Report to the National Allied Health Professional Advisory Board on the outcomes of the Modernising Allied Health Professional Careers Programme

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Report to the National Allied Health Professional Advisory Board on the outcomes of the Modernising Allied Health Professional Careers Programme

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Foreword

The public want to receive the right care at the right time, in the right place for them. Having a health and social care workforce that is flexible and able to respond to the different needs that people have at different stages of their life is essential.

Allied health professionals make a unique contribution to people's lives whether they are in hospital, in their homes or the community at large. They work across the NHS, social care, the independent and voluntary sectors adding life to years not just years to life.

It is important that the NHS makes best use of its existing workforce as well as ensuring that the future workforce are able to deliver the best quality care in the most efficient way possible ensuring improve outcomes for patients. The current economic climate gives us an opportunity to make this happen.

The National Allied Health Professions Patients' Forum believe that this report will be useful to help commissioners and service providers make the best decisions about patient care and make the most of this under utilised part of the heath and social care workforce.

Jack Booth of Ashington had a raised cushion supplied to help him when he is sitting watching television, also a raised toilet seat and support rails and a seat in the bath to make him comfortable at home. The 75-year-old was recovering from surgery to his abdomen and called Northumberland Care Trust to see of there was anything staff could do to help him around the house.

"I was in hospital for 16 weeks and my legs were weak. Doctors told me not to strain my abdomen when I came out came out. I didn't know anything about the aids I could have and I was struggling around the house. I called the Care Trust to see if they could do anything for me and they came out the next day. They did this really quickly. Pam came round and she had everything in the van ready. She asked me what difficulties I was having made all the adaptations and said if I needed anything else not to hesitate to call. It was so quick and she was great – a real asset.

The adaptations have really helped Jack with his recovery at home where he lives with his wife Wendy, 74.

"I don't need the equipment anymore now as I am much better, I hope other people can benefit from the service as I have."

I commend this report to you.

Roswyn Hakesley-Brown CBE
Chair
National Allied Health Professional Patients' Forum

Introduction

Allied health professionals make a significant contribution to delivering high quality services for patients and the public. They will play an increasingly important role in meeting the unprecedented challenges currently faced by the health and social care system:

- Patients and the public will have much greater access to information about their health and consequently have higher expectations of the type and quality of care they will want to receive, where they will receive it and how long they will have to wait.
- The UK population is ageing rapidly. By 2033, almost a quarter of the population will be over 65. The number of people dependent on social care for support to look after themselves will increase by 53% by 2026. By 2025, the number of older people living in care homes will have increased by 23,000. The number of people with dementia is projected to double to 1.4 million by 2030.
- The nature of disease is changing. People with long-term conditions are proportionately far higher users of health services, accounting for around 70% of health and care spend.
- The UK has the highest public spending since 1983, the lowest tax burden since 1961 and the highest borrowing since World War II. The newly elected Government's first priority is to reduce the deficit and restore economic growth.

The Rt Honourable Andrew Lansley MP, Secretary of State for Health, has set out his ambition for health services by making patients the driving force of improvements to the NHS[i].

- **Giving patients greater choice –** focusing on personal care that reflects individuals' health and care needs, shared decision making and choice and greater access to information. Rehabilitation and reablement are core elements of allied health professional practice, working with patients, carers and clients to support them to manage their own care and live full productive lives.
- **Improving healthcare outcomes** - focusing on outcomes and the quality standards that deliver them. Allied health professionals measure the impact of the care that they deliver, particularly focusing on the patient's experience and their ability to live and function independently. Allied health professionals are experts in rehabilitation and have the knowledge, skills and experience necessary to lead the way in developing new and innovative solutions to a more streamlined and effective delivery of long-term, integrated care.
- **Increasing autonomy, accountability and democratic legitimacy –** empowering professionals and providers, giving them more autonomy and making them more accountable for the results they achieve. As highly skilled and specialist first, and often only contact practitioners, allied health professionals are perfectly placed to lead services and service transformation to deliver better outcomes for patients.
- **Cutting bureaucracy and improving efficiency –** reinvesting savings made from efficiency gains in front-line services to meet the current financial challenge and the future costs of demographic changes and technological advances. Productivity saving can be made by making better use of the existing workforce and ensuring that expensively trained professionals are doing what only they can do. The allied health professional workforce is currently under utilised and are already competent and confident to take on more advanced and specialist roles, such as non-medical prescribing.

In 2008, the UK-wide DH published *Modernising Allied Health Professional (AHP) Careers: A Competence-Based Career Framework* and an associated set of web-based tools to support competence-based workforce planning and development. The second phase of the Modernising Allied Health Professional Careers programme that commenced in 2009, built on the competence-based approach to workforce planning and development by putting in place the educational drivers necessary to build and maintain a flexible and responsive allied health professional workforce.

The second phase of work was overseen by the National Allied Health Professional Advisory Board, which provides national stakeholder consensus on the strategic vision for the future shape and contribution of the allied health professionals workforce necessary to drive up quality and productivity. The Board is made up of representatives of patients and carers, health and social care services and employers, education, the professions and their regulators.

