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Using QCF Units to Train and Assess Competence of Personal Assistants in Health– Evaluation Report

May 2016

Version 2

Thanks and Acknowledgements

This report represents the findings of a project examining the use of QCF Units to train Personal Assistants in delegated healthcare tasks. The project was funded by NHS England and ran from January 2014 until May 2015.

NHS England and Skills for Health would like to thank each project site and all project members for their enthusiasm and engagement throughout the project.

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1. Executive Summary

This project arose out of a need to enable NHS staff to understand how to provide appropriate training and assessment of competence when delegating clinical tasks to Personal Assistants (PAs). The intention is that this will contribute to ensuring that people using personal health budgets (PHB) to employ their own PAs are confident of receiving high quality, safe, effective and efficient care and support in their own home. It is also believed that providing appropriate training and assessment of competence for PAs will have additional benefits both for healthcare professionals and the PAs themselves.

Registered healthcare professionals remain accountable for the decision to delegate a healthcare task. Having the reassurance that PAs have received training and assessment of competence for clinical healthcare tasks against an externally regulated and quality assured qualification, should assist in the willingness and confidence of the healthcare practitioner to delegate. The role of a PA has many unique characteristics; the environment within which they work is dynamic, the needs of their employer can be complex and change very quickly. Ensuring that they receive standardised, transferrable and quality assured training in knowledge and skills should enable them to provide better quality of care. Basing training around a regulated qualification also helps to demonstrate the value of the PA role.

For many people, employing a PA or a team of PAs is a major part of how they use their personal health budget and ensure their care and support arrangements are personalised and responsive to their individual needs and circumstances. Understanding how best to provide PAs with training and assessment of competence in delegated healthcare tasks is therefore a critical element in the delivery of personal health budgets. For this reason, in 2014 the NHS England personal health budget delivery team commissioned Skills for Health (SfH) to work with them and a group of NHS demonstrator sites to examine the suitability of using qualification units that sit on the Qualification Credit Framework (QCF) in training and assessing the competence of PAs on delegated healthcare tasks.

Units available on the QCF must comply with the regulatory requirements of the QCF and are presented in a common format which describes what the learner must know or be able to do (the learning outcomes) and how the learner will be assessed as meeting the learning outcomes (the assessment criteria). Units are then packaged together to create a qualification which will have a clear title, credit value (to indicate the size of the qualification) and a level (to indicate the 'challenge' to the learner). As well as being based on National Occupational Standards (NOS) each QCF unit carries a credit rating and level of its own.

The standalone, accredited nature of these units lend themselves well to the purpose of training PAs because a learner can receive a certificate to show that they have completed individual units even if a full qualification is not within their reach. The QCF units offer quality assurance, validation and consistency and the potential portability of skills between employers is seen as a potential benefit for PAs. The QCF approach also allows freedom for training providers to use whatever mode of delivery they feel is most appropriate for the learners.

This report explores the wide range of evidence gathered throughout the project, and forms an interim report with key findings and learning points that are relevant to employers or commissioners of training for PAs.

For the duration of this project, the PAs undertook units that were contained within qualifications that sat within the QCF. On the 1st October 2015 the QCF (and NQF-National Qualifications Framework) were replaced by the Regulated Qualifications Framework (RQF). The qualifications containing units undertaken by PAs in Health as part of this project have now all migrated onto the RQF. This new framework is still regulated by the Office of Qualifications and Examinations Regulation (Ofqual). In outlining our findings throughout this phase of work we refer exclusively to the QCF as this was the framework in place throughout this phase of the project.

Findings from the project

It is important that the findings of this interim report are set against the background and starting point of each site. There was a varied level of development across the sites at the start of the project both in relation to the uptake of personal health budgets (PHB) and the training available to PAs on healthcare tasks.

There was only one site that, at the start of the project, had a long standing systematic approach to training that was already embedded into the local delegation process.

Many sites highlighted the variable nature of training that has historically been provided to PAs and in some cases there was concern about some healthcare tasks, which require high levels of competence, being undertaken by PAs without a systematic approach to training and refreshing of skills.

Some of the sites also outlined a historic perceived lack of confidence amongst healthcare professionals in the sign off of competence of PAs and how they believed this negatively impacted upon effective delegation of healthcare tasks.

There was a high level of positivity from site leads in relation to focusing on and improving the skills and competence of PAs, all sites talked passionately about the positive impact that a systematic approach to training and assessment of competence could have on PAs, PHB holders and healthcare professionals.

Key Research Questions

The main research questions that we were seeking to explore as part of the project were:

> *"Are QCF units a suitable framework to train and assess the competence of PAs in delegated healthcare tasks?"*
>
> *And*
>
> *""Does the use of QCF units enable healthcare tasks to be delegated more readily to PAs from registered professionals?"*

In order to assess the suitability of using QCF units to train PAs in delegated healthcare tasks we have had to consider the full range of benefits and challenges that have been articulated by sites.

Benefits of using QCF units were broadly in line with the benefits that SfH had previously identified; these included delivering units that are part of a recognised national regulated framework that links to NOS, the flexibility to build credits at a pace that suits the learner and the consistent approach to training and assessment of competence. One significant additional outcome of the project was that for those PAs participating in group or classroom learning, this gave them the opportunity to develop peer support for PAs.

Despite the wide ranging benefits, sites also faced a number of significant challenges in delivering QCF units to PAs. The most significant challenges for the majority of the sites was the identification of a suitable training provider and that the time required to undertake a QCF unit conflicted with the need to speedily delegate the healthcare task. There was also concern regarding the costs associated with the delivery of QCF units, particularly when these were delivered in a personalised way in people's homes and that for some PAs their roles were not sufficiently broad enough to achieve the unit accreditation.

The conclusion that we draw from the evidence presented within this report is that QCF units can provide a framework to train and assess the competence of PAs in healthcare tasks as part of the process of delegation of these tasks. Sites did however express concern around the time required to complete the QCF units and how this can conflict with the need for speedy delegation of clinical tasks.

More work is clearly needed to understand how the time needed to provide suitable in-depth training and assessment of competence can be balanced with the immediate need to delegate, what might feel like a short term expense for commissioners could have significant long term benefits both in terms of long term costs and the overall quality and effectiveness of patient care. Sites were also concerned about the costs associated with the QCF unit approach, although the absence of any comparators makes it difficult to say with any certainty how these costs compare with alternative approaches.

The second key research was concerned with whether QCF units enable healthcare tasks to be delegated more readily to PAs from registered professionals. One of the problems with trying to answer the research question above was that throughout this project the sites were focused on their existing PAs and providing them with further training on delegated healthcare tasks that they were already delivering to PHB holders. This was partly because for some sites, the total number of PHB holders is relatively small and they were unable to predict that new PHB holders would emerge during the course of the project. It was therefore more practical to concentrate on existing PHB holders and existing PAs.

This approach did not enable us to explore if using QCF units as a framework for high quality training for PAs has a positive impact on the initial delegation itself.

We conclude that any training process needs to be integrated and embedded into the wider local delegation process. In addition PAs, PHB holders and Healthcare Professionals require clarity regarding when, where and how they can access training. Clarity of the delegation process and how training and assessment of competence links to this is likely to have significant benefits for all stakeholders.

Sustainability of the approach

Views on sustainability of the approach were linked in part to cost, with those sites delivering lower volume less likely to identify their approach as sustainable. However there was greater concern about the flexibility of the QCF unit approach. Whilst the model of teaching and assessment of competence was seen as important, and the rigorous nature of the QCF units were highly valued, questions remained around whether the approach was flexible and responsive enough to allow delegation of new healthcare tasks to happen quickly and effectively.

