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Skills for Health

New Roles and Progression Pathways in Newham University Hospitals Trust

Assistant Practitioners

Newham University Hospital NHS

NHS Trust

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Introduction

'Growing Your Own: a Practical Guide to Growing Your Own Professionals for the New NHS' is about learning and career progression for staff in Agenda for Change pay bands 1 to 4 and is aimed at NHS organisations in England. It is available as a PDF at www.skillsforhealth.org.uk. It emerged from a government funded project called 'Growing Our Own Professionals for the New NHS', and distils the key messages from all project work stream reports into one succinct and usable guide for health sector organisations. The project's central aim was to produce an integrated model of progression for healthcare employers to use that would set out how staff in Agenda for Change pay bands 1 to 4 could be supported to progress through learning and career interventions into assistant practitioner roles at band 4 or into pre-qualifying professional training. For all reports produced by the project, go to www.skillsforhealth.org.uk/gateway-reports

This case study was commissioned to test the usefulness of the guide against the realities of front line delivery of an NHS Trust. Newham University Hospital Trust (NUHT) was involved in the original project and was approached and generously agreed to share its experiences of assistant practitioners for the case study. All the key people involved in the Trust's assistant practitioner and foundation degrees programme were interviewed including the learners, clinical mentors, matrons, programme facilitators and senior managers in workforce planning, midwifery and nurse education.

The many issues arising from the interviews neatly cohere under the following section headings to give the case study its structure:

- Improving patient care
- Utilising the skills of assistant practitioners
- Increasing the capacity of clinical teams
- Ensuring the quality of learning
- Providing effective learner support
- Integrating service redesign with workforce planning and learning for progression
- The business case for assistant practitioners.

The case study is written at a time of increasing focus on productivity linked to improving the quality of patient (user) outcomes. The new assistant practitioner roles are key to delivering services re-designed around the clinical patient pathway. The case study chimes with government objectives for local delivery of an integrated patient led service redesign model linking finance to multi disciplinary workforce planning and learning and skills development, with a focus on bands 1 to 4:

'Many of the ***existing processes and ways of working have developed over time and follow traditional patterns by looking at supply and demand factors in single professional silos.*** *The potential for improving quality and productivity through skill mix change and developing the wider health care team including those in career framework levels 1-4 is underdeveloped.'*
(Developing the health care workforce - consultation proposals published in December 2010)

The wealth of experience the Trust is acquiring from assistant practitioners in clinical areas is evident from the report. This experience taken together with its strong commitment to the programme and its determination to embed it over the long term, makes NUHT's reputation as a leader in this area fully deserved. The Trust and Skills for Health wish to share this case study with its good practice and practical tips, and hope it will be useful to a wide range of NHS organisations, learning providers, trade unions, and professional bodies who are engaging with assistant practitioner roles.

Insights from the Practical Guide which could be used to benchmark current Trust practice are cross-referenced in the following grid which was originally devised as a tool to summarise where Trust practice supports the guide, diverges from it, or adds new interesting practice and themes that it missed.

Key points from the Practical Guide	Additional points from the NUHT case study
a) Improving patient care	
• The wider health care team is essential to the quality of patient care • Curricula for assistant practitioners should be designed around the patient pathway • Learning should be measured for its impact on care quality • Involve service users and carers in the design and delivery of learning.	• Many examples of how patient care has been improved by assistant practitioners • Need for systematic impact evaluation of learning recognised • Examples given of how the foundation degree curricula are designed around the patient pathway • Steps to achieving Public and Patient Involvement in learning design and delivery are given.
b) Utilising the skills of assistant practitioners	
• Review team skill mix and reallocate roles with assistant practitioners included with clear boundaries • Ensure job descriptions are job evaluated under Agenda for Change • Involve unions in the process • Engage team leaders and qualified staff in the design of the new role at an early stage • Ensure mentors, managers and qualified staff in the team are aware of the curriculum and involved in assessing and signing off competences • Plan for posts to be available for assistant practitioners on successful completion of the course • Introduce a standards driven framework for practice based learning.	• Well developed skills utilisation method at NUHT including clinical team involvement in learning design and delivery, job role design and acquisition and signing off of competence according to a rigorous quality assurance procedure • Distinctive uniforms for assistant practitioners • How the role boundaries are clearly set • Business planning method to fund band 4 posts in the team once trainees have completed the foundation degree.

c) Increasing the capacity of clinical teams	
• Assess the impact of new band 4 roles or extended roles at band 3 on the team workload and make adjustments to the team as necessary • Recognise and reward staff learners' achievement • Have a method to ensure that learners can use their new skills in the workplace under supervision.	• Many examples of how assistant practitioners increase the capacity of clinical teams • Need to capture good practice and share with teams without assistant practitioners.
d) Ensuring the quality of learning	
• Involve staff, patients and unions in curriculum design • Ensure the learning provider delivers the curriculum that you need • Ensure teaching staff are occupationally competent and empathetic • Ensure that mentor and supervisor roles are clear and support is provided for them • Ensure that learning delivery methods are varied and suit the needs of workplace based learners • Ensure learning is transferable and supports progression into higher pre-qualifying training • Devise a learning agreement to support staff learning with the staff side unions.	• The collaborative partnership between the University, the clinical teams and the learners is described • How teaching staff keep up to date with the latest practice is described • Course units are based on National Occupational Standards. • How the balance is struck in the curriculum between the genericism required by supporting the patient pathway versus the specialist skills needed by specific clinical settings is described • The need for a formal programme committee to monitor and evaluate learning and support is identified to underpin the informal feedback loop operating between teaching staff and the clinical areas • Examples given of how the University responds to changing practice in the clinical areas.
e) Providing effective learner support	
• Ensure the learning provider specifies how they will provide study skills support • Consider devising a bespoke Careers Information and Advice framework for the workplace • All the elements of a personal learning support network identified, including the role of union learning representatives • Web based and open source technologies can be used to provide e-learner support and create electronic peer support networks.	• Examples of the difficulties faced by work-based learners given and how the University and employer have responded • The triangular method of learner support between the clinical mentors, the facilitators and the University staff described in detail • How the University briefs the clinical mentors and ward managers on the curriculum and their support role is described • NUHTs Learner Support Model highlighted.

f) Integrated service redesign, workforce planning and learning progression	
• Set up a learning committee as a mechanism for involving union learning representatives in the learning and development strategy • Set up a multi disciplinary project team to bring those involved in service redesign together with workforce planners and education commissioners and plan a new roles strategy • Design transparent learning and careers progression routes as part of the learning and development strategy • Sources of funding for learning identified.	• The need for an integrated service redesign, workforce planning and education commissioning approach in the Trust is recognised • The challenges involved in achieving that objective are discussed • Many elements of an integrated approach are already in place and are described including the business and workforce planning approaches used • The need for seamless progression routes around the patient pathway recognised • Student selection procedure described • A model of integrated service redesign, workforce planning and learning progression is given.
g) The business case for assistant practitioners	
• Business case needed to underpin the case for investment in assistant practitioners • Need for impact evaluation to support the business case going to the board and covering impact on productivity, team performance and quality outcomes • Board support needed for investment in the learning and development strategy • The essential elements of an impact evaluation providing evidence in support of the business case are given.	• The case study locates assistant practitioners within the QIPP agenda • The case study assesses the changing funding regime and the possible effect of Skills Networks on assistant practitioner programmes • The case study argues for a board led investment strategy in assistant practitioner programmes underpinned by impact evaluation • The case study includes the list of essential elements to address in a business case and suggests what evidence is needed from the impact evaluation. • There is an NUHT costing model for assistant practitioners.

Thanks are due to all of the Trust staff who have been very generous in giving up the time to speak to us and support us in carrying out this project, despite the fact that they are very busy people. The Trust is to be commended for openly sharing its experience and innovative practice.

Improving patient care

The Practical Guide and the whole 'Growing Your Own Project ' was inspired by Lord Darzi's 'High Quality Workforce Report' of 2008. This report recognised the critical importance of designing pay band 4 support roles around the clinical patient pathway if we are going to significantly improve the quality of patient experience. The Trust has shaped its assistant practitioner programme to support the improving quality outcomes and patient pathways agenda, despite the fact that it was also originally introduced as a response to the Hospital at Night programme and as a 'grow your own' solution to nursing and midwifery staffing shortages:

"The patient is at the centre of this… As the patient progresses on their journey through, with the clinical assistant practitioners (CAPs) there are more people around to provide the contact and the care requirements that the person needs. With paperwork and assessment and booking and evaluation, it doesn't have to be the registered nurse to do that. The CAPs can settle the patient in. They can make them feel confident and reassured and do their observation. They don't have to wait around for a registered nurse to do that. So it's just at every point in that patient's journey there are other people with skills, so it makes it much more streamlined and much smoother. But also from the quality point of view, it enables the registered staff to focus more on the advanced support that is required."
(Lead Nurse for Education and Professional Development)

The Head of Midwifery explained how the midwifery assistant practitioners (MAPs) in his community midwifery team support the midwife in the delivery of care:

"There's lots of ways they are helping us. By providing the care, by improving care and satisfaction, by reducing complaints. By releasing other members of staff to provide one to one care in labour by a midwife because that is what is needed in labour, which they cannot do if they are distracted by providing routine post natal care and carrying out observations and doing those sorts of things. So the MAP provides the care and support necessary to enable the midwives to deliver care."

There are many similar stories about how assistant practitioners improve patient outcomes from across the Trust. However, more objective evidence from the patients, their carers and families about the impact of the assistant practitioners is needed, for a number of reasons:

- It is good for the morale of assistant practitioner staff to have clear feedback about the impact, both positive and negative, that the care they are providing has on patients and public. It is often the case that staff have no sense of whether they are doing a good job, because too often patient and public feedback about their care comes to them via the complaints procedure.
- Structured and objective feedback to the clinical teams about the impact their assistant practitioners are having on care will lead to higher visibility for them and better recognition of the positive contribution they make. This in turn will increase their acceptance by professional staff within the clinical teams.
- Harder evidence of impact could be used to promote the introduction of new roles into clinical and other areas of the Trust where assistant practitioners do not yet exist or where their skills are not being sufficiently utilised. Good practice captured in an impact evaluation can be shared across teams and used to improve practice.
- The results of impact evaluation in terms of what works and the way patients and their carers perceive the role can be usefully used as teaching material in the foundation degree courses.

