Why you should read this article:
- To update your knowledge of managers' decision-making around staff training and education
- To understand how effective decision-making can improve patient care
- To ensure the effectiveness of training for nurses

Development of a tool to support managers in planning and evaluating staff training

Wendy Padley, Jaqui Long, Nikki Welyczko et al

Abstract

Aim To explore decision-making and evaluation strategies used by healthcare managers in relation to staff training and education, and to develop a tool to support managers with these tasks.

Method Using snowball sampling, 30 healthcare managers in a variety of healthcare settings were recruited and interviewed using semi-structured interviews. Data were transcribed and analysed using thematic analysis.

Findings Four overarching themes were identified in relation to decision-making regarding staff training: the nature and characteristics of courses relevant to practice; the effect of practice requirements for education and training; staff motivation and interest; and the process of staff selection for training. Managers did not use formal, structured processes to make decisions about staff selection for training, nor to evaluate the outcomes of the training. Instead, they largely relied on their personal experience, knowledge and professional judgements. Based on these findings, the study team developed the Assessment, Planning and Evaluation of Training (APET) tool to support the planning and evaluation of training, and they invited feedback from healthcare managers. Positive feedback suggests that this tool could support managers' decision-making in relation to planning and evaluating staff training.

Conclusion Healthcare managers' decision-making in relation to the planning and evaluation of staff training relied on judgements based on their personal experience and knowledge. The APET tool developed by the study team has the potential to ensure vital resources such as time and money are used optimally, which would improve outcomes for staff, patients and healthcare organisations.

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Keywords

Managers have an essential role in ensuring healthcare staff are trained effectively so that they can undertake their work to a high standard (Alvarez et al 2004, Duffield et al 2011). However, several high-profile reports in England have identified significant failings in healthcare delivery, and have made recommendations to improve workforce education and training to enhance safety, care quality and patient outcomes (Cavendish 2013, Francis 2013, Keogh 2013, Imison et al 2016). In January 2018, the Commons health committee in the

UK stated that 'Health Education England must reverse cuts to nurses' continuing professional development (CPD) budgets. Funding allocated to trusts should be specifically ringfenced for CPD for nurses, and specific funding should be made available to support CPD for nurses working in the community' (House of Commons Health Committee 2018). The committee indicated that it had heard 'a clear message… that access to CPD plays an important role in retention' (House of Commons Health Committee 2018).

In a climate where time and financial resources are limited, it is important that managers make informed decisions about staff education and training that demonstrate value for money, as well as improved service quality. However, factors such as competing organisational priorities and managers' time constraints may affect their ability to make such decisions and to evaluate the outcomes of any training that their staff have attended. Decision-making about the education and training that staff require is undertaken using a variety of methods, including staff appraisals. This can result in choices that do not optimally serve staff, patients or healthcare organisations, for example because of conflicting interests. In this context, a tool to aid managers' decision-making regarding staff training may be valuable.

Literature review

Measuring whether nurse education and training is effective in assisting nurses to acquire relevant skills can be challenging (Gauntlett 2005), and a range of tools has been produced to support this process (Kirkpatrick 1976, Kirkpatrick and Kirkpatrick 2006, McConigley et al 2012, O'Malley et al 2013, Kirkpatrick and Kirkpatrick 2016). However, these tools do not always fully address the complex requirements of healthcare settings, for example meeting the needs of a range of healthcare professionals with various skills, within the constraints of healthcare budgets (Ellis and Nolan 2005). Additionally, there is little clarity regarding the strategies adopted by healthcare managers

to identify staff training needs, how they evaluate the outcomes of staff training, the ability of staff to transfer that training to action in the workplace, or the effect of training on the quality of patient care (Baldwin and Ford 1988, Bhatti et al 2013).