In terms of long term sustainability, site leads expressed some concern around how training of PAs would be funded in the long term. There was some belief that gaining funding for full qualifications may be easier, however there was also recognition that many PAs might lack the scope within their role to satisfy the practical assessment elements of a full qualification.

Site leads also spoke about differences in funding and training for PAs funded via health budgets in comparison with PAs funded through social care. CCGs are required to fund everything necessary to deliver the care plan, including any training and assessment of competence required to delegate clinical tasks. However this is still often dealt with on a case by case basis. There appears to be a lack of understanding and commitment in some CCGs in relation to the need for strategic planning and investment in training for the emerging PA workforce.

2. Learning Points

The following is a summary of the main learning points arising from the work within the project. These learning points are relevant to anyone who is seeking to examine how delivering training to PAs should be approached and developed:

1. Senior buy-in is needed within CCGs and by other stakeholders in order to successfully develop delegation processes and protocols that include the identification of suitable training and development for PAs.
2. CCGs and commissioners need to consider how best to meet the need for training and assessment of competence associated with delegating clinical tasks to PAs and put in place clear protocols and delivery plans.
3. Training and assessment of competence is one element of the delegation process. Significant work is required to understand and provide clarity relating to how training supports, and is embedded in, the overall delegation process and how assessment and sign off of competence works.
4. Commissioning the right training provider is crucial to the success of training PAs. Not only do PAs require high levels of flexibility in how and when training is delivered, the training also has to be appropriately contextualised to the role of the PA, with training providers recognising how this role is different to other roles in the sector.
5. The provision of a structured programme of training with formal recognition of learning and portable qualifications could contribute to recruitment, retention and career development for PAs. Creating a role that is supported through appropriate skills and development should assist in creating careers for PAs that are interesting and rewarding.
6. PAs welcome opportunities for training and for getting formal recognition of their learning and there is also significant interest from family carers to participate in training opportunities and get formal recognition of their skills and knowledge.
7. PAs valued the opportunities for peer support in group training approaches. Whilst timescales did not allow us to explore the long term impact of this, it could have positive effects including increased self- esteem, perceived value and retention for PAs.
8. QCF units can provide the relevant framework for training and assessment of competence required in specific clinical tasks. However, some sites viewed this as being more than is required to be able to carry out a delegated health care task, or some PAs may not carry out the full range of tasks within specific units. It may therefore require more time than is actually needed in relation to the specific task.
9. If QCF units are to be delivered to PAs, then a classroom based component with a large number of learners enables a more cost effective model for delivery. However the issue of backfill and release of PAs for classroom based activities remains a significant barrier. E-learning could be an appropriate mode of delivery of the knowledge component of the training and may help overcome some of the difficulties associated with releasing PAs to attend training. Training providers need to choose the appropriate blend of modalities that they feel is most appropriate for their PAs
10. Training in core competences needs to be available for PAs in addition to training in health care tasks.
11. Training programmes for delegation must take into account the need to relate learning to the individual PHB holder's circumstances and needs, as well as the need to assess competence in the workplace i.e. the home.
12. Exploring and understanding relevant QCF units can inform the development of non-QCF based local training modules for delegation, where that is considered more appropriate. The QCF approach contains best practice that local training design can learn from.

3. Key Findings

Evaluation and feedback from the current phase of activity have surfaced the following key findings:

- The majority of sites pointed to a historic lack of structured or methodical approach to training PAs on delegated healthcare tasks. This was viewed as a significant risk by all sites. Appropriate training and assessment of competence of PAs is a need.
- Training and assessment of competence of PAs is an important component of a successful delegation process. Such training and assessment therefore needs to fit and be integrated within the local process of delegation.
- Training providers need to be aware of the local delegation process and how the training and assessment of competence fits into this. They need to provide flexibility in order to deliver training and assessment that is contextualised to the work of PAs and the needs of PHB holders and their families.
- Over 300 QCF units were delivered to 40 PAs over the course of the project.
- There was huge variability in the overall cost of delivery of individual QCF units. Costs varied between £75 and £650 per unit. Some variability is to be expected dependent upon the specific unit and the level it is being delivered at. However, in general terms, lower costs were achieved by the site that delivered the underpinning knowledge to large numbers of PAs in a classroom environment. Comparison across sites demonstrated that bespoke training in the PHB holder's homes was the most costly.
- The evidence within this report demonstrates that QCF units can be successfully delivered to PAs. However there is no 'one size fits all' model that works for all sites. The cost of delivery is an important factor in sustainability.
- Despite the successes some sites questioned whether QCF units could be delivered fast enough and flexibly enough to enable delegation of healthcare tasks to happen quickly. Where there might be concern around costs or timings for using QCF units, organisations may want to examine whether the QCF approach provides the most benefit when they are focused on tasks that are complex and carry greater clinical risk.
- There are unique features around the role of PAs that impact upon the ability to plan training in the long term. PAs work in a very dynamic environment where the needs of the PHB holder can be very complex and change very quickly. They therefore require training and assessment of competence that can adapt and support this.
- Some sites struggled to engage and get buy in from stakeholders, including commissioners/CCGs.
- Many sites struggled to engage healthcare professionals in the project.
- During this phase of work PAs were trained on tasks they were already undertaking. This meant we were unable to examine how well the training supported and fitted in to the local delegation process.
- There is anecdotal evidence and expert testimony that points to the training changing and influencing the practice of PAs. PAs reported valuing the wider knowledge and understanding they developed through the QCF unit. They believed this knowledge would improve the quality of care that they provided.
- Feedback from PAs was overwhelmingly positive; PAs reported feeling more knowledgeable and confident following the training.
- Adequate provision of funding can be a barrier to providing training for PAs.
- Sites engaged in the project developed significantly in terms of the overall learning around how training can be commissioned and delivered. This increase in knowledge and understanding increased site leads confidence in what they would look for in training providers in the future.

4. Background

PHBs are one way to give people with long term health conditions and disabilities more choice and control over the money spent on meeting their health and wellbeing needs. A PHB is an amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local Clinical Commissioning Group (CCG). It is not new money, but a different way of spending health funding to meet the needs of an individual. Adults eligible for NHS Continuing Healthcare and children in receipt of continuing care have had a right to have a PHB since October 2014. There is a longer term objective to widen availability of PHBs to others who could benefit.

Being able to make decisions about their own health care can mean that people have a much greater choice about who they want to deliver that care. People with PHBs often choose to employ their own PAs to help with their care and support needs. When PAs are working with people with complex care needs, this may mean that they may be required to carry out activities that are of a clinical nature. The role of the PA is well established in social care but is a relatively new and emerging one in the health sector, and is set to be a growth area over the coming years for the health sector workforce. Currently no formal qualifications are required to become a PA in health. PAs in health carry out many important clinical tasks for people at home, all of which should be delegated by registered healthcare professionals.

The issue of delegation of clinical tasks from registered healthcare professionals to PAs is emerging as a particular concern since there are many tasks that require a level of clinical skill and competence. A registered practitioner who delegates a clinical task remains accountable for the decision to delegate and cannot delegate that accountability. However, provided the decision is made appropriately (this includes ensuring that the PA has the skills, knowledge and competence to perform the task and the level of supervision and feedback is appropriate), the PA is accountable for accepting the delegated task and is responsible for their action in carrying it out. There is considerable variation across the country in the approach that particular areas have taken to the involvement of the healthcare professionals in the training of PAs in health and in how willing healthcare professional are to delegate clinical tasks to PAs. Training of PAs, assessment of competence and the involvement of healthcare professionals in the delegation process is therefore one area that has been identified as requiring further development.