Many trusts already undertake work on the patient experience of care so are therefore well placed to build Public and Patient Engagement (PPE) into assistant practitioner role design, curriculum design and delivery of learning. It is worth noting that PPE in role and curriculum design aligns with the government thinking in this confluence of workforce development, curriculum design and PPE:

'To support healthcare providers in working together to develop strong and effective local arrangements, (for provider led workforce planning), this consultation proposes a number of duties on any provider of NHS-funded care:

- *A duty to consult patients, local communities, staff and commissioners of services about how they plan to develop their workforce;*
- *A duty to provide data about their current workforce and future workforce needs;*
- *A duty to cooperate in planning the healthcare workforce and in the planning and provision of professional education and training'.*

(Ibid P34)

Improving Patient Care - Points for trusts to consider

- Undertake an impact evaluation to show any effect that assistant practitioners are having on quality of care
- Devise and implement a plan to engage the public and patients directly in :
  - designing and amending band 4 assistant practitioner roles
  - contributing to evaluation of how assistant practitioners impact in practice on patient care outcomes
  - designing of relevant foundation degree (or other qualification) curricula for trust assistant practitioners - in collaboration with the university
  - involving patients and public in foundation degree validation and revalidation - in collaboration with the university
  - the delivery of learning - in collaboration with the university.

Utilising the skills of assistant practitioners

There are a number of potential barriers to prevent the skills that assistant practitioners have learned on their course being fully used in the workplace .These potential barriers need to be tackled if the significant investment of time and effort in learning and workforce re-design is to be realised in improved outcomes. To encourage clinical teams and professional staff to fully use the skills of trainee and qualified assistant practitioners requires careful planning and relationship management. How the learning provider ensures that the learning is relevant and has credibility with both learners and supervising professional staff requires close collaboration and empathy between teaching staff and the clinical teams. NUHT is evolving a skills utilisation methodology for tackling this critical issue and this is described below.

Professional staff are the guardians of high quality care and patient safety and each of them are accountable professionally for the actions and omissions of any unqualified member of staff to whom they delegate tasks. When assistant practitioners undertake high level procedures such as cannulation, which are normally the remit of qualified nursing staff, those nurses will need to be confident that assistant practitioners will perform such procedures effectively and safely. In addition, both registered staff and assistant practitioners will need clear boundaries drawn between their respective roles. Any blurring of boundaries has the potential to create confusion, even conflict, and could dissuade the registered practitioner from delegating any higher level tasks.

Professional staff will also need reassurance that their own jobs are not under threat from the less expensive assistant practitioners. Although there is a need to do things differently and great pressure on all trusts to increase productivity, NUHT does not see the assistant practitioner programme as being crudely about replacing nurses with clinical assistant practitioners (CAPs):

***"The focus is all around quality, safety and efficiency. It is not about reducing qualified staff, although it is going to have an effect because you don't need as many band 5s if you have a more advanced and skilled band 4. You might go from an establishment of six band 5s, down to four band 5s, and two band 4s. But at the end of the day they still require supervision, because the band 5s will have the responsibility and the accountability"* (Lead Nurse for Education and Professional Development).**

With nurse workforce annual turnover approaching 10% in many parts of the country, it should be possible to shape teams over a two year period without threatening any individual's jobs even though the skill mix might change.

The Practical Guide states that involving professional staff and clinical managers in the design of the new band 4 role *at the outset of the programme* is a necessary starting point in securing their support. In NUHT, this first step is achieved by the Lead Nurse for Clinical Workforce and the Lead Nurse for Education and Professional Development combining to undertake a skill mix review with matrons and band 7 ward managers, with the aim of identifying opportunities where the introduction of a band 4 role might benefit the patient and the clinical team.

Once the opportunity for developing a new role is identified, the next step is to work up a job description for the band 4 post .The clinical team leaders continue to be involved in designing the role over time as it becomes clearer what skill set is actually needed in light of experience. Clinical assistant practitioners work in a variety of clinical areas such as Outpatients, ITU, Sexual Health, Care of Older People, Medicine, Surgery and Gynaecology. The Trust has trainee CAPs who have completed their training within Emergency Department and Coronary Care Unit but are not currently employed as Clinical Assistant Practitioners within these areas. There is a core of common generic skills shared by all of these CAPs, but significantly different specialist skills are also required by each clinical area. Finding the right balance between genericism and specialism is not easy but the Trust has evolved an inclusive method of finding this balance with regard to role design and writing job descriptions.

The clinical teams all begin working with a generic assistant practitioner job description, but supported by the workforce and education nursing leads, each team then develops the job description over the period of the two year foundation degree course to cater for the specific skills identified for each setting. The Lead Nurse for Education and Professional Development explains how this process has evolved since the first assistant practitioners were introduced:

"When they started we had a generic core job description (JD) because the way the foundation degree students were first facilitated, they would rotate all around the different areas, so they were really quite generic in their experience and that's the way we wanted it, because we wanted them to be able to apply for any job in any area. We would then work with the clinical teams, and work on the JD to develop the specifics."
(Lead Nurse for Education and Professional Development)

Honing the generic job description takes place during the second year of the course when the students are studying the workplace based learning units which are designed to teach the specific skills needed. In this way the teaching and the definition of the role by the clinical teams in an evolving job description are deliberately knitted together.

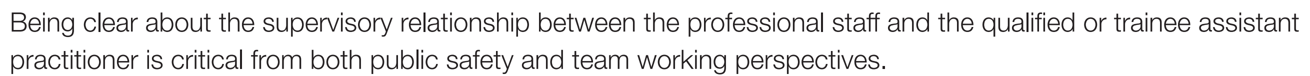
Clinical mentors play the crucial role in supporting practice based learning and the consolidation of theory and skills that the assistant practitioners have studied at university.

"I work hand in hand with the clinical assistant students every day and support them in the clinical aspects of their role. I sit down and reflect with them and offer advice and support to help clarify understanding of their roles. I sit down with them even if it is my break time and catch up with them and deal with any questions. I care for patients as well as carry out my mentor role while she is also working as a trainee CAP."
(Clinical Mentor)

The foundation degree clinical mentors advise and observe the trainee assistant practitioners as they undertake procedures such as venepuncture or cannulation. Only when the procedure has been satisfactorily completed about ten times and the trainees have demonstrated that they are confident, competent and safe will the clinical mentors or staff nurses sign off the assistant practitioners as competent to undertake the procedure in the future, under indirect supervision. Using this intensive method of observation and supervision, the professional staff grow confident in assistant practitioner capabilities, and come to appreciate the value the post adds both to their own working lives, and the reconfigured team:

"The whole idea is that they come from their clinical areas and the reason they are supported is that the clinical areas very much see that role as being part of their team."
(Lead Nurse for Education and Professional Development)

It is important that it is not just a single clinical mentor who signs off competences achieved because this could compromise quality if there is too much familiarity between the mentor and the assistant practitioner. Facilitators play a quality assurance role here. They have copies of what the supervisors have signed to keep in their own files, and can challenge this if there were too few qualified staff undertaking assessments. The intention is that most of the staff nurses in the clinical area undertake assessment, which in turn builds trust more widely across the whole team. To carry out this role registered staff as well as clinical mentors will need to understand clearly how far the assistant practitioner has progressed through the course programme, so they know when new skills and knowledge can be deployed and supervised in practice.



Being clear about the supervisory relationship between the professional staff and the qualified or trainee assistant practitioner is critical from both public safety and team working perspectives.

"Being a qualified CAP doesn't make them autonomous, unlike a qualified nurse practitioner, which means you are specialised in the role. They are assistant practitioners, that is, assisting practitioners in their role. So they are not autonomous. They are assessed and are able to do some skills but still under indirect supervision. So they are still responsible to the staff nurse."
(Clinical Facilitator)

Without the registration of assistant practitioners it is the qualified member of staff who is ultimately responsible and accountable for the tasks that they delegate to assistant practitioners, and this can make nurses and other professionals reluctant to do so. In some areas of the Trust the band 4s are not allowed to use their skills and are effectively being deployed as a band 2 health care assistant, although they are being paid as a band 4.

"I think there are some difficulties around accountability. This is a massive issue around band 4s because they are now doing things that a HCA didn't do before and are maybe doing procedures and looking after patients in ways that were previously within the remit of the nurse. But they are not accountable (registered). So nurses find it difficult to let go of something when there is no accountability around the individual. So what happens if something goes wrong? Because they are still responsible for the patient..."
(Lead Nurse for Clinical Workforce)

On the other hand, the assistant practitioners, with their extensive life and caring experience, their clinical mentoring and their two years of foundation degree level study, are well prepared to undertake some high level and complex procedures and extend their knowledge and application of learning. NUHT puts much thought and effort into managing the interface between the band 4 assistant practitioners and registered supervising staff and defining the scope of practice of each. This part of the Trust methodology is sufficiently robust to manage the problem effectively from professional accountability and public safety perspectives, and should therefore avoid the regulation issue being used as an excuse to resist introducing and using assistant practitioners.

Increasing the capacity of clinical teams

Improving patient care and increasing productivity are interlinked since the assistant practitioner can save the registered practitioner time and enable them to attend to more acute and complex patient care needs. In NUHT, the rehabilitation assistant practitioner (RAP) in care of older people is a role which includes some nursing skills alongside physiotherapy and occupational therapy skills. One of the RAPs is clear about his impact on the team:

"The team has improved. Before when catheterisation was needed they had to call the doctors but now I can do it myself. No need to call another department to do the catheterisation"
(Rehabilitation Assistant Practitioner)

His band 6 Clinical Mentor reinforced this:

"The physios are happy that there is somebody on the ward team who has physio knowledge as well as nursing knowledge. He can advise nurses about the physio side of things..... He has the skills of the physio and the nurse. It's holistic and what the patient needs…He knows how to move people with his physio skills ...but he also does cannulation as well."