With the ambitions and priorities for the NHS laid out by the Government, it is clear that the competence-based approach is more crucial now than ever before. The work to take forward the modernising programme for the allied health professional workforce will seek to highlight what we can do further to ensure that the system can take full advantage of what allied health professionals can and should be doing to drive up quality and improve productivity.

1. The Allied Health Professions

The allied health professions[1] are a diverse group of clinicians who deliver high quality care to patients and clients across a wide range of care pathways and in a variety of different settings.

As of September 2009, 84,042 allied health professionals worked in the NHS in England[ii]. Significant and increasing numbers work in other public services including social care and education, and in the private and charitable sectors.

Allied health professionals are graduates. From the point of registration, they are in the main autonomous practitioners. A quality workforce depends on the recruitment of high quality individuals to these professions.

All allied health professionals have four common attributes:

- They are, in the main, first-contact practitioners
- They perform essential diagnostic and therapeutic roles
- They work across a wide range of locations and sectors within acute, primary and community care
- They perform functions of assessment, diagnosis, treatment and discharge throughout the care pathway – from primary prevention through to specialist disease management, rehabilitation and reablement

Allied health professionals are the essential 'rehabilitationists' of the health and care system. The collaborative model of working of many allied health professionals, means that they educate, train and enable a significant number of other support staff, patients and carers to develop their skills in rehabilitation.

Allied health professionals have a key role in public health services. From a public health perspective, rehabilitation can be understood as one of four main healthcare strategies;

- Prevention – where allied health professionals provide advice that supports patients, their families and carers to avoid developing illnesses or readmission to hospital, such as falls prevention advice
- Cure – where allied health professionals deliver primary interventions, diagnose and treat ill health such as delivering nutritional support following surgery
- Rehabilitation - where allied health professionals support patients and clients to optimise their functional capacity such as speech and language therapy following a stroke
- Support – where allied health professionals educate patients, their families and carers and other health and social care professionals to support people to live a normal life such as occupational therapists enabling people to return to work

These characteristics are essential for transforming health and social care. The knowledge, skills and experience they bring will be crucial if we are to continue to provide a sustainable service that not only 'adds years to life' but also 'adds life to years', for example by not only doing hip replacement surgery, but by ensuring that the patient gets back to work as soon as they can.

[1] The allied health professions are: art therapists, chiropodists/podiatrists, dietitians, dramatherapists, music therapists, occupational therapists, orthoptists, orthotists and prosthetists, paramedics, physiotherapists, radiographers (diagnostic and therapeutic), speech and language therapists

2. A competence-based approach to workforce planning and development

The competence-based approach to workforce planning and development starts with needs of the patient and their carers, focusing on the desired outcome of care and the size and shape of the workforce required for delivery. The allied health professions competences address the stages of the patient's journey from presentation through assessment and diagnosis on to recovery, rehabilitation and reablement. A competence describes what individuals need to do and know in order to carry out specific work activities. The competence-based career framework competences are National Occupational Standards against which performance can be measured. Moreover, the framework describes the knowledge and understanding required to undertake the activities described in the National Occupational Standards successfully. Put together, the competences in the framework meet the key aims of healthcare services i.e. to promote, maintain and improve health, with each competence focusing on the individual function needed to deliver that key aim.

Allied health professionals were early adopters of the competence-based approach, recognising the value of developing flexibility in the workforce as early as 2005. Evidence suggests that best care can be achieved only where there is flexibility in the workforce, enabling them to respond quickly to changes in service delivery driven by patient need. There is also evidence to suggest that a flexible and responsive workforce is a cost effective way to deliver high quality care. A cost effective workforce, taking a competence-based approach maximises the potential of the staff to deliver best care by making appropriate and effective use of all of their skills, with individuals predominantly doing what only they are competent to do i.e. services delivered by the right people, in the right place at the right time.

The competence-based career framework was designed to support allied health professionals to maximise the contribution that they can make to transforming healthcare for the benefit of patients, by providing a range of competences that highlight the diverse roles allied health professionals perform. The framework takes a patient-centred approach to role and service development, career development and education planning, commissioning and delivery.

The career framework describes eight components of a job, and nine different levels at which each component might be undertaken, from initial entry jobs to consultant practitioners and more senior staff. The components are:

- Knowledge, skills, training and experience
- Supervision
- Professional and vocational competence
- Analytical/clinical skills and patient care
- Organisational skills and autonomy/freedom to act
- Planning, policy and service development
- Financial, administration, physical and human resources
- Research and development

The web-based tools can be used by:

- **Service managers and planners** to define the competences that services, teams and individuals must have in order to meet patient needs, and to develop roles, teams and services that reflect these needs;

- **Clinicians and support staff** to define their current competences and skills, and to identify areas for development and potential career pathways; and
- **Education planners and education commissioners** to identify the development needs of allied health professionals, and to plan and provide training and development that meets these needs.

The framework is based on a substantial database of competences (National Occupational Standards) that were extensively field-tested over a 2½ year project.

