Allied Health Solutions

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Allied Health Services
Support Worker Policy Landscape
End of study report

Developing people for health and healthcare

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Allied Health Services Support Worker Policy Landscape study commissioned by Health Education North Central and East London.

'The support workforce make up 40% of the total NHS workforce and provide around 60% of patient care and receives less than 5% of the national training budget'.

Health Education England Talent for Care

'As a therapy support worker, I'm helping to give them their life and independence back where they might have lost something. I think that that is the best thing that I could ever be doing'.

Band 3 Therapy Support Worker

'*We do not realise how valuable the support workers are until they are not there'.*

Senior Radiographer

ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

Background and approach to the study

This study was commissioned to gain a greater understanding as to how allied health support workers (AHSWs) are employed and deployed in three areas of North Central and East London:

1. Barking and Dagenham, Havering and Redbridge
2. Barnet
3. Tower Hamlets

It also aimed to gather evidence about the education and training needs of the AHSWs and raise the local Allied Health Professionals' (AHPs) awareness of current support worker policy landscape.

Since the publication of the Francis Inquiry into Mid-Staffordshire Foundation Trust there has been an increasing appreciation of the importance of the support workforce in delivering healthcare, and the potential this group of workers has to significantly enhance the patient experience. Many of the recent studies and policy developments have focussed on the nursing support workforce. This study, however, has concentrated solely on the support workforce that is employed in services delivered by AHPs.

The approach to the study has been to engage as many of the AHSWs, and the AHPs they work with, as possible. This has been achieved primarily through a support worker survey, focus groups with AHSWs and workshops with AHPs.

Accessing some of the AHSW groups has been very challenging. This has resulted in the greater number of study participants being recruited from the acute sector, although not exclusively, and from therapy and diagnostic imaging services.

Key messages from the study

- Many of the support workers who engaged in this study really enjoy the work they do, understand their contribution to patient care and value the education and training opportunities they have received in particular the Trusted Assessor Training.

- This study has prompted AHP managers to reflect on how they employ and deploy AHSWs. There is no doubt that the contribution that the AHSWs make to delivering the service is significant and worthy of greater understanding.

- AHPs who work closely with the AHSWs freely admitted that they do not really appreciate the support workers' current contribution to, or their potential to further enhance, the patient journey.

- The scope of practice of the study sample of AHSWs is diverse, particularly those working in community therapy services. The study identified that over 25% of this support workforce are well educated with either a first degree, or a professional qualification from another country. However, they are seldom given the opportunity to demonstrate their knowledge and skills.

- AHSWs reported feeling quite isolated and the SWAP study has provided an opportunity for them to network. They also commented that they are not sure they are truly valued as a workforce and that SWAP has given 'permission' for a dialogue about what would help them to perform more efficiently and effectively.

- The current support worker policy landscape is not well understood. SWAP has raised the awareness particularly in relation to the Care Certificate.

- There is a paucity of standardised education and training for the Band 3 and Band 4 AHSWs. The majority of education and training is delivered through the in-service model, much of which has been designed for newly qualified practitioners. However, the study found some excellent local examples of how organisations are supporting the education and training of AHSWs.

- The AHSWs suggested that the following education and training would help them to be more proficient:
    - Formal programme on medical terminology
    - Specific clinical skills to help them in their day to day work
    - Basic anatomy
    - English language sessions
    - Basic clinical leadership skills

- Very few of the AHSW study participants engaged with professional bodies or understood the benefits of doing so.

- The career ceiling at Band 4 is a potential barrier to recruiting and retaining AHSWs.

- Throughout the study the naming of this workforce generated a lot of discussion and is an area for further consideration.

- The voice of this workforce is often lost in a large organisation. Their impact on services might be better understood through appointing experienced AHSWs as champions, and/or AHSW team leaders.

Study recommendations

The study identified six key recommendations which consider education and training (1 and 2), deployment of support workers (3), the environment in which they are employed (4), the naming of this workforce (5) and the support provided by professional bodies (6), as set out below:

1. Trust education and training departments should work closely with HEE to standardise an approach to developing this workforce.
2. Trust education and training departments should ensure all their allied health support workers have the opportunity to achieve the Care Certificate and that the learning outcomes are of direct clinical benefit to this workforce and the service they provide.
3. Human resources and organisational development departments should review their approach to employing and deploying allied health support workers and aim for parity of activity.
4. Organisations and departments should review the environment in which the allied health support workers are employed. With the aim of:
    a. enabling them to network together within and outside of the organisation
    b. enabling their profile to be raised
    c. ensuring the contribution, they make to patient care, is evidenced.
5. Organisations should adopt a more consistent approach to naming this workforce.
6. Allied Health Professional Bodies should consider reviewing their approach to supporting the allied health support workers including clarifying the misunderstanding that you have to be regulated by the HCPC to be employed at Band 5.

The Report

The full report (page 9 onwards) is the output of the SWAP study. It has been written for Health Education England North Central and East London (HEE NCEL) local office directors, and AHP managers in North Central and East London.

It will also be of interest to other local HEE offices, AHP manager networks across England and the other Home Nations, and allied health support workers. It is anticipated that the AHP professional bodies will find this report of value when determining any advice, they wish to give to their members.

1.0 INTRODUCTION

This end of study report brings together all the activities associated with Health Education England North Central and East London (HEE NCEL)'s funded study into how allied health services employ and deploy support workers.

There are 4,966.85 whole - time equivalent (WTE) Allied Health Professionals (AHPs)[a] employed in HEE NCEL (annex A1). Of whom 10.3% or 511.72 WTE are employed as support workers.

The ambulance workforce data is reported pan-London. There are 1,916.37 Paramedics and 1,347.3 ambulance technicians, 924.97 of whom are employed on Bands 2-4. In addition, the London Ambulance Service (LAS) employs 140 call takers and 92 Non-Emergency Transport Service (NETS) staff.

There is a greater awareness of the importance of valuing the healthcare support worker[1,2], and identifying them as a key resource in healthcare service provider's strategic plans, rather than employing them as a substitute for other workers. Recent studies have shown that support workers have an increasingly important role across the NHS, social care, independent and voluntary sectors in supporting a wide range of health professionals[3,4,5].

A priority for HEE NCEL is to develop a greater understanding of the roles of the Allied Health Support Workers (AHSWs) and their education and training (annex A2). There are four key strands to this study:

I. Raising the awareness of the local AHPs with regards to current support worker policy landscape.
II. Mapping of the current support worker roles in services delivered by AHPs.
III. Identification of potential new roles for support workers and apprenticeships in these services.
IV. Collating information about the current education, training and development opportunities for this workforce.

2.0 POLICY CONTEXT

As the number of healthcare support workers has increased so too has the scrutiny of their training and development. In February 2013, the long-awaited report of the Francis Inquiry into Mid Staffordshire Hospital[6] was published. This report highlighted two key areas for attention that are particularly relevant to this study:

[a] AHPs included in this work are Arts Therapists, Dietitians, Occupational Therapists, Orthoptists, Paramedics, Physiotherapists, Podiatrists, Prosthetists and Orthotists, Radiographers (Diagnostic and Therapeutic) and Speech and Language Therapists.

a. There should be a uniform code of conduct that would apply to all healthcare support workers who should receive education and training in accordance with common national standards (recommendation 195).
b. There should be a uniform description of healthcare support workers, with the relationship, with currently registered nurses, made clear by the title (recommendation 207).

Later in that year (July 2013), Camilla Cavendish published her independent review[7] into healthcare assistants and support workers. The Cavendish Review highlighted the education and training problem and reported that *'almost 40% of those undertaking direct care roles in social care possess no qualifications'*.

In the same year (August 2013) a third report was published about improving the safety of patients in England[8] in which the authors restated the importance of training and development of support workers (box A).

Box A Recommendation 9 from the National Advisory Group on the Safety of Patients

The Government should ensure it is possible for healthcare support workers to receive training and development in order to meet clear codes of practice as is the case with medical, nursing and other professions.

These three reports prompted NHS Employers, in 2014, to acknowledge that the NHS employs over 340,000 support workers and that they provide a *'huge proportion of the face to face care'.* During the same year, Health Education England launched a national strategic framework to develop the healthcare support workforce: Talent for Care[9] strategic framework. One of the three primary themes of Talent for Care is to Get On - Support people to be the best they can be in the job they do and in particular recommended that:

- Every NHS employer and contractor should be challenged and supported to implement a development programme for all support staff, that is over and above annual appraisals and mandatory training.
- All new Healthcare Support Workers and Adult Social Care Support Workers to achieve the new Care Certificate, which will be introduced in March 2015; and, for those that want it, a universally recognised Higher Care Certificate.
- Double the number of HEE funded or supported apprenticeships will be available by March 2016 and an NHS Apprenticeship offer to rival the best in the country will be established.

Most significantly the authors of the Talent for Care framework highlighted the unacceptable situation concerning the lack of investment in this vital workforce (box B).

Box B HEE's Talent for Care framework[9]

While the support workforce make up 40% of the total NHS workforce and provide around 60% of patient care, this group receives less than 5% of the national training budget. We are working with various national, regional and local partners to change this picture, to increase investment in the support workforce and to spread good practice and innovation.

In the Shape of Caring review[10] Lord Willis highlighted the lack of investment in the support workers and observed that although the '*support workforce provide over 60% of hands-on-care'* they have '*little access to training or personal development'*. The Royal College of Nursing (RCN)[11] subsequently published a policy about registered nurses and support workers and stated that support workers must be developed so they have the knowledge and skills required to deliver the care that they are employed to give. The RCN also specified that a structured career framework for this workforce should be developed.

At the end of 2015 the Department of Health[12] announced the introduction of the proposed nursing associate role (Band 4) which will provide '*greater support for nurses and help bridge the gap between healthcare support workers*' normally employed at Band 2 and clinical nurses employed at Bands 5-8. At the time of writing this report the nursing associate test sites are being piloted.

The NHS has been slow to implement the government's apprenticeship model, particularly in AHP led services. There are two models of apprenticeship: the traditional route for young people and the second route for existing employees who wish to learn some new skills within their normal role[13]. The latter may appeal to organisations that wish to develop their allied health support workers.

Lord Carter's 2016 review of operational productivity and performance[14] suggested that one of the areas that need to be looked at is the contribution that the unregistered clinical support staff can make in optimising the role of AHPs.

The Department of Health in Australia has some of the same healthcare workforce challenges that we experience in the UK. They have been exploring how they can more effectively deploy Allied Health Assistants (AHAs). One of the particular problems that they face in Australia is the different approaches taken by the Federal States with a wide variety of tasks and responsibilities allotted to the AHA. In a report by the Grattan Institute[15] it is argued that increasing the use of allied health assistants does not reduce the quality of care and that there is evidence to suggest that using these assistants can in some cases improve patient outcomes by reducing length of hospital stay.

3.0 STUDY DESIGN AND DATA COLLECTION

This study aimed to gather information as to how allied health services, based in five North Central and East London (NCEL) London Boroughs, currently employ and deploy support workers.

The five London Boroughs chosen by HEE NCEL for this study were:

1. Barking and Dagenham
2. Havering
3. Redbridge
4. Barnet
5. Tower Hamlets

3.1 Community Education Provider Network (CEPN) sites

HEE has identified that the healthcare workforce needs to be capable of 'team working across professional and organisational boundaries[16]' to prevent the fragmentation and duplication of care, and improve the patient's experience. In 2014, in response to this situation, the then LETBs (Local Education and Training Boards) developed local Community Education Provider Networks (CEPNs) to develop the local workforce to meet the needs of the local population.