When it has been decided through the care planning process that delegation to a PA is appropriate, there are three key stages:

- Initial training and preparation
- Assessment and confirmation of competence
- Confirmation of arrangements for on-going support, updating of training and reassessment of competence

This research concerns itself with exploring the nature and content of the training and assessment of competence that should be provided as part of this process. The intention is that this will inform other work that is being undertaken to examine and report on the whole process of delegation to PAs.

This phase of work follows previous work by SfH that explored with a broad range of stakeholders the competences required by the PA workforce and identified existing NOS that could be mapped to these competences. The work identified that there were a significant number of QCF units that would be suitable to train PAs and assess their competence in a range of delegated healthcare tasks. The report also identified a small number of gaps in QCF Units. The report outlining the full findings of this work was delivered to the Department of Health in April 2013 and is available on request. Since the work carried out in 2012 by SfH, the personal health budget delivery team who commissioned the work has moved from the Department of Health to NHS England and therefore the commissioning of this current phase of work was by NHS England.

Investigating the Suitability of Using QCF Units to Train and Assess the Competence of PAs in Health

In January 2014 SfH was commissioned by NHS England to 'Test the use of regulated qualifications in the training of PAs in delegated health care tasks'. The requirements of the tender were for SfH to:

- Help to design a system of evaluation of the use, in the training of PAs, of regulated qualifications and units that use the rules of the QCF.
- Work with NHS demonstrator sites to support their partnerships with training providers and provide expert advice and guidance on issues relating to skills development.
- Contribute to collecting and evaluating quantitative and qualitative data from the sites through focus groups and quarterly systematic reporting.
- Participate in the project advisory group to provide expertise on training and competency assessment and contribution to establishing principles, taking an overview of progress and monitoring and coordinating learning.
- Contribute significantly to producing a report based on this evidence. The report evaluates the suitability of regulated qualifications and units, which use the rules of the QCF, in a context where training needs to be highly personalised and based on an individual's care plan.

The project was initially due to complete in December 2014. However, due to the length of time taken for sites to set up the necessary systems to allow for the training and assessment of competence of PAs using QCF qualifications and units, the decision was taken by NHS England to extend this commission into 2015 to allow more PAs to complete QCF units. The cut off point for PAs taking QCF units that have been included in the evaluation of the project was the end of May 2015.

Systematic evaluation was planned throughout the project to enable us to answer the following key research questions:

- *"Are QCF units a suitable and sustainable way to train PAs?"*
- *"Does the use of QCF units enable healthcare tasks to be delegated to PAs from registered professionals?"*

In order to try to answer these questions, and to understand the experience of the sites, training providers, PAs and PHB holders throughout the process, we used a mixed methodological approach. This consisted of data gathering from demonstrator sites and training providers as well as qualitative analysis through the use of online questionnaires, focus groups, reflective analysis and in-depth interviewing. This report represents the findings of this work and attempts to answer the research questions above.

5. The Demonstrator Sites

Requests for expressions of interest were sent out to CCGs via the PHB learning network. Sites were selected on the basis of the number of PHB holders employing PAs, their interest and commitment to exploring delegation of clinical tasks and their potential to engage with suitable training providers.

There were five pilot sites included in the use of QCF units; the lead organisation for each site is below:

- NHS Dorset Clinical Commissioning Group
- Kent County Council
- NHS Nene Clinical Commissioning Group
- Oxford Health NHS Foundation Trust
- North of England Commissioning Support (NECS)

Sites were provided with a small amount of funding from NHS England to support them in the setting up and delivery of the project. Each site was asked to sign a Memorandum of Understanding between NHS England, SfH and themselves at the outset of the project.

Overseeing the work of the project, and reporting into NHS England, was a Project Advisory Group which met for the first time in March 2014. The group agreed the overall aims and objectives for the project, agreed a project plan and a process throughout the project for the collation of evaluation material.

SfH has provided support to sites through facilitated discussion at face to face group meetings, providing technical advice and guidance through all site meetings and individual meetings. Telephone and email guidance has also been provided to individual sites as required in between face to face meetings.

5.1 The Process of Introducing QCF Units

National Occupational Standards (NOS) describe individual functions or competences. They contain all of the information that someone needs to know, understand and be able to do to be considered competent in that function. NOS are developed by sector representatives and agreed for use across all four countries of the UK.

In the health and social care sectors NOS are widely used in workforce development, learning design and even job descriptions. When the QCF was introduced in 2011, it made sense for SfH to continue to use the NOS as the basis for the units within the new qualifications that would form part of the new framework. These qualifications were designed with the support workforce in mind. Some of the units contained within them are common to both health and social care qualifications, particularly within the mandatory sections of the qualifications and in relation to functions like communication, health and safety, safeguarding etc. The qualifications were developed in conjunction with QCF Awarding Organisations. The purpose of the qualifications is to check occupational competence. QCF qualifications and/or units must be assessed in the work place by occupationally competent assessors and in line with the SfH Assessment Principles. Requirements for external quality assurance are integral to all of the occupational competence qualifications. A registered practitioner may have more confidence to delegate a task if the PA has already achieved a competence based QCF unit in the relevant area since learners who have achieved a QCF qualification have been assessed as achieving a defined set of learning outcomes.

Assessment is carried out by a suitably qualified assessor and assessment of QCF competence units requires the direct observation of a particular task being carried out by a PA within the workplace. In addition rigorous external quality assurance systems are in place. The assessment requirements are defined in each QCF unit and overarching principles are defined in the SfH QCF Assessment Principles http://www.skillsforhealth.org.uk/getting-the-right-qualifications/vocationalqualifications/qualifications-and-credit-framework-%28qcf%29-qualifications/

In England, the most commonly used qualifications for the support workforces in health and social care are as follows: diplomas in Clinical Healthcare Support (QCF) at levels 2 and 3; diplomas in Health and Social Care (adults) for England (QCF); a diploma in Allied Health Profession Support (QCF) at level 3; and a diploma in Healthcare Support Services at level 2.

It was to these qualifications and individual units that the project team turned when scoping for units that may be applicable to PAs carrying out delegated healthcare tasks. The project team also referred to the mapping work that was carried out by SfH in 2013 to identify NOS which describe the functions carried out by PAs in health and mapped these to corresponding QCF units. The work in 2013 found that almost all of the competences and knowledge requirements identified by stakeholders as relevant to PAs in health can be mapped to existing QCF units which can be taken as part of an existing qualification as listed above.

Units available on the QCF must comply with the regulatory requirements of the QCF and are presented in a common format which describes what the learner must know or be able to do (the learning outcomes) and how the learner will be assessed as meeting the learning outcomes (the assessment criteria). Units are then packaged together to create a qualification which will have a clear title, credit value (to indicate the size of the qualification) and a level (to indicate the 'challenge' to the learner). As well as being based on NOS, each QCF unit carries a credit rating and level of its own. The standalone, accredited nature of these units also lent themselves well to the purpose of this project because a learner can receive a certificate to show that they have completed individual units even if a full qualification is not within their reach.

Using the SfH report from 2013 as a basis, the project team and site leads worked together to scope which units were most relevant to each site. This was done partly via on-line surveys and partly via group and individual discussions until each site was happy that they had a list that was reflective of their needs. A few gaps were also identified where no units existed. Due to the short timescale of the project it was agreed that there was not sufficient time to try and get units developed for those gaps and so the testing went ahead using existing units only.