3. Building and maintaining a flexible and responsive allied health professional workforce

In *Framing the Contribution of allied health professionals: Delivering High-Quality Care*, published in 2008, the Department of Health committed to the following outcomes for the second phase of Modernising Allied Health Professional Careers:

- Focus on putting in place the educational drivers necessary to ensure that pre- and post-registration education supports a flexible and responsive approach to allied health professional careers
- Sharing best practice regarding the implementation of the competence-based career framework
- Considering how we might better secure the quality of practice placements across a variety of settings
- Taking forward the UK Clinical Research Collaboration recommendations for developing a clinical academic training pathway for allied health professionals
- Considering the benefits of preceptorship for newly qualified staff

Our approach and the outcomes of this work are described below.

Workstream 1: Focus on putting in place the educational drivers necessary to ensure that pre- and post-registration education supports a flexible and responsive approach to Allied Health Professional careers

Developing flexibility in the workforce is a key factor in the services ability to respond to the needs of the community it serves. Moreover, individual clinicians who are able to recognise their own competences and how to use them transferably, are more likely to be able to respond to the changing needs of patients and carers and thus deliver better outcomes. Better use of transferable skills across the workforce, with highly skilled clinicians doing what only they can do, developing advanced practice to take on extended roles, such as prescribing, and better use of support worker roles will improve patient care and be affordable.

This workstream involved a number of collaborative projects aimed at overcoming barriers to flexible career progression:

a) Working with the National Leadership Council (NLC) to develop a Leadership Competency Framework:

The NHS Institute for Innovation and Improvement (NHS Institute) has been working with the Academy of Medical Royal Colleges to develop the Medical Leadership Competency Framework (MLCF) since 2006. The MLCF describes the leadership and management

competences doctors need in order to become involved in the planning, delivery and transformation of services. While the context and scenarios in the MLCF are relevant to doctors, the leadership competences will be applicable to all clinicians in their practitioner roles. With that in mind, the NLC asked the NHS Institute to test the applicability of the generic leadership competences in the MLCF for other clinical professions, including allied health professionals. The aim of this work is to build leadership awareness and capability across the health service by embedding leadership competences in undergraduate education, post-graduate training and continuous professional development. The final report of this work will be presented to the NLC at the end of July 2010. This final report will include 3 case studies; case study based describing the process for embedding leadership competences in speech and language therapist pre-registration programmes, a case study describing how leadership can be addressed through professional regulation and a case study describing the way that workplace leadership training can be delivered vocationally.

b) Maximising the contribution of allied health professionals to the development of the Bands 1-4 Career Framework

Health care support workers will play an increasingly important role in supporting the delivery of front-line care.

Through widening participation and the development of cohesive seamless routes for people from widely varying cultural, social and educational backgrounds, people are able to experience work-related learning, work placements and train for a healthcare role or profession.

43% of the NHS workforce is currently made up of staff in Bands 1-4. There are productivity benefits of developing support workforce capacity and competence as a major element of health service reform and workforce transformation. This will improve the experience of people using NHS services, to widen choice, reduce inequalities, and will meet the following important goals:

- Direct benefit to patients, service users, carers and the general public
- Value for money and improved productivity in healthcare
- Tackle basic skills needs of any employees who lack essential literacy, numeracy and communication skills
- Prioritise the recruitment of local people from the most disadvantaged neighbourhoods and communities
- Train and assist local people to overcome barriers to work and learning
- Substantially increase the number of young people employed in public services through a high-quality apprenticeship programme
- Deliver a diverse workforce for the health and social care sector
- Link skills acquisition with the development of new healthcare and support services
- Work in partnership with social enterprise and Private, Independent and Voluntary sector to ensure plurality of provision and choice
- Furthering of the planned transformation of healthcare and system reform
- Contribution to the aim of making every healthcare organisation a model employer
- Showcasing local employers as employers of choice for young people and adults seeking work and careers

The further development of this part of the workforce is central to developing a skilled, flexible and productive workforce. Improved and increasing opportunities to grow the NHS workforce from people in local communities, from a range of diverse groups will allow access and progression to NHS careers. Developing health care support worker roles enable the professional worker to do what only they can do and thus support the development of a flexible workforce that is able to deliver high quality patient care within a cost effective service.

The Department of Health is working with Skills for Health to develop support worker career framework pathways, by describing the competences, education/training and progression routes for support staff in clinical healthcare. Moreover, we will provide specific frameworks for a rehabilitation support worker, a maternity support worker and a healthcare support worker in acute care. Each specific framework will set out role requirements, core and specific competences, education and training requirements, progression routes and, where appropriate, the regulatory regime. A reference pack that will provide guidance for employers, employees and education and training providers of the recommendations to assist in the consistent application of the roles in practice. The reference pack will also include signposting to other Skills for Health products, such as the Modernising allied health professional competence-based Career Framework and the National Transferable Role, illustrative best practice and case studies.

The Support Worker Career Framework will identify potential links to jobs/roles that allow and improve greater career flexibility and improved responsiveness to changing service delivery patterns across a range of care pathways, through adapting the specific competences against the care pathways. By identifying best practice and sharing effective and efficient approaches, it will identify best value. The framework will define the education and training requirements from when employees enter the role through induction to a point where the employer and employee are satisfied that they are maximising their potential. It will also define the equivalence of current and future formal education and training qualifications.

