NHS YORKSHIRE AND THE HUMBER ON BEHALF OF THE DIRECTORS OF MENTAL HEALTH AND LEARNING DISABILITY SERVICES

REPORT OF THE WORKFORCE DEVELOPMENT PROJECT –Associate practitioner section

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SUE BEACOCK

PROJECT MANAGER

A Workforce that is

Capable

Available

Affordable

Sustainable

Introduction

This report presents the issues, evidence outcomes and recommendations from the project work on the development of the Associate Practitioners (A/P's) role. The full report can be found at WWW.FHSC.Hull.ac.uk . This section is an annotated version of the extensive work on the A/P role development as this formed a key work theme form the work.

Overview of the project

In July 2007 representatives from mental health and learning disability NHS services, along with colleagues from regional academic Institutions and representatives from NHS Yorkshire and the Humber met to discuss a new proposed model of preparing the future mental health and learning disability workforce (Figure 1). The model was presented on behalf of the Directors of Nursing, having arisen from regional discussions on concerns over workforce issues, these being both the availability of and the skills required by that future workforce. It was agreed that a consultation period be undertaken to gather opinion, consider viability of the model and explore options for addressing workforce concern. This occurred over August and September 2007. The results were presented at further consultation event in November 2007. Whilst there was a mixed reaction to the proposed model, with most respondents agreeing that the proposal did not, in that original form constitutes a viable option, it was agreed that there are some crucial workforce issues in terms of mental health and learning disabilities. Further evidence and investigation was identified as essential in providing a basis for the development of a framework for commissioning education for mental health and learning disability practitioners in the future.

Aim of the project

The overall aim of the project has been to develop '**an evidence based framework for the future commissioning of education for Mental Health and Learning Disability practitioners in Yorkshire and the Humber'** so that in planning workforce development:

- Providers of services, in partnership with people who use those services, understand what to ask for in terms of education for their workforce
- The SHA and other potential commissioners of education and training understand what they need to commission
- That Universities, in partnership with FE and other education providers understand what to deliver

Principles

From the meetings in July and November 2007, and as part of the consultation process, some key principles that guide the development and implementation of the project emerged, whilst some of these are values based in their nature, included are some that highlight the reality of the project in terms of impact on traditional work-force roles:

1. T
he project is based upon partnership, collaboration and communication.

2. Service users and carers are central to the project and their views have been sought in appropriate and meaningful ways
3. There has been a focus on finding out what already works well, with a need to evaluate current activities, draw out examples of best practice from both service delivery and educational programmes and consider outcomes
4. The project outcomes inevitably impact upon the nursing workforce and reflect the DH reviews of the contribution of mental health nursing-From values to action-The Chief Nursing Officer's review of mental health nursing (DH 2006) learning disability nurses-Good practice in learning disability nursing (DH 2007) Laterally being influenced by the key themes in 'Front line care' the report of the prime ministers commission (DH 2010)
5. The project on the future of pre-registration nurse training NMC 2009; ***which is being undertaken alongside*** has a major impact and is viewed within the context of the NMC review of Continuing Professional Development (CPD)
6. Whilst acknowledging the impact upon nursing, the project must also reflect the inter-professional nature of services for mental health and learning disabilities
7. A key driver has been the development of new roles in practice with the impact of ' Mental Health- new ways of working – developing and sustaining a capable and flexible work-force' (DH May 2007) and similar aspirations arising out of 'Valuing People Now- From progress to transformation'- Chapter 14- improving the workforce DH December 2007)
8. The project is essentially focussed upon the Health Communities that make up the SHA region, however, acknowledgment made of the presence of other service providers and the impact that they inevitably have upon workforce planning, in particular the emergence of independent hospital facilities.
9. The interface between health and social care has been an influential factor, driven by policy, and the emergence of new service models, the project has taken account of these
10. This project has not been linear in nature, therefore it does not fit into discreet pieces of work, and it relied on negotiation, the building of relationships and themes that were revisited, refined and developed throughout.

Specific topic areas:

There were some themes that emerged from all of the aspects of the work and the inclusion of these when considering the development of A/P's is essential, therefore they are included here.

Throughout the project there have been a number of recurring themes that have emerged as being essential to a good service and must be part of the educational commissioning process, all are able to be mapped to subject benchmarks (QAA), professional competencies and National Occupational Standards (NOS). We know they exist in curricula and when you read them you will think…***Well we do that anyway***

BUT……….

They are clearly very important to people, they are the areas that have recurred in all of the following places It is important to explicitly list these areas and to ensure that when we develop future programmes they are addressed fully and in the spirit of the project principles.

