Study Skills for Master’s Level Students
A Reflective Approach for Health and Social Care

This revised and updated edition adopts a reflective approach using exercises that are related to the development of the skills required to make the transition from undergraduate to postgraduate thinking and writing. Questions and activities encourage readers to identify the skills that the postgraduate student should possess and to demonstrate an understanding of how those skills are developed.

Topics covered include:
• Critical thinking
• Developing independent study skills
• Finding and using literature
• Applying postgraduate skills in the workplace
• Writing at Master’s level
• How to get published.

The book is easy to use and jargon-free with clearly defined learning goals. Reflection points are included in order to support independent learning and enquiry, and there are also suggestions for additional reading throughout the book. Study Skills for Master’s Level Students can therefore be used as an independent student study tool or by lecturers in workshop settings.

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APPLYING POSTGRADUATE KNOWLEDGE AND SKILLS IN THE WORKPLACE

This chapter covers the following key issues:

- the concept of employability and employability assets;
- the importance of critical thinking, decision-making and problem-solving in the workplace;
- the importance of postgraduate skills in service development and doing things differently;
- the importance of postgraduate skills in professional practice;
- the importance of postgraduate skills in leadership roles;
- the importance of postgraduate skills when working in a patient-led, consumerist health and social care service.

By the end of this chapter you should be able to:

- discuss the importance of postgraduate skills in the workplace;
- describe the concept of employability and employability assets;
- demonstrate an awareness of the importance of postgraduate skills in relation to decision-making and problem-solving, service development, professional practice, leadership and working in the current context of health and social care services.

INTRODUCTION

As early as 1996 the American Association of Colleges of Nursing (AACN) reported general agreement that Master’s education is achieving notable goals, including the development of refined analytical skills, broad-based perspectives, enhanced abilities to articulate viewpoints and positions, clearer ability to connect theory to practice, and enhanced skills in a specific
profession (AACN, 1996). They cited research (Conrad, Howard and Miller, 1993) that gave strong support to the important role that graduate education plays in developing a cadre of skilled professionals who make important contributions to the health, education, business, political and social structure of the United States. As a result, and in recognition of this, career progression is increasingly linked to academic achievements, with an increasing number of health and social care practitioners pursuing Master’s and even doctoral levels of study. Having a definable knowledge base is important. For nursing and allied health professions, what is increasingly under the microscope is the knowledge base for the profession and what it is that expedites the ways in which professionals provide care and influence patient outcomes (Jasper, 2006). Education, the means to improve the knowledge base and importantly its application across health and social care professions, is therefore about enabling and improving the individual’s autonomy, control and accountability in a given practice situation and such skills are very important in the workplace. This chapter will examine why postgraduate skills and knowledge are essential to the workplace and examine this in the context of employability and quality assurance.

**KNOWLEDGE AND SKILLS DEVELOPMENT IN MASTER’S EDUCATION**

We will begin by reflecting on the knowledge and skills that Master’s level education develops. In Chapter 1 we identified the Master’s level attributes from the QAA that are necessary for employment (QAA, 2010). They state that, typically, holders of a Master’s will have:

- the qualities and transferable skills necessary for employment requiring:
  - the exercise of initiative and personal responsibility;
  - decision-making in complex and unpredictable situations; and
  - the independent learning ability required for continuing professional development.

**ACTIVITY**

Consider your current role or the role that you aspire to move to once you have completed your Master’s qualification. Why are the three QAA attributes important in that role? Will improving your skills in this area make you more likely to be successful in the role, or more likely to gain ‘promotion’ within your field?
The concept of ‘employability’

The concept of employability is a very important one for anybody wishing to undertake further study in order to increase their career aspirations. There is a national policy focus on what is described as the ‘skills agenda’ following the Leitch Review of Skills, published in 2006, which highlighted that employability skills are essential not only to business competitiveness but also to prosperity and fairness (Maxwell et al., 2009). But what are the skills that employers are looking for in graduates and what do we mean by employability? Employability is a difficult concept to define succinctly and comprehensively (Lees, 2002). Very simply, employability is about having the capability to gain initial employment, maintain employment and obtain new employment if required. According to a report authored by Hillage and Pollard (1998, p. 1), for the individual, employability depends on:

- their assets in terms of the knowledge, skills and attitudes they possess;
- the way they use and deploy those assets;
- the way they present them to employers;
- and, crucially, the context (for example, personal circumstances and labour market environment) within which they work.