The framework will strengthen the drive to adopt consistent training and development of support workers including innovative learning methods such as e-learning. It will support transferability between employers through a common understanding of roles and education frameworks, stimulate the development of support worker roles and clarify the skills, knowledge and competence required when re-designing services. This will enable employers to get a more consistent application of roles and skills across care delivery teams and a more mobile workforce who can adapt to new technologies and revised care pathways. Moreover, it will increase the self-esteem of support workers and maximise their potential thus improve the understanding and acceptance of these key team members' roles by staff and patients.

c) Working with Skills for Health to develop an advanced an practitioner career pathway

In July 2009, the Council for Healthcare Regulatory Excellence (CHRE) published the results of the work commissioned by the Department of Health to attempt to generate a consistent definition of advanced practice across the health professions as well as to determine whether advanced practice was a regulatory issue[iii]. The review concluded that:

- the term 'advanced practice' is not used consistently across the professions
- much of what is often called advanced practice appears to represent career development and not a fundamental break with a profession's practice such that the risks to patient

safety are not adequately captured by the existing standards of proficiency which makes additional statutory regulation largely unnecessary

- additional intervention by regulatory bodies would only contribute to public protection were the arrangements in place inadequately controlling the types of practice professionals were undertaking where the nature of a profession's practice changes for some professionals to such a significant extent that their scope of practice is fundamentally different from that at initial registration
- primary responsibility for the governance of new roles designed to meet the needs of the service provision environment should rest with employers and commissioners

Consequently, in July 2009 we consulted with our stakeholders and identified two areas of concern regarding allied health professional advanced practice; that there was a lack of clarity regarding both the definition of allied health professional advanced practice and the career pathway for development as advanced practitioners.

Skills for Health defines advanced practitioners as *'experienced professionals who have developed their skills and theoretical knowledge to a very high standard, performing a highly complex role and continuously developing their practice within a defined field and/or having management responsibilities for a section/small department*. *They will have their own caseload or work area responsibilities'.* This definition relates to level 7 and above on the Modernising Allied Health Professional Careers Competence-Based Career Framework.[2]

A Task and Finish Group was established to address these concerns. They highlighted that the continuum of advancing practice spreads through all levels of the career framework, but advanced practitioner careers commence at level 7. Skills for Health developed four high level characteristics of advanced practitioners - leadership, mastery, excellence and innovation. Specific qualities are described for each characteristic[iv]. They are broad descriptors, which can be interpreted or contextualised at a local level.

The Task and Finish Group identified that advanced practitioners maximise the allied health professional contribution to high quality care in roles that may affect clinical care, organisational management, economic sustainability, productivity and all aspects of quality – patient safety, patient experience and the effectiveness of the care that patients receive.

Differentiating the competence requirements at each level of the career framework provides a vehicle for individual career progression and for succession planning. The latter is of particular importance to workforce planning for the smaller, more vulnerable allied health professions, such as orthotists, prosthetists and orthoptists where a lack of succession planning for advanced practitioner roles can make services unviable. However, the need to plan for adequate succession of clinical leaders from an allied health professional background is a key concern for all of the allied health professions.

The Task and Finish Group identified that, whilst the Modernising Allied Health Professional Careers Competence-based Career Framework was innovative, the concept of taking a competence based approach is not new and these 'level descriptors' have been used successfully in academia for many years.

[2]Modernising allied health professions (AHP) careers: a competence-based career framework, (2008) Department of Health

The NHS Constitution makes a commitment to staff that they should be able to progress and develop rewarding and worthwhile jobs[3]. Developing as an advanced practitioner is a normal expression of how allied health professionals achieve this. However, advanced practitioner career development is not only about career progression. Many well established advanced practitioners continue to improve and develop practice within their existing roles, thus advancing practice without further progressing along the career pathway.

In areas where advanced practitioners already exist, they are well received by their colleagues. They are seen as providing a positive impact on patient care and are good value for money. However, allied health professional advanced practitioner roles do not exist in all services and where allied health professional advanced practitioners are not embedded in service design, an opportunity is missed to maximise the potential of an under-utilised group of highly skilled and trained individuals who can deliver best quality and cost effective services to patients. An advanced practitioner within a service can have whole system benefits. Support for others in the team to perform at their optimum, creating a sense of work excitement and expectation of service improvement and innovation, encouraging a focus on evidence to innovate services and better use of support workers.

In 2009 the Department of Health commissioned research on whether there was a case to be made for allied health professional advanced practitioners[v]. The key findings of this research are summarised below:

