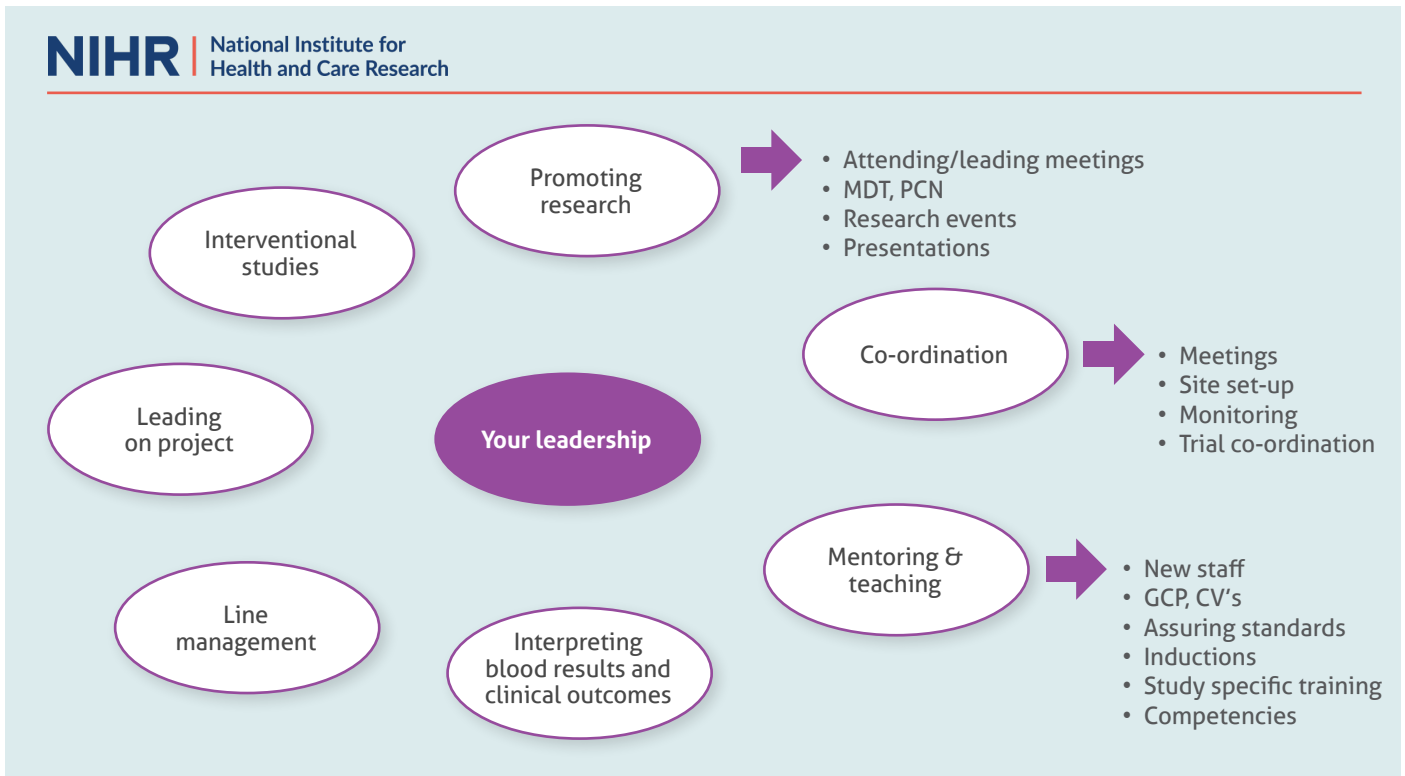
is about flexibility² and although CRPs have diverse educational backgrounds and experience, they are now part of a PSA-accredited register in the UK through a partnership between the NIHR and the Academy for Healthcare Science³. This recognises the need for standardised practices, advanced skills, and personal development⁴. It also includes the need for leadership, which includes influencing, empowering and motivating others (Figure 1).

Using leadership skills in practice: a reflection

Leadership skills are a necessity for healthcare professionals, even in junior roles. This also applies to CRPs. Planning and coordinating clinical trial activities requires regular and constant communication with others, making decisions, identifying training needs for oneself and others and ensuring that all steps are carried out correctly.