The first two of these elements warrant further consideration.

Employability assets

An individual’s ‘employability assets’ comprise their knowledge (i.e., what they know), skills (what they do with what they know) and attitudes (how they do it).

**ACTIVITY**

Think about your job or profession. What knowledge (what you know); which skills (what you do with what you know); and what attitudes (how you do it) are important for you to progress in your career?

Those of you working in the NHS will have recognised the elements here that make up the NHS Knowledge and Skills Framework (KSF) (DH, 2004). Although the NHS Staff Council has developed a simplified KSF that is intended to be easier to use in practice, the original principles still underpin the process of appraisal and development review, and the application of these elements has been described in the KSF as the assets that make up ‘competence’.

Thinking more closely about these assets, it may be that you are able to distinguish between:

- **baseline assets** such as basic skills and essential personal attributes (such as reliability and integrity);
• intermediate assets such as occupational specific skills (at all levels), generic or key skills (such as communication and problem-solving) and key personal attributes (such as motivation and initiative); and
• high-level assets involving skills that help contribute to organisational performance (such as teamworking, self-management, financial awareness and leadership).

(adapted from Hillage and Pollard, 1998)

**ACTIVITY**

For those of you working within the NHS:

- Access the summary descriptions of the KSF Core Dimensions at [www.nhsemployers.org/SiteCollectionDocuments/Summary_KSF_core_dim_fb131110.docx](http://www.nhsemployers.org/SiteCollectionDocuments/Summary_KSF_core_dim_fb131110.docx)
- Examine the Core Dimensions and identify the levels at which you feel Master’s level assets apply.

For those working outside the NHS, it might be useful to examine the competency framework used by your employer or the essential and desirable attributes described on your job description and undertake the same exercise.

**Deployment**

Hillage and Pollard (1998) also argue that assets are a linked set of abilities that include career management skills. They state that these are commonly identified as self-awareness (including the ability to recognise one’s own occupational interests and abilities), opportunity awareness (knowing what work opportunities exist and their entry requirements, including labour-market knowledge), decision-making skills (to develop a strategy of getting from where you are to where you want to be) and transition skills. Transition skills can be about issues like possessing job-search skills in order to find suitable jobs, which might include networking (formal and informal) and having a strategic approach to employment and so being adaptable and flexible, but this can also be about recognising transferable skills and having the confidence to try them out in new arenas. This demonstrates an important interrelationship between assets and deployment. The extent to which an individual is aware of what they possess in terms of knowledge, skills and attitudes and their relevance to the employment opportunities available may affect their willingness to undertake training and other activities designed to upgrade their skills. Critical thinking and reflection are key to this.

**Critical thinking and employment**

Why is critical thinking important to both professionals and employers? Critical thinking is clearly not restricted to the world of academia. It is a skill used in a variety of situations in that
it enables us to make informed decisions about events and issues in our everyday life – such as making choices about our lifestyle or attempting to understand the behaviour of others. Critical thinking therefore appears to be a desirable characteristic for all human beings in that it is associated with tolerance and rationale decision-making. Taylor (2000) suggests that it ‘… turns an unconsidered life to one that is consciously aware, self-potentiating and purposeful’ (Taylor, 2000, p. 10).

Others have suggested that critical thinking is fundamental to the survival of a democratic way of life (Ennis, 1996, p. 17) and is associated with making fair collective decisions. Certainly oppressive regimes have been implicated in the oppression of academics and students in universities, presumably fearing the effects of those who can think critically about moral, ethical and social trends. Daly (1998, p. 232) goes as far as suggesting that the ability of a society to make rational, informed and tolerant decisions is proportionate to the critical thinking abilities of individuals in a democracy.

The notion of critical thinkers being crucial in health and social care is discussed by Fook and Gardner (2007). They suggest that critical reflection:

… involves the unsettling and examination of fundamental (socially dominant and often hidden) individually held assumptions about the social world, in order to enable a reworking of these and associated actions for changed professional practice.