For the duration of this project, the PAs undertook units that were contained within qualifications that sat within the Qualifications and Credit Framework (QCF). On the 1st October 2015 the QCF (and NQF-National Qualifications Framework) were replaced by the Regulated Qualifications Framework (RQF). The qualifications containing units undertaken by PAs in Health as part of this project have now all migrated onto the RQF. This new framework is still regulated by the Office of Qualifications and Examinations Regulation (Ofqual).

During the process of scoping the QCF Units that would be used by each site, Oxford Health NHS Foundation Trust took the decision that they would not progress the use of QCF Units in training PAs. The reasons for this decision are complex but were significantly influenced by the existence of robust processes already in place to train people undertaking delegated healthcare tasks. Oxford Health NHS Foundation Trust have participated in qualitative evaluation activity to help us understand their learning from the project and this is reported in the form of a short case study which is an appendix to this interim report and they continued to share their experience and learning with other sites throughout the time of the project.

5.2 The Evaluation Process

The evaluation plan at the inception of the project outlined a mixed methodological approach to evaluating the activities of the project, these included:

- Quantitative data gathering
- Pre-questionnaires with PAs, PHBS and healthcare professionals
- Focus groups
- Post training questionnaires
- In-depth interviews

As the project progressed, the methodology had to be flexed in order to take account of work that had already been undertaken in project sites and in some cases the difficulty engaging participants at certain points of the evaluation process.

Whilst the broad overall approach to evaluation has not therefore changed, there has been a flexible approach adopted which has allowed all pilot sites to engage as fully with the process as they are able.

The diagram below outlines the activity that has taken place in each site as at the end of March 2015.

Figure 1: Evaluation Activity Matrix

	Dorset	Kent	Nene	Oxford	Tees
Pre-training questionnaires (Provided to PAs and Health Professionals)	Yes	Yes	Yes	No	No
Quantitative Data Gathering (Number of PAs and Units delivered, provided by Site Leads)	Yes	Yes	Yes	No	Yes
Focus Group (training providers)	Yes	No	Yes	No	Yes
Reflective work (site leads)	Yes	Yes	Yes	Yes	Yes
Interviews with site leads	Yes	Yes	Yes	Yes	Yes
Post-training questionnaires* (PAs)	By training provider only	By training provider only	By training provider only	N/A	By training provider only

*Post-training questionnaires have been conducted by all training providers, however not all sites have provided in-depth post-training evaluation reports.

This document therefore formulates findings that have come from the activity throughout the project lifecycle together with some formative recommendations that may be useful to employers and commissioners.

6. Project Updates and Quantitative Outputs

This section of the report provides an overview of the progress that was made within each pilot site together with an overview of the activity that has been delivered in terms of the achievement of QCF units.

We begin by outlining the broad approach to delivering QCF units to PAs that have been successfully implemented and then providing an overview of the outputs from each pilot site.

Below are the key points that have emerged from the evidence presented here:

Key Points

There were two main models of using QCF units to assess the knowledge and competence of PAs that emerged from the pilot sites. The first model was a very tailored bespoke model with training and assessment individualised to small numbers of PAs and delivered and assessed within the PHB holder's home. The second model was a mixture of classroom based learning, distance learning and on the job assessment. The second model enabled a high number of PAs to undertake the initial training in the time available.

Key Achievements

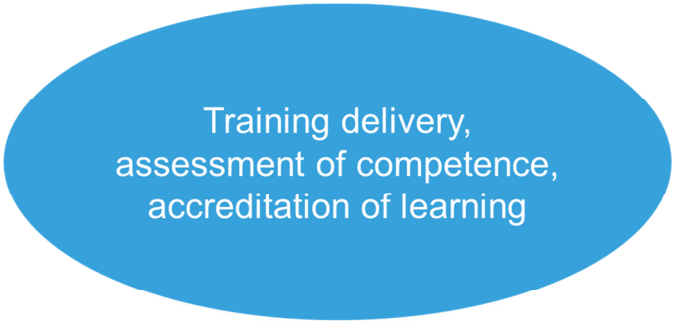
24 PHB Holders have engaged with the project and 40 PAs have been trained over the course of the project. Across these 40 PAs over 300 individual units have been delivered to PAs.

6.1 Methods for Delivery and Assessment of Achievement of QCF Units

There was variation in the models the sites used to roll out QCF units to PAs in Health and this resulted in variation in the number of QCF units achieved by PAs within the timescales available.

In the broadest sense there were two models of delivery which were seen across the pilot sites and these are outlined below

Figure 2: Model of delivery 1 – implemented by three of the pilot sites



- Flexible location, close to home or in the Budget Holders' homes
- Workshops are run by a health professional usually with small groups of learners

Within this model the training and assessment of competence was carried out usually by a single training provider.

The training and assessment was conducted in the workplace (the budget holders home) with someone who is occupationally competent to assess the competence of the PAs.

In terms of delivery methods, the majority of the pilot sites opted for this model of delivery because it allowed them to deliver to teams of PAs together in their workplace and it actively engaged the client/PHB holder.

This model required a large degree of flexibility from training providers and assessors and is very much focused on delivering bespoke training, using the equipment available within the workplace and meeting the needs of the individual client/PHB holder.

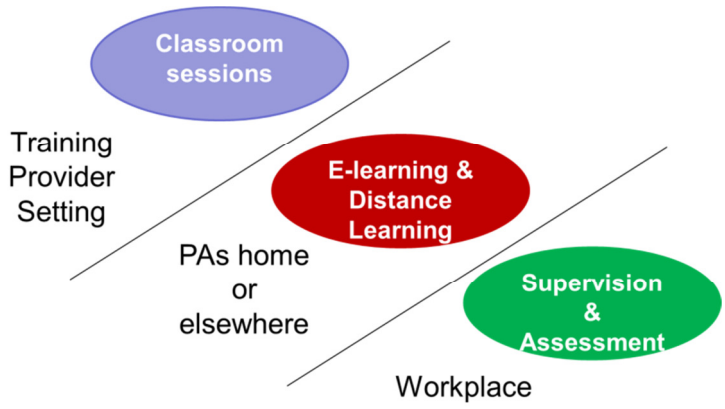
Sites articulated the benefits of this model as:

- High level of flexibility with training being conducted in the workplace at times convenient to the PAs and PHB Holders
- Training that is contextualised not just to the role of the PA but to the individual work environment of each PA, using the equipment that they use on a daily basis
- The involvement of the PHB holder in the training so that they have confidence in the skills their PAs are acquiring
- All sites using this method chose it because they believed it delivered the high levels of quality

Sites articulated the limitations of this model as:

- Lower number of PAs are trained at each available session
- The training provider has to be prepared to travel to the learners and accommodate the needs of the learners and the PHB holder
- High delivery costs due to the very individualised nature of the training being delivered

Figure 3: Model of delivery 2 – implemented by one of the pilot sites



Within this model the training and assessment of competence was carried out by different training providers.

The initial learning was conducted in the classroom supporting materials being delivered through e-learning and workbooks.

The supervision and sign off of competence was conducted by a separate training provider.

Interestingly the above model was believed at the outset to be more difficult to implement in terms of getting PAs to agree to attend training as it was perceived to be less flexible and moved the learning out of the workplace. It was a model that most sites had rejected in terms of delivery.

However the site that utilised this model delivered the highest number of QCF units achieved by PAs over the life cycle of the project and perhaps demonstrates that where training is made relevant to their role PAs are eager to take up the off-site training opportunities.