1. Service users work -
2. Sub- group work- LD/ AP/ Steering group
3. Interviews with directors of services and senior managers
4. Feedback from workshops with operational managers- NHS and HEI's
5. QCQ reports on Independent hospitals and areas of inspection they are not meeting (appendix?)
6. CQC analysis – 10% Sample
7. CQC analysis – what makes a good service
8. Also supported by the evaluation project of the BSc Acute Mental Health at The University of Hull

The main topic areas fall into the following- the top twelve areas we have been told are important:

- Communication listening and knowing where to take a conversation with service users
- Person centred approaches to safety risk, risk management and prevention of harm and suicide, managing people in a crisis whatever this may look like
- Understanding and knowing how to work with somebody's specific health condition- a grasp of evidence theory and what to do with it
- Medicines management
- Making sure people access what they need- health social recreational and employment help
- Some good 'clinical skills' First aid, infection prevention, recognising and assessing physical health need
- Leadership, accountability managing yourself being a good role model- a recognition that with fewer qualified staff in the system, how people manage services will be very different
- Working with family and carers
- Creating a culture where people can recover, adapt and or reach their potential within their health and disability limits.
- Therapeutic skills and understanding that what seems an ordinary action is a really skilled intervention, being able to celebrate with users every little step
- Working across third sector organisations and using in a positive way the contribution and impact that such organisations have at both a strategic and operational level, understanding the role that social enterprise has in the future development of provision
- Working with new ways of funding and care management –individualisation, individual budgets and service brokerage

Support worker development

When considering the career framework support worked development is recognised as the first step on the development, this section is included as a pre-requisite for the development of the A/P role.

This is a crucial element in the career framework and where there needs to be an emphasis on providing access opportunities. It is quite clear that support workers need to feel valued for their contribution and to have access to education that firstly enables them to move through the career framework and more importantly provides a means for the best quality and most competent staff.

The NHS health communities for learning disabilities and mental health have been able to take advantage of the use of training secondments. This has meant that the Universities and the NHS have collaborated closely on developing staff through these routes and it has been extremely beneficial in terms of recruitment and retention. It does appear that there will not be the same number of secondments in the future but that we will need to continue with the development of the workforce towards higher levels of qualification through other systems and strategies. The incentives for the workforce are that they can clearly see progression, particularly where there is an opportunity for associate practitioner roles

The major recommendation here is that HEI's, FE Colleges, Schools and the NHS collaborate to develop frameworks of traineeships and apprenticeships that provide people with the entry criteria for either Foundation degrees or pre-qualifying. APEL must be considered here – See the associate practitioner section.

The associate practitioner role

Introduction

From the analysis of the original model and through the scoping exercise, it became apparent at an early stage that one of the key workforce issues is the development of new practitioner roles. Policy and demographic factors led the health communities to a feeling that there really is a need to invest in developing a practitioner role specific to meeting the needs of their service users. What becomes apparent is that the flexibility within the development of these roles means that in each of the area described in the career framework (Figure 12 page 36), an associate practitioner can make a significant contribution. The project has coincided with a significant investment by the SHA in the modernisation programme; the project team has been supported all the way along by Ian Wragg and his colleagues in developing the work we have done.

This section begins by describing what is meant by an associate or assistant practitioner, it presents examples of the models of roles that are possible. The drivers and rationale for the development are then explored and the relationship to existing recruitment and workforce strategies considered. From there an overview of how the project has been involved in development is presented. The detail is once again available as appendices. The next steps are discussed and there are links to external resources and documents for your use. Finally recommendations and strategies for the future development are discussed

What is an associate practitioner?

An associate practitioner is described as:

The Assistant/ Associate Practitioner role has been defined by Skills for Health as "*An Assistant/ Associate Practitioner is a worker who competently delivers health and social care to and for people. They have a required level of knowledge and skill beyond that of the traditional healthcare assistant*

or support worker. The Assistant Practitioner would be able to deliver elements of health and social care and undertake clinical work in domains that have previously only been within the remit of registered professionals The Assistant Practitioner may transcend professional boundaries. They are accountable to themselves, their employer, and, more importantly, the people they serve.”

(Skills for Health, 2009 – National Standards for assistant and associate practitioners)

Within this project the aim is to introduce a practitioner who can deliver a range of protocol driven input, across the client group and working to a standard job description with job roles and personal development plans that reflect the workforce need in local organizations.