- The literature shows that in parallel sectors, the equivalents of advanced practitioners would be expected to bring about very considerable economic benefits - certainly sufficient to outweigh the costs, and usually enough to justify investment when compared to alternatives (taking account of the return on that investment and the opportunity costs of preferring such investment over alternatives).
- The literature allows a model to be constructed that identifies where the expected costs and benefits of advanced practitioners would arise. Critically, the literature on High Performance Work Places provides some comfort that understanding or measuring the exact impact of each cost and benefit independently is not necessary: it is more that a High-Performing Medical Workplace is likely to require the presence of advanced practitioners.
- The interviews showed a broad consensus amongst practitioners, academics and commissioners that there was a clear economic case for advanced practitioner roles. This did not go so far as to suggest that any advanced practitioners role in any profession or any care setting would make economic sense; rather than most existing advanced practitioner roles did make economic sense and there was clear evidence that making advanced practitioner roles much more widespread would be justified on economic grounds.
- The main barrier to predicting the benefits of advanced practice roles was the lack of a methodology for demonstrating the likely benefits in any specific setting, so allowing robust business cases to be developed for new advanced practitioners' roles. In other words, the evidence could *show* economic benefits, but could not so easily *predict* them.
- The main response to this must be stronger and more robust metrics to measure costs and benefits in more settings. This in turn requires a better understanding of what metrics will be credible with commissioners and other decision-makers; what metrics are available from management information systems or elsewhere and how metrics can be built into new service delivery models from the start, so providing not only more case

[3] NHS Constitution for England, Department of Health, 2009

studies or other evidence, but also evidence that can be applied across different settings, care pathways or even professions.

In establishing our approach to developing advanced practitioner career pathways, we recognised that it is crucial that the roles at the top of each of the career pathways are adequately defined. It was felt that top strategic and academic leadership roles are already clearly defined multiprofessionally. However, the roles at the top of the clinical and research pathways were not as well recognised.

The Task and Finish Group identified that the pinnacle of the clinical career pathway is that of consultant allied health professional. These roles have been shown to improve patient care[vi]. The consultant allied health professional role has some distinct differences from that of a clinically based advanced practitioner, as shown below[vii].

Advanced Practitioners	**The consultant practitioner**
Advanced Practitioners are experienced professionals who have developed their skills and theoretical knowledge to a very high standard, performing a highly complex role and continuously developing their practice within a defined filed and/or having management responsibilities for a section/small department. They will have their own caseload and work area responsibilities.	Consultant practitioners may be expert practitioners and/or practitioners who have a high level of responsibility for the development and delivery of services. There is a strong element of research within the role. They will have responsibility for the coordination of R&D programmes as well as ensuring that current research findings are used by all staff to inform their practice. The consultant practitioner will lead by example in developing highly innovative solutions to problems based on original research and inquiry. They will apply a highly developed theoretical and practical knowledge over a wide range of clinical, scientific, technical and/or management functions.

Skills for Health and the Department of Health will be working to build on the existing advanced practitioner career pathway on the Skills for health website by developing a Non-Medical Consultant National Transferable Role.

In the first instance, this will be developed for allied health professional consultants. Consultant allied health professional posts are making a difference to improving patient outcomes, e.g. in the South West a consultant allied health professional for stroke rehabilitation has led the redesign of the clinical pathway from end to end. This has led to improved patient outcomes through earlier intervention and community rehabilitation and reablement. Allied health professional consultants facilitate the sharing of good practice; improve productivity, strengthen clinical leadership, advance the research agenda and extend and enhance the quality of patient care. They provide a key component of development in allied health professional services and provide career development opportunities, which encourage the retention of allied health professional staff and offer an attractive development for those returning to the NHS. There are allied health professional consultants working in a wide range of specialties including

rehabilitation, public health nutrition, forensic mental health, pre-hospital emergency care, intermediate care, palliative care and podiatric surgery.[viiiix]

Workstream 2: Sharing best practice regarding the implementation of the competence-based career framework

Skills for Health have overseen three implementation projects to highlight the concept of a competence-based career framework for allied health professionals in practice and embed the outcomes locally.

Project 1: Calderdale and Huddersfield Foundation trust
Since 2001 the Clinical Therapy and Rehabilitation Directorate of Calderdale and Huddersfield NHS Foundation Trust (CHFT) have been working on The Calderdale Framework which provides a clear and systematic method for analysing and transforming services. This leads to skill mix review, role redesign and management of delegation to support staff, all of which ensure high quality, productive services for patients. For this an early implementer site project aimed to explore skill mix, the role of the competence-based career framework level 4 worker and blurred boundary working (levels 6/7) in the MacMillan community Rehabilitation Team and the Rehabilitation at Home (Early Orthopaedic Discharge Team). The 7 stages of the Calderdale Framework were implemented over 12 months, resulting in the identification of competences and National Occupational Standards for delegated (level 3), allocated (level4) and cross professional (levels 6/7) work. Alongside this the project aimed to identify the educational requirements to support these new ways of working, with an emphasis on accrediting work based learning. The University of Bradford used Skills for Health design principles to develop a new course to support the level 4 worker. This is a 'shell' Certificate in Higher Education award (120 credits), with accreditation of prior learning (APEL) of the local work based learning to a value of 50 credits. Post-graduate study days to support blurred boundary working have been developed by The University of Huddersfield. An additional outcome has been the production of examples of Nationally Transferable Roles for Skills for Health. The benefit evidence will be collected throughout 2010.