“CRPs, like other healthcare workers, should possess adaptable skills that facilitate positive changes to practice”

Figure 1: Essential areas where CRPs apply leadership skills to clinical trials practice



I am from a scientific background but have some nursing support skills acquired in previous roles. I have been working as a CRP for nearly 20 years in Oncology. Being a professionally registered CRP means that I am competent, qualified, and personally committed to integrity, competency and ethical conduct. I must also use leadership skills to deliver and improve services.

My leadership vision is to improve research awareness by exploring transformational ways of using digital enablers in practice, as well as empowering others to develop sustainable systems that respond to global health challenges. I have been proactively using boundary-spanning techniques to build trust outside my team and improve my ability to empower others using influencing and negotiating skills.

To illustrate how I have been using leadership skills in research advocacy, I share below a reflection on my own practice using the STARL model: Situation, Task, Action, Result and Learning.

Situation: There was a low level of awareness of clinical trials within the Trust. It was challenging to make progress when needing the involvement of other teams. Most were reluctant to offer their services as part of our trials. We encountered bottlenecks and delays, resulting in missed targets and sometimes a failed study set up.

Task: I encouraged my team to improve this situation. A meeting led to a decision to review the involvement of

supporting departments in setting up and running studies. We asked them these questions: How much do you know about our activities? Are you aware of the benefits to your team and the Trust? What level of engagement is there? We also compiled historical data on departments to find correlate positive or negative responses with study outcomes.

The resulting feedback helped us understand the complexities of dependence and involvement of other external teams. Areas identified for improvement included clearer initial agreements and Standard Operating Procedures (SOPs), and the need for a link person in each supporting department.

Action: The audit generated ideas on how to work more effectively and engage better with other departments. For each area we identified and put forward a strategic solution. I was confident in pushing across boundaries and introduced small changes to deliver

a better service through partnerships and new alliances, to work more smartly and efficiently.

I set up the "Reach2Connect" initiative to improve awareness of clinical research within the Trust. This included installing roller banners in four strategic places in the hospital that introduce the team and trial activities within the Trust. We engaged a link person in each department to establish a standard SOP and had an informal chat with the rest of their team to promote our activities.

Another important step was setting up a research staff forum.

“Continuous learning is crucial for me to keep up with the latest developments in my field and those related to my work ,,”

This was created in collaboration with another colleague to bring all research nurses, practitioners and administrators together to share practices and learning. The forum aims to build the confidence of research staff members to take responsibility for self-development and encourage others to do the same, especially in setting career goals geared towards individual passions. We organised the first International Clinical Trials Day 2019 in the Trust and addressed knowledge gaps by inviting different teams to lunchtime discussions on trials at MDTs and site initiations.

Result: There was increased interest from other staff in collaboration and they were positively enthusiastic to support studies. With increased visibility, research staff became more confident in approaching other teams, with better navigation around roadblocks. We developed excellent working relationships and they became more familiar with our activities and processes. Changes are communicated to us as soon as they are aware they might impact our workload.

Overall, I have expanded my horizons to open trials in collaboration with teams previously not wanting anything to do with research. This supports the NHS's 10-year forward view of greater connectivity, better networking, and patient involvement and engagement for local Clinical Research Networks, leading to improvements in patient recruitment and a better NHS through making high-quality research an integral part of healthcare. New frontiers are emerging with improved collaboration and the use of digital tools to network. The overall aim is to create a stronger and more visible trust research workforce.

Learning: I initially faced resistance from long-term staff. I addressed this by encouraging them to share ideas and take the lead in improving our processes. Evaluation and feedback have allowed us to identify areas for improvement and make necessary changes, and collaboration and communication are seen as key in decision-making. We prioritise safety and well-being and I intervene promptly in negative situations and actively address performance issues. Despite past conflicts and confusion, I have worked successfully with others to establish mutual agreements. Creating a research forum has fostered open communication and the sharing of accomplishments.

Continuous learning is crucial for me to keep up with the latest developments in my field and those related to my work. I invest in e-learning, face-to-face learning, conferences, and webinar attendance. I belong to a community of practice and online professional groups and support the professional development of others through coaching and mentoring.