Sites articulated the benefits of this model as:

- Learning that is contextualised to the role of the PA, all training materials were rewritten to better relate to the role
- The ability to deliver underpinning knowledge to large numbers of learners in single sessions
- Cost effectiveness

Sites articulated the limitations of this model as:

- Requiring PAs to travel, sometimes requiring PHB holders to source backfill to meet their care needs when PAs are on training
- The need to build a 'critical mass' of PAs requiring training to make the classroom sessions viable
- Increased likelihood that classroom training sessions may get cancelled due to low take up or dropout of PAs (due to the way the needs of their PHB holder can change unexpectedly)

6.2 Project Outputs

Across all four sites a total of 40 PAs have received training and been assessed against QCF units, over 300 QCF units have been achieved by PAs. 24 PHB holders have been involved in the project and have had some or all of their PAs trained in a selection of QCF units during the course of the project.

This represents a significant amount of activity, although we can see that the activity within individual demonstrator sites is variable in terms of the quantity of QCF units achieved.

Activity within each of the sites in outlined below:

6.2.1 NHS Dorset CCG

NHS Dorset CCG adopted Model 2 for delivery of training; they worked in partnership with two established training providers, one to deliver the training in a classroom and one to complete the assessments of competence in the PHB holders' home.

The training that was provided as part of the project covered:

- 14 PHB holders
- 28 PAs

Throughout the project life cycle a total of 268 QCF units have been delivered, 126 at level 2 and 142 at level 3.

6.2.2 Kent County Council

Kent County Council adopted Model 1 for the delivery of QCF units to PAs; they worked with a single training provider that provided the relevant training and assessment of competence in order to sign off PAs in the delegated healthcare task.

Training commenced in November 2014 and 23 units have been delivered to 11 PAs and two family carers. Training has taken place in the PHB holder's home, with the involvement of the PHB holder.

6.2.3 NHS Nene CCG

NHS Nene CCG has worked in partnership with a training provider and a broker in order to coordinate and deliver training to four PAs from an original pool of 19 PAs that were engaged in the project.

Nene have adopted Model 1 in terms of overall delivery, however they are working to deliver full qualifications rather than individual QCF units to the PAs that are engaged in the project.

6.2.4 North of England Commissioning Support (NECS)

North of England Commissioning Support (NECS) works across NHS Hartlepool and Stockton on Tees CCS and NHS South Tees CCG. NECS has worked in partnership with a single training provider for delivery and assessment of QCF units. They have used Model 1 in terms of overall delivery with PHB holders actively engaged in the training.

There are a total of eight PAs engaged with the project, with each PA undertaking three QCF units. These PAs work within packages of care for three PHB holders.

7. Evaluation Findings

There are a number of qualitative findings that have emerged throughout the project lifecycle and the evaluation work. This section discusses each of the key findings with examples from site leads, training providers and PAs where appropriate.

Key Points

- The majority of sites had not yet developed a structured or methodical approach to training PAs on delegated healthcare tasks. The risks associated with this were articulated as a key driver for the development of high quality training and assessment of competence. We must however also recognise that PAs in health are a new and emerging role.
- Training and assessment of competence of PAs is an important component of a successful delegation process. The training and assessment of competence of PAs therefore needs to fit and be integrated within the local process of delegation.
- Training providers need to be aware of the local delegation process and how the training and assessment of competence fits into this. They need to provide flexibility in order to deliver training and assessment that is contextualised to the work of PAs and the needs of PHB holders and their families.
- Despite the successes some sites questioned whether QCF units could be delivered fast enough and flexibly enough to enable delegation of healthcare tasks to happen quickly. Where there might be concern around costs or timings for using QCF units, organisations may want to examine whether the QCF approach provides the most benefit when they are focused on tasks that are complex and carry greater clinical risk.
- There is anecdotal evidence and expert testimony that points to the training changing and influencing the practice of PAs. PAs reported valuing the wider knowledge and understanding they developed through the QCF unit and that they believed this knowledge would improve the quality of care that they provided.
- There was huge variability in the overall cost of delivery of individual units. Costs varied between £75 and £650 per unit. Lower costs were achieved by the site that delivered the underpinning knowledge to large numbers of PAs in a classroom environment and comparison across sites demonstrated that bespoke training in the PHB holder's homes was most costly.
- There are unique features around the role of PAs that impact upon the ability to plan training in the long term. PAs work in a very dynamic environment where the needs of the PHB holder can be very complex and change very quickly. They therefore require training and assessment of competence that can adapt and supports this.
- Some sites struggled to engage and get buy in from stakeholders including commissioners/CCGs.
- Some sites struggled to engage healthcare professionals in the project.
- During this phase of work PAs were trained on tasks they were already undertaking, this meant we were unable to examine how well the training supported and fitted in to the local delegation process.
- In at least one area the training has been the catalyst for PAs to set up their own network and this could have positive benefits for PHB holders.

7.1 Previous Training Arrangements in Each Site

Work with the sites during the project highlighted that, with the exception of Oxford Health NHS Foundation Trust, there was a lack of a structured and methodical approach to training PAs on delegated healthcare tasks.

"…there was little or no formal training available for PAs prior to the training demonstrator. Basic training was available from one of our local authorities that had no formal recognition apart from attendance. There were concerns expressed by both PHB holders and PAs about the relevance of this and how useful it was. There were no elements relating to clinical care included.

Clinical training on specific tasks was split between the hospital, district nurses and community matrons and/or specialist nurses. The situation was very patchy with some practices happy to undertake training and sign off and others refusing point blank to do anything.

There were many risks to this as there was no consistency of approach however where there were any particular medical risks these were monitored on a regular basis by community staff etc."

Site Lead

It was clear that, as highlighted by the previous work by SfH; there was a feeling that the lack of consistency in training and assessment of competence for PAs represented a risk both in terms of quality and safety. All project sites that implemented QCF units were hopeful that this approach could help address these risks whilst also enhancing the profile of PAs, and increase the willingness of healthcare professionals to delegate healthcare tasks to this emerging section of the workforce.

"Training of PAs has been ad hoc, with no formal sign off of competences. There was mandatory training but this is universal training, not specific and while it is called 'mandatory' it's not actually mandated, there are no controls or measures if the training isn't undertaken"

Project Support/Training Provider

7.2 Stakeholder Learning

The individual Site leads and wider project stakeholders had a significant learning curve at the start of the project in order to understand the QCF regulated qualifications/units and the various models available for training delivery and assessment of competence. This personal learning was highlighted in the reflective work done with site leads.

Site leads identified learning around not only the QCF units but also internal organisational learning. This included the processes for contracting, finding and choosing a training provider and working across multiple stakeholders across health and the local authority. They also began to establish protocols around delegation of clinical task to PAs including identify tasks that could be delegated or not and establishing processes in relation to this.

"I know far more now about the correct processes to follow and have benefited from working with a training provider and have a better working knowledge of QCF and how this can be applied and the areas covered."

Site Lead

"I have personally had a steep learning curve relating to contracting for services, especially training organisations. As we work within NHS rules this has caused long delays in being able to proceed with the training this delay has also added to the loss of enthusiasm from PHB holders. This delay affected our relationship with the provider and posed some issues which have now been resolved."

Site Lead

Undoubtedly this learning will have had a positive impact on the Site Leads' confidence in defining, and negotiating their needs with training providers. Whatever model these sites take on next, the learning here will underpin their discussions and help them develop a solution that meets their needs.

The project site that decided not to implement QCF units was also able to outline how they had developed significant learning and implemented changes to their existing local training and development. They believe this has improved the quality of their delegation and training process.