At the first workshop in November 2008, a debate was started in terms of ‘are we are developing assistant or associate practitioner?’ Whilst it is entirely up to each organisation to decide the names of the practitioners that they wish to use, there were a few issues raised that supported the view that associates is a more appropriate name for the practitioners we wish to develop.

These are:

- Whilst some practitioners are clearly aligned to professional groups e.g. occupational therapy assistants , the idea of new practitioner working to a range of protocol driven outcomes across professionally boundaries is very appealing within services that are designed around user pathways
- There is confusion over the term assistant as stated above some of the clear assistant roles are termed, for example, assistant physiotherapist; not assistant practitioner we already have a range of titles and nomenclature to deal with it was thought that standardising the term to associate would help to eliminate confusion.
- One of the key issues is that of transferability of roles, a practitioner who is not aligned to one professional group built works across professional boundaries within user pathways is more likely to be able to transfer skills
- Feedback from other aspects of the SHA project on modernisation and from other areas show that assistant roles may be graded as Agenda for Change band 3 not 4

The following presents some ideas of the types of roles that have been discussed, they have been mapped out to show some details but overall the roles do fit with evidence found in the project of service delivery issues, the national review of job vacancies presented in the commissioning section and the development of roles to support service reconfiguration and the implementation of pathways and packages:

What people have told us about the kinds of roles they envisage?

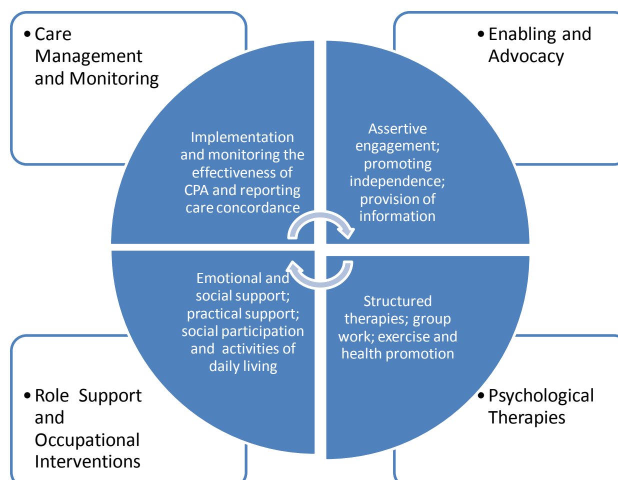
- *In the new and expanding services around low and medium secure services there is always a need for quality practitioners; the ability to recruit sufficient and skilled staff to these areas*

leads us to consider the development of specific new roles in secure and specialist environments.

- *The learning disability services are moving to a more community based focus for some of the services for people with higher levels of need and challenging behaviour, this is being done in partnership with the Local Authority, an associate practitioner who can work within this environment would be ideal*
- *We have an increasingly recognised issue about the provision of high quality health care within limited resources in the community, especially where we have a number of people from black and ethnic populations, a practitioner who could work in inclusion- a health care navigator is a role we would like to see.*
- *The move in services away from a medical to a recovery based approach opens up opportunities for practitioners to develop and implements skills that support a range of professional roles, somebody who has experience of each of the professional practitioners and can work to implement a patient focused care plan*

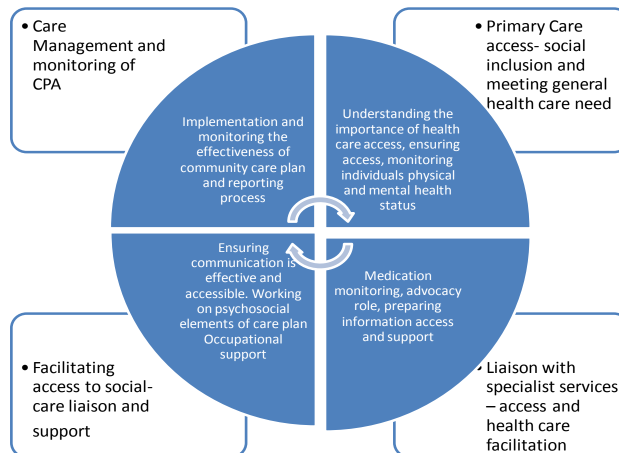
Example 1:

The role of the generic associate practitioner within specialist health care services:



Example 2 :

An associate practitioner working in the role of the 'health' care navigator:



The examples above show how the roles can be developed to meet a number of identified health care needs.

Some examples of A/P roles from other Regions:

East of England:

Have a patient pathway for people with Down's syndrome with dementia, a condition associated with the syndrome. The pathway provides the Alzheimer's medication prescribed at an early stage to prevent the condition from worsening, a common side effect of the medication is a sudden and dangerous increase in blood pressure, and this needs to be monitored at least once every 2 weeks. An associate practitioner has taken on this role and manages a full caseload.