Future developments for CRPs

CRPs will need to leverage data analytics techniques to improve clinical trial outcomes. Workforce development will also focus on developing essential skills for research visibility and participation, such as digital skills for virtual trials, e-consenting Digi trials, electronic health records, wearable

devices, and telehealth platforms. CRPs may also see a trend towards specialisation, focusing on specific areas such as oncology, cardiology, dementia, or diabetes. They will also take on more prominent roles in advocating for evidence-based policies within healthcare organisations, professional associations, and government agencies. CRPs will also play a pivotal role in education and mentoring, quality improvement initiatives, and ethical and regulatory compliance.

Conclusion

As a CRP you are called to be a competent leader. Take positive steps to gain the necessary skills and experience alongside your other competencies.

Applying for membership of a professional body and confirmed registration on the CRP register is a useful starting point for formulating a personal development plan, using established career progression pathways.

Figure 2 – Qualities needed by CRP leaders



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HEALTHCARE SCIENCE REVEALED: INSIGHTS & LESSONS LEARNT

My career in healthcare science started one cold February morning in 1977. A group of us undergrads were sitting around wondering what we were going to do with our lives. Our finals were just three months away.

My friend Trevor passed me a copy of *New Scientist*, open at the jobs page. It contained an advert for a trainee medical physicist post in Leicester. Trevor knew I might be interested because I had completed a six-month placement at Bristol Royal Infirmary a year earlier as part of a four-year sandwich course in applied physics at Bath University.

I applied for the job and got it. There were over 100 applicants, and I am convinced that my prior work experience proved crucial. I learnt a lot in those six months about medical physics but more importantly about how working relationships are built and how to get the best out of a team.

At Leicester I went through the Basic Grade Physicist training programme and completed a two-year Medical Physics MSc on day release. One of my lecturers gave me some sage advice on scientific writing: "Remember Philip", he said, "scientific reports should be terse; do not use three words when one will suffice." Lesson learned.

I decided to specialise in nuclear medicine after my basic training and was promoted two years later. My main clinical interest was nephro-urology, which became the focus of the department's research and development activities.

By the mid-1980s I was starting to think, "what next"? There was no opportunity for further promotion where I was, so it was time to look elsewhere. I found out about a Head of Department job coming up at Pilgrim Hospital in Boston, a large District General Hospital (DGH) that I had visited a couple of years earlier. I did some research into the job before applying.

The interview was very formal and included a lunch attended by all senior consultants. The General Manager also made a convincing pitch for Boston as a rapidly developing and ambitious DGH and I decided to take the post even though I had originally thought of moving to a teaching hospital. My thinking was, and has always been, to 'go for it; you can usually correct a mistake or bad decision, but you can never go back and take an opportunity once it has gone.

I thoroughly enjoyed my career as head of a scientific department in a large DGH with its mix of science and management. I also took on being head of Nuclear Medicine across three acute hospital sites. My last five years were taken up increasingly with management tasks which I found more draining, especially in the bureaucratic NHS. Professionally I became Honorary Secretary and Chairman of several



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committees and task groups associated with the Institute of Physics and Engineering in Medicine, the British Nuclear Medicine Society and the European Association of Nuclear Medicine.

What are some of the lessons I have learned along the way?

Managing change

Managing technological and organisational change is one of the most challenging aspects of any healthcare scientist job. It is said that "necessity is the mother of invention" and this is certainly true when it comes to new technology or to significant changes such as standardising clinical procedures across different sites in the same Trust.

When considering change it is important to know how your department compares with others. This is best done by participation in audit schemes and by external reviews, often organised by relevant professional bodies. Many scientific departments are also subject to mandatory periodic inspections by the Health and Safety Executive, the Quality Care Commission and other government agencies, but these tend to focus more on safety aspects.

Introducing technology that requires significant capital investment and staff re-training is difficult enough but reorganising staff and getting them to work differently can be more challenging. This problem is often encountered when starting a senior job in another department, when on investigation some of the practices being followed do not have any obvious justification and not all staff may be working to their job descriptions.