7.3 Overall Cost

The project has shown that there is huge variation in the costs involved in the delivery and assessment of QCF units for PAs. The average cost of a unit is dependent upon many factors, including the model of training delivery and assessment and the level of the unit. Model 2, with underpinning knowledge delivered in the classroom followed by workplace assessment, resulted in the lowest cost per unit. Model 1 carried a higher cost per unit due to the bespoke nature of the underpinning knowledge training delivery to a small number of PAs at any one time within their place of work. Model 1 was also followed by workplace assessment of competence.

Qualitative work with the project sites outlined how negotiating the delivery of individual units restricted the availability and willingness of training providers to engage. At the time of seeking a training provider to work with through the project, many of the sites had not fully worked through who would be trained and on what units. This may have made finding suitable training difficult, and may also have made some providers reluctant to engage in the project.

Some of the sites outlined how finding a training provider to work with, that could provide the flexibility required, was very difficult. In some cases this lack of choice of training providers then made negotiation on price difficult.

> "We had big issues finding a suitable training provider, when there is no choice it is difficult to negotiate in terms of finance, especially when you are working to a tight deadline to get things delivered in the timescales of a project"
>
> **Site Lead**

Other sites were unable to deliver level 3 QCF units as the training provider required sign off of competence to be completed by a healthcare professional and they felt the cost therefore became prohibitive within the scope of the project. The requirement of the SfH QCF Assessment Principles is that the person signing off competence has to be occupationally competent; it does not dictate the job role of the assessor. However, in practice particularly in healthcare the higher the level of QCF unit being delivered, the more likely it is the assessor will have significant clinical experience and be a healthcare professional.

Within the project we found the average cost of unit delivery to vary between £75 and £650 per QCF unit.

The issue of overall cost needs to be balanced against the quality that can arise through highly personalised, bespoke training that is made relevant to the individual circumstances of the PHB holder or PA.

> "Mandatory training/off-site generic training is not people-centric and not highly rated by the PAs"
>
> **Training Provider**

7.4 Engagement of PAs

In order to progress the training and to understand what could be delivered in each site, all of the site leads actively engaged with PAs at the outset. The activity undertaken varied from questionnaires (both online and by post) to short face to face discussions.

All of the site leads reported high levels of enthusiasm from PAs to be involved in the project. However, as the training was made available, some PAs who had expressed an interest in being part of the pilot decided not to engage with the project further. Lower take up is not uncommon in any training activity, but, for some sites and PAs, they were unable to undertake the training as the health status of the person they care for had deteriorated and they were no longer able to commit to it. It is therefore clear that there are some unique features of the PA role that can impact upon the ability of PAs to engage in training activities.

> "PAs felt enthusiastic about having the opportunity for accredited learning and overall felt valued to have a voice."
> **Training Provider**

However as another site lead noted:

> "It was necessary to cancel the first of the basic training groups due to minimum take up by PAs."
> **Site Lead**

There are therefore some important facets about the employment of PAs that impacted upon the ability of PAs to continue to engage with the project. At least two of the sites reported that either PHB holders had sadly passed away or had been admitted into residential care. This meant that PAs that were willing to participate in the project found themselves no longer employed as PAs and therefore unable to participate in the project further.

The experience of the project in respect of engaging with PAs in the research is that there were challenges in engaging them remotely; responses to online questionnaires were very low across all sites. The conclusion from this is that any further work with PAs may need to be done face to face or be facilitated by a face to face discussion from site leads. It is also important that further evaluation activity reduces the number of individual times PAs are required to engage with the project. There is a need to maximise the intelligence that can be gathered in as few contacts as possible.

7.5 Engagement of Healthcare Professionals

At the outset of the project many of the site leads actively engaged with healthcare professionals in order to understand what tasks were likely to be delegated to PAs in their locality. This information was used to narrow down the full list of QCF units that might be delivered.

Unfortunately, beyond this activity, site leads found it difficult to maintain engagement with healthcare professionals. The vast majority of PHB holders engaged with the project were existing PHB holders with established PAs. These PAs in place were already delivering the delegated healthcare tasks relevant to the QCF units they were receiving training in. Together this meant that the need to engage with health professionals was limited as the tasks were already delegated.

One key question for the phase of this work was to try to understand if the use of QCF units in the training of PAs makes healthcare professionals more likely to sign off and delegate healthcare tasks. However as yet there is insufficient evidence for us to form a view on this

7.6 Experience of the PAs

The feedback from PAs, although limited in overall number has been overwhelmingly positive in relation to their experience throughout the training process.

In broad terms all PAs, for which we have received feedback data, rated the training as excellent (84%) or good (16%) and 95% of PAs indicated that they felt more confident after the training.

PAs who received training in the workplace particularly valued the flexibility of the training provider; PAs noted that they felt "more comfortable" undertaking the training in their familiar work environment and that there was "flexible arrangement adapted to our training needs".

PAs also appear to have valued the breadth of the knowledge provided by the QCF approach. The following is a selection of comments from PAs in relation to how they and their employer have benefitted from the training.

"It has given me a broader knowledge of the subject matter"

"It has given me a better understanding of my client's condition and is helping me to manage it better"

"A better understanding of how the body works. Learned a lot"

"Have gained so much knowledge for care observation and prevention of pressure area"

"Feel more confident and understanding especially from the law aspect"

"More thorough knowledge to improve everyday tasks"

PAs Feedback from post-training questionnaires

The commitment and enthusiasm of PAs that site leads and training providers spoke about in their qualitative feedback was also evident. 100% of PAs who had undertaken QCF units and responded to the post-training questionnaire said that they would like to undertake further training in the future.

7.7 Experience of Training Providers

We conducted a focus group with training providers as part of the project activity to understand how they had found the process and any learning points that could be shared wider.

This intelligence points to some interesting themes:

Preparation work with site leads and CCGs

The training providers felt that they had all had to work to educate the site leads around QCF regulated qualifications and that there was lots of work needed to understand the requirements of the sites and find a solution that would fit.

"They knew what they wanted but not necessarily how they could get it."

Training Provider

Some training providers also highlighted how this work took much more time than they or the site leads thought it would. Understanding what needed to be delivered and at what level was necessary before they could move forward with the design and delivery of training.

"We probably spent three or four months trying to decide on what units should be delivered and whether they should be at level 2 or 3."

Training Provider

Qualification approach vs unit approach

Many of the training providers felt torn between trying to deliver full qualifications versus delivering individual units. They felt the remit of the project was clearly on individual units however their natural tendency was to perhaps identify where people might be able to undertake full awards.

They were keen to highlight how the delivery of units in a mix and match approach is maybe easier, however the learning for the individual is perhaps not as great or broad as when they are undertaking a full qualification. They also acknowledged how full awards were potentially more attractive to learners.

Providers did acknowledge however that full qualifications were not suitable for all PAs. For many PAs the narrow scope of their work would not enable them to fulfil the practical elements of a full award. There was clarity that this group of learners needed an offer in terms of training that is flexible, responsive and adaptable; there is no 'one size fits all' approach that would work.

Cost

The training providers were acutely aware of overall cost within the project. There were several financial barriers that they felt had impacted on delivery.

Delivering level 3 units was seen by some as prohibitive in terms of cost, particularly in a model that was very individualised and delivered in the PHB holders' home. The main reason given for this was the belief that they needed to use a health professional in the training or sign off and that, as these skills were not within their existing workforce, they would need to contract them in at additional cost.

PA ability and commitment to training

Many of the training providers expressed that the calibre of PAs undertaking the QCF units was high. They described how they found them to be highly engaged, knowledgeable and enthusiastic.

7.8 Experience of the Site Leads

All of the site leads fully engaged in the qualitative intelligence gathering as part of the project.