Wales:

Development in CAMHS- primary responsibility to provide assessment and therapeutic intervention to children and adolescents their families / carers referred to the CAMHS team in conjunction with the multi-disciplinary CAMHS team. The development represents the opportunity to develop skills within the field of Child and Adolescent mental health through supervised practice and on-going training within the CAMHS team. (NHS Jobs)

East London:

Life Skills Recovery Workers-This role will mainly focus on forming therapeutic, meaningful relationships with patients, you will use a range of interventions/activities to enhance patients care and improve their inpatient experience. This will include assuming a lead role in specified areas, e.g. bi-lingual support, vocational and employment advice to service users, activities coordination,

assisting in individual and therapeutic group work.
You will work with the registered nurses to provide supervised primary nursing and deliver individual treatment packages with an emphasis on shared patient/staff ownership that forms on the recovery / rehab process and the need to work towards discharge. (NHS Jobs)

South Central:

Childcare Practitioner

The Mother and Baby Unit (MBU) is a purpose built in-patient Unit. It is a seven bedded unit that providing care for mothers with mental health needs whilst enabling them to care for and bond with their babies during the treatment and recovery journey.
We have recently reviewed our skill mix and increased the number of Childcare Practitioners within the team. This is an exciting opportunity for a Childcare Practitioner to join the Specialist Psychiatric Team at the Mother and Baby Unit, in providing excellent evidence based care.
Your role will encompass supporting and educating a mother with her baby during a time when parenting capacity may be impacted upon, due to Mental Health issues. (NHS Jobs)

Senior Intermediate Care Therapeutic Assistant

An integral member of the multi professional Intermediate Care Rapid Response and Re-ablement Team. The post holder will be working with patients registered to General Practitioners in the PCT. The post-holder will undertake assessments of patients when a rapid response referral is made through the Single Point of Access (SPA). The post holder will have a dual role assisting patients to remain at home either through re-ablement to independence or by undertaking tasks that the person is unable to perform. The role involves supervising and teaching practical skills to junior therapeutics assistants and students. The post holder will assist in; the production of statistical information; also to ensure that supplies are maintained within the budget; maintaining training records ensuring mandatory and statutory training is allocated. The role involves lone working and it is essential the post holder has an interest in mental health as this will form a large part of their workload. (NHS Jobs)

Why should we invest in developing these roles?

A cultural shift in services will mean that people with the most experience and skills will work face to face with people who have the most complex needs. More experienced staff will then support other staff to take on less complex or more routine work. All qualified staff will be able to extend the boundaries of what they do (i.e. non medical prescriber) and there will be more chances for new roles such as support time and recovery workers (STR), primary care mental health workers and assistant practitioners to take their places within teams" Professor Louis Appleby – Launching "New ways of working in mental health" (Department of Health 2007)

The development of associate practitioners presents a range of opportunities for all services. Where services are new or undergoing a change of direction the inclusion of A/P's can enhance the skill mix, provide quality user focussed care and meet workforce need in a time of challenge which includes recruitment difficulties and financial pressures. This development of associate and assistant practitioners is central to the Regional Strategy for workforce for mental health and learning disability services; it also forms part of a broader Regional and National Strategy based on the concept of 'Modernisation of the Workforce' which has been supporting the introduction of new roles for the last 10 years.

Best Practice example

Humber Mental Health NHS Trust is developing a specialist personality disorder service. They are recruiting band 4 associate practitioners. The development is designed for a practitioner who works to a prescribed care plan and across professional boundaries. The development has formed part of the YELLN (Lifelong learning network project. In negotiation with the University of Hull a pathway has been designed linked to the KUF (Knowledge and Understanding Framework for personality disorder) outcomes ensuring that all learning is either applied or specifically designed to meet user need

The following issues present a strong rationale for the development of the roles:

- Service user need, the support that the A/P can bring in implementing recovery based models, meeting specific health issues and supporting inclusion and addressing inequalities.
- The flexibility of workforce that A/P's can bring to new and innovative service delivery.
- Relationship of the development of the role and the implementation of the QIPP and LEAN approaches.
- Pathways and packages maps out a role for an A/P at band 4 (Appendix 2) this provides an overview and guidance on where A/P's meet user need and provides a driver in transforming mental health and learning disability services.
- Workforce demographics – the need to ensure a high quality workforce for the future in light of reduced pre-registration output and the age profile of staff.
- Difficulty in recruitment and retention to areas in mental health and learning disability services.
- The ability to define the role and to grow your own practitioners through a career pathway that meets both personal and service outcomes.