The vision that HEE NCEL set out at that time was for the CEPNs to:

- Support workforce planning
- Support workforce development
- Respond to local workforce needs
- Provide education programme coordination
- Ensure education quality
- Develop educational faculty

There are 13 London Boroughs in North Central East London (figure 1). Some of these have joined together to form a total of ten CEPNs.

Figure 1 London Boroughs in North Central and East London

HEE NCEL set up the ten CEPNs in two Waves, with five CEPNs in each Wave (table 1) The CEPNs chosen for this study had previously agreed with HEE NCEL that support workers would be one of their priority activities.

HEE NCEL Wave one CEPNs	HEE NCEL Wave two CEPNs
Islington	**1. Barking and Dagenham, Havering and Redbridge**
Barnet	2. Camden
Tower Hamlets	3. City and Hackney
Newham	4. Enfield
Waltham Forest	5. Haringey

Table 1 Health Education England North Central and East London CEPNs clustered by Wave

3.2 Service provider organisation engagement by CEPN

One of the challenges for the SWAP study has been that many of the service provider organisations that employ allied health support workers, provide services across the CEPN boundaries, resulting in a more complicated study than originally anticipated. All the service provider organisations listed below (3.2.1-3.2.3), except for East London Foundation Trust, actively participated in SWAP.

3.2.1 Barking and Dagenham, Havering and Redbridge

This CEPN, in the East of NCEL, has been created from the three separate London Boroughs of Barking and Dagenham; Havering, and Redbridge (figure 1).

The two main service provider organisations in this CEPN are:

a) Barking, Havering and Redbridge University Hospitals NHS Trust with two separate main hospital sites in the CEPN boundary:

1. King George Hospital
2. Queen's Hospital

b) North East London Foundation Trust provides mental health and community services.

3.2.2 Barnet

Barnet is a very large Borough in the North West of NCEL. It shares part of its boundary with the London Borough of Enfield, part with the London Borough of Haringey and the remaining part with the London Borough of Camden (figure 1). There are two key service provider organisations that employ Allied Health Support Workers (AHSWs) in this CEPN:

a) Royal Free London NHS Foundation Trust with three separate Hospital sites:

1. Barnet Hospital in Barnet
2. Chase Farm Hospital in Enfield
3. Royal Free Hospital in Camden

b) Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) provides a range of mental health inpatient, outpatient and community services.

3.2.3 Tower Hamlets

This CEPN, in the South of NCEL, has a much smaller footprint than the other two CEPNs but has a very high population density. There are two main service provider organisations that employ AHSWs in this CEPN:

a) Barts Health NHS Trust. This is comprised of the following sites:

- Mile End Hospital- Community Hospital
- Newham University Hospital

- The Royal London Hospital
- St Bartholomew's Hospital
- Whipps Cross Hospital

It is important to note that Barts Health straddles two of the other Wave one CEPNs: Newham and Waltham Forest, which were not included in this study.

b) East London Foundation Trust (ELFT) provides mental health and community services.

3.2.4 Engagement with the London Ambulance Service

As mentioned in 1.0 the London Ambulance Service is organised pan-London, so it is not possible to separate out the NCEL ambulance workforce. Although the aims of SWAP do not align fully with the ambulance workforce, some very useful information about the Emergency Ambulance Crew has been collected. This has been used to enhance the study and inform the final recommendations.

3.3 Approach to the study and data Collection

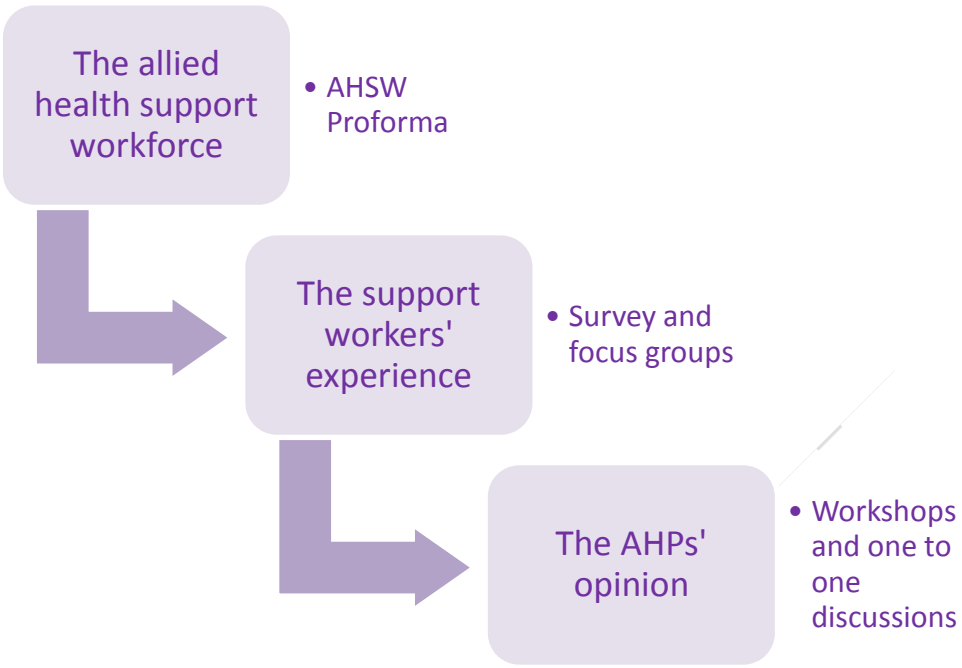
Three sets of data were collected as part of this study (figure 2):

1. The number of allied health support workers employed in NCEL. This quantitative data was collected using a proforma circulated to AHP managers.

2. The allied health support worker's work experience. A mix of quantitative and qualitative data was collected from an online survey and further qualitative data was collected during focus group meetings.

3. The Allied Health Professionals' opinion as to how the AHSWs are employed and deployed. This data was qualitative only and collected during workshops and discussions with senior staff.

Figure 2 Stages of data collection and methods used in the study



3.3.1 Proforma information

AHP leads or professional leads were asked to provide details on a proforma (annex A3) of the number of AHSWs employed in their organisation, by title/role, including the WTE by Band. Some of the forms were returned and where there was missing information this was followed up. The number of reported AHSWs employed across the three CEPNs is 248.5 (breakdown in appendix 8.1 page 63).

3.3.2 Online survey

A survey for completion by support workers was drafted on Survey Monkey and forwarded to the SWAP Steering Group members for comment. Amendments were made and the survey link was made available to the AHP managers for distribution to their AHSWs (questions can in found in appendix 8.2 page 63). The managers were asked to enable the support workers to complete the survey during the working day.

143 support workers completed the survey. The response by CEPN is as follows:

Barking and Dagenham, Havering and Redbridge – 42

Barnet – 40

Tower Hamlets – 53

The details by CEPN are illustrated in annex A4. An additional eight respondents advised they work in the NHS but not which organisation.

3.3.3 Focus groups

AHSWs were invited to attend a focus group with the study team. The aim of the focus groups was to explore in more depth the way that they are deployed in the service and their education and training opportunities (focus group briefing paper in annex A5).

16 focus groups for AHSWs were held across the three CEPNs: five in Barking Havering and Redbridge, six in Barnet and five in Tower Hamlets (details in annex A6).

99 (66 females, 33 males) support workers attended the focus groups:

Barking and Dagenham, Havering and Redbridge - 27

Barnet - 43

Tower Hamlets - 29

3.3.4 AHP workshops and one to one discussions

AHPs who line manage the AHSWs were invited to attend a workshop with the study team (annex A7). The workshops were delivered in two parts: a short presentation (annex A8) about the current policy context of health and social care support workers, and a focus group discussion about the current and potential contribution the AHSWs make to the service they work in. During these discussions, the study team also explored training and development opportunities for the AHSWs.

15 workshops for registered AHPs, from across the three CEPNs, were held. 66 AHPs (50 females, 16 males) attended workshops. 20 attended from Barking and Havering, Redbridge and Dagenham; 23 from Barnet and 23 from Tower Hamlets. The professional profile of the AHPs who attended the workshops is shown in table 6 and detailed in annex A9. Ten of them worked in the community, the remainder in the acute sector. The AHPs attending the workshops were not asked specifically about their employment Band. However, 30 chose to share this information: four are employed at Band 8, ten at Band 7, 11 at Band 6 and the remaining five at Band 5.

In addition, the study team spoke directly to seven senior AHP managers about SWAP: two from Tower Hamlets, two from Barking and Dagenham, Havering and Redbridge, one from Barnet and two from the London Ambulance Service.

Ten of them worked in the Community, the remainder in some part of the acute sector.

Main role/title	Number
Dietitian	4
Generic Therapist	3
Occupational Therapist	19
Physiotherapist	21
Podiatrist	1
Radiographer	14
Rehabilitation Lead	2
Speech and Language Therapist	2
Total	**66**

Table 2 Number of AHPs, by profession, who attended the workshops

3.3.5 End of study workshop

At the end of the study HEE NCEL hosted a half-day SWAP findings event for invited participants (annex A10) to learn about the project findings and inform the final recommendations.

40 people attended this event including HEE NCEL staff; senior AHP managers; AHPs who line manage the support workers and AHSWs. A copy of the schedule for the afternoon can be found in annex A11.

4.0 STUDY FINDINGS

This section presents the key findings from the SWAP study. It draws together the data collected from the main study data sources. Where certain aspects of the study have been consistently explored as part of the survey, focus groups or workshops they have been thematically collated and presented in sections 4.1-4.10 below.

4.1 Reported number of Allied Health Support Workers by CEPN

As reported in 3.3.1 above the number of AHSWs employed across the three CEPNs (excluding the number of Emergency Ambulance Crew who are employed pan-London) was 248.5 WTE: 111 in Barking, Dagenham, Havering and Redbridge; 64.5 in Barnet; 73 in Tower Hamlets. A breakdown is in appendix 8.1 page (64).

The highest reported numbers of support workers are those who work in Therapy and Rehabilitation Services (figure 3). It is important to note that this number includes those working in community services as well as acute services. Many organisations reported that these staff may work across site.

The way in which the different organisations, within a CEPN, employ assistants in Diagnostic Imaging varies considerably.