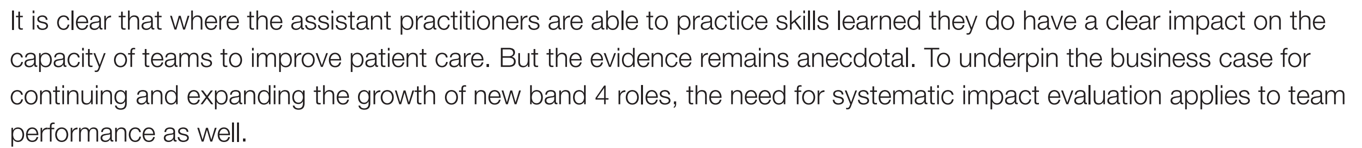
The whole team also works better if the individual qualified team member benefits personally, and if this is the case it helps persuade the registered practitioner of the need for the band 4 role to be included in the team on a permanent basis. As one clinical mentor put it about her mentee:

'She has improved a lot. She does all the cannulation. She takes the load off other team members - the qualified staff'
(Clinical Mentor)

Having credibility within their host area and having 'permission' to practice their new skills is of obvious significance to the assistant practitioner. When the programme first started, the assistant practitioner was visually indistinguishable from the health care assistant (HCA) group of staff that they came from, and more often than not they continued to be treated as HCAs by qualified staff and not allowed to practice their new skills and knowledge. The introduction of a distinctive uniform for all assistant practitioners has helped resolve this problem:

"The majority of students were HCAs, but while they are doing the course they need to practise their skills under supervision at the same time so they could become assistant practitioners. But it's hard to be doing the HCA job and being a foundation degree (FD) student as well, because the requirements for developing those skills are quite different. Like doing two different jobs. So the facilitator got them different uniforms and name badges so they were clearly clinical assistant practitioners. Because they were perceived differently in their uniform, they got the opportunity then to carry out the clinical skills that they needed to do, and participate in the care delivery that they needed to do."
(Lead Nurse for Education and Professional Development)

The uniform raised their status and self esteem but also established their position within the team, as qualified staff came to recognise this as a new and different role and began to expect more of them.



It is clear that where the assistant practitioners are able to practice skills learned they do have a clear impact on the capacity of teams to improve patient care. But the evidence remains anecdotal. To underpin the business case for continuing and expanding the growth of new band 4 roles, the need for systematic impact evaluation applies to team performance as well.

If there are areas which do not yet have assistant practitioners or where they are not allowed to practice as band 4s, it would be advantageous to capture the experience of those areas where workforce planning around the introduction of band 4 roles has been undertaken imaginatively and effectively. This learning could then be shared and discussed across teams and indeed between trusts where the assistant practitioner role has not yet been successfully introduced. The learning could take the form of both written good practice guidance reinforced via short ‘live’ face to face sessions, as well as by electronic means. The Practical Guide proposes using open source adaptive technologies to support group learning and knowledge. This is one very practical, simple and inexpensive means by which trusts can assert their corporate view of how the assistant practitioner programme should be implemented in all areas. Best practice guidance put in the hands of team leaders will also diminish the extent to which successful introduction of assistant practitioner roles depends on the awareness and attitudes of individual team leaders.

The NUHT Skills Utilisation Method

- **Involve professional staff and clinical teams at the outset**. As a first step, nurse workforce planning and education leads work with matrons and ward managers to identify where there might be space in their clinical area for an assistant practitioner role, designed around the patient pathway
- **Support the clinical team to develop a specific job description that caters for their needs**. The clinical team begins with the generic job description based on the common core assistant practitioner competences and are encouraged to amend it to make it more specific to the needs of the particular clinical area and define the role precisely over the two years
- **The university designs the curriculum to support the acquisition of specific skills and knowledge needed in each setting.** The curriculum has work based learning modules in the second year of the foundation degree which are flexibly designed to develop the skills and knowledge needed in each specific clinical or other setting
- **Assistant practitioners (APs) come from the clinical team where they will work**. APs are recruited to the programme from their clinical teams and continue to work with them for the two years of study. This builds the confidence of the team in the capabilities of the AP. They get used to having a band 4 role in the team
- **The signing off of competence is handled by clinical mentors from the clinical area.** The competences learned in theory at the university are supervised in practice by clinical mentors from the same clinical areas and often from their own clinical team. The clinical mentors and learners form a plan about how to organise the achievement of these competences. The plan takes the form of a learning contract between the learner and clinical mentor
- **The facilitator organises the acquisition of competences from outside the immediate clinical area.** Where APs need to acquire additional competences not available to them within their own clinical area, arrangements are made with the relevant department by the facilitator. The AP has the opportunity to work in another clinical area so they can acquire the competences required by the (generic) curriculum (e.g. Electrocardiograms)
- **Competence is acquired via a rigorous procedure with good quality assurance**. Competences are listed in a competence book and are signed off by the clinical mentor/supervisor after a rigorous process of observed practice in which each procedure is practiced ten times successfully before being signed off as competent in the competence book. All registered staff in the team are encouraged to get involved in assessment and signing off of competence. This builds the confidence of the responsible registered practitioners that the AP can complete delegated tasks safely
- **Boundaries of the role are clearly set.** Boundaries of the role are drawn in the job description and reinforced in the teaching where APs are equipped to recognise their own limits and know when to refer
- **Distinctive uniforms give APs visibility, status, and recognition and helps them gain the space to use their skills.** Distinctive uniforms for the APs give them recognition as a new and different role from that of an HCA. Being visible encourages professional staff and the clinical teams to make good use of their skills and to accept the band 4 post in the team
- **The clinical team is encouraged and supported to budget for the band 4 role in their establishment.** The head of workforce development works with the team to undertake the business and workforce planning necessary to ensure the clinical area has funding available to support the band 4 post once the learner has successfully completed the Foundation Degree
- **Once the learner completes the course they apply for a band 4 post via a selection process and interview.** They are not slotted into the post. This maintains transparency and effectiveness.

Ensuring the quality of learning

From the employers' perspective it is crucial that the skills and knowledge taught during the Foundation Degree do actually enable trainee assistant practitioners to deliver the competences making up their job description. But that is often easier said than done. Designing the curriculum and delivering what is needed requires a very close and trusting working relationship between the learning provider and the Trust. This process is best achieved through collaborative partnership working. The programme leader for the rehabilitation therapy foundation degree explained how the collaboration works on an everyday level:

"I think it's just that collaboration. The communication. Being a face for the University and me being out there. Being approachable. We're not a separate entity. And what the students say to me is how much they appreciate seeing me when I go out. Sometimes there are real dilemmas and students are saying I can't get this done and this is a real problem, and being really anxious. Or the mentors don't understand how it all works. So then we sit round the table and get an action plan. It's that face to face communication that makes the difference."
(University Programme Leader and Lecturer)

The collaborative partnership also works at the higher level of curriculum re-design and course revalidation. The University manages this challenge in a variety of ways. Their learners evaluate every teaching unit and the University uses their feedback. The hospital also has its service user involvement programmes including user involvement forums, and the University gets reports of these.

It is also extremely important that there is mutual respect and trust between the students and the teaching staff who must empathise with these mature students who often have domestic and work responsibilities to cope with as well as a steep learning curve to negotiate. This empathy and trust leavens the partnership between the teachers and learners:

"The tutors were very helpful. They give you one to one help. They are very, very, good. I think they realise that we are not just students who go to college. We have families and children and other responsibilities."
(Trainee Assistant Practitioner)

To make sure the curriculum continues to be relevant and accurate, the teaching staff need to be finely attuned to picking up any new procedures and care protocols being introduced in the clinical areas. It is the ongoing contact with clinical mentors, the facilitators and ward managers that keep the tutors up to date with the latest practice which they can then feed into both curriculum redesign and their everyday teaching.

There is a lot of telephone discussion between the tutors and the facilitators and, once a semester, that is every four to five months, the tutors and facilitators meet with current students and the clinical mentors in a 'mentor support group'. This meeting provides opportunities to talk about changes they would like to see to the curriculum, or changes that the University is proposing.

"London South Bank University do their evaluation of the students. We do our own evaluation as well and provide feedback to the University Foundation Degree Programme Lead and we see her anyway very often. We use this also to exchange feedback on any changes that would go in the September session which would be the new academic year. Also when the students have done their exams and coursework then we also have the time in that period to feedback and to give suggestions from our evaluation about how to help the students be more proactive in their learning."
(Facilitator)

It is worth noting that University staff teaching on the programme have clinical backgrounds and use their wider networks of friends and colleagues alongside other methods to keep themselves up to date:

"I keep up with topical issues from service users and I have friends and colleagues in mental health who keep me involved in what the issues are. For example, last September I did more on dignity and care issues and releasing time to care and the work that's been going on with that. I look at what's going on in the workplace- keeping the programme up to date. I might be doing sessions on assessments, so I need to be aware of what type of assessments are being used most. We are continually tailoring what we do to what's topical and what's new"
(University Programme Leader & Lecturer)

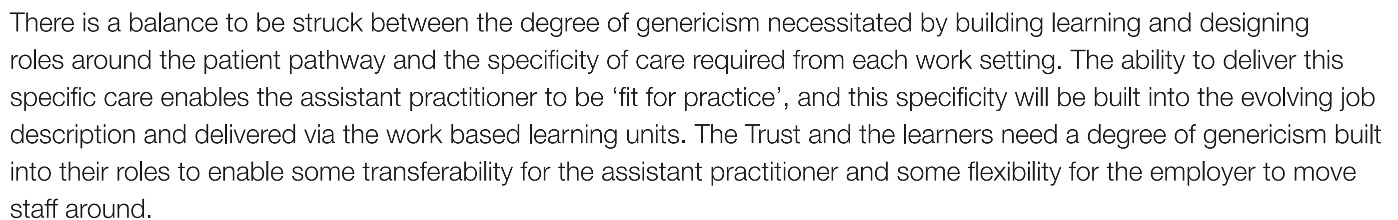
To ensure the relevance and accuracy of learning, it is also important that the competences used in the job description and then used to underpin the course Units are based on National Occupational Standards (NOS). These ensure that the learning accurately supports the acquisition of the right skills and knowledge defined in the job description, and which has been carefully designed by the clinical teams. This is important to the employer, but is also important to the learner, because the use of the NOS guarantees consistency across the country and enables learning and job descriptions to be recognised by different employers and learning providers. The NOS developed by Skills for Health are also all mapped to the NHS Knowledge and Skills Framework (KSF).

Once competences are selected for the job description, the acquisition of these by learners is achieved via the rigorous assessment procedure described earlier. One of the lecturers described how the procedure functions in teaching terms:

"For the skills and knowledge that are being assessed in the workplace, they get the competency pack in September to be finished the following May. They get that right at the beginning of the year so they have plenty of time to prepare over the 9 months. They also get a Personal Development Plan and they then sit down with their mentor to plan out how they are going to achieve their competences"
(University Programme Leader & Lecturer)

For the very good reasons explained earlier, assistant practitioners are hosted by their own clinical area where they spend around 80% of their time. Sometimes however, the course requires achievement of competences not undertaken in their clinical area or where there is insufficient expertise available to support the assistant practitioner effectively. The facilitators get involved in making arrangements between teams so that assistant practitioners can get exposure to the full range of competences required by the course units:

"They have their assessments from the University, which are practice based, so when they come into the clinical area we do a review to see what they can achieve within that clinical setting. And if in some settings, say in clinics where they don't do direct patient care and handling, then we arrange for them to go into another clinical area to enable them to competently perform the task. So, we have students in Out-Patients who rarely do ECGs. So if they have that as a learning outcome then we arrange for them to have a session in an area where the clinicians will do the electrocardiograms or go to the ward to actually assess the patient."
(Facilitator)



There is a balance to be struck between the degree of genericism necessitated by building learning and designing roles around the patient pathway and the specificity of care required from each work setting. The ability to deliver this specific care enables the assistant practitioner to be ‘fit for practice’, and this specificity will be built into the evolving job description and delivered via the work based learning units. The Trust and the learners need a degree of genericism built into their roles to enable some transferability for the assistant practitioner and some flexibility for the employer to move staff around.