There are some common themes experienced by many of the sites that have important learning and implications around sustainability. These are presented below.

Understanding QCF

Many of the site leads highlighted their personal learning that had taken place in respect of the QCF and how they could use the units to train PAs. They valued the advice and guidance they had received and many highlighted how they felt they would be more confident should they need to work with training providers in future.

The training provider

Having a good training provider was cited by all of the projects as key to successfully delivering QCF units. However many also highlighted that finding a training provider that was willing and able to deliver what they required within the scope of the project was often difficult.

"There were some difficulties in getting training providers to commit to the programme there were initially two providers who were prepared to undertake the "Theory" elements. However only one of the providers was prepared to commit to the programme without significant pump priming."

Site Lead

Through the experience of the sites we have developed some important considerations when sourcing a training provider to provide training to PAs. As a minimum, site leads outlined the importance of sourcing a training provider that is:

- Able to work with stakeholders to understand the training requirements across the locality
- Flexible and can adapt to the requirements of PAs
- Able to appropriately contextualise the learning they deliver to the role of PAs
- Able to deliver training and assess competence at the appropriate level required by employers and commissioners

7.9 Impact of the Project

In terms of delivery of achievement of QCF units, below is a list of the units achieved as part of the project across all of the sites:

Level 2 units		
Principles of safeguarding and protection in health and social care	Handle information in health and social care settings	Communication skills for working in the health sector
Carry out personal hygiene for individuals unable to care for themselves	Support individuals to eat and drink	Move and position individuals in accordance with their plan of care
Meet food safety requirements when providing food and drink for individuals	Assist in the administration of medication	Receive and store medication and products
Support individuals to manage continence	Assist in implementing treatment programmes for individuals with severely reduced movement/mobility	Undertake agreed pressure area care
Level 3 Units		
Administer medication to individuals, and monitor the effects	Safe administration of medication and monitoring techniques for individuals with diabetes	Assist in the implementation of programmes to increase mobility, movement and functional independence
Prepare for and carry out extended feeding techniques	Care for individuals with urethral catheters	Provide support to continue recommended therapies
Promote nutrition and hydration in health and social care settings		

There is some evidence of impact within this stage of the project; however the numbers of PAs and PHB holders participating in the project in some sites was too small to make any generalised statements of impact. Some of the stronger evidence is therefore drawn from a single demonstrator site and should be read with some caution.

As per the pre-course questionnaires, it was very difficult to engage PAs following their achievement of QCF units in terms of gathering their views on the process. In many sites the training providers undertook post course questionnaires and some of this data has been shared with us.

Much of the information we have around impact is expert testimony or anecdotal data drawn from the focus group with the training providers, feedback from site leads and post course evaluation from PAs. This evidence is drawn together in the sections below.

For at least one site, the volume with which they have been able to deliver training has meant that they are now looking at the possibility of setting up a registry of PAs who have completed training and assessment of competence that is quality assured.

> "One outcome that is still to be achieved is a register of "Trained PAs" that are quality assured by trading standards. (This is a work still in early stages of development)"
>
> **Site Lead**

7.9.1 Impact on PAs

Some of the sites provided information in relation to how taking part in the project has changed and improved the practice of PAs. The focus group with the training providers also surfaced lots of anecdotal evidence relating to PAs and the positive impact of the training. The positive impact on PAs is a significant outcome of this phase of the project.

> "PAs are telling us that the training has encouraged them to be more involved and aware of what they do"
>
> **Training Provider**
>
> "Anecdotally PAs and PHB holders have reported back on how their practice is being positively influenced"
>
> **Site Lead**
>
> "I have no doubt that what we have done has empowered some of the PAs; they tell us they feel like they have prospects now"
>
> **Training Provider**

In one of the demonstrator sites the training has been the catalyst for PAs to begin to set up their own PA networks and to look at ways in which they can work together for the benefit of their PHB holder.

> "One consequence of the training is that PAs are networking amongst themselves for the first time. This has already led to PAs picking up shifts with other PHB holders and backfilling for holidays etc."
>
> **Site Lead**
>
> "PAs can be isolated, the training gave them an opportunity to meet other PAs and get them working together, developing networks"
>
> **Training Provider**

Many sites also pointed to the way in which PAs have developed personally as well as professionally through the process of the training.

> "You can see the self-esteem of the PAs literally growing in front of your eye, it's wonderful to see"
>
> **Training Provider**

7.9.2 Impact on PHB Holders

Because of difficulties engaging with PHB holders directly there is limited evidence around the impact in this area. There is some logic that can be applied to the positive impact on PAs and how this would impact on PHB holders but actual intelligence gathering in this area is limited.

The ability to offer training to their PAs is attractive to some PHB holders;

"As employers PHB holders told us they liked being able to offer something more to their PAs"

Site Lead

"An unintended consequence has been that we have given the PHB holders the opportunity to offload a little, through the process we have found examples of welfare issues, benefits that were not being claimed etc. and we have been able to rectify this"

Site Lead

7.10 Sustainability

One of the key questions regarding the use of QCF units to train PAs is whether such an approach is sustainable. There was a mixed picture in terms of site lead views on this issue, many of the sites felt that it was too costly, however the model of training that utilised a classroom based approach was perceived to be more sustainable in terms of cost. Most of the sites felt however that the training took too long to implement and, although they could see the benefits of providing wider knowledge and understanding around areas of care, they noted that for some areas this was felt to be more than was necessary in order to delegate the healthcare task safely.

Towards the end of the project site leads were already contemplating ways in which they could use the knowledge they had gained to adapt and improve the training process in the future.

"Although the way PAs are trained needs to be reviewed I don't think using the QCF units is necessarily the most appropriate approach. I think a more flexible approach which can be put in place as soon as someone becomes eligible for CHC or employs a PA is needed.

I think a better approach would be to work in partnership with a local hospital that already has a training programme in place to train their nurses and support staff. We didn't use our local hospital for this project as they did not offer QCF units."

Site Lead

"I will be interested in the feedback from PAs once they have been through the process to gather their views on suitability."

Site Lead

Conclusions

The evaluation activity within this phase was designed to answer the following research questions:

> *"Are QCF units a suitable way to train PAs in delegated healthcare tasks"*
>
> *"Does the use of QCF units enable healthcare tasks to be delegated to PAs from registered professionals?"*

The review of the evidence gathered indicates that, whilst **QCF units can be used** to provide the knowledge and skills base necessary **to train PAs on healthcare tasks**, sites felt that the time required to complete and the relative complexity of the QCF units mean that they do not fit with the requirement for timely delegation. The cost of delivering the QCF units was also considered to be an issue in terms of sustainability however the issue of cost is related to the model that is implemented.

There were many successes achieved throughout the project, significant outputs were achieved in respect of the number of QCF units delivered and the number of PAs and PHB holders engaged in the project. Positive impacts have been identified across the whole range of evaluation activities for site leads, PAs and PHB holders. PAs valued the breadth of learning they were able to undertake as part of the QCF unit approach. They outlined how this had given them a greater understanding of their day to day activities and how they believed this would enhance the care they provide. Site leads developed their knowledge and understanding of the training process and regulated qualifications.

This report outlines the evidence gathered throughout the duration of the project, in any evaluation activity there are always potential long term benefits that cannot be examined within the restricted timescales available. However, there was a strong belief from sites that investing in the skills of PAs would have other positive impacts upon issues such as recruitment and retention of staff.

There were some aspects of delegating healthcare tasks that remained untested through this phase of the project. The training activity undertaken was with existing PAs who were already undertaking the healthcare tasks for which they were receiving training. It was therefore not possible to examine the interface between the training approach and the act of delegation itself. **Questions therefore persist around how high quality training and robust assessment of competence based around QCF units can assist delegation of healthcare tasks to PAs**.