Issues raised:

There are however some concerns that do need to be considered, in every meeting and workshops there have been some recurrent themes that represent people's legitimate concerns. It is understandable that existing staff will be cautious about the introduction of what may be considered another 'fad'. What the project has clearly shown is that without some changes in the way those services organise their workforce

we appear to be heading for some real issues in the future. The development of the new roles does offer an opportunity to address some of the very serious workforce issues that have been raised in the project. The collective desire to move away from a medical model to one that follows people's needs and provides clear and understandable pathways of care cannot be delivered without consideration of where a quality workforce to meet that agenda is going to come from. Although the SHA is committed to maintaining pre-registration numbers within the constraints of the current climate and in line with the cost savings that need to be made , the evidence points to the fact that in the medium to long term there will simply not be enough skilled and competent professionally qualified staff.

Examples from the productive ward work, combined with evidence from the impact of Nicky Hollingsworth's work on Creating Capable Teams (CCTA) does show that there are other ways to organise workload and to achieve a different without compromising quality.

> Best Practice Example
>
> The west Yorkshire Lifelong Learning Network has sponsored a project to develop a "Shell Framework" for foundation degrees in Health and Social Care. This means collaboration between the Universities of Huddersfield, Bradford and those FE colleges in the area, for sharing of core and applied modules and an understanding that students can transfer credit for specific modules that are only available from one University or College http://www.brad.ac.uk/escalate/current-activities/wylln-apel/#d.en.6709; the process being developed to allow this is APEL

The development of the associate practitioner cannot be seen in isolation it is part of a cultural shift towards workforce planning and development that is in line with contemporary views on user need and patient pathways. Integrating the development of new roles into innovation and service redesign is having an impact; it is more difficult to make the change in long established services. There are challenges for the providers of education; some Universities are involved in the development of these roles in terms of delivering Foundation Degrees themselves. Foundation degrees are also found within further education centres where they form higher education provision and are validated by Universities. There has to be progression routes from the FD's and one option is a route to pre-registration nursing or other professional qualification. Another route is to top up using Level 6 study to BSc allowing professional development to continue. There has to be an opportunity for collaboration on the development of A/P programmes, evidence from our existing models of education delivery shows that competition between HEI's is not always healthy where are is a limited number of potential recruits, as is the case in the small services for mental health and learning disabilities but services that require a range of inputs and specialism's. The best practice example and the work proposed through the learning disabilities subgroup are attempts to maximise the benefits of flexibility in workforce deliver. Whilst the development of flexible and collaborative approaches in education is fully supported by the SHA and desired by service partners, there are a number of barriers to this which revolve mainly around commercial sensitivities and a fear of impact on finance.

Where such collaboration can be seen to be working effectively, FDF cites examples in its evaluation work, the benefits do outweigh the problems

One of the key recommendations of the project in terms of the development of associate practitioners is that we move towards greater collaboration making full use of the flexibilities within current Higher Education policy. These drivers come in the form of the review of funding systems- "*As HEIs build on their strengths, they also need to collaborate more to meet an increasingly diverse Set of needs. Some partnerships will be between Universities and colleges, sharing expertise and resources to achieve what they could not do individually, for example through Lifelong Learning*

Networks – groups of HEIs and FECs that come together across a city, area or region to offer new opportunities for students on vocational programmes to progress to HE. Other partnerships will be

with organisations and stakeholders outside HE – business, the voluntary sector and local communities. We believe that such collaboration is essential to the success of individual HEIs and the Sector, but we acknowledge that it can be challenging, and takes time and effort." HEFCE Strategic plan (2009).

Questions and answers-What people said about their worries of new roles (Figure 16) :

- They are an unregistered workforce – where does accountability lie – what if something goes wrong?

  Yes they are currently unregistered – we are assured that the DH is looking at this with a view to registering them with the HPC, however they are employees, they will be subject to CRB and safeguarding and all the other levels of accountability that comes from employment in your services; you will need to make sure the right protocols are in place – for instance lone working, you will need to ensure adequate and proper supervision

- It's the enrolled nurse revisited!