While mandatory staff training requires systems to be in place to support its delivery, decisions regarding non-mandatory staff training can be influenced by a range of factors, including managers' own experiences and views of training (Hughes 2005, Gould et al 2007). Little is known about managers' decision-making strategies in relation to staff training and whether a tool could support this process. Therefore, this study was undertaken to explore this area further.

Aim

To explore decision-making and evaluation strategies used by healthcare managers in relation to staff training and education, and to develop a tool to support managers with these tasks.

Stage 1: exploring decision-making and evaluation strategies used

Method

Managers who had experience of making decisions relating to staff training were recruited from a range of healthcare settings. Participants were identified among managers in Leicestershire and Lincolnshire using a snowball sampling technique (Atkinson and Flint 2001), in which early participants known to the study team were asked to identify other managers who met the inclusion criteria.

Semi-structured telephone interviews were conducted by members of the study team. An interview schedule generated from the literature was used to explore several core areas, including:
» The manager's role in the healthcare organisation.
» Reasons for sending staff to attend training or education.
» Views of the nature and type of courses available.
» Factors affecting the selection of staff to attend courses.
» The evaluation of the effect of attendance at courses.

Interviews lasted between 20 minutes and 60 minutes, and were audio-recorded and transcribed verbatim.

Thematic analysis was employed to analyse the data and an inductive approach was used to enable the main themes to emerge (Braun and Clarke 2006). Each interviewer undertook a preliminary analysis of their own transcript, and these were then synthesised into an initial coding framework by the study team to ensure consistency and accuracy in the analytic process. A full analysis of all the interview data was undertaken by two researchers (WP and CG) who refined the coding framework until saturation was reached and no new themes emerged. The process led to the identification of four overarching themes that captured participants' experience.

Ethics

Ethical approval for the study was obtained from De Montfort University Ethics Committee. Verbal consent was obtained from participants before the telephone interviews were undertaken. To preserve participants' confidentiality, any personal data necessary to the study was kept on a password-protected university server, and all quotes and other data used in this study have been anonymised.

Findings

A total of 30 healthcare managers were recruited. Participants were predominantly female (28/93%), aged between 45 years and 55 years (23/77%) and white British (18/60%). Most participants (26/87%) had an undergraduate degree, with 11 (37%) having a variety of further professional and academic qualifications. The managers who participated were working in a range of healthcare settings, including: care homes specialising in the care of older people, people with learning disabilities and mental health issues; various roles and specialisms in hospitals and hospices; and in the community. Seven (23%) of the participants had teaching or training roles; sometimes this was in addition to

their management responsibilities, while other participants had moved from management into education. Participants had been responsible for staff development for varying lengths of time, ranging from just over one year to more than 20 years. Twelve (40%) participants had over ten years' experience in staff development. The managers had responsibility for the development of nurses and healthcare assistants; however, the interviews focused on managers' decision-making and, as such, individual staff members were not identified or discussed.

During the interviews, the managers did not differentiate between education and training, so the term 'training' is used generically throughout this article. Much of what the managers reported in the interviews related to decision-making captured during staff appraisals, but did not exclude other scenarios such as ad-hoc staff requests for training. Four overarching themes were identified from the data: the nature and characteristics of courses relevant to practice; the effect of practice requirements for education and training; staff motivation and interest; and the process of staff selection for training.

Nature and characteristics of courses relevant to practice

Managers described their preferences in relation to the format of training, particularly in the context of time and resource pressures in their healthcare organisations.

In-house training was identified as a format that reduced the amount of time required by staff to attend training, with some managers able to liaise with training departments to organise tailored training by known providers, particularly for clinical skills training and maintaining staff competency. Other strategies to reduce time 'lost' to staff training included distance learning or e-learning, as well as other forms of learning such as undertaking training in personal time or organising sessions during lunch breaks. In contrast, external courses that required travel were likely to be more expensive and could also present challenges for low-income staff who lacked transport:

'*If it is a course that's further away, we really have to scrutinise what added value that course would give us*' (Participant 10).