(Fook and Gardner, 2007, p. 21)

In other words, health and social care professionals need critical thinking skills in order to challenge current ideologies and practices with a view to achieving better practice. This seems particularly important in the current health and social care environment with some of the pressures and challenges facing professionals today, in particular the tensions between value-based practice as espoused by professional ethical codes, and the technical, economic and outcome-focused organisations where practice occurs. The increasing complexity of the care environment and the need to protect and risk-manage services mean the increasing need to unsettle dominant/fundamental theories in current practice to offer the potential for improved practice.

**ACTIVITY**

Reflect on your current job or profession. In what ways has the environment increased in complexity over the past decade? You may want to consider issues of:

- ‘tasks’ undertaken;
- skills required;
- service-user or ‘consumer’ expectations;
- access to information;
- the increased requirement for collaborative working across professional and service user groups.
It has been argued that the need for high-level clinical reasoning, for example, arises from the increasingly high level of complexity seen when dealing with the health and health deficits of human beings as complex holistic organisms, who compromise individual ontological constructs, perspectives, abilities, levels of physical and cognitive functioning, expectations, responses and coping mechanisms (Daly, 1998). It is thus essential for health and social care practitioners to consider both technical rational aspects of care alongside the humanistic aspects of care that extend beyond simple judgement.

There is therefore a strong relationship between decision-making skills and the ability to think critically. An early piece of work by Girot (1995) acknowledged that there was a growing recognition of the importance of critical thinking as an essential requirement for nurses to engage in safe, competent and autonomous practice. Certainly the seminal work of Benner (1984) based on Dreyfus’ model of skills acquisition, suggests that practitioners move through five cognitive stages to become an expert nurse. The novice relies on abstract principles and the application of rules to guide their practice. However, the expert performer no longer relies on analytical principles to connect her or his understanding of the situation to an appropriate action. The expert nurse, with an enormous background of experience, now has an intuitive grasp of each situation and makes an accurate assessment of the problem. This ability to recognise context, without conscious consideration of a large range of unfruitful, alternative diagnoses and solutions, is clearly allied to the skills of the critical thinker. Indeed, a recent Department of Health (DH, 2008) document suggested that clinicians increasingly were:

- dealing with complexity and managing uncertainty;
- working with patients to take legitimate risks and effectively managing risk by providing information alongside professional judgment to maximise patient independence and choice;
- grasping clinical situations intuitively based on a deep, tacit understanding of their area of practice.

(DH, 2008, p. 14)

It could also be argued that the ability to apply critical thinking to clinical decision-making is what distinguishes professionals from the non-professional assistant worker. This is of particular relevance when we consider the current developments around the role of the assistant practitioner in health and social care. This was brought sharply into focus by the press release on the publication of care standards for assistant practitioners by Skills for Health in November 2009:

The Assistant Practitioner would be able to deliver elements of health and social care and undertake clinical work in domains that have previously only been within the remit of registered professionals. The Assistant Practitioner may transcend professional boundaries.

(Skills for Health, 2009, p. 2)
It may be that the role of critical thinking and decision-making skills in practice is a key element in any debate around the role and scope of the assistant practitioner in health and social care in the future.

**PROBLEM-SOLVING AND DECISION-MAKING**

The features of the cognitive processes involved in problem-solving and decision-making are directed towards acquiring and evaluating data in order to make decisions and judgements about problems and appropriate solutions. In health and social care settings multiple actions and interactions are exemplified for the purpose of gathering information by consulting and collaborating with members of the multidisciplinary team, reading case notes, observations and assessments in order to undertake a systematic physical assessment and evaluate a service user’s needs. Processes involving the collection, organisation and assimilation of written and verbal information are undertaken to assist decision-making, problem-solving and critical thinking in both clinical arenas (Fairly and Closs, 2006) and non-clinical health and social care settings.

The process of decision-making and, integral to this, the ability to solve problems, are key skills to be developed within Master’s level courses and can be described as critical thinking in action. While on first consideration it might be perceived that the consequences of decisions by professionals impact on the recipients of services, it is important to point out that decisions are made all the time that also affect the team members within any service organisation. So consideration of problem-solving and decision-making must take into account the needs of all those affected, not simply those who access services.