  No its not, the associate practitioner role gives you the opportunity to redesign your workforce to something that really meets the needs of your service users, you may well want a generic type worker who is largely supervised by nursing staff, however you may wish to develop a role that works across professional boundaries or one that fulfils a specific criteria and function – see the examples

- We are diluting professional roles – it's the end of the RMN and any other professions too

  Perhaps we should try to turn this argument on its head, nursing has been moving toward a fully professional place in health care, the advent of all graduate entry, the opportunity to develop careers in all sorts of directions, to undertake Masters courses and PHD's has been pushed by policy makers in nursing for a long time. Raising professional aspirations is a key feature of current nursing. That does not mean that the role of the nurse in providing excellent care is in anyway diminished, it just provides an opportunity to refocus what nurses contribute to health care .There are a couple of bare facts- there will not be the same numbers of registered staff in the system in the future and we will continue to drive up standards in care Both of these factor open up the possibility not just for nurses but for other professional groups to really deliver what they are trained to do and to consider how teams are configured in terms of the profile of associate practitioners.

- I worry it will be like the STR workers again- the roles just ran away with us , became something they were not designed to be , we have had lots of people with different training , lack of supervision and no career progression for them

  It is really understandable that when organisations have some changes imposed upon them with no real planning and thought, there will be problems, all the research shows that the introduction of new roles requires careful planning, cultural shift and management of change. What we have is the opportunity to learn from previous experiences and to make sure that the same things do not happen. That's why the principles that have been agreed reflect the need for careful planning, the use of annex U, the need to develop good protocols and to ensure that systems and supervision supports the implementation of the role. There is also a commitment to make the role as

transferrable as possible by using consistent job descriptions and underpinning the roles with competences.

- There is not enough good supervision around – our staff are expected to supervise everybody, we have all sorts of students and now you are telling us we need these people too

  The real benefit of this is that you are working with your own staff, these practitioners are likely, in the first instance to have come from your own workplace, if not they will be individuals who are recruited to a specific job in your team. There will of course be challenges in helping the individuals throughout their training and allowing them the opportunity for role change within their own workplace. However what you are assured of is a member of staff who will be motivated to seek out support form a range of people. You will need to make sure that you formalise the supervision process and do make it happen.

- What do I want one of those for? – Come on – tell me how they are different to health care assistants?

  It starts with your workforce planning, you need to know what you want from the job and be sure that it is an associate practitioner and not just another health care assistant. It moves on to the job description and the role you want. Have a look at the Skills for Health National Standards- PUT IN LINK- this clearly demonstrates what is expected of an associate practitioner – it's down to you and the organisation to make put those standards into practice

- I worry about changing the culture- what are the other staff going to make of it, the qualified staff will worry about risk and also about losing their jobs, the Health care assistants will resent them as 'jumped up' – I just don't want to shove a load of these people in and not know what to do with them.

  This is a crucial issue. One of the recurring themes as the project has been working through the impact that new roles may haves. As previously stated, introducing new roles it means that others need to change too We want to promote some of the Creating Capable Teams Principles and in the resources section there are some links to this. As ever we find the NHS is still changing in terms of priorities and how things are delivered. Managing change management is a crucial feature. One of the key messages is communication and fostering an understanding in everyone about what the role can bring. Put in the context of recruitment and age profile issues, the need to focus on what works best for the service users and some strategic direction many of the obstacles can be overcome. When we have looked at areas where the role has been implemented the real positives are that support staff begin to see a career pathway , they understand there is a job for them that is other than professional training , they are motivated to make it happen and the outcomes do seem very positive , not only for the individual but the whole team

Barriers

In addition to the concerns raised which have themselves become barriers to development, it has become clear that there are other factors which have meant that people have been slow to consider

the uptake if new roles development, whilst some are covered in the section above there are some other issues to consider, this is what people have told us:

Current vacancies and students (nursing and others) exiting programmes this summer:

We have been told that for this year, with management of vacancies and reviews of staffing in line with budget constraints some of the communities do not envisage shortages of recruits from the Universities, there are exceptions, in particular Humber is re-engineering the staffing profile for new and existing developments. This does generally mean that the need to consider new roles in workforce planning is not a major issue at this point in time, however in 2/3 years this will not be the case as the evidence in the project confirms.

"*We know that we are going to need the A/P role in the medium to long term it is apparent that we need to start planning for this process"*

Workforce planning processes:

There has been a consensus that there needs to be new approaches to workforce planning, refer back to section on helping the NHS to make the right choices in commissioning. – The recommendations here refer to associate practitioners.

" *There seems to be no real impetus for change, every year we seem to just repeat what has gone before, I do not think this is sustainable; we need a more focussed approach to workforce planning at all levels*"

Strategic decision making:

There does seem to be a relationship between strategic decision making and leadership at senior level which makes a difference to the workforce planning process and provides a clear steer in terms of where workforce needs to go. Throughout the project we have tried to ensure engagement at a variety of levels. Some of the most successful activities have been when we have been able to get managers who make the operational decision about workforce planning together to consider and debate the introduction of new roles. This is always more successful if there at a senior management level; the organisation provides a strategic imperative to consider workforce planning and new role creation. Continuing the development within organisations is a recommendation for organisations and we suggest that internal work on the profile of the introduction of the A/P role continues. In the resources section there are a couple of readymade power points that you can use as you wish.