“Good judgment comes from experience, and a lot of that comes from bad judgment,,

Will Rogers

Planning

Implementing any change requires planning, which revolves around the question “what is going to work best in this setting”? To answer that it is useful to find out how other departments have handled similar changes and to do some benchmarking, as part of a wider preparatory exercise.

All large procedure-based changes should be handled as formal projects. It is essential to follow a recognised project management system¹ and to appoint a project manager from within the department.

Change involving the roles and performance of individual staff should also be approached formally, initially as part of department-wide performance reviews. Close monitoring of change is essential, and documentation is vital, especially if expected progress is not realised.

I have witnessed a couple of catastrophic corporate IT system implementations, including one that reduced out-patient admin staff to tears on go-live day, so the importance of adequate planning cannot be overstated.

Implementing change

There are generally two schools of thought on this topic. One is to follow a “slow and steady” approach, keeping the current system running while a new system is introduced gradually. The other approach is “big bang” where the new system goes live on an agreed date and the old system is abandoned – apart, that is, from securely archiving any records. The latter is typical of a move from paper to computer-based records and in many other types of major technological change.

Subject to adequate preparation and staff training I would always favour a ‘big bang’ approach, as it provides a clean break and means that staff become familiar with the new system much faster. The key is ensuring that adequate technical support is available *on the ground* for several weeks after a new system goes live. This is usually in the form of an expert user who has been trained by the manufacturer or who is an expert by virtue of having designed the system, for example when new software has been developed in-house.

Learning from the process

No matter how much planning and preparation is done it remains unlikely that everything will go completely smoothly on changeover day. It is essential to resolve any urgent issues and to learn how things can be done better next time. Staff need to be encouraged to report any teething problems so that they can be properly documented and resolved by the project manager.

A department may also need to demonstrate improved efficiency if funding for the new system was based on recurrent cost savings. In any event, a formal review should be performed by the project manager after six months to confirm that the new system is providing the expected benefits.

You should do your utmost to take everyone with you but don't wait for unanimous support. Trust your instincts as a leader and be brave with your decisions. You will make a few mistakes – everyone does – but you will earn respect if you admit to and learn from them.

Final recommendations

Based on my observations of what did and didn't work at junior and middle career grade, and from experience of working in diverse scientific teams and managing routine clinical services, I offer the following recommendations to healthcare scientists making their way in their chosen profession.

- Be proactive in developing your network of contacts. Do things to raise your profile and that of your department, such as publishing and contributing to conferences.
- Pick the brains of clever people. True experts are always generous with their time. Be generous with yours, and acknowledge support when it's given.
- Go for it! Life is short and good opportunities don't come along too often. Don't allow yourself to get into a rut or be taken for granted.
 - Don't be afraid to make mistakes or admit to them; just give some thought to how best to correct them. Making a bad decision is sometimes better than making no decision. Ask for help if you need it.
 - If you have a problem, tackle it head-on. Hoping it will somehow go away is not a good strategy.
- Don't be defined by your job. If work becomes all-consuming, you will find life outside work very tough. Do you 'live to work' or 'work to live'?
- Finally, look after yourself and try to stay as healthy as possible. This sounds like a glib statement but it is possibly the best advice anyone can receive. Retirement will be a lot more fun if you can still do all the things that you enjoy doing now. Remember, no one ever lay on their deathbed saying they wish they'd spent more time at the office (*quote generally attributed to Rabbi Harold Kushner*).

When I look back on my career, I sometimes wonder where I would have ended up if my university friend had not passed me that copy of *New Scientist*. I would never have met my future wife and had two beautiful daughters, one of whom now works for NHS England. It is rather mind-boggling how the paths we take in life are mostly governed by chance meetings and random events.

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“ Trust your instincts as a leader and be brave with your decisions ,,”

JOANNA ANDREW: MY LEADERSHIP JOURNEY (SO FAR)

Joanna Andrew is network lead managing Blood Sciences across the Scarborough, Hull and York Pathology Service. She is current President of the Institute of Biomedical Science¹ and represents over 21,000 members in 74 countries.

What attracted you to Biochemistry?