**ACTIVITY**

1. Think about your workplace. Identify decisions that have been made recently that have affected you or members of your team. You may want to consider issues of deployment or working practices.
2. What decisions have been made that have a direct impact on the client group or individual service recipients?

**Models and methods of decision-making and problem-solving**

There are many theoretical approaches or models of problem-solving and decision-making that lead the individual through a process or number of steps in an attempt to improve their skills. These include a traditional problem-solving seven-step model.

1. Identify the problem.
2. Gather data to analyse the causes and consequences of the problem.
3. Explore alternative approaches.
4. Evaluate the alternatives.
5. Select the appropriate solution.
6. Implement the appropriate solution.
7. Evaluate the results.

In this model the decision is made at Step 5.

There is also the managerially-based model:

1. Set objectives.
2. Search for alternatives.
3. Evaluate alternatives.
4. Choose.
5. Implement.
6. Follow up and control.

In this model the decision is made at Step 4.

(Marquis and Huston, 2008, p. 26)

Often individuals may try to make decisions without being completely clear about the goals, and they can fail because decisions have to be made using available knowledge and information. This is where the value of having developed Master's level skills can be identified.

**ACTIVITY**

Consider the following list of Master's level attributes from the QAA and think about the way in which the stages of the decision-making process described in one of the models above match the attributes below.

<table>
<thead>
<tr>
<th>Master's degrees are awarded to students who have demonstrated:</th>
<th>The stages of decision-making</th>
</tr>
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<tbody>
<tr>
<td>i. a systematic understanding of knowledge, and a critical awareness of current problems and/or new insights, much of which is at, or informed by, the forefront of their academic discipline, field of study, or area of professional practice;</td>
<td></td>
</tr>
<tr>
<td>ii. a comprehensive understanding of techniques applicable to their own research or advanced scholarship;</td>
<td></td>
</tr>
</tbody>
</table>
iii. originality in the application of knowledge, together with a practical understanding of how established techniques of research and enquiry are used to create and interpret knowledge in the discipline;

iv. conceptual understanding that enables the student:
- to evaluate critically current research and advanced scholarship in the discipline; and
- to evaluate methodologies and develop critiques of them and, where appropriate, to propose new hypotheses.

Typically, holders of the qualification will be able to:

| a. deal with complex issues both systematically and creatively, make sound judgements in the absence of complete data, and communicate their conclusions clearly to specialist and non-specialist audiences; |
| b. demonstrate self-direction and originality in tackling and solving problems, and act autonomously in planning and implementing tasks at a professional or equivalent level; |
| c. continue to advance their knowledge and understanding, and to develop new skills to a high level; |

and will have:

d. the qualities and transferable skills necessary for employment requiring:
- the exercise of initiative and personal responsibility;
- decision-making in complex and unpredictable situations; and
- the independent learning ability required for continuing professional development.
Types of decision

It is true to say that not all types of decisions are the same. Marquis and Huston (2008) defined three types of decision as routine, urgent and considered, arguing that each of these takes a different approach and skill. A routine decision is one that usually does not cause difficulty or disagreement, an urgent decision has an immediate and informed response, and considered decisions are often the most difficult, with input from a number of different people, each of whom may be affected by the decision made and who have the expectation, if not the right, to be involved.

ACTIVITY

Can you identify decisions in your workplace that could be categorised as routine or urgent?

Considered decision-making

Considered decisions within a care situation will normally entail shared or collaborative decision-making (Hayes and Llewellyn, 2010) and it is essential that a stepped approach to the consideration of options and outcomes is adopted. It is also important to recognise that individual decisions are based on the individual’s own value system and that, regardless of how objective the criteria used are, value judgements will always play a part (Marquis and Huston, 2008). Value judgements can be referred to as intuition based on past experiences and professionalism but it is essential to think carefully about the decisions made and justify them according to objective criteria. Developing self-awareness and reflective practice is an important element in problem-solving outcomes.

There are therefore a number of critical elements in problem-solving and decision-making that should always be considered.