The process involved in the project:

The associate practitioner work began at a very early stage of the project, Ian Wragg held a workshop where a number of disciplines were present, and the project was represented by Sue Beacock and Tony Flatly. It was agreed that the SHA would support a work-stream within the Project to explore and develop frameworks for the delivery of A/P roles. In November 2008 a workshop was held with representations form the Health Communities- training departments, HR and managers, HEI's and some partner FE colleges. The outcome from the workshop was an agreed set of principles (Figure 17) and an action plan. The work then moved to working with individual health communities and the project manager presented and attended at a number of meetings in each of the health communities over the lifetime of the project this has totalled 59 meetings in NHS , HEI's, joint and some of the Regional Strategic groups. At the end of the first year it was clear that there needs to be practical support in the development of the roles, we developed a toolkit, and this was well received and included some of the basic stages of development and resource. We have revisited that resource and have integrated it into this report under the section where there are some resources to

support development. From an evaluation of the key issues and in discussion with the SHA it became apparent that there was need to meet again, the decision was made that this should be service providers as the key issues are essentially within HR and organisations delivering services. The recommendations for HEI's and partners are within the next stages and recommendations for delivery

Representatives from 5 of the Health Communities and agreed the following:

- Standardisation of the Job description- it was agreed to use as a model the job description that has been developed by Humber with a drop down space for specific elements to be added. The job description has also been mapped to Skills for Health occupational competences for mental health/ learning disabilities and to pathways and packages, a link to the job description is in the resources section
- Developing a 'virtual network' there was a strong feeling that being able to share experiences, resources and issues across the organisations developing new roles is really useful. Various formats were considered, we knew it would be impossible to expect to actually meet up, using a web based approach will not happen because people find it difficult to spare the time to log onto anything new; so it was agreed to set up an email link. Those who were unable to attend the meeting are also included and it does extend to HEI's
- To consider the development of a Regional Framework using APEL as a means to develop and implement a range of optional modules/ educational opportunities to ensure that the more specific and specialist elements within roles can be addressed

Principles for the development of associate practitioners for Mental Health and Learning Disabilities in Yorkshire and the Humber (Figure 17).

1. A commitment to ensuring that service user views form an integral part of the process of development of the associate practitioner role.
2. The overall aim is to meet need and enhance service delivery in promoting wellbeing, supporting health care and facilitating social inclusion.
3. Adoption of the Skills for Health Standards for Assistant and Associate practitioners.
4. Adoption of the QAA code of practice section 7- programme design and approval, is essential in underpinning quality in placements also of the QAA Code of practice section 9 Work-based and placement learning (2007)

5. The core values of the 10 shared essential capabilities, the principles of valuing people and competences form skills for health are used as the basis of the competence approach within the role development.
6. Whilst subscribing to the development of consensus over what the roles should look like, the development at a local level should reflect the requirements of the local population and the organisations who serve these needs.
7. The ethos of the Associate Practitioner role is aligned to the aims and objectives contained within " Healthy Ambitions" (Our NHS , Our Future – Next Stage Review 2008)- in particular reference is made to the chapters on mental health and learning disabilities.
8. There is a commitment to promote a best practice approach to the development of the associate practitioner role, to share information and resources, to support all organisations and to learn from what has gone before, undertaking a critical analysis of successes and problems found in other similar pieces of work.
9. There is a shared commitment to using resources in the most effective way.
10. Evaluation of the impact of the role in terms of a range of indicators including the impact on the quality of experience of service users to be an integrated part of the work
11. To explore and capitalise on collaboration with other education providers, including the NHS, to develop programmes of study that meet the needs of service users, employers and associate practitioners as students
12. To exploit fully the opportunities offered through APEL and APL , the development of learning pathways and transferability of credit to ensure full recognition of the prior experiences of students
13. To develop and implement articulation routes and further opportunities that include professional, academic and practice based pathways
14. To consult widely in programme development and programme management, to include service users, prospective students and non NHS service providers in this process.
15. To embrace innovation in the way that programmes are delivered into organisations, to re-visit the role of the lecturer practitioner/ practice educator and to consider the most appropriate form of blended learning for the delivery of education
16. A promotion of the use of agenda for change annex U as a means to provide training contracts
17. An option to develop direct entry into educational programmes
18. Commitment to mentorship and support for associate practitioners as students and learners
19. Commitment to the principles of shared responsibility for the learning experience

Where the project leaves this development....