The balance can be managed well if health care foundation degrees are designed upon a common core of generic units that everybody needs to complete no matter what setting they are working in. NOS are written in a generic way so they can be applied to rehabilitation therapy, whether they are working in mental health, stroke or learning disabilities settings. The specific NOS are then taught in the second year:

“What we try to do is to provide the units that everybody has to do, whether they are working in a rehab or clinical environment. I would expect anybody who is working in a ward or an outpatient’s environment, or theatre environment, to take blood pressure for example. The specifics really come in a double unit in the second year, called ‘developing skills and confidence through work based learning’, where the students are helped to draw up a contract of a specific skill that they want to do and which is relevant and useful to their place of work.”
(University Senior Lecturer)

In terms of the financial viability of courses, the University cannot afford to produce high numbers of very specific foundation degrees for limited numbers of students. However, within that financial and student numbers paradigm, the University does try to respond by listening to what trusts need and then flexibly bringing units into the curriculum:

“We used to run a unit about fluid balance, elimination and nutrition a while ago but then it was agreed that the trusts wanted it replaced with our current approach. But now changes in practice mean they now want the unit resurrected. So we will offer it as an optional unit.”
(University Senior Lecturer)

An effective feedback loop is needed between the University and the Trust to allow this rapid response to changing needs to happen. The feedback loop needs to exist informally between Trust and University colleagues and also at the more formal levels of a joint review committee and degree revalidations. The facilitators feed back their ideas about how the curriculum needs changing to the Trust manager with the lead education commissioning role for the Trust, who then brings these ideas to the attention of the main University contact by phone or e-mail. This is of mutual benefit because the University might well have learning solutions to problems that the Trust is grappling with, while the University is able to improve its offer to its clients.

There is also a need for a formal meeting mechanism between the University and the Trust to discuss curriculum and programme developments and address any concerns arising from the delivery of the programme in practice. A formal programme committee provides the opportunity to engage matrons and ward or other managers more closely in the development and delivery of the programme. It also provides a formal voice for the clinical mentors, and of course, the learners themselves. Union learning representatives can make a contribution via the programme committee. It could also be one mechanism for feeding into foundation degree revalidations. For the University, it provides opportunities to feedback to the Trust any problems about future employment of assistant practitioners or quality of manager or mentor

support that it is picking up when the students are away from the workplace- acting as a critical friend. Although the setting up of a committee adds two or three annual meetings to already busy schedules, the benefits and improvements made by giving the collaborative partnership a forum for review and challenge would make the time invested worthwhile.

An effective collaborative partnership therefore has specific elements to ensure that the learning delivered is high quality, relevant, and produces assistant practitioners who are fit for practice. These elements are summarised in the box for trusts to consider regarding their own practice.

Delivering quality learning in a collaborative partnership

- Clinical mentors in the workplace support skills development and help the trainee apply the theory learned at University in practical settings
- The University builds the curriculum around a core of generic NOS required by all assistant practitioners with the specific skills required in each setting taught via work based learning units in the second year
- Job descriptions and learning outcomes are based on NOS
- A competence pack is supplied to learners, their managers and clinical mentors in September -giving 9 months for the assistant practitioners to acquire the competences needed
- The clinical mentors and learners negotiate how each learner will achieve their competences and agree this in a learning contract. The facilitators review which competences need to be acquired outside the host clinical area and make the necessary placement arrangements to ensure this happens
- University tutors have empathy and respect for assistant practitioner students who are often mature students with domestic responsibilities and particular learning needs
- Ideally the University has a presence on the hospital site or is at least in regular face to face contact with facilitators, clinical mentors, and ward managers, with once a semester mentor support group meetings held to review curricula and learning delivery
- University tutors are registered practitioners with the clinical skills and background relevant to the curriculum and they also keep themselves clinically up to date if they are teaching clinical skills.
- Learners evaluate each unit and the University uses their feedback to make improvements
- The facilitators carry out their own evaluation and feedback results to the University
- Trust service user forums feedback about service changes is transmitted to the University
- Explore the involvement of service users in teaching
- The University and the Trust ensure there is an effective informal feedback loop between University staff and those in the Trust responsible for identifying and transmitting curriculum changes arising from shifting service needs. The University responds as flexibly as possible to meet those needs
- A formal programme committee to meet two or three times a year to agree curriculum changes, review all aspect of learning delivery and feed Trust perspectives into degree revalidations.

Providing effective learner support

“It was really tough. We had a 3 year old baby. My wife is a qualified nurse working in CCU. We therefore have to manage alternating shifts. When she is working I am off and vice versa. I was a full time student, full-time worker and full-time carer. It was really tough.”
(Rehabilitation assistant practitioner)

“The first year is always tough. It’s a big learning curve. It’s adjusting to adult learning. The academic level is high. Anatomy and physiology, Harvard referencing, using the computer. So in the first year people need time to adjust but very few drop out for academic reasons. I would say less than five since 2006”
(Lead Nurse for Education and Professional Development)

Everybody agrees that for these mature learners undertaking foundation degree level study places them and their families under enormous pressure. Therefore, to avoid unacceptably high rates of attrition, an effective system of learner support needs to be in place. The University and the NUHT have elaborated a triangular learner support model, adapted from the nurse training context and applied to assistant practitioners. It is constructed from the close collaboration of the clinical mentors, facilitators and University teaching staff.

Some of the clinical mentor contribution has been described already in terms of the practice based teaching of clinical skills. In addition, mentors provide much needed support with academic learning:

“I teach her how to complete the curriculum. She asked how to do cannulation. I give her leaflets and generally teach her how to do the various procedures properly, under my supervision. She will work with other members of staff too, when I’m not on. I am there to support her. I help her with her essays. I actually read and comment on these before they are submitted.”
(Clinical Mentor)

To do this critical job the mentors must want to do it, have the time to do it, and understand the curriculum. All mentors agreed that mentoring is a two way learning process, because they pick up new ideas about the latest practice that the students have encountered at the University. All mentors enjoy the role and see it as an integral part of being a registered practitioner, and it also helps them meet the Trust’s updating requirements and their own prep.

The University has the key role in briefing both the mentors and managers about where the students are in the curriculum:

“They (the managers and mentors) have all the information in advance. They know when the programme is starting. They start with a whole week of study skills. They have an outline of the course. They know what’s being covered. On the week by week sheet it shows when the assignments are coming in... The role of the mentor in terms of supporting people academically is discussed. They know the content - an overview of what’s being covered.”
(University Programme Leader)

Mentoring on busy wards is difficult and mentors have to be creative and flexible to make the time their mentees need:

"I always make sure that I create time, so they are there to learn as well as work and achieve their learning outcome. I need to create the time even if it's only 10 to 15 minutes to reflect on what they have achieved. This is so important."
(Clinical Mentor)

There is a balance to be struck between how much time the team can allow the student to be away from the workplace studying and the time a mentor can spend away from direct care delivery. This is set against the impact on the team's ability to provide quality patient care because the assistant practitioners are not supernumerary. They are productive team members which is advantageous because it helps build the confidence of qualified team members in their abilities.

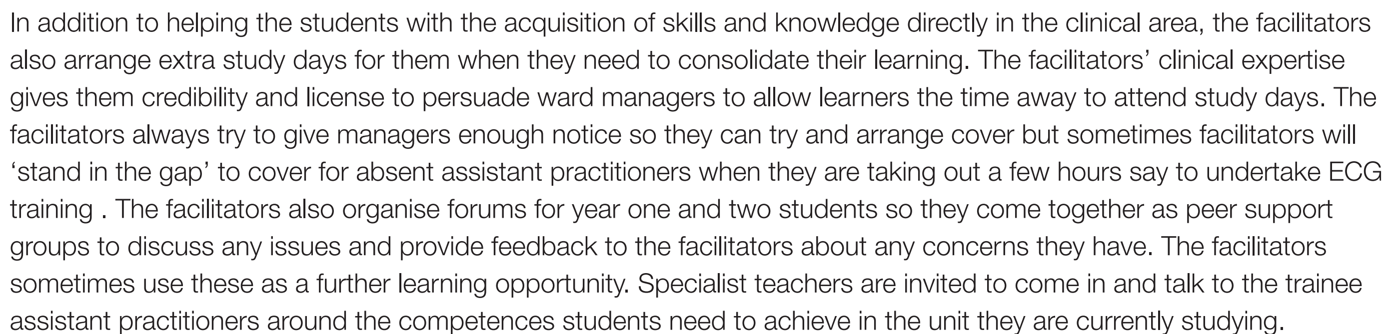
However, some trusts have made their assistant practitioners supernumerary and trusts should consider undertaking a short analysis of the costs and benefits of what that would mean in practice both in terms of costs, the reduction of pressure on the students and the impact on the clinical teams.

The clinical mentor's contribution

- Development of assistant practitioner clinical skills and theoretical knowledge applied in practice
- Assessment of clinical competence which includes the application of knowledge.
- Understanding the curriculum and what the students are studying at any point
- Liaising closely with university teaching staff and keeping them up to date with the latest practice
- Commenting on assignments before submission
- Making time for mentoring.

Finding a solution to the time issue is as difficult as it is important. Newham has two highly skilled facilitators who provide back up and support to the clinical mentors and 'stand in' any gaps opening up because of time pressures. They are therefore a very flexible and resourceful part solution to the time issue:

"I am working in clinical areas, so I know sometimes that mentors have got so many things to do they are rushed off their feet. So when I go, because I'm dedicated to just being with them for a couple of hours, then I am able to help them finish doing a task and then go though the care plans and identify things that they are struggling with regarding the assessment they need to do. I check their skills and knowledge in that particular area. Then I do say just 10 or 15 minutes of teaching. That's really helpful to consolidate the learning because they may say I asked my mentor but she didn't have the chance to actually explain."
(Clinical Facilitator)



In addition to helping the students with the acquisition of skills and knowledge directly in the clinical area, the facilitators also arrange extra study days for them when they need to consolidate their learning. The facilitators' clinical expertise gives them credibility and license to persuade ward managers to allow learners the time away to attend study days. The facilitators always try to give managers enough notice so they can try and arrange cover but sometimes facilitators will 'stand in the gap' to cover for absent assistant practitioners when they are taking out a few hours say to undertake ECG training . The facilitators also organise forums for year one and two students so they come together as peer support groups to discuss any issues and provide feedback to the facilitators about any concerns they have. The facilitators sometimes use these as a further learning opportunity. Specialist teachers are invited to come in and talk to the trainee assistant practitioners around the competences students need to achieve in the unit they are currently studying.