- It is essential that decisions have a clear objective.
- Decisions are based on knowledge and so the acquisition of knowledge and information is a clear and important need (for both care professionals and clients).
- As problem-solvers gather information it must be recognised that preference is not mistaken for fact. This is why it is so important that many alternatives are generated in the decision-making process and also that ethical decision-making is considered (see below).

Ethical decision-making

Consideration of ethical issues is also important. This is because of the importance of taking time to consider our own personal values and the impact they may have on our practice, as well as on those involved as decision-makers or individuals who will be affected by the consequences of the decision.
By considering the ethics of a decision we are acknowledging that there is a moral code that underpins practice, based on ‘the primary principle of obligation embodied in the concepts of service to people and respect for human life’ (Carper, 1978, p. 17). In ambiguous situations, it may be difficult to predict the consequences of one’s actions and the moral context of making difficult personal choices, determining what is good and bad or what ought to be done in a situation, must be considered (Hayes and Llewellyn, 2010). Reflective thinking refers to the capacity to develop critical consideration of one’s own worldview and its relationship to the worldview of others. It is the ability to transcend preconceptions, prejudices and frames of reference and it underlies the capacity to learn from others and from experience (Warn and Tranter, 2001).

Decision-making must therefore reflect the four ethical principles as first discussed by Beauchamp and Childress (2001).

- **Autonomy** – the right of a person (that is, both service users and the professional as an employee) to make their own decisions and direct their life.
- **Beneficence** – the responsibility of doing good and so providing benefit or beneficial treatment/care to the recipient of services or individuals you are working with.
- **Non-maleficence** – the responsibility of avoiding harm to the person (fellow employees or clients).
- **Justice** – the responsibility to be equitable and fair in the way we treat all others.

(adapted from Hayes and Llewellyn, 2010)

**ACTIVITY**

Consider again the list of Master’s level attributes from the QAA. How do these attributes enable the development of these ethical principles?

- Autonomy.
- Beneficence.
- Non-maleficence.
- Justice?

Writers (Alfaro-Lefevre, 1995, and Daly, 1998) also talk about effective clinical judgements as reasoning strategies that can arguably be applied in a number of arenas not solely confined to clinical ones. Daly talks about ‘precise, disciplined thinking that enhances accuracy and depth of data collection’ in order to identify the issues at hand (Daly, 1998, p. 327). To achieve this there are principles that should be followed such as:

- acquiring a factual knowledge base;
- using models as reasoning frameworks (such as the nursing process);
- exercising accountability in the recognition of limitations;
- the importance of prioritising one’s reasoning and actions.
THE IMPORTANCE OF POSTGRADUATE SKILLS IN SERVICE DEVELOPMENT OR IN DOING THINGS DIFFERENTLY

Sometimes the outcome of decision-making at service level is actually a recognition of the need to do things differently. Master’s level working can engender this by encouraging people to question established knowledge, and therefore promoting a culture of open and intelligent debate that stimulates innovation and new approaches to tackling difficult challenges.

Service improvement is an important element of practice in health and social care organisations and there are different aspects to the process of improving services. In 2007 the NHS Institute for Innovation and Improvement (NHSI, 2007a) published a series of improvement leaders’ guides aimed at developing sustained service improvement across the NHS. Although the Institute was replaced by a new body in April 2013, the work of improvement continues. The specific areas the Institute focused on in their guides included:

- improving knowledge and skills;
- managing the human dimensions of change;
- building and nurturing an improvement culture;
- evaluation improvement;
- leading improvements;
- involving patients and carers;
- process mapping, analysis and redesign;
- measurement for improvement;
- matching capacity and demand;
- redesigning roles.

**ACTIVITY**

Reflecting on the areas listed above, how might your Master’s course or a Master’s level qualification prepare you to undertake service development and change?

Undertaking a Master’s course may enable you to lead service development (and leadership will be discussed in more detail below) and/or enable you to undertake extended roles or do things differently with your services. Such extended roles, when supported by educational development, have been seen to give real benefits for service users, team members and individual staff by:

- improving access to care, diagnosis and treatment;
- improving quality;
- reducing waiting lists;
• managing ever-increasing workloads;
• job satisfaction;
• career development.