Project 2: Critical Care - Cheshire and Merseyside Critical Care Network
Cheshire and Merseyside Critical Care Network are undertaking a review of Critical Care services, specifically around the workforce and training issues. They are keen to maintain and improve the quality of care provided by Critical Care services, including outreach and also along patient pathways into rehabilitation. The early implementation project has been initiated to identify the education and training to achieve this aim through identification of competences (National Occupational Standards) in relation to pathways in Critical Care, and the production of competence profiles for a range of staff working in the Critical Care services. Additionally, the project will inform the development of an education programme using packages of learning that can be delivered in ways that fit the requirements of the workplace. This will include consideration of the use of short modules, IT support, tutorials and tutor support, work based learning and practice assessment. The project finished in June 2010 and the data is not yet available, however, early indicators suggest improved quality outcomes for patients, safer practice and more efficient commissioning of education.

Project 3: NHS London
Working with the SHA the project is in the process of highlighting how individuals can use the competence-based career framework to help skills and career development. The project is in the process of identifying how and where the allied health professional advanced practitioner will benefit the patient and productivity in the stroke pathway and also identifying the transferable and specialist functions/National Occupational Standards required for this role. The project will finish in July 2010 and is expected to demonstrate where allied health professional s can make a significant contribution to the stroke patient pathway with regards to better quality outcomes, improved productivity and innovative practice.

A number of Strategic Health Authorities have set up regional approaches to adopting the competence-based career framework with varying success. The evidence suggests that these are more easily adopted where champions exist and the messages about the benefits of the programme and disseminated using real life examples.

Workstream 3: Considering how we might better secure the quality of practice placements across a variety of settings.

This workstream considered two key areas; whether the accredited training of allied health professionals practice educators should be mandated and how to secure practice placements for allied health professionals outside of hospitals?

a) Mandating practice educator training

The term 'practice educator' is used in this document to describe the identified practitioner in a practice placement who facilitates student learning face to face on a daily basis and generally has responsibility for the assessment of the student.[1]

Practice education training is mandated for nurses by the Nursing and Midwifery Council (NMC) in their Standards to Support Learning and Assessment in Practice that defines and describes the knowledge and skills nurses and midwives need to apply in practice when they support and assess students undertaking NMC approved programmes that lead to registration or a recordable qualification on the register.

Allied health professionals are regulated by the Health Professions Council (HPC). The HPC Standards of Education and Training state that allied health professional practice placement educators must have relevant knowledge, skills and experience and that they must undertake appropriate practice placement educator training, but stops short of defining what that training should be.

The Modernising Allied Health Professionals Careers work stream considered whether it was the role of the Department of Health to provide this definition and thus nationally mandate the type of training allied health professional practice educators should undergo.

Working with key stakeholders, including the allied health professional bodies, Council of Deans of Health, SHAs and NHS provider organisations and services, current activity being undertaken in relation to allied health professional practice educator training was captured and a wide variety of activity across the country, professions and services was found.

There is evidence to suggest that a great deal of work is done nationally to ensure that clinical educators are supported, and that guidance is readily available. Some professional bodies provide optional programmes of accredited education and universities may offer Masters level modules. In addition, some employers are offering in-house practice educator training.

The Modernising Allied Health Professionals Careers stakeholders reported that occupational pressures that have a negative impact on clinicians' ability to supervise students effectively are widespread, although not standardised across the professions or regions. Education Commissioning for Quality (ECQ) has put in place levers to ensure safe and effective placements by making clear through the commissioning relationship the responsibilities of provider organisations in delivering practice placements and of commissioners in quality assuring them. ECQ is in place for the foreseeable future and the principles within ECQ remain valid in any education system.

In light of all of the good practice already in place, the task and finish group concluded that there was no case for mandating practice educator training nationally as the perceived benefit did not outweigh the costs of administering a national system and the potential risk that innovation in practice educator training is stifled.

The following examples demonstrate some successful optional approaches being taken to support practice educators.

- Practice educators teaching radiography, physiotherapy and occupational therapy students can gain accreditation under schemes promoted by their professional bodies. The majority of universities delivering pre- registration education for these professions deliver the Chartered Society of Physiotherapy Accreditation of Clinical Educators Scheme (ACE), the College of Occupational Therapists Accreditation of Practice Educators Scheme (APPLE) and the Society and College of Radiographers Practice Educators Accreditation Scheme (PEAS). These professional bodies are now collaborating to identify how they may be able to deliver a shared framework for practice educator training with bespoke uniprofessional elements. Other allied health professional bodies have also shown an interest in this collaborative work.
- A number of universities in Yorkshire and the Humber have collaborated on a Support for Learning in Practice (SLIP) Framework for occupational therapists, physiotherapists, nurses, and midwives accredited for APPLE and ACE.
- Nine universities use the Physiotherapy Placement Integrated management System (PPIMS) and this provides a rolling programme of practice educator days that can be accessed at any of the participating universities.
- Common assessment tools and processes across disciplines help clinicians in managing their students. One model has been developed in Yorkshire and the Humber through the HEFCE-funded Assessment and Learning in Practice Settings (ALPS) project.

b) How to secure practice placements for allied health professionals outside of hospital

Allied health professionals work across a wide range of sectors including health, social care and schools. They also work in a variety of clinical environments, often seeing patients in their own home or in the community. They may work in public health or in the independent sector. However, practice placements still predominantly take place in acute hospitals.

This work stream focused on how to secure good quality placements outside of the acute hospital setting. This is particularly important to ensure the workforce is equipped for changing service delivery models, for example, delivering care closer to home.