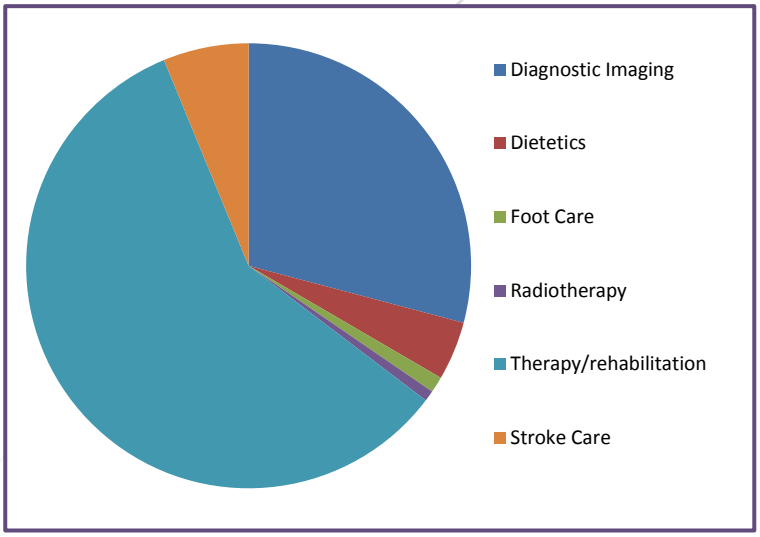


Figure 3 Number of support workers by service

4.2 Employment profile of Allied Health Support Workers

143 AHSWs answered the survey (referred to as respondents). The department they work in is listed in appendix 8.2 and detailed in annex A12. The two main department clusters that the respondents identified working in are therapy departments (n=89), including rehabilitation, and imaging departments (n=29). 99 AHSWs attended the focus groups (referred to as attendees), only 19 (19%) of whom are employed in a community setting. The majority (97%) of respondents are employed at Band 3 with a further 29% employed at Band 4 (see figure 4).

Not all the AHSWs who attended the focus groups stated their employment Bands. Of those who chose to give this information the majority are employed at Band 3, some at Band 4, two at Band 2, one at Band 5 and one reported having a split post working as a Band 4 for part of the week and Band 6 for the rest of the time.

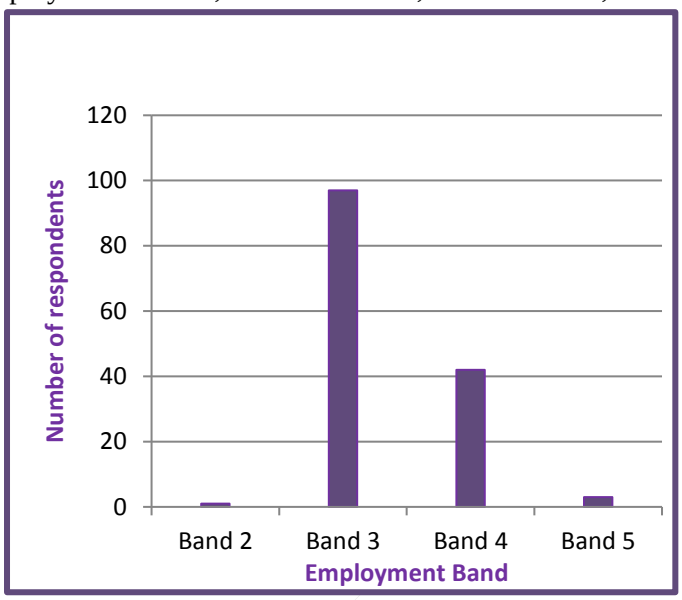


Figure 4 Employment profile of AHSW survey respondents

The AHPs who participated in the workshops also reported that the support workers are primarily employed at Band 3 or Band 4. Very few of them noted working with a Band 2 AHSW or a Band 5 support worker. According to a physiotherapist the value of employing both Band 3 and Band 4 support workers is that '*the Band 3s can aspire to become a Band 4 and the Band 4s level is far more advanced than a Band 3'*. The study did find some departments that took this approach to employing AHSWs but in other departments it appeared more 'ad hoc', where the support staff demonstrate the same level of skill irrespective of the Band they are employed on.

73% of the respondents work full-time and just less than one-third reported that they benefit from flexible working. Of the 39 respondents who work part-time 22 reported that they work a four-day week, eight a three-day week, six a five-day week (mornings only), four a two-day week, two over a seven-day rota, the remaining part-time workers did not advise on their working hours.

The AHSWs who attended the focus groups also reported considerable flexibility in their work patterns which have been determined through local negotiation and former employment models. However, only 34 (34%) provided details about their working pattern, and some advised that the working day may start as early as 08:00. 21 stated they work full-time and only three of these reported working weekend shifts. Of the 13 who reported they work part-time seven of them work four days per week, one works three long days per week and the rest work either two or three days per week.

"The department has just started a rotation and it is not going too well, some people in the department are too set in their ways and don't want to rotate".

Band 3 Ultrasound Helper

Although 32% (n = 39) of the respondents stated that they would like to rotate in their job to give them different work experience, only 15% of them reported that they currently work in a rotational post. Normally this involves going to another trust site to cover for annual leave or sick leave. A podiatric support worker noted that they rotate every two months. It was acknowledged that for rotation to work effectively all staff must willingly engage which does not often happen.

140 survey respondents commented on how long they had been in their current post. 15 of the respondents reported working in their current post for only five months (n=15), whereas seven reported staying in the same post for more than 20 years. The distribution is illustrated in figure 5. It is a normal distribution with the highest number of respondents reporting that they had remained in post between two and four years.

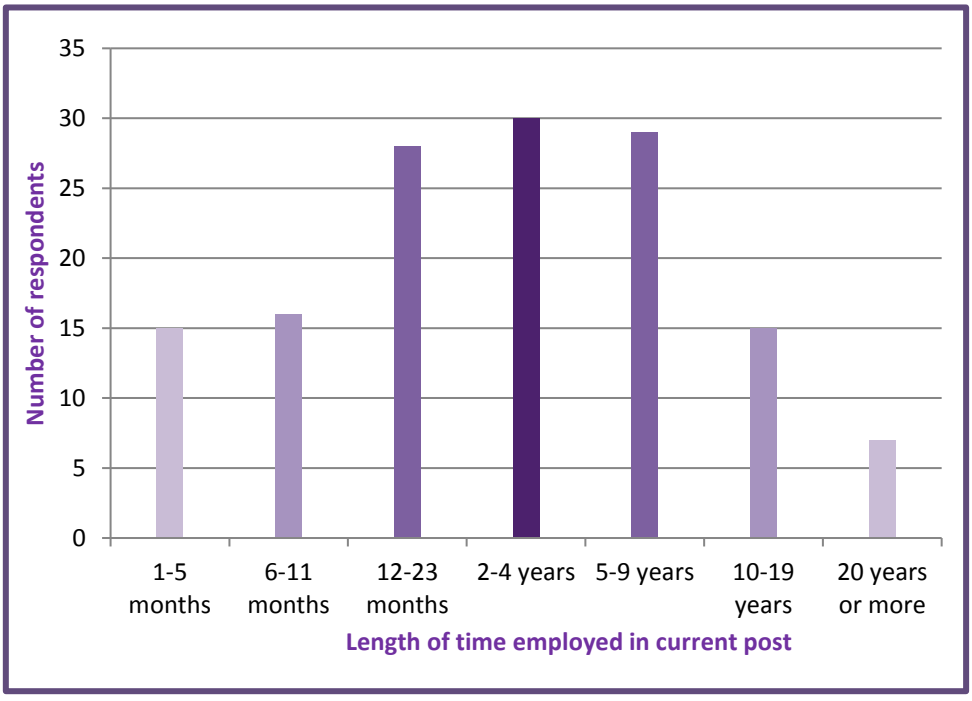


Figure 5 Length of time the survey respondents have been employed in their current post

Similarly, 83 (84%) of the AHSW focus group attendees reported a very comparable employment history (figure 6). It is interesting to note that 15 of them reported they have been in the same post for 11 years or more, an unusual situation for healthcare staff in London.

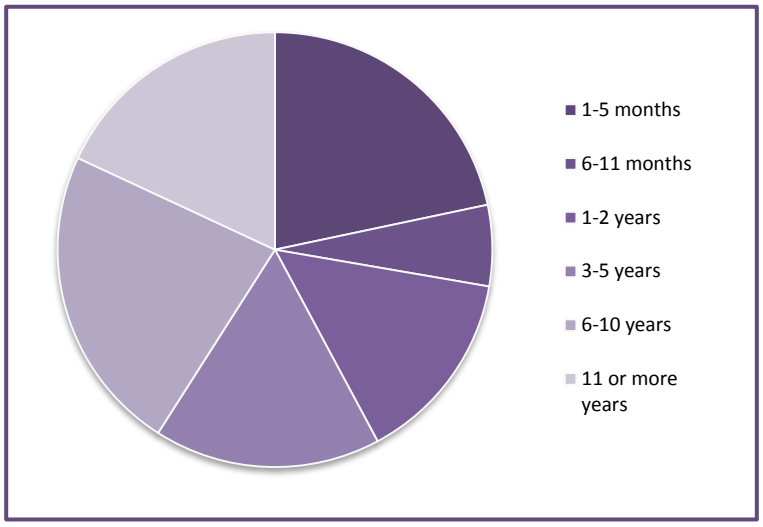


Figure 6 Length of time AHSW focus group attendees reported they had been in their current post

4.3 Management of the AHSWs

Many respondents stated that they report to more than one clinical professional. Some identified the senior team leader as their line manager while others specified those that they worked with on a day to day basis. This range of responses is shown in the figures 7 and 8. It is interesting to note that staff employed at Band 7 may be the line manager even where there is an AHP employed at Band 8 in the team. However, a Band 7 may also be the most senior manager in the team with staff employed at Band 5 and 6 line managing the support workers.

137 respondents provided information as to how often they see their supervisors. 101 stated that they work with them every day, six noted that they never saw them. It is unclear as to why this is the case. The remaining 30 suggested that the time they spent with their supervisor is not fixed and for some it may be as little as two hours a week.