'*A lot of my care staff do not have cars and therefore find them [courses] difficult to access, so that's a massive issue. It rules out a lot of my staff [who] just won't go to courses because they cannot get there*' (Participant 17).

Despite the challenges of covering staff absence, managers frequently expressed a preference for face-to-face staff training formats. These were considered to be most people's preferred learning method, while also enabling interaction to embed learning and avoiding some of the challenges of self-directed study:

'*If you are actually attending lectures or have got deadlines that are set by the university, you are more likely to complete them*' (Participant 24).

Cascade training, where learning is passed from one cohort of students to the next (Karalis 2016), was identified as offering a compromise between releasing staff for external training and providing in-house training:

'*We sent two staff members… when they came back to run the training trainer bit [where staff members were being trained to teach their colleagues], you could bring it back to base so we were not having to send staff out to training*' (Participant 10).

While cascade training offered advantages, its effectiveness relied on the recall abilities and communication skills of the 'cascaders', as well as the willingness of the 'receivers' in terms of time and commitment, challenges which had not always been fully considered.

Similar challenges were identified in relation to mentoring, with managers noting that there was a lack of staff who were willing to act in this unpaid capacity, particularly GP mentors, which limited the number of staff who could be trained in this way. However, mentoring did offer advantages, giving mentors an opportunity to pass on their knowledge in practice and enabling mentees to benefit from contact with staff with a higher level of skill:

'*You get the whole team growing. And what we are seeing from that particular ward is a level of enthusiasm and confidence*' (Participant 30).

Effect of practice requirements for education and training

Managers noted that service and national requirements to some extent determined what type of training was undertaken and for which staff. For example, registered nurses have a professional requirement to maintain their competency levels, therefore accreditation of training was a consideration in some instances:

'*An awful lot depends what it is about, if it is training to [become a] practitioner it is got to be an accredited course. If it is something*

Key points

● It can be challenging to measure whether nurse education and training is effective in assisting nurses to acquire relevant skills

● Among the healthcare managers surveyed, a lack of career progression was seen as symptomatic of a healthcare organisation's lack of coordination regarding staff training and professional development

● Healthcare managers' decision-making in relation to planning and evaluating staff training relied on judgements based on their personal experience and knowledge

● The Assessment, Planning and Evaluation of Training (APET) tool developed by the study team has the potential to ensure that vital resources are used optimally, which would improve outcomes for individual staff, patients and healthcare organisations

like learning to suture, then we are not worried about credits for that' (Participant 3).

Managers observed how high-profile instances of suboptimal practice had led to a focus on providing training that would improve patient care:

'Really it is to improve knowledge and to improve care … So I think it is just crucial from those point[s] of view. I think it leads to better care and a reduction in the risk of abuse' (Participant 17).

Overarching directives for training were sometimes seen as leading to a focus on skills acquisition and measurement, with little consideration of the overall educational value to individual staff members or whether the training addressed the healthcare organisation's needs:

'These national programmes … are "must dos" in terms of implementation, but actually [there is] no real analysis of whether that [the training] will resolve the problem in that particular setting' (Participant 30).

For unregistered staff such as healthcare assistants whose professional requirements were less specified, the development of skills and knowledge, and the ability to work proactively with registered nurses, were identified as important. Training was seen as a means of addressing unregistered staff's feelings that they lacked confidence and were not valued, and changing their relationships with other staff members:

'It is about their feelings of worth, about being able to challenge registered staff' (Participant 25).

Staff motivation and interest
Managers recognised that staff often valued training because it provided a sense of recognition and investment in them by the healthcare organisation. However, a perceived lack of interest in training among some staff was identified by some managers, which could have been for a variety

of reasons. A fear of education and of failing was considered to be a factor that impeded some staff, particularly unregistered staff and those on lower grades, while those close to retirement age were sometimes perceived as lacking motivation to undertake even mandatory training. In some instances, lack of motivation appeared to be because of a staff member's lack of clarity about the most appropriate training to attend, which was linked to the absence of clear career progression or monetary reward for skills development:

'There is not really any career path. So, however much they did, and I think this is where the motivation might be lacking… however much motivation they have and however much knowledge they gain, the most that would happen is they would go up to senior carer, which is a few pence an hour difference. So our staff are paid the same whether they have got an NVQ [National Vocational Qualification] or not and that is a big issue' (Participant 17).