The facilitators back up the briefings that the University staff give by advising managers about the programme and explaining what the course entails for them and the students logistically. Sometimes there is conflict between mentors, managers and learners which the facilitators help resolve.

The University staff and facilitators have very close links, talking on the phone as necessary, and meeting face to face in the Trust once a month. The facilitators therefore act as the bridge between the clinical areas and the University. As part of this linking, we have already seen that the facilitators evaluate learning and feedback student and mentor issues to the University. As part of their learner support role, the facilitators keep abreast of student attendance, any lagging behind with course work, any late submissions of assignments and giving any personal support needed to help students continue coping.

The facilitator role also includes the recruitment and selection of students onto the programme as well as marketing the programme to health care assistants at the twice yearly health care assistant forum days the Trust organises. The demand in the Trust coupled with the amount of resources available currently make a cohort size of around 10 in each year. With one having clinical responsibilities and the other working as a facilitator half time, the current group of 18 students across the two year groups is sufficient for them to manage. There is a learner support advantage to having assistant practitioners in numbers of more than one or two, because with larger numbers they can form study groups and e-mail each other for peer support. Higher numbers also make it more feasible for the Trust to provide the additional named facilitator support, which in turn leads to higher completion rates:

"The students who do have that level of in house support have a better pass rate and less attrition than the students who don't have that in house support. It really is the key to success. And when I go out to trusts who are interested (in foundation degrees and assistant practitioners), I always say it is much better if there is somebody specific. So it's easier for Newham to have a specific person responsible for half a dozen students. Some trusts have just one person and they are the ones who tend to fall by the wayside. They haven't got a peer group in the classroom and they haven't got a clear support mechanism in the trust." (University Senior Lecturer)

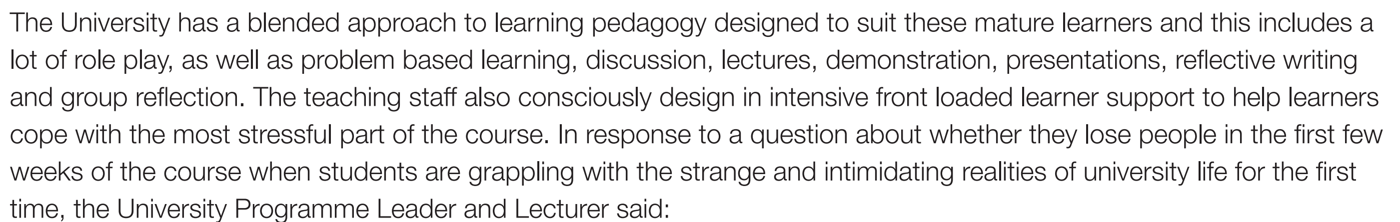
This multi-faceted facilitator role is absolutely crucial to the success of the programme. Facilitators are the glue that holds the partnership between the clinical teams, the University and the students together. They provide backup teaching support, counselling, negotiating and a shoulder for the students to lean on when the going gets particularly tough. Without the facilitators, the quality of learning and learner support would decline. It is important that trusts find resources to keep the facilitator role in place as the programme grows.

The facilitator's contribution

- Supporting clinical mentors in their practice based teaching and mentoring role by 'standing in the gap' when there are time pressures
- Consolidating what the clinical mentors teach on a one to one basis as well as via group study days which they organise
- The facilitators are clinical practitioners and they bring clinical or other expertise to the role from their experience and clinical background
- Provision of additional briefing to managers about the curriculum and assistant practitioner programme
- Recruitment and selection of students
- Persuading managers to allow students time to attend study sessions
- Organising student year group forums to provide feedback and raise any concerns
- Resolving any conflicts arising between mentors, managers, students
- Liaising very closely with the university teaching staff and meeting monthly to provide feedback to them and be updated about changes
- Being the link between the University, the clinical mentors and managers.
- Keeping abreast of individual student progress and providing support when necessary
- Organising student recruitment and selection
- Marketing the assistant practitioner programme to potential learners
- Organising a preceptorship programme for qualified assistant practitioners

The third part of the learner support model is of course the University staff and much has been said already about their role, in particular their empathy with the students and the amount of thought and time that goes into briefing and keeping close working relationships with the managers, clinical mentors and facilitators within the Trust. Universities need to pay detailed care and attention to making each of these critical relationships work and this is central to the philosophy of collaborative partnership that the University and NUHT follow. One example of how the relationship works with the clinical mentors gives a sense of this:

"Often they are worried about signing them (the students) off. What does their competency mean in terms of what's on the grid? What does level 2 mean? What does level 4 mean? How many times should I see them? How will I assess them? I go out to see every mentor and every student at least once a year. If there are any difficulties I go out more often. I keep in touch via e-mail. The scheme is built on collaborative working and I keep in touch on a very regular basis."
(University Programme Leader & Lecturer)



The University has a blended approach to learning pedagogy designed to suit these mature learners and this includes a lot of role play, as well as problem based learning, discussion, lectures, demonstration, presentations, reflective writing and group reflection. The teaching staff also consciously design in intensive front loaded learner support to help learners cope with the most stressful part of the course. In response to a question about whether they lose people in the first few weeks of the course when students are grappling with the strange and intimidating realities of university life for the first time, the University Programme Leader and Lecturer said:

"No. The first semester is the hardest. At the end of week when some of them are thinking I can't do this. They have their moments of turmoil. That's why I spend more time with them at that point. I say to them right at the beginning, come and talk to me if you are struggling. We have small groups so I can keep a close eye on them."

The university lecturer's contribution

- Empathy for these learners
- Maintaining very close working relationships with the clinical mentors and facilitators by e-mail and face to face
- Briefing managers, clinical mentors, and facilitators on the curriculum and any changes to it
- Keeping up to date on any changing practices in the clinical areas
- Involvement in student selection
- Providing blended learning to suit the learning styles of these learners
- Designing in intensive learner support at the beginning of the course when the pressures are greatest.
- One to one support for each learner

There is potentially a fourth part of the learner support model, namely the support of a union learning representative (ULR). ULRs have a very positive and unique contribution to make and even if the learner support system is working well their contribution could make it even stronger because their 'trusted intermediary' status often makes it easier for learners to raise personal or work related issues with them rather than with their mentor or manager in the first instance. ULRs are also trained to provide careers information and advice and to help sort out any problems to do with getting jobs, mentoring, not being allowed to practice skills and so on.

The final piece of good practice in the learner support model is the preceptorship programme which the assistant practitioners undertake alongside newly qualified nursing staff once they have successfully completed the course. The majority of foundation degree students were previously HCAs, and despite the two years of learning they still need to change their mindset from HCA to qualified assistant practitioner. Even with this deeper knowledge, most still need to acquire the demeanour and confident manner of a higher graded assistant practitioner, with its enhanced status compared with an HCA, and thereby encourage team colleagues and service users alike to see them in a different light:

"When registered nurses were students they were supported and tended to rely on their mentors. So how do they transform themselves from students into becoming staff nurses? Similarly with the assistant practitioners. They have gained knowledge and gone through the foundation degree but some of them may still be working as HCAs in their role. It's always difficult to drop the HCA cap they are wearing and now say I'm a qualified assistant practitioner. Hence the preceptorship programme."
(Facilitator)

An effective learner support model

- Devise a collaborative and triangular model of learner support with clinical mentors, facilitators and university teaching staff working closely together
- Maximise the contribution that union learning representatives (ULRs) could add to the triangular model and work out how best to do that
- Encourage a culture of mentoring amongst qualified staff so they see mentoring as a natural part of their role and clearly appreciate the value it adds for them personally
- Have systems in place to ensure that mentors have enough time to perform the role effectively
- Have systems in place so that all relevant mentors and managers understand the curriculum, the programme and how far the student has progressed through it
- Ensure the curriculum is taught by empathetic teachers, using learning methods suitable for this particular group of learners
- Invest in facilitators with professional credibility and in sufficient numbers to effectively cope with the numbers of students on programme.
- Arrange an assistant practitioner uniform and make sure it is worn in all areas
- Organise a preceptorship programme for qualified assistant practitioners

Integrated service redesign, workforce planning and learning progression

The Practical Guide sets out the main elements of a model of integrated service redesign around the patient pathway, with workforce planning and learning and career progression routes. It argues that these functions need to be closely interconnected at employer level if the benefits of a learning and career progression programme for bands 1 to 4 are to be fully realised and that the new skills acquired are fully utilised to benefit both patients and productivity . This same message is emphasised in the government's consultation document on developing the healthcare workforce:

***'Service development is often poorly integrated with financial and workforce planning**, reflecting a lack of alignment of accountabilities and incentives'*
(Ibid para 3.19 p26)

The division of education commissioning and workforce planning into registered and non-registered workforces is usually done this way but it makes the design and delivery of seamless career and learning pathways to facilitate the progression of unqualified staff more difficult to achieve. In addition, many healthcare trusts manage organisational development through directorates of the large staff groups like nurses and medical staff with strong professional identities and who play a central role not just in care delivery but in organisational development as well. This makes organising across such directorates to integrate service redesign with financial and workforce planning challenging.

Establishing a formal mechanism where everybody with an involvement could come together and plan, could maximise efficient use of resources and improve communications between those responsible for service design and those responsible for education commissioning and workforce planning. To tackle this planning problem in a proportionate and realistic way, the Practical Guide suggests that the board should require the setting up of a multi disciplinary working group to devise a Trust wide strategy for introducing new roles at band 4 as a first step towards achieving more integrated planning. The working group should include those leading service redesign together with those who have workforce planning and education commissioning responsibilities. It could usefully bring in representatives from the relevant learning providers, the various service managers, assistant practitioners and potential assistant practitioners, together with the staff side and union learning reps. One output of the working group might be a Trust policy and procedure which triggers the automatic involvement of relevant workforce and education planners whenever and wherever service redesign is initiated. This simple collaborative mechanism can improve planning relationships across any internal configuration of management and directorate structures.