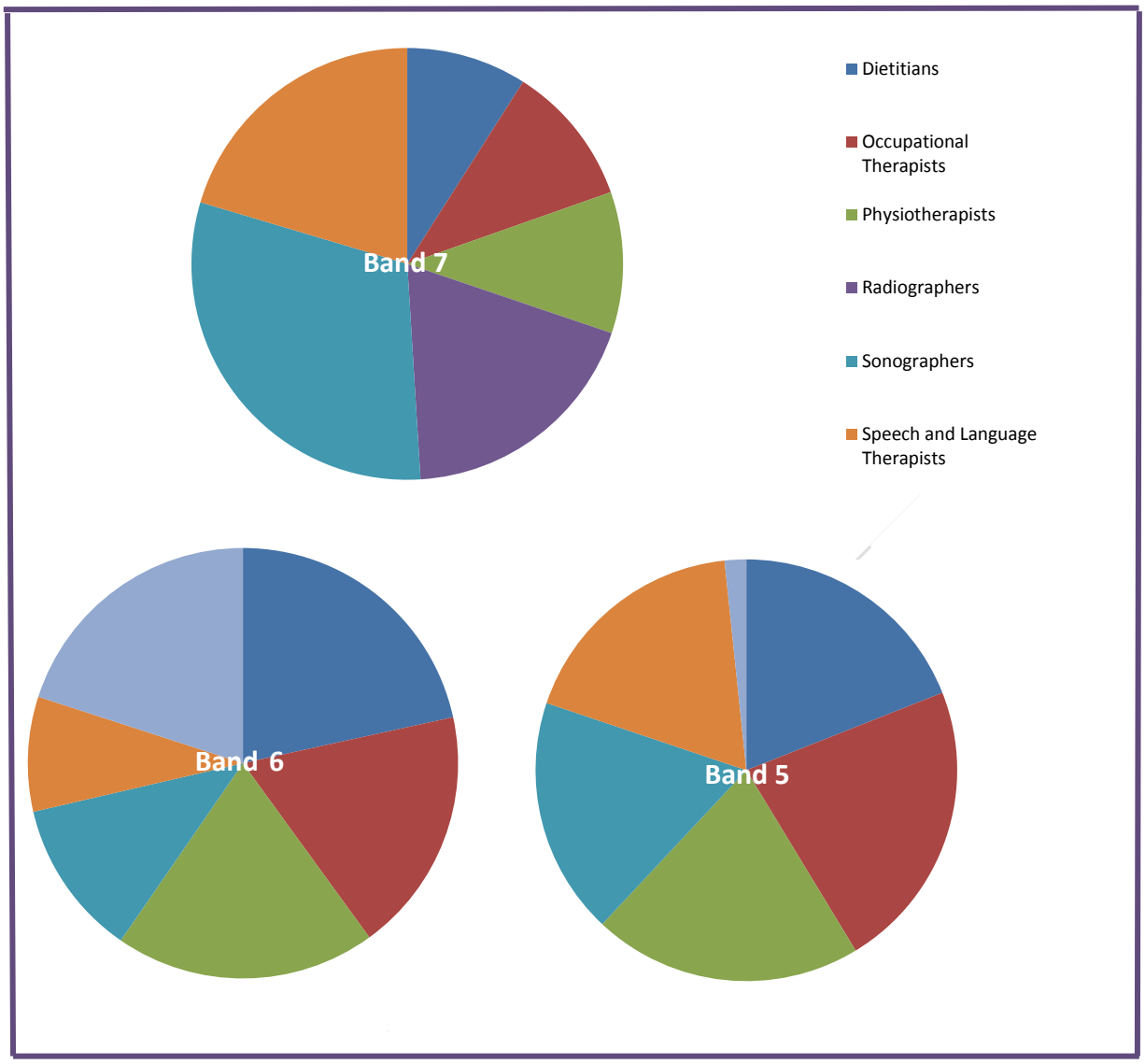


Figure 7 Proportion of line managers by profession and Band

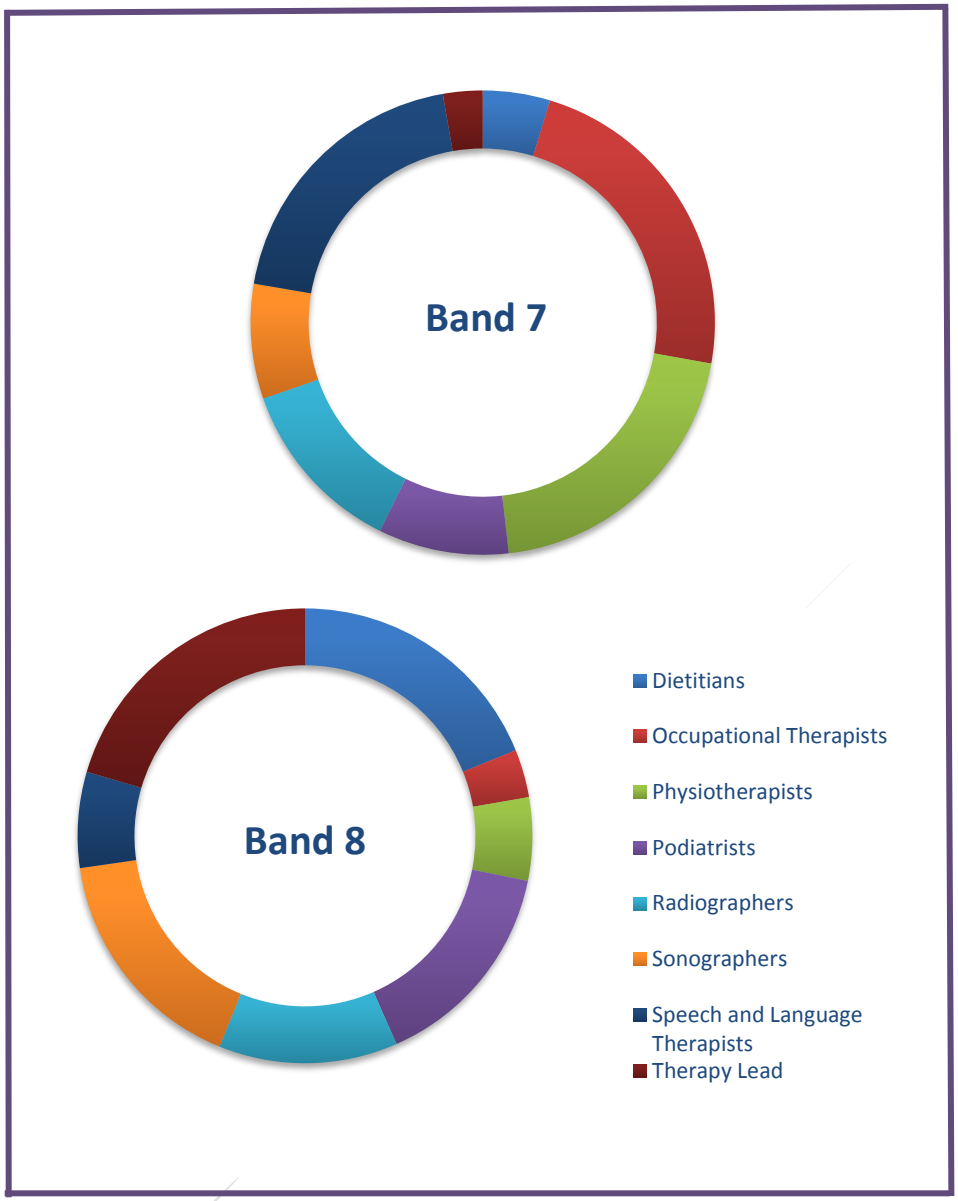


Figure 8 Number of senior managers by profession at Band 7 and Band 8

4.4 Deployment of allied health support workers

How service provider organisations employ and deploy the allied health support workers is largely locally determined by service need, often based on an historical model that has evolved over time. The study team did not uncover any robust organisational operational approaches to employing and deploying this workforce, although the study identified a number of local department based models that demonstrate a standardised approach to how the support workers are deployed. For example, one hospital employs Band 3 support workers in the therapy departments and another hospital employs both Band 3 Imaging Assistants and Band 4 Assistant Practitioners in the imaging departments.

The delegation of tasks and the boundaries of the clinical care that the support workers can give are often determined by their grade and length of service. As one physiotherapist employed in critical care and surgery explained: '*they have got loads of experience so they have quite often…seen it, done it, they have got the ideas and they help us develop and shape the service'.*

A robust approach to allocation of duties is summed up by a senior occupational therapist (box C).

Box C Examples of therapy support worker activities within the scope of occupational therapy services

Band 2 support worker will conduct initial interviews, order equipment, based on occupational therapists clinical reasoning. Accompany occupational therapists on home visits, fit equipment, and carry out a prescribed exercise programme with a patient.

Band 3 support worker similar to the above but with the autonomy to choose which piece of equipment is the most suitable. They are also given the discretion to progress the patient's level of activity within agreed parameters; they can exercise a certain amount of judgement.

Band 4 support workers are given more autonomy. The occupational therapists will review the referral and if deemed suitable the support worker will manage the patient's therapy.

Some of the AHSWs have a significant clinical role: assess and discharge patients, write in patients' notes or undertake plain film imaging, while others spend most of their time undertaking administrative tasks and provide patient support such as checking identity and chaperoning. 134 (94%) of the AHSW survey respondents gave details of the key tasks that they perform in their job. Some of them reported that they primarily have one key role such as helping patients with exercises. Others gave comprehensive reports of the range of activities that they are asked to undertake, as illustrated overleaf.

The most frequently mentioned tasks that the survey respondents reported undertaking are listed in table 3 below, in order of frequency that a task was mentioned. Please see annex A13 for more detail.

Many of the support workers carry out a mix of both clinical and administrative tasks. Overleaf are two examples of the detailed breakdown of AHSWs' job role: Occupational Therapy Technical Instructor 2 and Band 3 Imaging Assistant. These two examples illustrate the diversity of the AHSW roles.

Task	Frequency of reporting	Task	Frequency of reporting
Administration	34	Stock management	18
Clinical Assessment	34	Patient exercises	17
Ordering equipment	28	Booking appointments	10
Other equipment related tasks	24	Reception duties	9
Patient rehabilitation	22	Discharge planning	8
Assisting patient to be independent	19	Record keeping	8

Table 3 Tasks undertaken by AHSWs who responded to the survey

Occupational Therapy Technical Instructor II job role

- *'Pre-op assessments in clinic or at client's home.*
- *Education to clients regarding their surgery and any recommendations following surgery. Provision of necessary equipment for patients, identifying which Borough the equipment comes from. Ordering, delivering and fitting, and re-stocking where appropriate.*
- *Report writing to inform colleagues of findings at pre-op level, to enable a smooth transition of client's hospital journey and any care required for discharge.*
- *Orientating and training new members of staff.*
- *Assisting inpatient staff with home visits and equipment deliveries as required.*
- *Office management of re-stocking paperwork and leaflets, as required.*
- *Computer work including reports, equipment orders, stats, CPD, audits, bookings and client administration.*'

Band 3 Imaging Assistant job role

- *'Check and update resus trolley every day.*
- *Check requested orders for inpatients and bring down patients to the department by calling helpdesk to book a porter.*
- *Help radiographers bring inpatients into the room.*
- *Help slide patients when required.*
- *Interpret when needed.*
- *Liaise with the ward staff and referring clinicians regarding X-ray examinations e.g. to establish NG tube position.*
- *Shut down the rooms at the end of the day.*
- *Take patients round to other modalities if they are scheduled for another imaging* procedure.'

Equipment featured strongly in the support workers' comments: ordering equipment, delivering and fitting equipment, retrieving equipment from store, cleaning equipment and teaching staff how to use equipment are some of the key tasks they undertake.

Some support workers have a clear pattern to their day such as an imaging assistant working in clinical ultrasound or a physiotherapy assistant (box D) working in the acute sector. Others will work a split day i.e. with a dietitian in the morning and a speech and language therapist in the afternoon.

Box D Day in the life of a Band 3 Physiotherapy Assistant in the acute sector

'I work four days a week 8:30 – 3:00. Sometimes I will see the patients that I didn't see the day before, if they are not having breakfast. At 10:00 we have our team meeting and that is when my work for the day gets designated, as the physiotherapists have been on the wards by then and know what is needed. They decide whether there is work for me on my own, or as a double with another assistant or with a physiotherapist.

At 12:30 I come off the ward and do my admin. There is a book in which they note jobs for me to do. Lunch is 1:00 to 1:30. After lunch I will work as a double for another hour. At 2:30 I will tidy up any admin and then I go home at 3:00pm.'

Whilst there are local variations as to how AHSWs are deployed there are clear patterns of deployment within a service. For example, the support workers who are employed in the community reported undertaking a greater range of activities than those working in the acute sector and that they may move from site to site during a working week. Whereas, those employed in the acute sector will either be static in one department (imaging) or work between a few specific wards (rehabilitation).

'She is actually a physio by background…she does bed and chair exercises with our critically ill in intensive care'.
Physiotherapist working on intensive care, surgical and respiratory wards

A number of the allied health support workers hold relevant professional qualifications from another country and although they are not recognised by the Health and Care Professions Council (HCPC), the AHPs they are working with reported having confidence in their knowledge and skills and will allow them, under supervision, to treat more complex patients. In some specialist services the AHSWs are all qualified professionals but not eligible for registration.