A lack of career progression could also be regarded as symptomatic of a healthcare organisation's lack of coordination or strategy in staff training and professional development. This could lead to available training not meeting the needs of either staff or the healthcare organisation, causing frustration for individuals and an inability to bring about the transformation required at an institutional level.

Process of staff selection for training
Managers took a range of factors into account when selecting staff to attend training, which related both to the individuals and the wider context of the healthcare organisation. In relation to individual staff, while appraisals were often an important mechanism by which discussions regarding training were initiated, several other factors were also considered, particularly in relation to non-mandatory training. For example, with limited budgets, opportunities

for non-mandatory training often had to be 'shared out' among staff:

'I try to be fair and equitable and if they went last year then it is somebody else's turn to go this year' (Participant 15).

As part of this process, one manager did not consider staff for any additional training until they had been in post for at least one year. This was part of a wider pattern of some managers considering training and professional development as 'a reward, it's a thank you' (Participant 2) for staff, rather than as part of a strategic decision-making process.

Managers also made their own informal assessment of staff's suitability for further training. While this was based to some degree on interests indicated by staff, an overriding factor was often the impressions that the managers had developed of their staff and their capabilities:

'When you work with them regularly you get a feel for whether they have got anything between their ears or not' (Participant 2).

In terms of the wider healthcare context, limited resources created a tension between providing opportunities for further development and meeting mandatory requirements, and organisational priorities to maintain service delivery. This resulted in a feeling of pressure to justify the costs and time allocated to training:

'I think any training that is allowed has got to be very specific and you have got to identify what the results of that training will be for the organisation, let alone the individual' (Participant 8).

'My managers, their drive was just to deliver the service more than develop staff. So no they… certainly did not encourage training really because it was taking staff away from the work place' (Participant 28).

In this context of limited time and resources, there was a strong belief among the managers that a change

in behaviour or performance was required to justify staff attending training:

'Before somebody goes on a course, I would always want to know what they anticipate getting out of it, which would be in terms of attitude and behaviours and impact on patient care… maybe three months or so after the course has finished, I would want to know from that individual what they feel has changed in their practice as a direct consequence of attending that particular course' (Participant 8).

Despite the significant resource implications involved, little reference was made to any formal evaluation of the outcomes of investment in staff training. Furthermore, while this kind of evaluation might be relatively straightforward in the case of skills-based training, the benefits of longer-term educational development were more challenging to define.

Despite the complexities of the issues involved, or perhaps because of them, few managers used any kind of tool to aid their decision-making in relation to staff training. Some managers considered that they did not require such tools because of their level of experience, while suggesting that they could be valuable for newer or more inexperienced managers.

Stage 2: development of a tool to support decision-making

Based on the themes identified through the data analysis and informed by the literature, a member of the study team (NW) drafted a decision-making tool, known as the Assessment, Planning and Evaluation of Training (APET) tool, which was reviewed by the team. The tool was intended to develop a structure that would enable managers to clearly identify the rationale for decisions made in relation to training. In addition, since it was clear from stage 1 of this study that there was little consistent evaluation of the outcomes of training, an evaluation section was included, based on Kirkpatrick's (1976) widely used Four-Level Training Evaluation

Model. The four levels of this model comprised: staff reaction to learning; reviewing what staff have learned; identifying changes in staff behaviour; and measuring the outcomes of training for staff.