Throughout the course of the project there has been significant learning that has occurred for all stakeholders in relation to successful delegation and the design and delivery of training to PAs. One of the most important aspects is that any training process or protocol must be embedded within and support the local delegation process so that there is clarity around issues of what tasks can be delegated, where training is available from and who is responsible for assessing and signing off competence of PAs. CCGs and commissioners therefore need to consider how best to meet the need for training and assessment of competence associated with delegating clinical tasks to PAs and put in place clear protocols and delivery plans.

Commissioning the right training provider is crucial to the success of training PAs. Not only do PAs require high levels of flexibility in how and when training is delivered, the training that is provided has to be appropriately contextualised to the role of the PA, with training providers recognising how this role is different to other roles in the sector. The provision of a structured programme of training, with formal recognition of learning and portable qualifications, could contribute significantly to PA recruitment and retention and the career development for PAs. Creating a role that is supported through appropriate skills and development should assist in creating careers for PAs that are interesting and rewarding.

PAs engaged in all sites welcomed the opportunities for training and for getting formal recognition of their learning. There is also significant interest from family carers to participate in training opportunities and get formal recognition of their skills and knowledge. It is clear that this is a highly motivated part of the health sector workforce that is ready to have their existing skills acknowledged in a more formal way and to expand their skills where appropriate in order to improve the care that they provide.

Many of the sites felt that they had matured a lot over the course of the project in respect of the learning that had taken place around how training PAs might work in future. The site leads were therefore **keen to build upon the successes** they had achieved in the project to adjust their model and test a solution to training PAs that is cost effective, flexible and sustainable.

Appendix – Case Studies

Case Studies follow – this page is intentionally blank

Training Personal Assistants in Delegated Health tasks in Kent

Background

Kent County Council in partnership with local Health sector organisations has been working with PAs and PHB holders to see if using units from existing health and social care qualifications within the QCF was the most appropriate way of training PAs in delegated health care tasks.

Why train PAs?

The role of PAs in the health sector is an emerging one and the demand for these skills is likely to increase in the future as more people with complex health needs request PHBs.

Historically there has been little focus on the skills and training needs of PAs and training has sometimes been ad-hoc.

In 2013 Skills for Health was commissioned by the Department of Health to review issues relating to the availability and delivery of quality assured training for PAs working with PHB holders. This work showed that most core and technical PA competencies are described in the National Occupational Standards and can be mapped to existing units in qualifications accredited to the QCF.

The Project in Kent

Kent was one of five pilot sites across the country to receive funding from NHS England 2014/15 to see if using units from existing health and social care qualifications within the QCF was the most appropriate way of training PAs in delegated health care tasks.

Working in partnership with a local training provider KCTA, a model of training was developed that meant PAs were trained and their competence assessed in small groups within the workplace.

The Project Outputs

- Training packages were developed for the following QCF units and mapped to delegated healthcare tasks
    - Pressure Area Care
    - Medication
    - Feeding Techniques
    - Managing Dysphagia

- 11 Personal Assistants and 2 family carers achieved between one and three QCF units

The Project Outcomes

- The training is high quality, individualised and valued by the PAs and family carers that have participated in the project
- PAs and family carers feel more confident in their role and in discussions with health professionals
- It is hoped that a greater focus on the training of PAs and the delivery of high quality training will make it easier for healthcare professionals to delegate healthcare tasks to PAs in the future

Case Study

One of the family carers that took part in the project has 2 daughters that are in receipt of Continuing Healthcare funding, one of which, Lisa*, receives this as a personal health budget and employs a PA. Both the family carer and the PA achieved QCF units in Administering Medication and Monitoring the Effects and Carrying out Extended Feeding Techniques.

Due to the personalised approach of the training provider, the family carer and PA received the training at the family home. If the training provider had been unable to facilitate this, then neither the family carer nor the PA may have been able to do the QCF units, as it was very difficult to get shifts covered by appropriately trained agency staff. The training provider was also able to tailor the training to their specific situation.

Being part of this project was a very positive experience for both the family carer and the PA. Following the training they both felt more confident and empowered, in terms of supporting the daughter, instructing other PAs and in discussions with agencies and health professionals. They both felt they were able to more quickly identify if there was a problem and what needed to be done to resolve the situation.

The family carer described one situation where she felt sufficiently empowered by her training to have a discussion with the dietician about changing the feed given to her daughter that was PEG fed. Gaining a qualification in Extended Feeding Techniques had given her the necessary knowledge and confidence to have this conversation which meant that action could be taken more quickly and her daughter saved a great deal of discomfort.

Another positive aspect of the training, in particular for the family carer, was gaining a formal qualification. It was important that the learning was accredited and contributed towards a qualification.

“This has been an invaluable experience. I would love to get qualified in what I do and have something to say that I can do it.”

* Not the PHB holder’s real name

Learning from QCFs in Oxfordshire

Background

Oxfordshire has a long history of delegation of healthcare tasks to non-registered care workers. The model of community nursing that has been in place since 2001 means that delegation and training is routinely carried out, supported by a Shared Care Protocol.

The Shared Care Protocol (SCP) is a joint working protocol between NHS Oxfordshire CCG and Oxfordshire County Council. It identifies 31 healthcare tasks delegated to paid care workers by an NHS clinician, a framework for training, and for older people and physical disabilities clients, a system for allocation of funding (health contribution) to support healthcare delivery by non-NHS care workers.

The clarity of this protocol, together with a clear delegation and training process means that Oxfordshire joined the project with existing processes that were robust and embedded within all stakeholder organisations.

The Project in Oxfordshire

Oxfordshire were keen to explore if having a relevant QCF qualification aided healthcare professionals in delegating healthcare tasks to non-registered workers.

The pilot site believed that if they could also link the model of delegation to QCF qualifications or units they could provide a training pathway linking to the QCF and ways to contribute to continuing professional development for a growing PA workforce that would also benefit clients.

Oxfordshire hoped that developing links to the QCF would:

- Help with the portability of training between clients
- Reduce the burden and need to repeat training for PAs moving between clients
- Assist/aid the delegation of healthcare tasks to paid carers
- Improve the wider skills of the PA workforce
- Improve care for patients

The team within Oxfordshire worked with a local training provider to undertake a significant amount of work to map their existing training within Oxfordshire under the SCP to the QCF units that were available. This work identified that the scope of the QCF units were in some cases much broader than the training under the SCP with many of the existing training packages mapping to a single QCF unit. There was existing training under the SCP that did not map to any QCF units, particularly in relation to continence care, tracheostomy, respiratory and laryngectomy care.

A move to providing QCF units would have meant that some PAs would have been undertaking learning and skills acquisition that were broader than the existing threshold for delegation and therefore more time consuming than the current training offer. Because of the gaps in the QCF units available, Oxfordshire would have had to run two pathways for training; one linked to QCF and one using local training where QCF units were not available.

The site leads, having mapped all of the existing training therefore took the view that they would not continue with the proposed QCF approach within Oxfordshire.

Learning from the QCF Unit approach

Even though the decision within Oxfordshire was that they would not move forward in the use of QCF units to train and assess the competence of PAs on delegated healthcare tasks, there was important learning that the site leads gained from their experience of looking at the QCF. They have therefore taken this learning and implemented it within their local training process and pathways.

Following the project, Oxfordshire are also expanding the training content for some healthcare tasks to ensure best practice is embedded and wider knowledge and understanding is developed.