Hopefully this report will help to explain why, as health communities need to ensure that the development t of new roles such as the associate practitioner is integrated into your workforce plans. The SHA needs to have a clear idea of the commissions that you are requesting and your plans for the future. It is quite clear that this development will be instead of rather than in addition to other parts of the educational contract. If you are a health community experiencing real recruitment issues with a demographic profile of your staff showing that there is a shortage on the way, the evidence you give to the SHA to provide a rationale as to why commissions for A/P's should be as well as current commissions for pre-registration and CPD must be strategic and compelling. The section in this report on supporting the commissioning process is designed to help that process.

When we first began the process of supporting the implementation of the A/P role there was a sense that this is a development that needs to be carefully thought through. The project has achieved its aims in this development and has produced the following outcomes:

- Awareness of the associate practitioner role- what the role is, the flexibilities it can bring to skill mix and how the role cab enhance service user outcomes.
- Rationale for the inclusion of A/P's in workforce planning
- Strategies for development
- Information for education commissioning
- Appointments made and students signed up to courses (small numbers but starting to develop and increase)
- Resources to support organisations
- Recommendations for education providers

Resources to support:

The following is a representation of the process of introducing the A/P role- you may not fully follow this and also you may already have got some of the work done. The table Figure 18 is designed to be a useful structure to organise the resource section so you can link straight to any of the resources:

Development activity	Actions	Resources
Identification of workforce need	Using workforce planning tools pathways and packages work , internal workforce planning structures	CCTA http://www.newwaysofworking.org.uk/content/view/29/440/ Pathways and packages – appendix 2
Planning the job role	Job design – adding to the regional job description, HR processes and annex U	Regional job description(appendix 1) Annexe U handbook http://www.nhsemployers.org/PayAndContracts/AgendaForChange/TraineesUnderAfC/Pages/Afc-TraineesUnderAfcv2.aspx National standards for AP http://www.skillsforhealth.org.uk/
Commissioning of education – organisations MUST make sure that the commissioning managers are aware of the development and that internal processes for commissioning of education for A/P's are in place.		
Recruitment and selection	Internal HR and also joint recruitment with education provider	Internal resources to be used
Programme of study	Identification of suitable programme and provider	FDF (Foundation degree Forward) http://www.fdf.ac.uk/; Links to local FD's -University based programmes that are specifically designed with mental health and Learning disability pathways- http://slb-fhsc.hull.ac.uk/programme.aspx?PCode=27; http://www.york.ac.uk/healthsciences/cpd/foundeg.htm; http://www.brad.ac.uk/university/ugpros2004/socialcare.php; Please note that there are validated programmes available through FE colleges , a list of these appear on the FDF website link above
PDP and APEL	Individual learning plans	KSF- http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4090843; Skills for Health Competences http://www.google.co.uk/search?sourceid=navclient&aq=1&oq=Skills+for+health&ie=UTF-8&rlz=1T4ADBS_enGB331GB291&q=skills+for+health+competencies, Mapping of own programme objectives (INS -LC)
Implementation of the roles	Mentorship and supervision Cultural shift	Placement guidelines CCTA 10 HICS ESC

Recommendations – Associate practitioner

1. Apprenticeships and traineeships are designed in partnership with NHS and education providers to develop entry requirements for programmes – Foundation degrees and Pre-registration
2. The development of the associate practitioner role is an essential part of the future of the workforce for mental health and learning disabilities and strategic decisions are considered as part of the wider workforce issues.
3. The implementation should form a cornerstone of service development and workforce planning and both workforce planning
4. Workforce planning and workforce engineering are essential to the process, organisations to take advantage of the skills for health and the SHA initiatives on supporting workforce planning at an operational level.
5. Articulation routes to pre-registration programmes are developed to enable routes to qualification.
6. Top up to non professional but more advanced associate roles are developed through CPD – e.g. management routes and therapeutic routes.
7. We continue to lobby the DH over the issue of registration with the HPC (Health professionals council)for these practitioners
8. Commissioning of contracts for these roles needs urgent consideration- for the commission of the roles to become part of the routine commissioning process
9. Education providers have an opportunity to collaborate on the development of Foundation Degree frameworks- This is the only way we can ensure that all types of services have access to the right educational frameworks- see recommendations from the learning disabilities work and best practice example the West Yorkshire Shell Framework