(NHS Institute for Innovation and Improvement (NHSI), 2007b)

As an example, advanced practitioner (AP) roles within nursing, which have been essentially service driven, have been researched and identified as having a positive impact on patient care and service delivery in their Trusts (Shapiro and the University of York, 2009). As Master’s graduates, advanced practitioners have demonstrated:

• the capacity to work beyond their base profession;
• being ‘advanced’ practitioners as opposed to highly skilled nurses, midwives or Allied Health Professionals;
• improving activity and service delivery;
• increasing workforce productivity by improving training and support for other staff, including junior medical staff and staff from partner organisations (for example, nursing homes);
• there was a noticeable increase in confidence in relation to communication with management colleagues.

(Shapiro and the University of York, 2009)

ACTIVITY

Reflecting on the QAA attributes for Master’s level qualification, why would doing a Master’s degree lead to increased confidence?

POSTGRADUATE SKILLS AND PROFESSIONAL PRACTICE

Earlier it was suggested that it is possible to argue that the ability to apply critical thinking to clinical decision-making in practice is what distinguishes professionals from the non-professional assistant worker. But what is professional practice? There are many theories of professionalism (Johnson, 1972) but a common way to define a group as a profession is to describe it as based on the creation and defence of a specialist body of knowledge, typically based on formal university qualifications; the establishment of control over a specialised client market and exclusion of competitor groups from that market; the establishment of control over professional work practice, responsibilities and obligations while resisting control from managerial or bureaucratic staff (Bilton et al., 2002, p. 426).
At a fundamental level professional practice is about what individuals in health and social care do as a result of being registered with a professional body; for example in nursing this is the Nursing and Midwifery Council (NMC) and for social workers it is the Health and Care Professions Council (HCPC).

Expectations of professional behaviour come from:

- professional bodies;
- legal regulation;
- policy directives;
- employers who set boundaries and expectations through employment rules and guidance and policy;
- service users and carers who have expectations or make certain demands of professionals.

Thinking about Johnson’s assertions, what is the particular body of knowledge that professionals working in health and social care settings ‘create and defend’ and what part does education play in this? In nursing terms it may be useful to return to Benner’s expert practitioner (Benner, 1984). In her model of professional development Benner describes a process of skills development titled ‘From novice to expert’ and identifies five stages through which nurses pass in moving from being a new recruit in the profession to reaching expertise as a practitioner. Jasper (2006) used Benner’s work and combined it with that of Robinson et al. (2003) to describe the expert practitioner as someone who:

- functions from an intuitive base;
- has developed a comprehensive knowledge base;
- is self-directed and flexible and innovative;
- operates from a deep understanding of a total situation to resolve complex issues;
- works collaboratively with other health care team providers.

ACTIVITY

Reflect briefly on Bilton et al.’s description of professionalism. Consider your own professional group. How does your understanding of your profession fit with Bilton’s description? You may wish to consider issues such as:

- academic qualifications;
- research in your field;
- professional body regulation;
- the ‘place’ of ‘unregistered’ staff.

Think also about the QAA Master’s level attributes. How do they engender membership of a profession?
• actively and positively influences the team, fosters critical thinking in others and forms mentoring relationships with other nurses;
• participates in and leads activities that improve systems for quality patient care;
• serves as a change agent to challenge themselves and others.

(adapted from Jasper, 2006, p. 22)

ACTIVITY

1. What is intuition?
2. Why would a Master’s course enable intuitive practice?

It therefore appears from Jasper’s work that expert practitioners, with a comprehensive knowledge base and assets such as innovation and flexibility, are in a key place to undertake leadership roles in practice. The Master’s graduate should demonstrate certain personal qualities and professional behaviours such as assertiveness, the responsibility to engage in professional activities and advocacy for change. Professionals thus may rely on the Master’s-prepared individuals to participate actively in the profession and exert leadership, not only within the profession but also across the health and social care system.

Postgraduate skills and leadership

Much has been written about leadership and it is argued that, while good management brings a degree of consistency and order, leadership skill contributes to the achievement of plans by motivating and inspiring individuals to keep up with the direction needed and enables individuals to both cope with and enable change (Kotter, 2001). Beyond the management tasks of organising and staffing, delegating duties and responsibilities, leaders communicate direction to the staff, who can then create ‘coalitions’ that understand the vision or direction of the organisation and, through commitment to it, move the agenda on (Kotter, 2001, p. 86).