Although it has traditional directorate structures and lacks a formal integrating mechanism, NUHT has nevertheless put in place some key elements of an integrated model. All of the various assistant practitioner roles are designed around the patient pathway, the crucial first step from which all else flows because all of these roles will have a degree of genericism and role extension designed into them and will therefore require multi professional and cross boundary co-operation to deliver them. We have already seen how the workforce and nurse education leads collaborate across their two directorates to encourage matrons and ward managers to identify opportunities for new band 4 roles within their teams. We have noted how those teams continue to lead role design and are centrally involved in skills acquisition and their assessment. This involvement of clinical teams increases the likelihood of the newly qualified assistant practitioner utilising their new skills as a valued and permanent member of the clinical team. All job profiles are job evaluated via agenda for change and come out as pay band 4 posts, which the qualified assistant practitioner can then apply for.

This all takes place in a highly fluid context of shifting priorities and changing care needs – all with a workforce impact:

"We don't have the numbers of beds we used to have and so obviously the need for the numbers of nurses has changed as well. The length of stay is shorter and we are trying to put back into the community what previously would have come into the hospital. We are setting up short stay units. People aren't staying in hospital so long. Our surgery is becoming more day oriented. So you can see how the needs and processes are changing and the demand from a workforce perspective has got to change with it"
(Lead Nurse for Clinical Workforce)

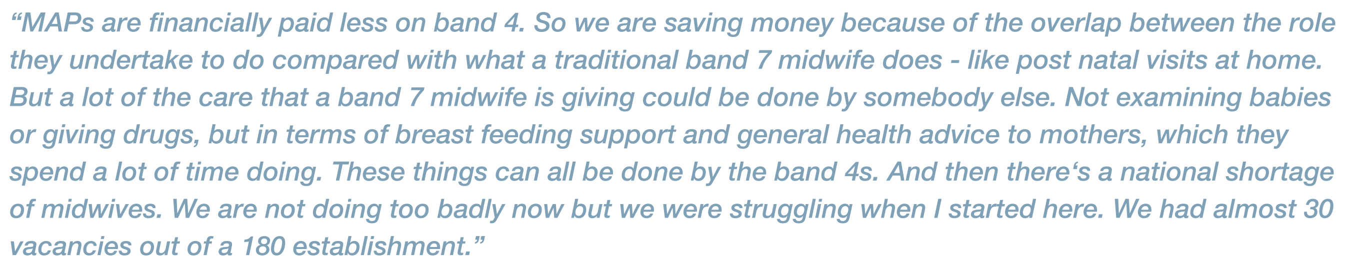
Operating within that changing landscape there are other parts of the jigsaw that must be in place for an integrated model to work effectively:

- How do teams make sure there is finance available to fund band 4 posts in the team?
- How do the numbers of assistant practitioners completing their training match the numbers of posts planned for them?
- How do you recruit the right people onto the course – so they complete
- How can transparent and seamless progressions routes be built *above* career framework level 4 –around the patient pathway?

In practice, the number of posts created is very closely linked to the process of securing available finance. Posts and finance have to match if we are to avoid the waste and demoralisation implied if qualified assistant practitioners have to work as band 2 or 3 HCA s, who through no fault of their ow*n* are unable to practice and maintain competence from their learning because there is no funded band 4 post for them to fill. To avoid this you need the fully functioning integrated model as the Head of Midwifery explained:

"You've got to have all parts of the system linked. So you've got to have an HR system in place to get the right people onto the programmes. Which we're kind of learning. There has to be money there for the posts for them. MAPs (maternity assistant practitioners) were very disheartened because they'd done all this programme and they were still band 3s. And we need the right people with the right skills fitting into the right part of the service. We need to know what the service will look like in three years time so we can work out who we need to provide that part of the service. What can we chop up? What can go to qualified staff, what can go to the people in the middle and then we need to make sure they have the right skills. So it's all those things really.'

In NUHT, the matching of finance to posts is successfully managed in most cases via the following, and still evolving, process. The workforce lead meets with ward managers and matrons every six months to review how the world of care is changing and how their workforce needs will consequentially also change. She supports them to identify how many assistant practitioner posts they can afford to fund from within their budget allocation. If their plans require an establishment exceeding the available budget, she will help them build the business case for more funding to put to their business manager and accountant. The space to make skill mix changes is also created through turnover so clinical team leaders need to know how many qualified staff are due to leave work in the two years ahead which can then inform their financial and other planning . In addition, assistant practitioner posts can be funded if a unit is carrying a number of hard to fill qualified staff vacancies:


"MAPs are financially paid less on band 4. So we are saving money because of the overlap between the role they undertake to do compared with what a traditional band 7 midwife does - like post natal visits at home. But a lot of the care that a band 7 midwife is giving could be done by somebody else. Not examining babies or giving drugs, but in terms of breast feeding support and general health advice to mothers, which they spend a lot of time doing. These things can all be done by the band 4s. And then there's a national shortage of midwives. We are not doing too badly now but we were struggling when I started here. We had almost 30 vacancies out of a 180 establishment."
(Head of Midwifery)

Once the numbers of funded assistant practitioner posts are agreed for the team, there remains the task of recruiting the right people onto the course. The Practical Guide argues that employers need a careers and advice framework and suggest some simple steps that employers can take to review their current practice in this area, and then make any improvements needed.

In NUHT, the right people come forward because they are spotted by the clinical team leaders as having the potential and motivation to complete the course and progress. They are then interviewed for the course by the facilitators and university staff:

"They are band 2 while doing the course and on completion they are eligible to apply for a band 4 role. And the clinical area has two years to plan it into their budget. So if you are in a clinical area that doesn't have FDs, then you will have to apply out to other areas where the band 4 positions come up. But most of the time they are accommodated within that clinical area. But there may be some competition so you've got to make sure it's equal and fair and there is therefore an application process. In my experience that has been quite smooth because it's what the clinical areas wanted. They often see the potential in their individual staff and see this as a way of developing opportunities for people."
(Lead Nurse for Education and Professional Development)

During the interviews however it became clear, that there were some people who applied for the course without knowing much about the content or how much time it would entail:

"I was quite keen that we should encourage our own HCAs to apply for the maternity support worker foundation degree. So for the second round of interviews two weeks ago, we were given 5 places on the South Bank course. We had 9 or 10 HCAs apply and we selected 5, but without much of a waiting list. Since then unfortunately two have pulled out. One doesn't want to do the programme any more. So we only have 3 - really disappointing. It's such a shame. Maybe we're not looking after them or training them well enough. But quite a few of them didn't really understand what the course was about or why they wanted to do it. So maybe our expectations were a bit high. Maybe we should have done a presentation on what the course is about."
(Head of Midwifery)

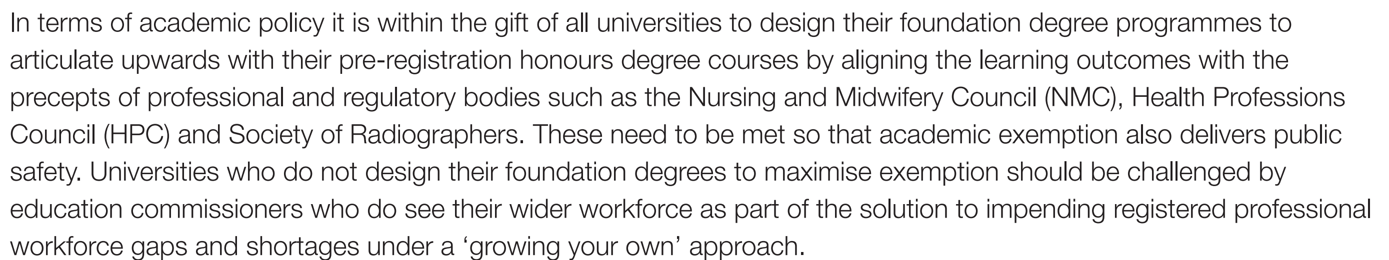
In scenarios like these, a careers information and advice framework coupled with active union learning reps offering advice and information about the course can really help staff make the right decision. While it is true that HCAs should have the motivation to find out about the course for themselves if they are going to succeed, it is also true that these adult learners typically need a big boost in self confidence to envisage themselves as the sort of people who could go to university and succeed. The initial information and support they get is often critical in persuading them that with all the learner support available that they can say to themselves: 'Yes. I can do it.'

The issue of managing student numbers through the course to match the numbers of posts planned for the team establishment also requires close attention to avoid leaving posts unfilled or having surplus qualified assistant practitioners with no post to apply for. This is hard to manage because of attrition which happens mainly for reasons such as maternity leave or the other life changes that inevitably occur. Attrition does not arise as a rule for academic reasons. The numbers of trainees selected therefore has to be greater than the posts available to allow for some attrition, but of course if all learners complete then the problem of surplus assistant practitioners, and what to do with them, will arise:

'Workforce planning is never exact. Because we can predict what we think might be needed but at the end it may not be exactly what we predict. It's never going to be exactly the case that everybody gets a post. At the moment we are holding our own, but I don't want to say that there's never going to be a point where that can't happen. You may find with bringing people through that there are two people dropping off each year. So we need to make sure that we keep that flow going but it maybe that in one year nobody goes anywhere, and there's not enough posts. So it is really, really, hard. And it's not an infinite budget. So I don't know what the answer is. It may that we need to start planning when we know there is no post for them. But we don't need that extra post at that point.'
(Lead Nurse for Clinical Workforce)

Because the NUHT programme is so well managed via the collaboration between the clinical teams, the facilitators and the University, attrition is low and the numbers of surplus assistant practitioners are also low. If there were no post for a qualifying assistant practitioner in their own clinical team, they can apply for posts in other parts of the Trust.

The Practical Guide also proposes as part of the integrated model, that trusts should construct learning progression routes which avoid gaps, randomness, dead ends and glass ceilings. However, constructing progression routes which go beyond career framework level 4 raises fundamental policy and design issues which are a huge challenge to overcome. There are progression routes for many assistant practitioners with exemption for the first year of the pre-qualifying programme into some existing registered occupations such as nursing or radiography. In nursing, direct entry into the second year branch programme is possible because the University has designed the foundation degree for clinical assistant practitioners so that they are able to clearly demonstrate the theoretical learning, academic good standing and application of clinical skills required to meet the precepts of the common foundation programme. Having academic exemption is good practise because it avoids repeat learning for the student and the waste of resources if an employer has to pay twice for the same learning. Designing foundation degree courses to enable exemption in this way is possible for some pre-qualifying programmes but not for others. There are also obstacles arising from academic policy or peoples' perceptions of their own professional role that are clinically unsupported and which could be removed. But despite this there are some situations where exemption cannot be available for good and legitimate reasons. In these situations, creating a progression route above band 4 needs a radical solution.