The support workers employed solely in the hospitals tend to assist the regulated professional, referred to as doubles. Whereas, those who work in the community and those who are community facing may have their own caseload and report back to the AHP who has delegated the activity. There are also mixed models of deployment where the support worker has a split responsibility. For example, when they are working on the wards they assist the physiotherapist but when they are seeing patients in rehabilitation they have their own caseload.

'We have our own caseload. We can report back to the physios, and we liaise with them, but basically, we run our own load and help with discharges. We do referrals'.

Generic Support Worker in the Accelerated Discharge Team

Whether the support workers are allowed to undertake an initial assessment of a patient is quite important to the individual support worker, even if they are working alongside the AHP. Support workers employed in highly specialised services such as neuro-surgery or neurology do not normally perform the initial assessment unless the patient is referred for a simple assessment, post a period of acute care. Nonetheless, some support workers, such as dietetic assistants, reported that they are normally responsible for the initial assessment and others that they only undertake an initial assessment under the supervision of a 'qualified' member of staff.

The specific information that is gathered by the support workers, during the initial assessment, will also vary according to the service. For example, a therapy support worker employed in an A&E Rapid Response Team advised that their initial assessment includes: a) establishing the patient's home circumstances i.e. what support they have at home and what help they may need to enable them to go home and function safely, and b) undertaking a cognition assessment i.e. short term memory, long term memory and assessing whether the patients are disorientated. However, those working in the community respiratory teams are likely to undertake both an initial assess and a final assessment after the patient has finished the course of rehabilitation.

A third of the AHSWs who attended the focus groups commented on the amount of administration they are required to do, which is locally determined. These administrative tasks can be categorised into general and service specific tasks. Examples of general administrative tasks include stock taking and replenishing forms, printing etc. whereas examples of specific administrative tasks include help with completing forms, logging specific patient data, helping with letters to patients, sending out flyers and dealing with promotional material.

'The admin part of it, we have to co-ordinate the list of inpatients in the morning make sure I ring the ward and find out how they are going to come down. After that find out about infection risk and then put the details on the ultrasound help desk list'.

Band 3 Imaging Assistant

Some of the therapy support workers spend as much as 60% of their time on administrative tasks and very occasionally they will be employed solely in an administrative capacity. Others may spend as little as 20% of their time on administrative tasks which easily managed in between clinical activities. According to one therapy assistant in the musculoskeletal (MSK) team: *'there is a lot of admin associated with setting up the gym groups and the hydrotherapy*

pool'. One support worker reported a very efficient approach to dealing with the administrative tasks: '*Wednesday is set aside for administrative tasks only, leaving the rest of my week to perform clinical facing tasks'*. Many recognised that the administrative burden is the same for all clinical facing staff but they noted that there has been a continued increase in the number of administrative tasks performed in the service.

How therapy departments deploy support workers

The therapists, who attended the workshops, recounted an extensive list of different clinical facing activities that the support workers undertake which are dictated by the service need. Many of the routine clinical facing activities relate to assessments, either assisting the therapists or, for the more experienced support worker, carrying out clinical assessments. The Band 4 therapy support workers tend to develop this level of skill in a bespoke area where they have been working supervised for many years. For example, a Band 4 occupational therapy support worker working solely in orthopaedics has been trained up to conduct the initial interview and undertake functional assessments for 'simple cases'. A simple case is locally defined as a patient who may need an increase in their package of care, or even a different package of care, and is already being treated in that department. The AHSWs are required to feedback to the occupational therapist if they think a patient requires rehabilitation or onward referral to a community service or a very complex package of care. However, if it is a simple increase in the existing care package they will write the occupational therapy report themselves. For AHSWs who hold a generic therapy post it is difficult to see how they could achieve this level and breadth of expertise across a wider scope of care.

The therapists frequently commented on the fact they do not have sufficient numbers of support workers in their service and that they have to share them with colleagues on other wards or in other services. Many suggested that the service would be more efficient if there were more of them: '*we have two and they are stretched over six or seven wards so I very rarely have contact with a rehabilitation support worker'* (Band 6 Physiotherapist). The therapy support workers who work on 'heavy' wards such as orthopaedic wards will 'double up' with a therapist in the mornings to help with the 'heavy work' and then for the rest of the day they will carry out the tasks as delegated.

'We have a lot of rehab support workers on this team but I have to book their time in advance, they work to support PTs in the morning and OTs in the afternoon'.
Band 6 Physiotherapist

The therapy professional will normally undertake the initial assessment of the patient particularly for those with more complex clinical conditions. Once the treatment progamme has been finalised the therapy support worker will carry out the prescribed interventions. The support worker is usually required to feedback to their supervisor about the session.

'They would come and get us for support but I would 100% trust them'.
Band 7 Physiotherapist

The range of clinical facing activities, that the AHPs reported the AHSWs undertake, can be found in in annex A 14. This study learnt that those working in the acute sector primarily helped with assessments and exercise programmes, while those who visit people in the community have a more diverse portfolio of clinical facing activities e.g. the Assertive Outreach Team.

Thirteen of those who took part in the focus groups engage the patients in exercise sessions or exercise programmes. These include group exercise classes for those who have fallen; individual ward based exercises for those who have sustained a fractured neck of femur; home based exercises for those who need to strengthen their muscles, and sometimes limited exercises for those who are bed based or receiving palliative care in a hospice. The therapy support workers repeatedly reported that they perform a number of different activities in a day as illustrated in the box E below.

Box E Example of typical activities undertaken by a Band 3 Therapy Support Worker

'I could do anything from delivering equipment to people's homes; I could go with the occupational therapist to do home visits with the patients. I could do kitchen assessments with the patients here in the hospital. I could do bathroom assessments and work with the patients on the wards in terms of their therapy. I support patients to practice transferring from bed to equipment and walking with aids. At the moment, my day is split between physiotherapy in the morning and occupational therapy in the afternoon and vice versa'.

Support workers employed in podiatric services run their own clinics according to the care plans, prescribed by the podiatrist. They will assist in high risk clinics and nail surgery but will also go out on home visits including visits to nursing homes and residential homes.

Increasingly service provider organisations are employing generic therapy support workers. This usually indicates they work to support physiotherapists and occupational therapists. However, it may mean that the same support worker can also help a speech and language therapist and/or a dietitian. The study did not identify any generic therapy support worker who supported more than three different therapy professional groups.

Many newly qualified therapists work in 'rotational' posts and the senior staff commented on the fact that the support workers are in static posts and know the clinical area very well and the patients on the wards and the therapy support workers can be relied on to keep the '*ward working efficiently'.*

'To be honest the community stroke service couldn't run without them, they very much carry a big chunk of the day to day work.
Community Occupational Therapist

The therapy support workers who work in the community therapy services are particularly key to supporting the ongoing care of the patients in that community. They often have more responsibility than the AHSWs working in the acute sector, with arm's length supervision and often undertake a large part of the day to day work. For very experienced

support workers who have previously worked with a particular clinical condition the therapist will trust them to give the treatment themselves, whereas those new to the service will always be accompanied by a qualified therapist. The demanding workload for many of these support workers can be quite stressful. As one dietetic assistant in the community pointed out: *'I have never had two consecutive weeks holiday because I have dreaded the amount of work I would come back to'.*

As mentioned above support workers employed in community settings are not so closely supervised as those working in the acute sector. The AHSW will accompany the professional therapist on the initial home visit for a new patient. The treatment plan, for the patient, will be set up and subsequently the support worker will visit the patient on their own and carry out the treatment as prescribed. AHSWs also have a significant role in ensuring that the patient successfully completes their package of care in a fixed time, as one occupational therapist explained *'because they are doing daily wash/dress practice, daily kitchen meal prep practice, our hope is, by the end of their input and their rehab the patient may not need a package of long-term care'.* The role that the support workers have in ensuring that the patient's care can be transferred from the acute service to the local community service is not fully recognised. If the therapy support worker's caseload is very high they may not have the capacity to support a patient in their own home, consequently, that patient will remain in the hospital for a longer time than necessary.

'It is quite difficult, because there's the side of me that thinks, actually the rules change according to the opportunities or the requirements. Then there is the other side of me that thinks this is a fantastic opportunity for me
Therapy Assistant Band 3

Repeatedly the support workers commented on the unfairness of the delegation of tasks, and the fact that the level of responsibility was not recognised by their managers. One Band 3 rehabilitation assistant observed: *'personally, I think that there should be differences between what assistants employed on different Bands do, I don't think there is a big enough difference between the Bands. With the responsibility, I take for discharging patients, I should be employed at Band 4'.*

The AHSWs often report dissonance with what they are allowed to do. For example, a dietetic support worker commented on the fact that they are not allowed to calculate a patient's dietary requirements, nonetheless, they are allowed to prescribe and give supplements. Another challenge exists where the employer has introduced a new generic therapy support role alongside existing physiotherapy and occupational therapy support workers, with the result that neither the AHP team nor the support worker themselves understand exactly what their role is, which can be demotivating for the generic support worker.

There are some very experienced AHSWs who have been working in the same service for many years and make a unique contribution to the care of the patients that use this service. One such example is illustrated in box F

Box F Example of the work a Band 4 Occupational Therapy Technical Instructor Level 2

'I see people who are going to have total hip replacements. I see them in clinic before they have their surgery and take initial assessment. I assess what they can do at the moment. I tell them their hip precautions. If I need to I will go out to their home and raise all their furniture. Or I arrange for somebody else to go out and do that.

Then I write a report and send it to the trust site where they will have their surgery. Once the patient has had their surgery they are normally discharged from the hospital within two days. I will recommend whether they need a care package or any other support and all their equipment will be in place ready for them to go home and they will already be aware of what is going to happen'.

Profile of a Therapy Assistant

The therapy assistant profiled here is based in the dementia discharge team of a large acute hospital. He started work in the trust as a porter 21 years ago, and has been in this post for three years. Prior to his current role, he was a physiotherapy assistant working on the Care of the Elderly Medical Assessment Unit at the same hospital. '*I really enjoy working in elderly care'* he said.

There are just two members of staff in the team, himself and a Band 7 occupational therapist. This team of two works with a specific group of patients who have been admitted to the acute elderly ward and who also have a diagnosis of dementia, or are suspected of suffering from dementia. This support worker explained *'the evidence is that a patient coming into hospital who has dementia has a greater chance of:*

- *staying longer*
- *passing away while in hospital, or*
- *being discharged to a residential or nursing home.*

Our role is to try to prevent that from happening and to help them return to their own home'.

His work is primarily occupational therapy services based either on a ward or in a patient's home. He sees his group of patients (those who have been referred to their team and have been admitted to the ward) every day. He went on to explain *'for these patients I am their day in and day out person'*.

This therapy assistant collects collateral history about the patients either from the patient themselves, the patient's carer or their relatives. This information helps him to build up a picture of how the patient normally spends their day and what they can routinely do for themselves. He went on to explain *'my role is to work with them to help then retain this level of independence so they are not deskilled when they return home'.*

He uses an 'Eight things about me' document for every patient when he first meets them. This records key information that all staff can access: patient's name, the name they would prefer to be called by, what their occupation used to be, what they like doing at home, what they like and what they do not like to eat, what upsets them and who knows them best. He explained that it may take a number of days for the staff to get accurate information about a patient.