The provision of high quality practice placements are the responsibility of all levels of healthcare provision including service providers, individual healthcare professionals, pre-registration education providers and commissioners.

Two key success factors in developing practice placements outside of hospital were identified as the funding of practice placements; the support of professional bodies; and a coordinated approach across a whole healthcare economy.

(i) The funding of practice placements

Currently, Strategic Health Authorities manage the MPET (Multi-professional Education and Training) monies. NHS organisations that receive some of this funding are obliged to enter into a Learning and Development Agreement (LDA) with the SHA which include the expectations of a healthcare provider in terms of practice placements. The Multi-Professional Education and Training (MPET) funding is currently under review. The shadow arrangements have been in place since April 2010. Although funding was described as a success factor, the following issues about the provision of funding currently exist:

- There is inequity of funding between some professions e.g. doctors and social workers, this impacts more on smaller organisations
- Travel costs in community services can be a barrier both for the student to reach the service and to travel between service users.
- Accommodation costs and actual scarcity of accommodation limits the HEIs' ability to use some community placements.
- ECQ[1] articulates the need to support and incentivise diversity of practice placements and acknowledges the shift to care in the community.

(ii) Professional body support

Support from professional bodies was identified as a key success factor.

- Several professional bodies have made explicit the duty of their members to develop the future professional workforce.
- In 2000, the Chartered Society of Physiotherapy agreed 5 key principles including all clinicians having a responsibility to educate students. The principles are supplemented by guidance for developing placements outside of the acute setting.[1] These emphasised gaining competencies rather than experience in a particular setting.
- Role emerging placements have been championed by the College of Occupational Therapists. This has led to innovation in practice placements for occupational therapy students. In particular, private and voluntary organisations where there is not an established occupational therapist role, take students who explore the potential for occupational therapy with long arm supervision, either from the university or an occupational therapist in another organisation.
- The Health Professions Council Standards of Education and Training and professional body guidance are explicit about the requirement to support practice educators, supervision of students on placement and the need for learning

agreement. Education quality assurance processes linked to standards are usually in place.[1]

There were a number of examples of good practice in developing practice placements outside of hospital identified by the Task and Finish Group, including those outlined below:

- Dietetic services are ensuring that students spend time in community aspects of their work eg enteral tube feeding programmes and diabetic clinic.
- Some ambulance services are making better use of walk in centres, minor injury units and GP surgeries
- Some universities have supported research on placements in non- traditional settings. Examples given include a doctoral research study into occupational therapy role-emerging placements and a project lead devoted to developing placements in palliative care, homeless hostels and charities such as MIND.
- One university describes an audit that demonstrates how taking speech and language students can actually increase capacity in some services.
- Peer assisted learning in particular using 2:1 models have been used to support students in new placement areas.[1]
- Some universities have made good use of placement management systems to co-ordinate placements and ensure best use of the available capacity.
- Many universities have been working to develop their practice placement circuits in community and charitable sector settings, predominantly through personal contact. Practice Education Facilitators are key to this placement capacity development.
- Some providers are working to create a culture where the expectation is that all clinicians, with preparation, can take students.

(a) Additionally, a number of barriers to developing more placements outside of hospital were identified:

- System change impacts on availability of placements
- Poor communication and lack of coordination across a healthcare economy
- Limited community facilities such as space in consulting rooms and access to IT
- High staff turnover
- High levels of part time staff requiring split placements are more complex to arrange
- Taking students for the first time in a team requires additional preparation
- Universities have found that more mature students with dependents cannot travel the greater distances to community placements.

The outputs of this workstream have identified that a wide range of good practice in overcoming these barriers and delivering quality practice placements outside of hospital exists. The focus for the National Allied Health Professional Advisory Board going forward should be on advising the Centre for Workforce Intelligence so that they can share the information services and education needed to adopt this good practice.

Workstream 4: Taking forward the UK Clinical Research Collaboration recommendations to develop academic career for allied health professionals

The National Institute for Health Research (NIHR) and the Chief Nursing Officer (CNO) for England, in collaboration with Economic and Social Research Council and Higher Education Funding Council for England, launched a clinical academic training pathway to boost clinical

academic careers for nurses, midwives and allied health professionals[1] working in England. Funding was secured to implement a number of research training schemes, which, collectively, will offer a comprehensive clinical academic training pathway. The schemes offer four levels of integrated training;

- **Masters in Clinical Research -** 70 places were funded on approved Masters degree courses in Research and Clinical Research. Funding covers the successful applicants' salary and course/tuition fees and is open to graduate clinicians who have worked as nurses, midwives or allied health professionals for a minimum of 1 year.
  83 clinicians were accepted onto NIHR/CNO funded Masters in Clinical Research in 2009, 45 of whom are allied health professionals*.*

- **Clinical Doctoral Research Fellowship -** The NIHR/CNO Clinical Doctoral Research Fellowship is aimed at graduate nurses, midwives and allied health professionals who have at least 1 year's experience of clinical practice since graduating; have had sufficient research experience or research training to prepare then to undertake a PhD; and wish to obtain a PhD by research whilst still developing their clinical skills. Individuals who can demonstrate a role in, or contribution to, improving health, health care delivery or services are eligible. The fellowships provide funding for salary and research costs appropriate for a research-training award.