In terms of academic policy it is within the gift of all universities to design their foundation degree programmes to articulate upwards with their pre-registration honours degree courses by aligning the learning outcomes with the precepts of professional and regulatory bodies such as the Nursing and Midwifery Council (NMC), Health Professions Council (HPC) and Society of Radiographers. These need to be met so that academic exemption also delivers public safety. Universities who do not design their foundation degrees to maximise exemption should be challenged by education commissioners who do see their wider workforce as part of the solution to impending registered professional workforce gaps and shortages under a ‘growing your own’ approach.

In midwifery, direct entry into the second year of a midwifery degree programme from a foundation degree is deemed not to be possible because this would contradict European Directive (2005/36/EC) which requires students to complete a midwifery degree programme of a minimum of three years full time study. The directive makes it clear that to qualify as a midwife you do need to undertake three years of dedicated midwifery theoretical and practical study. The wording also currently precludes the use of Apel in midwifery, unlike in nursing, and therefore also precludes the possibility that part of those three years of study could be achieved via a full time foundation degree which meets the required educational and professional standards, and is then topped up with a further two years of full time degree level study. Not having a shorter progression route for this group of maternity support staff may act as an obstacle to developing a ‘grow your own’ part solution to the national shortage of midwives. Some would like to see the position change, as the Head of Midwifery at Newham commented about their MAPs:

“What I find disappointing is that they can’t progress onto midwifery training at the moment….When I’ve had discussions with the NMC and the national heads of midwifery and the foundation degree people, there’s lots of politics. I think things would change with regulation if the NMC takes it on board then so might others take in on board. It’s also up to the universities to decide. I think it would be fantastic for them to go on to do their midwifery training”

Finally, there is a ‘glass ceiling’ at band 4 unless assistant practitioners progress into existing professions via appropriate pre registration programmes. Progression from a band 4 role designed around the patient pathway in a multi disciplinary way into an existing profession not designed around the patient pathway is difficult. For example, progression with exemption into physiotherapy training or occupational therapy training is not possible for the rehabilitation assistant practitioner (RAP) which is a multi professional role very clearly designed around patient needs because the course covers too many disciplines to merit advanced standing in physiotherapy, occupational therapy or nursing:

“If you look at the rehab foundation degree, you are giving the students elements of physio, OT, speech therapy, podiatry, and nursing over 2 years. You would not be able to put enough of any of those together to balance what would be recognisable enough to replace a block. The only way you could do it would be if there were a foundation degree in physio or OT but that defeats the object of the exercise. It wasn’t the expectation that all assistant practitioners would want to go down a progression route and I think we have to recognise that there’s a huge value in them stopping and being very good at their band 4 role”
(University Senior Lecturer)

Many assistant practitioners will be happy to remain within their band 4 role and do it well. It is however an unintended consequence of the system that the more a band 4 role is designed to be multi professional in its support of the patient pathway there is less opportunity for the assistant practitioner to progress, compared with progression routes available to band 4 assistant practitioners in less multi professional roles, such as the CAPs. The rehabilitation assistant practitioner is a very beneficial role but the glass ceiling effect discourages staff from applying for it- as one Rap explained in answer to a question about whether he would encourage other colleagues to take the foundation degree:

"*Yes of course. I have encouraged others. But I would have to tell them that if they are planning for nursing that they may have to go for the clinical one instead. It's not a waste of time but if you are planning to be a nurse it will only take you two years. Different if you want to go for physiotherapy." (Rehabilitation Assistant Practitioner)*

The lack of a shorter progression route for the RAPs is therefore undermining the popularity of one of the most inventive roles with its great advantages for patients and clinical teams alike. The radical solution to this problem is to design rehabilitation assistant practitioner roles at band 5 and above to create a progression route for this multi disciplinary role. Some trusts are beginning to develop such roles at band 5 and the University is looking to develop a course to support band 5 rehabilitation therapy.

Model of integrated service redesign, workforce planning & learning progression

Suggested steps towards an integrated model include:

- As a first step, set up a working group to devise a Trust wide band 4 roles strategy, reporting to the board to give it authority;
- Encourage collaborative working by all directorates and key staff involved in workforce planning and education commissioning;
- Encourage collaboration between education and workforce leads with clinical team leaders and matrons to identify opportunities for new roles in the team;
- Ensure that clinical teams lead the design of the role around the patient pathway;
- Ensure the involvement of clinical teams in the acquisition and assessment of assistant practitioner competences;
- Ensure that all new roles are designed to be band 4 roles under agenda for change job evaluation and map to National Occupational Standards;
- Ensure that clinical team leaders have the business planning support needed to identify funding from their budget allocations for band 4 posts in their team establishment;
- Create a 'pool' or other method of making sure that assistant practitioners for whom there is no post immediately available, can work as band 4 staff pending a permanent vacancy arising;
- Review course selection procedures to make sure they are sufficiently rigorous to identify staff with the motivation and talent to complete the course;
- Consider designing a bespoke careers and advice framework to suit the Trust's needs;
- As education commissioners, challenge your learning provider to maximize academic exemption if necessary and challenge any other obstacles to progression beyond pay band 5 which are not clinically justified;
- Particularly for more multi-disciplinary assistant practitioner roles, work with your learning provider to design and support roles above band 4 - to enable career and learning progression routes supporting the patient pathway.

The business case for assistant practitioners

"It seems to me that some of the drivers are around opportunities. We've always as an organisation been interested in innovation in the broadest sense. So anything that looks a bit different, a bit edgy, a bit more exciting, you know we're interested in that at all levels. At both leadership and practical levels. And then there's a much more prosaic driver. What's the best way to staff maternity? We know we can't recruit midwives at the level we need to. Big gaps. We recruit people and then we lose people. It's all too unstable. So what are the other ways of giving the patients what they need? And that's not always going to be a band 7 midwife."
(Director of Workforce and Governance)

All trusts have to find savings under the Quality, Innovation, Productivity and Performance (QIPP) initiative and in the past investment in training of staff in bands 1 to 4 in particular has been reduced when there are pressures on trust finances. Historically, trusts have tended not to see the value of investing in the learning and development of pay bands 1 to 4 much beyond their statutory and mandatory training. However, in the past three years investment in pay bands 1 to 4 has increased partly because of funding made available to health care employers under the Skills for Health / SHA brokered Joint Investment Framework (JIF), but also because of the growing recognition by Lord Darzi and others of the contribution that staff in pay bands 1 to 4 can make to increasing productivity, improving direct care delivery and moving care closer to the home. Health care employers have also been encouraged in recent years to have workforce development and learning plans in place for pay bands 1 to 4, as part of their service level agreements for the use of MPET (Multi-Professional Education & Training) funds. Specifically in terms of assistant practitioner programmes in London and other parts of the country, JIF funding has been used to meet the tuition fees and back fill costs of trainee assistant practitioners undertaking foundation degrees, as well as funding the acquisition of level 2 and 3 NVQs by many staff progressing towards their selection as trainee assistant practitioners. This boost to funding and growing recognition of the valuable contribution of staff in pay bands 1 to 4 has increased interest in the business case for their learning and development, and as a consequence, has stimulated the design of metrics to measure its impact and produce the hard evidence needed to build a compelling business case.

JIF funding ended in 2010 as a national scheme and has not been replaced, although there is still some funding available for the learning and development of bands 1 to 4, including assistant practitioner programmes via widening participation and apprenticeships budgets. At the same time, university funding has also reduced and tuition fees increased with a potential impact on the costs of foundation degrees. As the transformation of the NHS gathers pace, the funding outlook for pay bands 1 to 4 learning and development is uncertain, although the government intends that providers of health care will have a duty to undertake workforce planning and take a lead role in education commissioning via local employer skills networks. It will therefore be possible to make the case for continuing investment in pay bands 1 to 4 learning and development from employers' own resources and possibly as part of the levy that each provider pays towards the costs of education and training generally as well. With this challenging financial background, making the business case for assistant practitioners and how they can help trusts meet their QIPP objectives becomes even more important.

NUHT has invested its own resources in the assistant practitioner programme alongside the funding it has received from NHS London and there is support in the Trust to continue investing because it makes good business sense to do so:

"I suppose from my perspective, at all levels, it's the way to go. That's the bottom line really. For us, we'll keep growing our own, because for years now that's the way we've moved forward. You are investing a lot of money in these individuals and you need to keep them at the end of it."
(Lead Nurse for Clinical Workforce)

This commitment to support new roles development into the future could be further strengthened with a board led investment strategy in assistant practitioners supported by an evidence based business case. Earlier we identified how an evaluation of the assistant practitioners' impact on both patient outcomes and team capacity could provide evidence for the business case. There is an additional need to measure the impact of assistant practitioner programmes on harder cashable benefits such as reduced staff turnover, sickness absence, skill mix changes and increased discretionary effort, since these directly contribute to increased productivity. When asked about how the course has affected the way he thinks about the employer, this one comment from an assistant practitioner is typical of much programme supporting anecdotal evidence that exists across the Trust:

"Yes. They have given me the chance to be a rehab practitioner. Yes, I do feel more happy about the employer. I am happy to stay here. I love working with care for the elderly. I want to work here for the rest of my working life."

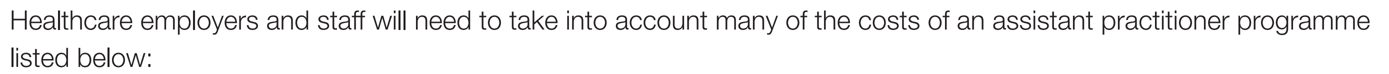
It is now time to collect and analyse such evidence systematically by deploying a robust evaluation methodology. The Practical Guide does indicate some of the elements which would feature in such an impact evaluation methodology. However, a comprehensive general widening participation in learning metric with specific impact measures has subsequently been published by Skills for Health as 'Demonstrating the Benefits of Investing in Widening Participation', and this can be applied to an assistant practitioner programme. The document includes illustrative case studies showing how the metric is used in practice in a number of trusts. It can be found at www.skillsforhealth.org.uk

It is highly recommended that trusts with an assistant practitioner programme underway undertake an impact evaluation of the programme in one or two clinical or other areas where it has been implemented successfully over a sufficient period of time to make its measurement meaningful. The information gathered via the metric can be used to spread good practice captured across internal trust teams and external provider skills networks, as well as for its primary function of supporting the business case. Neither the Practical Guide nor the impact evaluation metric give direct guidance about building the business case and most trusts will have their own business case templates to follow. However, the simple business case model below has been adapted from the one produced for the 'Growing Our Own Professionals for the New NHS' project. Trusts may find it useful. The metric will provide the evidence needed to populate each element of the business case.