Much leadership research has until recently been based within the military context, which tends to require inspirational leaders who could persuade individuals to sacrifice even their life for the greater good. These so-called ‘great man theories’ were based on the personality traits of high-energy, charismatic extroverts. But, in organisations where leadership focuses on one person, others may think that whatever is wrong will be fixed by the leader and do not consider or look for solutions of their own (Mintzberg, 1996). Much human potential is therefore lost.

This is demonstrated by two very different types of manager/leader as described by Burns (1978). Transactional leaders direct individuals to a certain outcome. The aim is to deliver certain results and is comparable to many task-oriented management theories. However,
transformational leadership is concerned with enabling others through identifying common goals and vision. Unlike the ‘great men’ models, transformational leaders give away their power, they serve others and, in doing so, enable others to lead themselves. Transformational leaders do not want to make mini-replicas of themselves but celebrate the difference of people as individuals (Alimo-Metcalfe, 2003). They acknowledge that others see the world differently and want to release an individual’s potential to find different solutions to issues within the workplace. This requires trust, removing barriers to communicating and also welcoming challenge, which may result in innovative solutions to old problems and has positive outcomes for all, as the greatest asset of any organisation – its workforce – is able or rather ‘enabled’ to release its full potential.

ACTIVITY

Consider the employability assets described by Hillage and Potter (1996) earlier in this chapter.

- _‘Baseline assets’_ such as basic skills and essential personal attributes (such as reliability and integrity).
- _‘Intermediate assets’_ such as occupational-specific skills (at all levels), generic or key skills (such as communication and problem-solving) and key personal attributes (such as motivation and initiative).
- _‘High-level assets’_ involvement skills that help contribute to organisational performance (such as teamworking, self-management and financial awareness).

How would these assets enable an individual ‘leader’ to release the potential of the workforce to its full potential?

While it is apparent that leadership characteristics are variable and applicable differently in different contexts, three clusters or qualities have been identified by the Institute for Innovation and Improvement within their NHS Leadership Qualities Framework (NHSI, 2007c). These are:

- **Personal qualities**, which includes: self belief, self awareness, self management, drive for improvement and personal integrity;
- **Setting direction**, which includes: seizing the future, intellectual flexibility, broad scanning, political astuteness and drive for results;
- and **delivering the service** which includes: leading change through people, holding to account, empowering others, effective and strategic influencing and collaborative working.

(NHSI, 2007c)
The importance of Master’s level skills in our modern society and in the current context of health and social care services needs to be acknowledged. As discussed by Crinson (2008), from 2001 the last Labour government’s policy for health and social care increasingly embraced the ‘choice’ agenda. This proposed the wrapping together of the delivery of public services with consumerism, and this ideology has further strengthened under the Coalition government elected in 2010 with the publication of the White Paper *Equity and Excellence: Liberating the NHS* (DH, 2010). Services have historically developed according to a welfarist model, where welfare professionals have identified needs and then provided services to address these needs. An increase in consumerism and consumer rights has led to a shift in ideology and power, with greater emphasis on user and carer involvement in care and individual assessment of need and care packages tailored to meet those needs (Hayes and Llewellyn, 2010). Thus there is a shift from service-led provision to needs-led care, with the care recipient at the centre of the decision-making process.

Such ‘consumer power’ forges a demand-led market within a neoliberal market economy that urges an opening up of public sector services to the exercise of service user choice (Crinson, 2008). In this context it is argued that consumerism and choice will lead to improved quality.

**ACTIVITY**

Visit [www.nhsleadershipqualities.nhs.uk](http://www.nhsleadershipqualities.nhs.uk)

1. Consider how the Master’s level attributes that you will develop on your course can be applied within these qualities.
2. Also, as you progress through your Master’s course, you may want to consider how you could focus on the development of these skills through the assignments that you need to complete or through your long project or research. An example may be fulfilling an extended study that focuses on leading a change project.