The APET tool is comprised of three phases:
» Phase one: assessment of needs. To be completed by the manager or staff member. Includes identification of education and training needs, the rationale underpinning the need, the proposed outcomes of the training and the identification of the learning support required.
» Phase two: collaborative planning. To be completed by the manager and staff member. The manager and the member of staff agree on the intended outcome(s), establish the delivery method, individually indicate how each anticipates that the training will make a difference, and identify a method for measuring whether the training has been effective.
» Phase three: evaluation of training, based on Kirkpatrick's (1976) model. To be completed by the manager and staff member.
The APET tool was reviewed using two strategies:
» A small group of four nurse managers working in a variety of hospital and community settings with responsibility for staff training were opportunistically sampled while attending a course being delivered by one of the study team (KF). The managers were asked to review the APET tool and give their feedback on the structure and its usefulness in practice.
» The APET tool was sent to a senior nurse with responsibility for managing training for a large private care home company with a proactive approach to staff training, to managers of a local hospice and to academic colleagues within the department. They were invited to comment on the usefulness of the tool, its structure and format.
Feedback was largely positive, with managers considering the APET tool appropriate for use in practice:

'I think [the APET tool] would be useful in my area and would be a good guidance to ensure staff

are sent on courses that will be of benefit to both them and the department' (Manager D).

One manager observed that the APET tool would be most appropriate for use with staff at more professional levels, and that a simpler version might be required for work with care staff, which could be integrated into appraisal or supervision meetings. They also emphasised that adoption of the tool would depend on managers identifying its usefulness in practice:

'The tool's success… will definitely hinge on the buy in from the person using it and if they see that there is a benefit to them and it will add value to what they need to achieve in their own role, they will use it' (Manager E).

Following review, some minor amendments were made to improve the APET tool's clarity and function.

Discussion
This study examined the influences on healthcare managers' decision-making with regards to staff training. Core themes relating to course delivery methods, practice requirements, staff motivation and the process of selection of staff were identified. In the context of competing resource priorities and a complex range of external and organisational requirements, it was clear that managers made decisions regarding staff training by drawing on a range of factors, largely based on their own experience and judgements rather than using formal tools or processes. This use of cognitive 'shortcuts' confirms Gould et al's (2007) suggestion that personal factors significantly influence managers' decisions. Similarly, the findings support Turpin and Marais' (2004) observations that many classic decision-making models unrealistically assume managers use a rational process based on complete information, but that in practice managers also draw on a range of other sources including previous experience, organisational procedures, and their own personality and background.

As a result of these findings, the authors developed the APET tool to support managers' processes of decision-making and evaluation in relation to staff training. Preliminary piloting of the APET tool indicated that this tool may be a valuable aid in some contexts, and further testing is now required.

Limitations
The study was limited to one geographical region, and the snowball sampling method may mean some groups of healthcare managers were not adequately represented. However, the considerable variation in participants' roles suggests the results may be widely transferable. Since most participants had been in a managerial role for some

time, it is possible the findings would differ with less experienced managers, and it would be valuable to undertake further research with this group. Finally, there is a need for wider testing of the APET tool, and the study team would welcome feedback from healthcare managers who wish to use it in their practice.

Conclusion
This study found that healthcare managers' decision-making in relation to planning and evaluating staff training relied on judgements based on their personal experience and knowledge. Despite the complexity of these decisions, they did not employ tools that could provide an increasingly coherent and informed framework for this process. The APET tool

developed by the study team has the potential to ensure vital resources of time and money are used optimally, improving outcomes for staff, patients and healthcare organisations.

IMPLICATIONS FOR PRACTICE
» Managers make decisions regarding the planning and evaluation of staff training using informal strategies based on personal knowledge and professional experience, rather than using tools to develop a framework for this essential area of practice.
» The evidence-based APET tool developed by the study team could improve decision-making in relation to staff training, ensuring maximum value is gained from staff training for individuals and healthcare organisations, thereby improving patient care.
» A framework for less experienced managers would assist in making equitable decisions around staff training when resources are limited.

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