As part of his work he educates staff about why these patients may appear agitated and the services available to support the patients. For example, some patients, who have their long term memory intact and have lived through a war, can find themselves '*in an organisation with people dressed in uniform, regimented and lined up, which may bring back distressing memories'.*

Not all his work is hospital based he also undertakes home visits, according to local protocol, where he will carry out environmental assessments, make recommendations to help patients with activities of daily living, or install equipment.

This particular therapy assistant has been profiled because his colleagues are very complimentary about him and explain he '*always goes that extra mile for the patient'*, as illustrated below.

'In the early hours of the morning one of the patients who lived an independent life was found walking along the North Circular Road and although she was physically very fit she was very vulnerable and as a team we decided that for her safety she should be placed in a local Care Home. On the day that she was discharged we escorted her to the new location. When we arrived at the Care Home the patient was angry because she wanted to go to her own home. She set off walking in the direction of her home, which was about a mile away, with 'our' therapy assistant following on foot behind her. When they arrived at her home he persuaded her to return to the ward with him until a new care plan was put in place. The outcome for the patient was that eventually she went back home with 24-hour supervision.'

He summed up his reaction to this event as *'I am so pleased we managed to do the best for the patient and keep her safe. I love my work it is the best job I have ever had'.*

How imaging departments deploy support workers

The imaging assistants tend to do more repetitive and supportive tasks, than their therapy support worker colleagues, such as identifying the patient, chaperoning the patient undergoing an ultrasound procedure, cannulating the patient in preparation for a CT scan, or carrying out routine (plain) X-ray procedures. The majority of support workers who are employed to help in imaging services do not undertake any imaging. The limited range of activities undertaken by the imaging assistants is related to the complexity of an imaging procedure or the radiation protection laws. Only those who have successfully passed the IRMER (Ionising Radiation Medical Exposure Regulations) assessment will be allowed to perform an X-ray procedure. This situation has been illustrated in the study as the team found very few support workers in imaging who are actively involved in irradiating the patients. Those who do perform general X-ray procedures, such as chest and extremity X-ray examinations, are employed as Band 4 assistant practitioners, hold an appropriate qualification and are supervised.

The consensus from all the senior radiographers who took part in the workshops was that the support workers should not perform any Computerised Tomography (CT) examinations as the radiation dose is high and there are greater risks to the patients. However, this is not the case in Magnetic Resonance Imaging (MRI) where if the support worker has successfully completed their training they are supervised to undertake some routine scanning procedures under strict agreed protocol. One of the senior radiographers who attended the workshops explained that they have a very experienced assistant who runs the DEXA scanning unit. This is the procedure that measures bone mineral density and the AHSW has their own patient list.

The ultrasound departments reported having the greatest need for imaging support workers. Because of the nature of the work the radiologists frequently request the help of this support workforce. They help with preparing the room for injections and sometimes inject the contrast under the supervision of the medical practitioner.

Cannulation prior to a patient having a CT scan is the most controversial activity undertaken by an imaging support worker. Many of the imaging assistants are competent at cannulation and train the radiographers to cannulate. Some of the workshop attendees explained how important it is that the imaging assistants insert the cannulas to keep the workflow momentum and increase the patient throughput. Others, however, argued that this is too risky a procedure for support workers to undertake.

'The Imaging Support Workers are the bridge between the patient arriving and being imaged, they check the patient identity, assist them with changing, escort them to the correct area and in many cases, they insert the cannula'.
Senior Radiographer

Sometimes the support workers also teach the students to do routine tasks such as ordering equipment, because as one participant explained '*the support workers may be very experienced and hold*

qualifications in the specific field that they are working in, even though they may not be registered, they may work at a higher level than a newly qualified practitioner, so the students love working with them as they are technically very good' (Band 6 Radiographer).

How the London Ambulance Service deploy support workers

The non-regulated clinically facing ambulance staff, the Emergency Ambulance Crew (EAC) are quite unique in that they are 100% patient facing. They form part of the ambulance crew that attends 999 emergency calls. They either work alongside a paramedic, or two of them work together attending the full range of calls comprised of See, Treat and 'Pathwaying' all groups of patients.

Sometimes this workforce will work alone on the fast response unit cars attending the full range of calls. The situation in the rapid response service tends to be more flexible and the teams report that they have a role for support workers in every part of the process.

4.5 Naming of the allied health support workers

One of the consistent threads running throughout this study is the variety of job titles given to the support workers employed in allied health services, particularly in the therapy services. In some trusts, they have attempted to standardise the title and in others the job title given to this workforce is determined by the specific nature of the work they do or the locally agreed preference. In one large provider organisation, based on multiple sites, all the job titles given to the support workers are locally determined and locally justified.

The professionals argue that the support workers have preferences and like to stay with a particular title. Some of the allied health support workers who have been working in the service for many years prefer to use the job title that they were given originally, even though through the HR process their title has been formally changed. Staff who are used to being called 'technical instructor' jealously guard this title and introduce themselves to the patient as a technical instructor. As one physiotherapist explained '*Sometimes they don't want to be generic they want to be identified with a particular profession like occupational therapy assistant, physiotherapy assistant because that is where their work is primarily*

> *'Again, it was the OT techs that had the issues in terms of the change of name. Because some of them felt they had done particular aspects to their training which other support workers hadn't. It was quite a difficult time and in the end, likewise, we left them with that title until they either resigned or retired'.*
> Clinical Lead for Rehabilitation

based'. Departments have tried to change this to a more readily understood title with little success. As a lead for inpatient rehabilitation recalled '*I try and use the therapy support worker title but they continue to use the technical instructor title'.*
Amongst the 143 survey respondents there were 43 different job titles. Some of the job titles used explain exactly what the support worker does, e.g. rehabilitation assistant, others are more generic e.g. imaging assistant. Examples of the more commonly used titles are illustrated in table 4. Detail is available in annex A15.

Title	Number of respondents	Title	Number of respondents
Rehabilitation Support Worker	25	Therapy Support Worker	10
Rehabilitation Assistant	17	Generic Therapy Assistant	7
Imaging Assistant	11	Technical Instructor	7

Table 4 Support worker job titles

Similarly, the 99 AHSWs who attended the focus group reported that the most commonly used title for those employed in therapy services are

- Therapy support worker
- Therapy assistant
- Rehabilitation support worker (abbreviated to rehab support worker)
- Rehab assistant (abbreviated to rehab assistant)

Detailed list in annex A16.

These generic titles are often used where the employee supports more than one professional group e.g physiotherapist and occupational therapist or occupational therapist and speech and language therapist.

The AHPs advised that some teams have stayed with the service specific job title such as

- Emergency Ambulance Crew (EAC)
- Dietetic Support Worker
- Podiatry Assistant
- Occupational Therapy Assistant (OTA)
- Physiotherapy Assistant (PTA)

One area where there is total standardisation of the title used for the AHSWs is for the clinical support staff who work in the London Ambulance Service. They are all called Emergency Ambulance Crew (EAC). Private services working in London may use an alternative title of Emergency Medical Technician.

Another area where there has been some standardisation of job title is in mental health services where the support workers are collectively referred to as 'mental health and support time recovery workers'. This job title appears to have been readily accepted by all staff.

In imaging services fewer titles are used for the imaging support workers but this is no less clear for the patients. There are generic titles and service specific titles. For example, those employed in a generic role at Band 2 or Band 3, who do not perform any imaging procedure, are normally referred to as Imaging Assistant. Those who are employed at Band 4 and have been trained to perform some core imaging are normally referred to as Assistant Practitioners. These titles have been recommended by the professional body. Other service specific titles used are Nuclear Medicine Assistant or Ultrasound Assistant.

The fact that there are so many titles for the AHSW workforce can be confusing for patients, their carers and other staff in the organisation. Some of the job titles are readily understood by patients and colleagues, such as physiotherapy assistant, however, others are somewhat meaningless, such as generic support worker. As one physiotherapist stated: '*I don't think the patients can distinguish between the qualified therapists and the support workers'*. This problem is further exacerbated by the way that some support workers introduce themselves. The AHPs reported that sometimes the AHSWs will say '*I am a support worker'*, sometimes '*I am a therapy support worker'* or sometimes '*I am with physiotherapy'*.

'I just love what I do and I am so happy I wouldn't want to change it, but I would like to be called something different'

Therapy Support Worker Band 3

The title that is used to describe the AHSWs is important to them. Many of them commented that they prefer the title they used to have rather than the more generic term of support worker: '*I am a Band 4 advanced rehabilitation assistant not a support worker'*.

One of the attendees was much less concerned about what she was called as long as she was paid at the end of the month. There is some concern about the emerging use of the word generic in the job title as that implies they do not have any specific skill and are there just to fill a gap.

4.6 The value of and valuing the allied health support workforce

SWAP never set out to ascertain how valuable and valued the AHSWs are by their colleagues, however, there were such a large number of comments made about the value of this workforce that it was decided that this aspect was worthy of separate consideration. Many of the workshop participants chose to tell us how invaluable the support workers (box G) are and many noted that they are also undervalued.

Not one of the AHPs implied that the support workers are surplus to the team or the service. In fact, the majority value the contribution they make and trust them to do their work. It is recognised how hard they work and that one of the reasons they work so hard is that there are too few of them and they have to be shared out between the teams. It was suggested that looking at staffing levels on a sheet does not

truly represent how AHSWs are deployed. As one occupational therapist observed, *'one assistant can be doing eight different jobs at once and running from one end of the hospital to the other to do these tasks which might be in many different locations'.*

Box G Raising the profile of the Allied Health Support Worker

'I am here because I want to value them and raise their profile as they deserve recognition. Without them we would not be able to work as efficiently as we do. We are very lucky as they know their remit really well.'

Band 7 Occupational Therapist

Often the support workers are not truly valued until they are on leave or off sick. One senior radiographer recounted a scenario when the department's three support workers were off sick at the same time and the radiographers had to '*step into their role. It made us realise how important they are'*. Similarly, an occupational therapist pointed out that often the true value of the support worker post is only realised when the qualified team is short of staff and then the support workers run the service on a day to day basis. One department signs off annual leave for qualified staff based on how many support workers are on leave at the same time.

The participants observed that some of the support workers really enjoy what they are doing but others are less satisfied with their work. *'I think we are quite lucky on our team. I don't know the support workers on the other teams, but on our teams they are very proactive and they love their jobs, which makes our lives a lot easier'* (Band 7 Physiotherapist).

However, one of the physiotherapists reflected on a cycle of negativity. This physiotherapist explained that there is a cycle within the support workforce where '*they feel a little bit undervalued because they get dumped with the stuff that either we don't want to do, or don't have the time to do, or seems a bit beneath us to do. Consequently, there is no real proactive approach on their part to better themselves because they feel they are only worthy of doing these mundane tasks'.*

Other AHPs pointed out that the support workers induct and train newly qualified staff who are earning more than the AHSWs are and this leads to resentment.

'We are expanding to a seven-day service and employing new staff. The plan is that the two support workers will take a role in educating and teaching the new staff that come in. They already *educate our students and our new vocational staff'.*
Physiotherapist

Some departments that operate a seven-day service will rota the support workers with a less experienced clinician for a

weekend shift as that provides more flexibility with the rota.

The AHPs questioned whether this was appropriate within their role, or simply an additional task given to them. However, other participants recounted that they had learnt such a lot from the support worker when they were novice practitioners, because many of the AHSWs had much more clinical experience than they did at that time.