I didn't do as well as I had hoped in my 'A' levels but managed to secure a place on an applied biology sandwich degree at the University of Hertfordshire. For my 12-month placement I applied to work in the biochemistry department at St Albans Hospital, because it looked like an interesting place to work! While I was there I fell in love with the job. I've been doing it ever since.

When did you first realise you wanted to be a leader?

Leadership for me began in the workplace. My motivation has always been to make things better, to make a difference. That means having a say and influencing how things are done. I wanted to be in a position to be able to make improvements from early-on.

Who have been your role models?

I have been lucky to have very good and supportive managers and role models. My head of department in York mentored me for over 15 years until I was eventually promoted into his post when he retired. He taught me a lot about how to lead and encouraged me to develop my career. I have a different but excellent relationship with my current line manager, whose views and insights I greatly respect. We can have a good conversation and bounce ideas around in a way that makes me feel trusted and respected.

I have met many people in the Institute of Biomedical Science¹ through my involvement in professional issues. Seeing senior colleagues and previous presidents operate in different contexts has expanded my understanding of leadership and challenged me to grow. Working alongside such inspirational people has helped me greatly.

What is your preferred leadership style?

I prefer a compassionate and inclusive leadership style, as



Joanna Andrew, President of the Institute of Biomedical Science
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I naturally get on well with people and can build rapport quickly. I try to be approachable, ready to listen, ready to admit mistakes and be prepared to change. It is always important to be honest and open.

I have also used the PRINT[®] tool to understand what drives my own behaviours². This taught me a lot about myself and those I work with and showed me how my actions might be interpreted by others. We all make mistakes and it can be hard

to face the sinking feeling that comes when you say to yourself, "if only I'd thought about that earlier." Once you understand what is triggering your reactions it becomes easier to change them.

I have always wanted to keep learning and developing. I went on a coaching course some years ago which improved my listening skills and my ability to develop others. I saw how I could help people find answers to their own questions.

How do you deal with people who work differently to you?

It is not always easy to work alongside people who see things differently. For example, some people are very data driven and want to know all the facts before acting whereas I am comfortable with a more empirical, 'let's try it out' approach.

I try to build bridges whenever I can. I work with many people across several sites and try hard to learn everyone's names and details. It is important to help people feel recognised. Saying 'thank you' also matters, as does listening to and taking account of different views.

“ I try to be approachable, ready to listen, ready to admit mistakes and be prepared to change „

How are you finding the President role?

I couldn't have imagined being elected President of my professional body. You don't always know if you are doing a good job, so it is affirming to get recognition from your peers. I am really enjoying it, especially promoting our profession. The importance of what biomedical scientists do is still largely unrecognised.

A big challenge has been learning how to lead and speak on behalf of a profession, when representing a range of views. I went for media training which I found fascinating although I didn't like seeing myself on screen! They taught me how important it is to plan what to say, get your facts straight in advance, make your key points as quickly as possible and be aware of your body language. These are all helpful pointers to follow when talking to any group.

What gives you the greatest satisfaction?

Two things in general: helping to make positive change and seeing people develop and grow. The favourite part of my career so far was when I was the departmental training officer supporting training within the department.

I get a great sense of pride from seeing people I have helped to develop, move into leadership positions and have maintained relationships with many of them. I am also passionate about being a biomedical scientist and about my profession.

What encourages you most when things are difficult?

It was very hard during the pandemic. So many things changed and we had to adjust to new ways of working, and new technology and methodologies very quickly. The uncertainty was hard to deal with. One lesson is that even when things are not going according to plan, remember that they will get better.

What would you say to developing leaders?

Be confident, believe in yourself and do what you believe to be right. Listen carefully, especially to what you see as criticism. No-one likes to be criticised but when it happens I find it very helpful to talk things through with someone else. Try to develop a supportive network of people whose opinion you trust and respect.

Actively look for gaps in your knowledge and skills, and seek out opportunities to do something about them. When I started working at senior level I struggled to develop a coherent vision for the future. I recently went on a Systems Leadership course run by the NHS Leadership Academy that has helped me understand how to work across complex organisations and health economies to create positive change. Plenty of leadership courses are available – don't be afraid to apply for them.