**POSTGRADUATE SKILLS IN A ‘PATIENT-LED’, ‘CONSUMERIST’ SOCIETY**

The importance of Master’s level skills in our modern society and in the current context of health and social care services needs to be acknowledged. As discussed by Crinson (2008), from 2001 the last Labour government’s policy for health and social care increasingly embraced the ‘choice’ agenda. This proposed the wrapping together of the delivery of public services with consumerism, and this ideology has further strengthened under the Coalition government elected in 2010 with the publication of the White Paper *Equity and Excellence: Liberating the NHS* (DH, 2010). Services have historically developed according to a welfarist model, where welfare professionals have identified needs and then provided services to address these needs. An increase in consumerism and consumer rights has led to a shift in ideology and power, with greater emphasis on user and carer involvement in care and individual assessment of need and care packages tailored to meet those needs (Hayes and Llewellyn, 2010). Thus there is a shift from service-led provision to needs-led care, with the care recipient at the centre of the decision-making process.

Such ‘consumer power’ forges a demand-led market within a neoliberal market economy that urges an opening up of public sector services to the exercise of service user choice (Crinson, 2008). In this context it is argued that consumerism and choice will lead to improved quality.

**ACTIVITY**

What are the challenges that consumerism and choice pose for the professional working in health and social care?
Consumerism and choice offer the professional working in health and social care a number of challenges. This shift in ideology and balance of provision of services has led to a need for more collaborative and partnership working between the different professional groups involved in the delivery of health and social care, and with service users and carers (Hayes and Llewellyn, 2010), and collaborative working in this way presents a number of challenges, not least in reference to the concept of co-production, where service users are seen as active contributors to every stage of their care. Co-production emphasises that people are not passive recipients of services and have assets and expertise that can help improve services. Therefore, it can potentially transform the way of thinking about power, resources, partnerships, risks and outcomes, and implies that there is not an off-the-shelf model of service provision or a single ‘magic solution’. It focuses on the empowerment of both users and providers to act as partners in the care process – co-production means involving citizens in collaborative relationships with more empowered frontline staff who are able and confident to share power and accept user expertise. It requires the creation of new structures, regulatory and commissioning practices and financial streams which are necessary to embed co-production as a long-term rather than an ad hoc solution; and it requires learning from existing international case studies of co-production while recognising that the contribution of initiatives reflecting local needs is important (Hayes and Llewellyn 2010).

Essentially, then, this new paradigm of service-led or consumer-led health and social care changes the rules for professionals and demands far greater collaboration and joint working. It also requires a heightened focus on equity as the promotion of a choice agenda raises important questions with regard to access. There have been concerns about the ‘inverse care law’ (Tudor Hart, 2006) where there is a greater utilisation of care resources by the middle classes who have the social, educational and economic capital to pursue their needs when compared with the lower socio-economic classes who do not access care to the same extent. Thus unequal health-seeking behaviours compound inequities of health and social care access (Crinson, 2008).

**ACTIVITY**

1. Why is it important for health and social care professionals to be educated to Master’s level in a ‘patient-led’ public sector? List at least eight assets or attributes.
2. Once you have identified your assets or attributes, consider how you could evidence these to a potential employer at interview.
This chapter has considered the application of postgraduate knowledge and skills in the workplace. The concepts of employability and employability assets were discussed and the importance of critical thinking in the workplace in order to develop service through decision-making, problem-solving and the application of leadership skills was appraised. Professional practice was also discussed in relation to postgraduate skills, and then the current context of health and social care was introduced in relation to the emerging patient-led and consumerist ideology. Finally, the reader was invited to consider how Master's level skills can be applied in order to improve the student's ‘employability’.

**SUMMARY**

**Reflection**

Identify at least three things that you have learned from this chapter.

1. 
2. 
3.

How do you plan to use this knowledge?

1. 
2. 
3.

How will you evaluate the effectiveness of your plan?

1. 
2. 
3.

What further knowledge and evidence do you need?

1. 
2. 
3.
FURTHER READING

NHS Institute for Innovation and Improvement (2007a) *Improvement Leaders’ Guides*. Warwick: NHSI

These excellent user-friendly guides give an outstanding overview of the essential elements of leading improvement in the National Health Service but the principles are universal and can be applied across all health and social care settings. They can be found at [www.institute.nhs.uk/improvementleadersguides](http://www.institute.nhs.uk/improvementleadersguides)