The Business Case for Assistant Practitioners (suggested template)

Business case	Suggested Impact Evaluation Evidence
Meeting the demographics of recruiting and retaining a local workforce and making your organisation an employer of choice	Retention
	Recruitment
	Use of agency staff
	% of Personal Development Reviews completed and Personal Development Plans acted upon
	Sickness absence
Contributing to social responsibility objectives	Recruitment of local people including those unemployed and from disadvantaged groups
	Job Centre Plus data
	Links with local schools and colleges
Improving the Quality of Care	Patient safety
	Length of stay
	Hospital acquired infection rates
	Number of complaints and ratio of these to compliments
	Clinical Negligence Scheme for Trusts (CNST) level
	Patient experience/patient surveys
	Effectiveness of care provided
Improving productivity	Changes in skill mix plus savings
	Recruitment costs
	Length of stay
	Readmission rates
Responding to health policy changes such as bringing care closer to home and services designed around the patient/service user pathway	Number and range of new roles
Increasing staff engagement	Turnover rates
	Sickness absence
	Numbers of grievance and disciplinary cases
	Discretionary effort levels
	Staff engaged in learning
	Capacity of teams

Healthcare employers and staff will need to take into account many of the costs of an assistant practitioner programme listed below:



- Backfill costs over the one or two days a week the trainee spends learning away from work
- Training costs such as tuition fees supply of folders or ICT use
- Student travel costs and expenses
- Childcare costs
- Programme management and administrative costs
- Mentor and facilitator costs
- Evaluation costs
- PPE costs such as expenses, honoraria, travel.

Some of these costs will be reduced or offset by funding from external sources for backfill or tuition costs for example, as well as by the increasingly productive contribution of trainee assistant practitioners as they acquire more skills and confidence.

The table below shows some of the financial considerations for trusts and learners when they undertake a foundation degree and assistant practitioner programme.

Financial Considerations - Trust	Financial Considerations - Learner
Tuition fees	
Backfill costs (1 day per week at Agenda for Change band 2)	
Costs of university training days (1 day a week at Agenda for Change band 2)	
Clinical facilitator costs (0.5 whole time equivalent Agenda for Change band 6/7 for each facilitator)	
	Student travel/expenses 30 weeks x £x
	Childcare 30 weeks x £x
Admin costs (X days a week at Agenda for Change band 2)	
Programme management costs (0.1 whole time equivalent Agenda for Change band 8b for each programme manager)	
Patient and Public Engagement costs (e.g.travel, expenses, honoraria)	
Evaluation costs	
	Costs of books
	Unpaid time spent studying outside of working hours

Steps for trusts to consider taking to build the business case and expand their band 4 assistant practitioner roles in future are included in the box.

Building the Business Case

- Use the Skills for Health published metric to gather evidence of assistant practitioner impact on patient care, capacity of teams and productivity;
- Share evidence of good business planning practice with internal teams and provider led local skills networks;
- Use the evidence to build a compelling business case to underpin a Trust wide assistant practitioner strategy and justify Trust investment in it;
- Trusts with assistant practitioner programmes should work with their local employer networks for education and training to make assistant practitioner programmes a high priority for development and investment in their plans

This case study of good practice from Newham backed up by impact evaluation evidence from various trust assistant practitioner programmes reinforces the business case for continued development and investment in them and will help those arguing for their continuation and expansion in these financially straightened times. Assistant practitioners do make a significant contribution to the QIPP agenda by delivering savings and by improving quality at the same time as well as providing career progression for the many staff in bands 1 to 4 who have both talent and motivation. Assistant practitioner programmes are therefore a triple win for staff, employers and above all patients. The question trusts should ask therefore is not '*how can we afford to have assistant practitioner programmes*?' but rather '*how can we afford **not** to have them and see them grow?*'

"There's nobody arguing with me that we shouldn't have them. If you listen to the midwives they're delighted to have them. In fact some of the team leaders would rather have more MAPs than midwives. I've not had any complaints about the MAPs from the women. The fears I would have had about chopping up somebody's care. It just doesn't seem to have happened. If you've got a problem with breast feeding and the person who turns up knows how to help you, it doesn't matter who they are. I've not had any complaints about us sending a MAP to a house with people saying 'no I wanted a midwife to come and help bath my baby'. And the midwives are selective about which women are seen by the Maps and which ones aren't"
(Head of Midwifery)

Acknowledgements

Special thanks are due to the following NUHT and London South Bank University colleagues who agreed to be interviewed despite very busy schedules:

- Dawn Kavanagh- Lead Nurse for Education and Professional Development
- Graeme Jolly- Director of Workforce and Governance (formerly)
- Toni Nettleton- Lead Nurse for Clinical Workforce
- Scott Johnston- Head of Midwifery
- Scott Fitzgerald- Assistant Director of Public and Patient Engagement (formerly)
- Sharon Rouse- Head of Workforce Development
- Stella Omogbehin - Clinical Mentor-Care of the Elderly
- Julie Remollo - Clinical mentor- CCU
- Rosemarie Dowdall - Clinical Mentor – Outpatients
- Oluwafiropo Olaofe - Professional Development Nurse -Facilitator
- Adetokunbo Ojo - Practice Learning Facilitator (Foundation Degree)
- Jaswinder Chauhan - Clinical Assistant Practitioner
- Dilshad Imambaccus - Clinical Assistant Practitioner
- Alice Avileli - Clinical Assistant Practitioner
- Judy Scotter - Senior Lecturer, London South Bank University
- Sandie Wood- Programme Leader/Senior Lecturer, Rehabilitation Therapy, London South Bank University

And to Tony Chandler who contributed to the preparation of this case study.

This case study was developed by Skills for Health in partnership with Newham University Hospital Trust (NUHT)

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Appendix 1

London South Bank University has recently revalidated all of its FD programmes and there are a number of changes including:

- Use of modules rather than units.
- The modules are all 20 credits rather than 15 and 30.
- The modules are now called 'Practice Assessment Documents'
- The term practice assessor rather than mentor is being used.
- The time to complete the competencies has changed (one semester) since the modules are now 20 credits, and there have been changes to the amount and type of assessment for each module.
- Recruitment is standardised with assessment of literacy, numeracy and interview with no specific qualifications for those under 21.

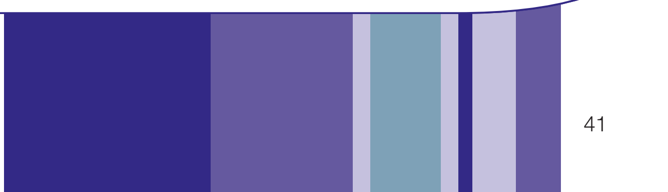
Appendix 2

Key Points from the Practical Guide mapped to Skills for Health's Products & Services (www.skillsforhealth.org.uk)

Key Points from the Practical Guide	Skills for Health's Product / Service
a) Improving patient care	
1. The wider health care team is essential to the quality of patient care 2. Curricula for assistant practitioners should be designed around the patient pathway 3. Learning should be measured for its impact on care quality 4. Involve service users and carers in the design and delivery of learning	1. Evidence can be found in the Practical Guide 2. Functional analysis methodology can support this 3. Utilise the Learning & Design Principles 4. Utilise the Learning & Design Principles
b) Utilising the Skills of Assistant Practitioners	
1. Review team skill mix and reallocate roles with assistant practitioners included with clear boundaries 2. Ensure job descriptions are job evaluated under Agenda for Change 3. Involve unions in the process 4. Engage team leaders and qualified staff in the design of the new role at an early stage 5. Ensure mentors, managers and qualified staff in the team are aware of the curriculum and involved in assessing and signing off competences 6. Plan for posts to be available for assistant practitioners on successful completion of the course 7. Introduce a standards driven framework for practice based learning	1. Web based Team Profiling tool 2. Development of competence based job descriptions 3. Practical Guide 4. Utilise the Learning & Design Principles 5. Utilise the Learning & Design Principles 6. Nationally Transferable Roles - business case 7. Six steps workforce planning 8. Career Framework development
c) Increasing the capacity of clinical teams	
1. Assess the impact of new band 4 roles or extended roles at band 3 on the team workload and make adjustments to the team as necessary 2. Have a method to ensure that learners can use their new skills in the workplace under supervision	1. Evaluation strategy Page 32 of Practical Guide 2. Six steps workforce planning 3. Career Framework development

d) Ensuring the Quality of Learning	
1. Involve staff, patients and unions in curriculum design 2. Ensure the learning provider delivers the curriculum that you need 3. Ensure teaching staff are occupationally competent and empathetic 4. Ensure that mentor and supervisor roles are clear and support is provided for them 5. Ensure that learning delivery methods are varied and suit the needs of workplace based learners 6. Ensure learning is transferable and supports progression into higher pre-qualifying training 7. Devise a learning agreement to support staff learning with the staff side unions	1. Utilise the Learning & Design Principles 2. Competence based development 3. Quality Assurance & Kite Marking 4. Utilise the Learning & Design Principles 5. Utilise the Learning & Design Principles 6. Career Framework 7. National Transferable roles 8. Practical Guide
e) Providing effective learner support	
1. Ensure the learning provider specifies how they will provide study skills support 2. Consider devising a bespoke Careers Information and Advice framework for the workplace 3. Web based and open source technologies can be used to provide e- learner support and create electronic peer support networks	1. Utilise Numeracy & Literacy tools 2. Careers Information advice and guidance service 3. E-learning & E-learning readiness tool
f) Integrated service redesign, workforce planning and learning progression	
1. Set up a multi disciplinary project team to bring those involved in service redesign together with workforce planners and education commissioners and plan a new roles strategy 2. Design transparent learning and careers progression routes as part of the learning and development strategy 3. Sources of funding for learning identified	1. Six steps workforce planning 2. Learning & Design Principles 3. Career framework 4. Engage with Skills for Health Academy

g) The Business Case for Assistant Practitioners	
1. Business case needed to underpin the case for investment in assistant practitioners 2. Need for impact evaluation to support the business case going to the board and covering impact on productivity, team performance and quality outcomes 3. Board support needed for investment in the learning and development strategy 4. The essential elements of an impact evaluation providing evidence in support of the business case are given	1. Practical Guide 2. Practical Guide Page 16 3. Practical Guide 4. Practical Guide



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