Know yourself and why you react or behave in a certain way. Taking account of different views and approaches can produce better outcomes and certainly helps to get things done.

What are you working on now?

We formed a pathology network across our different sites: Scarborough, Hull and York. We haven't gone for a hub and spoke model due to the distance between our sites and because each site needs to work appropriately to meet the needs of our different hospitals and GP services. Within this we are creating a forward-looking acute laboratory service in Scarborough where we can trial new technologies and innovative services.

This is a big project. We are looking at skill mix and training, and seeking capital funding for laboratory refurbishments. With multiple strands to deal with it will take time and effort to bring all members of staff on board.

What are your current concerns?

It is important to realise that the NHS is still very much in a post-pandemic phase³. We are still dealing with what was a major disaster. Staff feel disengaged and disempowered, with major psychological effects on well-being and morale;

and there is a changed workforce culture, with greater readiness to raise grievances and more long term sickness.

We are all disaster survivors who have been impacted in multiple ways, whether at work, through illness or by lockdowns. The full repercussions are just beginning to emerge and will be with us for many years⁴.

I have been working with our Organisational Development team to improve our culture and address issues raised from our 'Freedom to Speak Up'

feedback. We need to create safe spaces where people can speak up and feel supported. We need capable leadership to bring people back together and to re-empower and re-engage all of us in building a new NHS. I am hopeful for the future.

What has your career journey felt like?

I can't believe I have been in the NHS for so long and achieved so much. I find myself thinking, 'how on earth did I get here?' The time seems to have gone past quickly and I have really enjoyed it.

“ Taking account of different views and approaches can produce better outcomes and certainly helps to get things done ,”

References

1. [The Institute of Biomedical Science](#) is the leading professional body for scientists, support staff and students in the field of biomedical science.
2. The PRINT® Survey is a psychological analysis tool designed to uncover the unconscious motivations that drive individual behaviours. For more information see for example: <https://www.paulhertzgroup.com/how-print-works/> (accessed 9/10/24).
3. See for example the Darzi Report Independent Investigation of the National Health Service in England, particularly chapter 8, p106-110. September 2024. <https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england> (accessed 9/10/24).
4. See for example *When the Dust Settles: Searching for Hope after Disaster*, Prof Lucy Easthope, Hodder and Stoughton 2022. Prof Easthope also has a short presentation about the NHS' future post pandemic on line at: <https://www.youtube.com/watch?v=lhUcOkesj4> (accessed 9/10/24)

UNLOCKING POTENTIAL: THE BENEFITS OF QUALIFYING IN ADVANCED PRACTICE

Seventeen years ago, I graduated from University as a Biomedical Scientist (BMS) and received my HCPC registration. I initially chose Cellular Pathology as my speciality as I enjoyed its hands on “bucket chemistry” nature. Even then, I was thinking ahead about where I would fit within the department once I had more experience. Did I want to go into management or did I enjoy the practical side too much? I had spent a year in industry working with a Chief BMS who was performing complex dissection, and this spiked a growing interest in histology.

Over the course of the next ten years, I worked through the Institute for Biomedical Science (IBMS) portfolios, gaining specialist and higher specialist diplomas and also a diploma of expert practice in histological dissection. To achieve these qualifications, I had to actively volunteer for extra duties and assist senior staff. I quickly realised I was suited to the practical and clinical aspects of the role.



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Over the years the demand for histology services has been growing without sufficient increases in work force to meet the need. Between 2010 and 2015 the IBMS and Royal College of Pathologists Histopathology Reporting Conjoint Board¹ was formed and introduced the Advanced Specialist Diploma (ASD) in histological reporting for biomedical scientists. The first two ASDs were in high workload specialities, Gastrointestinal and Gynaecology. The ASD mirrors medical Specialist Registrar training, with four separate stages:

Stage A: This initial stage focuses on foundational knowledge and skills in histopathology.

Stage B: Involves more specialised training in the chosen area of histopathology.

Stage C: Candidates continue with specialised training and have an increasing involvement with multi-disciplinary team (MDT) case review meetings.

Stage D: The final stage requires candidates to demonstrate their ability to report independently, to obtain their certificate of completion.