'I was supported to do the Care Certificate. It was interesting to know that we are appreciated. Before my colleagues and I were sent on this course we didn't think there was much recognition for us, but now we definitely feel that somebody is recognising the work that we do.'
Community Occupational Therapy Support Worker

'It is important to keep them interested and valued'.
Band 7 Radiographer

The registered staff appreciate the fact that many of the support workers have always lived in the locality and they are able to teach the AHPs about local demographics. One of the Dietitians explained that the Dietetic Support Workers *'help us a lot with our nursing home training on things like how to thicken drinks correctly and different consistencies of food'*.

Many trusts have a named person who is responsible for supporting the AHSWs. In some trusts this is a senior AHP with overall responsibility for all the support workers in their department, in other trusts this is a more junior member of staff who has delegated responsibility for networking a specific group of support workers across all sites.

One Clinical Lead Therapist observed that in order to value this workforce we need to understand what motivates them to stay in the organisation, or to leave and seek a post elsewhere. Her view was that *'there are two distinct groups: those who want to develop themselves and progress up a professional ladder and are frustrated with the flat structure, and those who are happy to remain as they are'*. They went on to suggest that some of the support workers may not have the academic skills to follow a professional route, but that doesn't mean they are not valued or respected for what they do.

Although the support workers were not asked specifically as to whether they feel valued or appreciated many chose to comment on this theme. For some of the support workers how valued they feel is reflected in the amount they are paid, as one of them explained **'**I *work thirty-one and three-quarter hours a week and I am lucky if I take home twelve hundred pound a month*'. There is quite a high level of cynicism within this workforce as to whether the employers do really demonstrate that they value them and that the Band 4 ceiling is an artificial barrier to progression. They hear the rhetoric about how important the support workers are and the need to develop this workforce but they do not see this being played out at employee level and '*translating into job role and salaries' (*Therapy Support Worker in a Core Rehabilitation Team).

Whether they are supported to join a course or a study day is also a marker as to how valued they feel e.g. attending the new Care Certificate programme. The AHSWs noted that normally it is only the

'qualified staff' who are given the opportunity to attend courses, although they suggested they would benefit equally from attending some of these courses, such as dementia awareness.

Some of those who commented on feeling valued by their current employers were able to make comparisons with the approach taken by their previous employers. As one respondent explained: '*where she had worked before she had received a lot of training to undertake specific clinical skills which had really helped her do her job and feel valued by that organisation'*. That same organisation was reported to have developed clear competencies by Band, and staff were encouraged and supported to achieve these competencies.

Some of those who attended the focus groups chose to report how their AHP colleagues demonstrate they are truly valued. As a technical instructor working in a community stroke team stated '*I do feel we are valued by the qualified staff, and they use us to carry on the therapy. I was more PT focussed but now I am working with OTs and SaLTs. I really like the SaLT aspect of my work'.* Another support worker was delighted to be transferred into the 'inpatient mental health team' as that enabled him to use his skills to a higher level and reaffirmed for him that his knowledge and skills were appreciated.

The fact that the patients really appreciate them and value the care they give did not go unnoticed, the AHSWs reported that they often know the patient's families and where the patient lives. They also recognise that they *'are making a massive difference to the patient'* and the patients often ask for them by name. One Band 4 therapy support worker explained that he used to run a falls class but the trust had closed this service down. The patients lobbied him to reinstate these sessions, which he does, as a volunteer, in his own time.

4.7 Education and training of allied health support workers

131 survey respondents provided details about their school education qualifications, many of them reported holding several qualifications and four reported they do not have any. 46% (n=60) hold fewer than five GCSEs or equivalent and the same number reported holding five or more GCSEs or equivalent. 31% (n=40) have an NVQ or BTEC equivalent qualification, 19% (n=25) hold at least two A-Levels.

Fewer respondents (n=115) provided information about attaining vocational or higher academic awards 44% (n=51) stated they hold an NVQ Level 3 or equivalent; 4% that they hold an NVQ Level 4 or 5. 30% (n=34) recorded that they hold a degree (see annex A17), 32 have a bachelor degree and two have a masters degree.

Nine of the respondents hold professional qualifications: four from the UK, three from Eastern Europe, one from India and one from the Philippines as listed below.

Diploma in Nursing –India
Physiotherapy- Lithuania
Physical Therapist - Philippines
Physiotherapy technician diploma - Poland
Physiotherapy technician diploma – Poland
Diagnostic Radiography UK
Nursing Diploma obtained UK
Occupational Therapy UK
Social Work, UK

This academic and professional profile was supported by AHSWs those who attended the focus groups, 17 stated what their first degree is (table 5), and seven reported that they hold a professional qualification from another country (5 physiotherapy, 1 radiography, 1 social work). One of these AHSWs has HCPC recognition to practice as a physiotherapist but has chosen to remain as a support worker for the time being.

First degree		Number of degree holders
Psychology		6
Nutrition	Food and nutrition	1
	Human Nutrition	1
	Nutrition	1
	Nutrition and Health	1
Sports	Sport and Exercise Science	1
	Sports Management	1
	Sports Therapy	1
Foundation Degree in Rehabilitation Therapy		2
Computer science		1
Public Health and Community Studies		1
Total		**17**

Table 5 First degrees held by focus group participants

The survey respondents were invited to give details about any specific support worker health related award that they have attained or were studying. 61 respondents provided details of the awards that they had passed 49 (80%) have an NVQ, 11 (18%) a foundation degree and 6 (10%) the Care Certificate (figure 8). Those who hold the Care Certificate are all from the same trust.

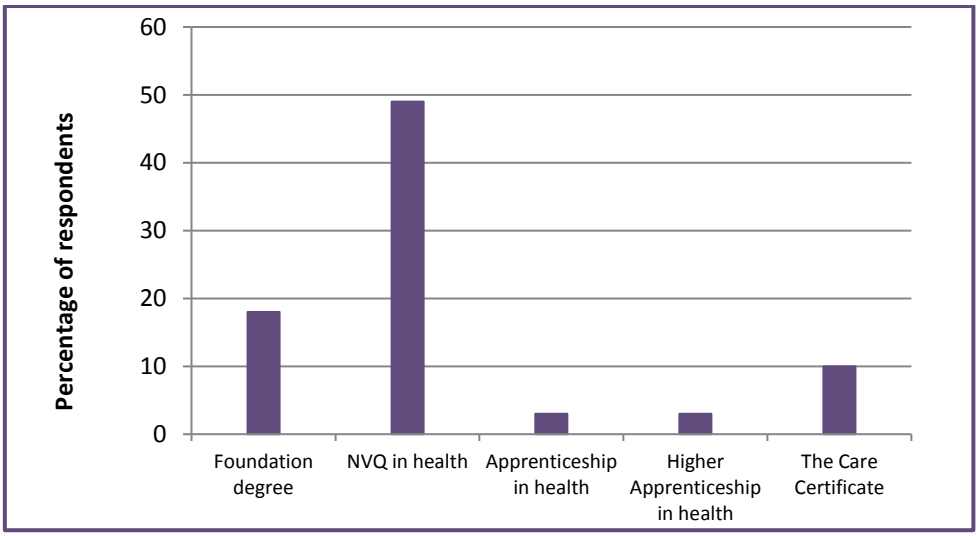


Figure 8 Health specific academic awards held by AHSWs

Only eight stated they are currently studying for one of these awards: five are studying the Care Certificate, two a foundation degree and one an NVQ.

When the survey was designed, it was assumed that the support workers would undertake the statutory and local mandatory training, an example is illustrated in box H and this assumption was correct as evidenced during the focus group discussions.

Box H Statutory and Mandatory Training

Conflict Resolution – All Staff
Equality, Diversity and Human Rights – All Required Staff
Fire Safety – All Required Staff
Health and Safety – All Required Staff
Infection Prevention and Control
Manual Handling All Required Staff
Patient Handling Staff
Resuscitation – Levels 1 – 4
Safeguarding Children – All Staff Groups
Safeguarding Adults All Staff Groups

Of the 96 respondents to the question about other staff development and training opportunities they had had since starting in the post, 24% (n=23) stated that they had not received any additional staff development. Most of the staff development that is available for the support workers is in-service training that is provided for qualified staff and they are invited to attend. A few reported attending a course on stroke care (n=6), the Trusted Assessor course (n=5), dementia training (n=4) and communication and cognition (n=4). A detailed list of the courses they have attended and the courses which currently exist are in annex A18. 39% (n==34) stated there wasn't any training available for them, as one therapy support worker explained: *'All TSW training was stopped and we are able to attend other teams' in-service sessions if we are interested in the topic'.*

Many of the participants in the workshops were not clear what level of formal education and training the support workers have had in the past. However, many pointed out that some of the support workers were qualified professionals from another country but were not eligible to register with the HCPC.

84 survey respondents commented on education and training that would help them be more effective in their current role, some offered more than one suggestion (see annex A19). 12 reported that they did not need any further education and training, 22 noted they would like to study for a degree leading to an AHP profession and 32 suggested a service specific course. Comments from the senior support workers can be summed up in the following quotes:

> *'Now working as a Band 4 there is no further progression available and I do not feel further training would change that'.*

> *'At present I feel that due to the number of years I have worked with the public and staff within my field I have gathered immense experience, however I also feel that there is always more to learn to benefit my role'.*

One of the current development opportunities for all support workers is the Care Certificate. Disappointingly only 16 of the AHSWs, who attended the focus groups, had been given the opportunity to study the Care Certificate. Although many of the AHPs had not heard of the Care Certificate those who had saw it as an opportunity to build an education and training framework for AHSWs.

The view held by those who had not been given this opportunity was that most of it was covered during induction and some reported that it was only offered to new staff. It was interesting to find that in one trust the experienced support workers are required to sign off the Care Certificate for new staff, even though they have not attended the Care Certificate course themselves.

The value of the Care Certificate was questioned by some of the participants who were not clear about the course. They suggested that the nursing focus made it less relevant to AHSWs and they proposed that the education and training departments of the trusts may wish to include some therapy specific skills.

When the focus group participants were asked about the education and training that they have received as part of their job 15 of them noted that they had only received the mandatory training as one Occupational Therapy Technician explained *'In our department there isn't hardly any education apart from the mandatory training'.*

The participants observed that there are very few courses available external to the trust and they appreciate the in-house development opportunities that the AHPs give them and are pleased to attend sessions that are arranged for the Band 5s. However, it was pointed out that '*on the job training is only useful if you are constantly doing that job'*.

They also commented on the paucity of formal education and training available, although one hospital has trained all their imaging assistants to cannulate the patients who are booked for a CT scan.

The most well regarded course is the two-day Trusted Assessor Training programme run by the Disabled Living Foundation (also mentioned in 4.3.4) which allows the support workers to prescribe equipment and adaptation under the supervision of an occupational therapist.

'The Trusted Assessor Training was a very good course and should enable me to free up some of the OT time'

Technical Instructor in a Community Stroke Team

There are some examples of best practice regarding education and training of support workers. The most frequently mentioned was the education and training that the dietetic support workers receive. Many of them evidence their competencies by completing a detailed training manual which has been based on the British Dietetic Association Assistant Practitioner Competency Framework[17] and the Dietetic Support Worker (DSW)and Assistant Practitioner Roles[18]. These competencies are readily available and have been adapted for local use.