  15 Clinical Doctoral Research Fellowships were awarded in 2009, 10 to allied health professionals. Begonya Alcacer-Pitarch, Comprehensive Local Research Network Research Officer (Podiatry) at the University of Leeds is undertaking research to explore the impact of foot problems in people with scleroderma and try to work out which features contribute most to causing lower limb problems. She is using patient recorded outcomes, combined with clinician assessment of the vascular, neurological and musculoskeletal systems, in addition to disease specific measures, to quantify the effects of scleroderma.

Clinical Lectureships (post-doctoral) - The NIHR/CNO Clinical Lectureship posts are intended to support postdoctoral level research training combined with the continuing development of clinical expertise. The balance of clinical and academic commitments

- will normally be 50:50. Applicants require nomination by both an English NHS or other healthcare organisation and an academic organisation such as a higher education institution. Applicants must propose how the award will enable the nominee to make a significant contribution to clinical practice and support their development as a potential clinical academic leader.
  10 Clinical Lectureships have been recommended for funding in 2009 including 4 for allied health professionals*.* Kika Konstantinou, Spinal Extended Scope Practitioner and Postdoctoral Research Physiotherapist is undertaking a lectureship project that aims to develop accurate and practical ways of identifying patients with low back pain and sciatica in primary care, develop optimal care pathways and identify factors that predict poor outcome in this group of patients.

The process has now commenced for awards in 2010.

Workstream 5: Considering the benefits of preceptorship for newly qualified staff.

The foundation period at the start of clinical careers that supports newly registered clinicians to develop from student to practitioner is defined as preceptorship.[1] Preceptorship acknowledges newly qualified clinicians as safe, competent but novice practitioners who will continue to develop their competence as part of their career development[1].

Those who manage the transition from student to practitioner successfully are able to provide effective care more quickly, feel better about their role and are more likely to remain within the profession. This means they make a greater contribution to patient care, but also ensures the benefits from the investment in their education is maximised[1].

In 2008, the Department of Health started work on a preceptorship framework for newly qualified nurses and made funding available to support its implementation. At this time, we considered whether similar arrangements were appropriate for allied health professionals. We undertook a preliminary scoping of the potential benefits and issues associated with implementing preceptorship for allied health professionals and further engagement with the allied health professional bodies, the SHA Allied Health Professional Leads and the Council of Deans for Health. A consultation event took place and the decision was taken to produce a shared preceptorship framework for nurses, midwives and allied health professionals and the *Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals*[1] was launched in 2010.

The framework is based on national and international sources and builds on the successful allied health professional preceptorship guidance and good practice from employers, other professions and notably the allied health professional bodies[1].

One such model was the work of the London Mental Health Professional Lead Occupational Therapy Group who, on behalf of the College of Occupational Therapists devised a preceptorship programme to support new practitioners as they start work[1]. The programme supports career progression through the use of observed practice to advance clinicalreasoning. This increases clinicians' confidence and competence to deliver better outcomes for patients and improve patient experience.

Underpinning the *Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals*[1] is the recognition that we will require a more independent, autonomous and innovative practitioner to meet the changing requirement of future healthcare provision. All this suggests that a different kind of preceptorship is needed to consolidate these qualities and enable newly registered practitioners to take responsibility for their own professional and career development.

Providing a structured approach to supporting newly registered allied health professionals through the transition from student to fully autonomous professional improves:

- **Patient safety** through assessment of current practice
- **Patient outcomes** through enhancing current practice
- **Patient experience** through building the confidence of allied health professionals to develop relationship based care
- **Productivity** through improved staff retention in the first year of practice

To further support preceptorship the Department of Health have adapted and are testing the Scottish 'Flying Start NHS' web-based, electronic preceptorship programme in a range of NHS organisations in England and with a higher education institution. This multiprofessional preceptorship programme, designed by NHS Education Scotland, has been in use in Scotland since 2006 and has been well received. Testing with nurses, against a range of existing preceptorship models started in autumn 2009 with a view to establishing the programme as an optional multiprofessional model for employers if the pilot is successful.[1]

4. Conclusion and recommendation to the National Allied Health Professional Advisory Board.

This report has highlighted the key outcomes of the Modernising Allied Health Professional Careers Programme and their impact on improving patient care and achieving improvements in quality and productivity. Collectively these outcomes demonstrate the significant achievement of the National Allied Health Professional Advisory Board that provided the strategic oversight for this programme and its constituent workstreams. Of particular significance has been the influence and effectiveness of the contribution of the patient voice through the National Allied Health Professional Patients' Forum.

It is recommended that the National Allied Health Professional Advisory Board

1. Promote effective dissemination and embedding of the outcomes of the Modernising Allied Health Professional Careers Programme
2. Consider how outcomes of the Modernising Allied Health Professional Careers Programme might usefully inform the future plan of work for the National Allied Health Professional Advisory Board

Ensure that the National Allied Health Professional Patients' Forum continues to play a key role in the future work of the Professional Advisory Board

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