Table 1: Summary of Advanced Specialist Diploma stage requirements

Stage	Requirements	Assessment
A	<ul style="list-style-type: none"> • 750 cases • 1 clinical audit and 1 case study • 18 work-based assessments (12 directed) • 1 multi-source feedback report • 6 monthly progress reports • 1 final educational supervisor report 	Portfolio OSPE exam ² (Objective Structured Practical Examination)
Both B and C	<ul style="list-style-type: none"> • 1000 cases • 1 clinical audit and 1 case study • 18 work-based assessments (12 directed) • Attend and present at MDT's • 1 multi-source feedback report • 6 monthly progress reports • 1 final educational supervisor report 	Portfolio Exam
D	<ul style="list-style-type: none"> • 1500 cases of varying complexity • Completed 48 months whole time training • Knowledge and skill at consultant level • Independent reporting • Experience with teaching • Prepare and present at MDT's • 1 clinical audit • 12 work-based assessments (CBD/ECE)³ • 1 multi-source feedback report • 6 monthly progress reports • 1 final educational supervisor report 	Portfolio

The requirements and assessment for each stage can be seen in *Table 1*.

In 2017 I applied to start training for the IBMS/RCPATH ASD in Histological reporting (Gynaecology). I had support from my Consultant Pathologist, Divisional Manager and Clinical Lead.

I was interviewed at the IBMS office by a panel comprised of Consultant Pathologists and Biomedical Scientists. I had read all the guidance and spent a couple of weeks reading my gynaecology textbooks. I was prepared, or so I thought. The interview did not test me on my current knowledge of gynaecology. Instead, it focussed on the type of person I am, including my ambitions, my goals and my understanding of where I would fit into the wider picture. I tried to show some knowledge by adding in some pathologies and how I would go about diagnosing cases but was told that was not what was needed that day. This was my first realisation of how big an undertaking this diploma is and how important it is to the wider pathology community.

The next eye opener happened when I received word I had passed the interview and could start the ASD any time. All my colleagues congratulated me but I was also told that this was a potential strategy for how our department would be able to meet ever-increasing clinical demand – so don't mess it up!

Undertaking the ASD in Histology reporting gave me more opportunities. As I was working through the stage A-C requirements my laboratory manager was promoted to Divisional Manager. He requested that I applied for his role as he had seen my potential. Even though I wanted to be a reporting BMS he explained that the experience would be invaluable to me. I applied and was successful. With my fellow laboratory managers we then led a merger of four laboratories in 2020.

I then moved to my role of trainee reporting BMS, which also included leading the specimen reception and cut up areas. I was given opportunities to be part of:

- The UKAS⁴ assessment technical and clinical team.
- Serious incident panels in Pathology and at Trust level.
- Trialling and implementing workflow and staffing efficiency improvements, both internal and London wide.
- Devising workflows, documentation and training for the outsourcing of neuropathology and insourcing of molecular whole genome sequencing.
- Presenting cellular pathology methodology to clinical teams to improve their understanding of the full patient pathway.

- Delivered pathology services briefings to clinical trainees.
- Presenting at professional body events including IBMS Congress and the British Association of Gynaecological Pathologists CPD day on topics including gestational trophoblastic disease.
- Providing subject matter expert input to PhD research projects.

I also took on responsibility for the training and leadership of Advanced Practitioner dissection and non-gynaecology cytology staff, both internally and externally. My training role includes mentoring other colleagues pursuing their own ASD training pathway.

Successfully completing my training and assessments has increased my confidence. I have also applied for roles that I feel I could make a difference to the profession, including becoming a HCPC Tribunal Service⁵ business partner.

Now that I have achieved the ASD in Gynaecological reporting I am part of the Consultant reporting team and an integral part of the rota. This has included preparing and presenting oncology and colposcopy MDT's, reporting, laboratory supervision for Junior Doctor dissection and being

a port of call for other Clinicians. I submitted my Stage D application in September 2024 for assessment by the RCPATH conjoint board and ratification by the RCPATH council in November 2024.

I am excited to see where this diploma can take me next. I am very interested in improving the patient diagnostic pathway, I am looking at potential research projects.

“ All of my colleagues congratulated me but I was also told that this was a potential strategy for how our department would be able to meet ever-increasing clinical demand – so don't mess it up! ,,

References

1. <https://www.rcpath.org/profession/committees/rcpath-ibms-histopathology-reporting-conjoint-board.html>
2. OSPE: Objective structured practical examination. For an overview of this technique, see for example: <https://www.nursingpath.in/2019/01/objective-structured-practical.html>. For a specimen OSPE answer in histopathology see, for example: <https://www.rcpath.org/static/5434bf19-7a5c-4b06-bf3ef7e9dabf31ef/Histopathology-Stage-A-Examination-Sample-Questions.pdf>
3. CBD (Case-Based Discussion) and ECE (Evaluation of Clinical Events). For more information on these and other assessment tools, see: <https://www.rcpath.org/static/bf959429-aa0c-48d7-a267902f7c8609dd/definitions-of-assessment-tools.pdf> [IBMS Histopathology Reporting - Institute of Biomedical Science \(ibms.org\)](https://www.rcpath.org/static/bf959429-aa0c-48d7-a267902f7c8609dd/definitions-of-assessment-tools.pdf)
4. <https://www.ukas.com/accreditation/standards/medical-laboratory-accreditation/>
5. Health and Care Professions Council Tribunal Service: <https://www.hcpts-uk.org/>

LEADING THE WAY: SHARE YOUR STORY TO INSPIRE CHANGE!

Imagine a healthcare scientist navigating the complexities of service delivery. They step forward to lead a team through the implementation of a cutting-edge diagnostic tool. Along the way, they encounter challenges—policy hurdles, resource limitations, and the need to inspire a diverse team. Through reflection and adaptation, they emerge not only as a stronger leader but also as a catalyst for change.

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We invite you to share your leadership story. Whether it's a reflection on a pivotal moment, insights from a successful initiative, or a deep dive into leadership theories, your experiences could inspire others across healthcare science and clinical research. Typical leadership themes include, but are not limited to:

- Policy and strategy
- Scientific and clinical practice
- Research, development, and innovation
- Management, education, and training

Previous articles have explored topics like navigating ethical dilemmas, applying leadership theories in practice, or building networks to drive meaningful change. We also welcome submissions reflecting on leadership courses or exploring new theories of leadership practice.

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CALL FOR COMMENTS:

Help Shape the Future of the AHCS Leadership Journal Strategy

The AHCS Leadership Journal is embarking on a transformative journey, reviewing its strategy to better serve the healthcare science and clinical research practitioner communities. We've developed an early draft strategy and now invite our readers, contributors, and stakeholders to share their insights, ideas, and feedback. Your input will directly influence the future direction of the Journal.

Key Questions:

- What should the Journal be achieving right now?
- How could it evolve to better meet the needs of its readership?

Draft Strategy Overview:

Our proposed strategy focuses on the following key areas:

1 ENGAGEMENT

- a. Strengthening connections with stakeholders through readership outreach, marketing, social media, limited physical copies, Journal Ambassadors, peer reviewers, and enhanced citation practices.

2 CONTENT

- a. Balancing leadership theory, practice, and development:
 - i. *Theory:* Exploring cutting-edge ideas and research.
 - ii. *Practice:* Showcasing real-world leadership approaches and outcomes.
 - iii. *Development:* Offering tools, resources, and experiences to grow as leaders.

3 DESIGN

- a. Structuring issues for clarity, accessibility, and impact, in collaboration with the AHCS and other stakeholders.

4 FUNDING

- a. Exploring sponsorships, adverts, and partnerships to support publishing cycles and content growth.

5 PUBLISHING CYCLES

- a. Considering increased frequency beyond the current twice-a-year schedule for greater engagement.

WE NEED YOUR FEEDBACK

This is your opportunity to help shape the Journal's future. Share your perspectives on how we can enhance engagement, enrich content, refine design, and align our publishing strategy with your needs.

HOW TO GET INVOLVED:

Please send your comments, suggestions, and ideas to leadershipjournal@ahcs.ac.uk by 31st March, 2025. Together, let's ensure the AHCS Leadership Journal continues to inspire, inform, and lead in healthcare science.