An example of best practice of an education and training pathway for DSWs is illustrated in figure 9.

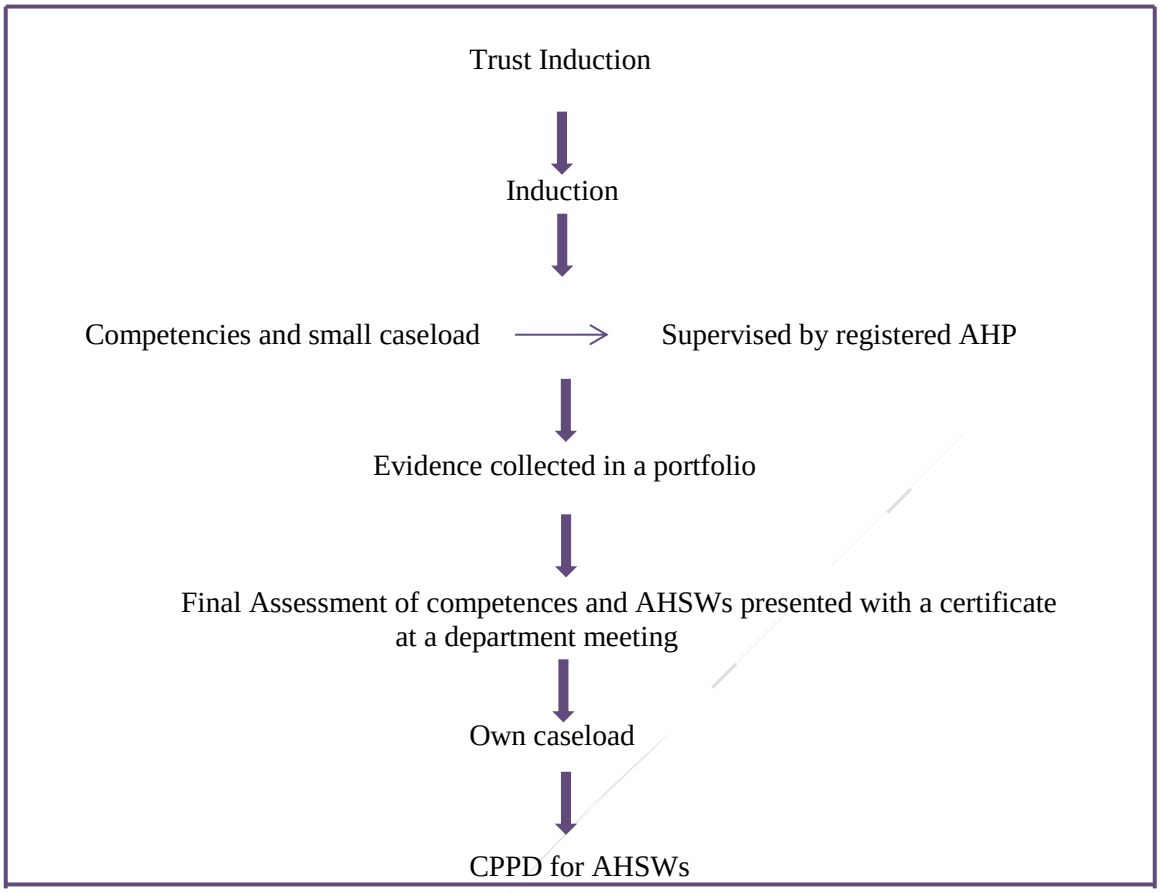


Figure 9 Example of an education and training pathway for Dietetic Support Workers

Early in the study it became clear that some of the support workers who attended the focus groups were worried about using medical terminology. The study team started to explore this further and to try and ascertain how the support workers, particularly those who write in patients' notes, learn the meaning of certain medical terms. Those who had been in the role for some time reported that when they started they had attended a trust based medical terminology course. However, those who have recently taken up their first post as an allied health support worker have not been given this opportunity. Many of them reported that they pick it up as they go along, others that they look on the internet to work out the meaning for themselves. None of the AHSWs, who attended the focus groups, reported being assessed on their knowledge or understanding of the terms.

This pattern of reducing the amount of training available to support workers is not only restricted to medical terminology. Others focus group participants, noted that over the past five years there has been a drop in the number of courses available to them and they recognise that even if courses were available they would not be released to attend them as there is no funding available.

Ten of the participants explained that they had completed a healthcare related NVQ Level 3 Diploma and one is currently studying for the NVQ Level 3 Diploma in Health and Social Care. Only seven of them mentioned studying a foundation degree.

In addition to formal sessions on medical terminology some of the participants suggested that it would be beneficial to have the following education, training or development programmes:

1. Specific clinical skills to help then in their day to day work
2. Basic anatomy
3. English language sessions
4. Basic leadership.

Some of the very experienced AHSWs noted that there used to be a course on terminology that was run by the trust education and training department especially for the support workers, but they reported they do not appear to be available anymore. The consensus is that it would be good to bring this course back. The other areas, that they recommended, could be included in any 'training package' are:

- Communication, because the support workers spend a lot of time with patients and their families whether they are imaging assistants or therapy assistants.
- Commonly treated clinical conditions.
- Movement disorders specifically for therapy assistants.
- Service specific basic clinical sessions.

Where there is a national programme of development for staff working in a service, such as the stroke service, the AHSWs who work in this service are also supported to attend the education and training sessions.

In contrast to the views held by the AHSWs the AHPs reported that there is a wide range of education and training opportunities available to the support workers. They did, however, report that education and training opportunities for AHSWs vary by team, and service, and range from the AHPs developing a formal training manual e.g. Dietetics or Foot Care based on professional body guidelines to nothing other than the mandatory training.

'After I had successfully completed the foundation degree course I was promoted from imaging assistant to assistant practitioner. Then after that I did the bridging course to gain access to the undergraduate radiography programme after finishing that I have just finished the bachelor's degree it has taken me four and a half years to qualify as a radiographer and I am very pleased. I am applying for a radiography post'.

Band 4 Assistant Practitioner in Imaging

Most of the AHPs advised that their department runs in-service programmes that the AHSWs are invited to attend, some are department wide and others are designed specifically for the support workers. They noted that the support workers really benefitted from attending sessions that are run for the newly qualified Band 5s. Where the departments have identified an AHP with responsibility for the education and training of support workers, the approach to development of this workforce is standardised (box I), and the registered staff reported having confidence in the support workers' knowledge and skills.

Box I Example of a one year in-service training programme for support workers

'Each support worker is allocated a supervisor who provides regular supervision and discusses the competencies with them. The in-service training programme for the training for this year goes through the competencies and covers a lot from the care certificate. It includes topics like dietetics, continence, and dementia. There are also sessions from speech and language therapists on communication. We've also got psychology sessions and occupational therapist sessions on cognition'.

Band 7 Physiotherapist

One of the challenges that the AHPs, with the responsibility for education and training for the AHSWs, have reported is '*how to maintain the competency of the AHSWs through a rolling programme'* (Band 7 Physiotherapist) as the support workers are not required to evidence their ongoing development in the same way as the regulated professional.

Another challenge for in-service training for support workers is trying to meet all their needs and keep their interest when their education background is so diverse. It is very likely that in one session there will be some support workers who hold a degree and others who have no formal qualifications. This scenario is difficult to manage particularly when the staff member delivering the training session does not hold any form of teaching and learning qualification.

The AHPs held differing views as to whether there was funding available to support the education and training of the AHSWs. Some believed the funding had been cut and others that their manager continued to support education and training opportunities for the AHSWs. Some departments enable, either through direct financial support or time off, the ambitious AHSWs to further their education and training, even though they acknowledge that this may mean they will eventually lose them to another organisation. However, for some of the AHSWs this approach is seen as the trust being a good employer and staff may well return at a later date as illustrated in the box J below.

Box J Example of to how retain the ambitious support worker through education and training

'There have been three physiotherapy assistants and two occupational therapy assistants that have come to work with us and then progressed to a qualified post in our Trust. They applied for the Band 5 post through the usual route. There was one particular young female assistant who came through this route. After working with us for a while left to get experience elsewhere and has now returned as a Band 6. From our perspective, this has been such a good investment in staff development.

Band 8 Occupational Therapist

Some of the participants expressed a concern about this workforce receiving no education and training as one Band 6 physiotherapist observed: 'as *a patient, I think I would be worried if someone was giving me therapy and they hadn't had any in-service training for a while or any real training. I would not be happy with that'*. This scenario is an obvious tension in the system when staff explain there isn't the capacity in the team to take a member of staff out of the service to formally teach the support workers or send them on a formal training programme. It is recognised that there is simply not enough training for the support workers who often mention it during an appraisal, nor is there any organisation that they can go to for their CPPD, and that the support workers are often left to search for training opportunities themselves.

How motivated the support workers are to attend programmes, study days or training sessions was another topic of discussion. Some of the AHPs reported that the AHSWs were very pleased with the training opportunities and formal training for specific roles. However, this was not everybody's experience as one physiotherapist explained we ask the support workers to give us a list of what they would really like to learn and what would help them do their job and what they find is that the support workers are very proactive when they have a guest speaker but if one of them is asked to present they are much less interested. Whether the support workers will attend training sessions also depends when the session is offered as one senior physiotherapist explained '*we run training programmes for the qualified workforce on a Saturday and allow the staff to take the time back when it is convenient to do so. Out of the eight support workers who were invited to attend a Saturday session only two of them said they were willing to do so, which is really disappointing'.*

Another example of this type of frustration in the system is where support workers are released to attend programmes of study, but then elect not to demonstrate their knowledge and skills in the clinical setting. As one lead therapist reported *'our trust supported six therapy support workers to attend a course at the University of Hertfordshire. This programme had an optional assessment at the end of the course only one out of the six chose to take the assessment'*.

However, an occupational therapist who is based in the community stated that '*there is no incentive for them to do more than they are doing. I think not having that training or support available makes them feel quite frustrated. It should also be reported that when support workers really want to attend a relevant training programme they are not allowed to go because of the pressures in the service'*.

The LAS takes a standardised approach to the education and training of the non-regulated clinical workforce. All their EACs have successfully completed the Qualifications and Credit Framework Level 4 Diploma for Associate Ambulance Practitioners[19]. This is comprised of approximately 20 weeks full-time initial in-house education and training and a one year consolidation in practice.

Once they have successfully completed this programme they have access to the in-house CPPD, the 24 hours of annual mandatory training, and workplace reviews by local clinical leads.

It is worth noting that the clinically facing support staff employed by the private ambulance sector also complete the same qualification.

4.8 AHSWs' career pathways

96 (69%) of the survey respondents reported they have healthcare experience prior to working in their current post. In table 6 below are examples of very different healthcare experience provided by six AHSWs prior to starting their current job. Many of the respondents have held similar posts in other organisations including as qualified professionals in another country.

A Band 4 Rehabilitation Assistant Rehabilitation assistant mental health trust (2 years) Therapy assistant NHS acute trust (2 years) Physiotherapy assistant NHS acute trust (12 years) Care home support worker (6 years)	**D Band 4 Assistant Practitioner Diagnostic Imaging** Phlebotomist (10 years) Radiography dark room technician (5 years) Radiographers assistant (10 years)
B Band 3 Rehabilitation Support worker HCA Band 3 Neuro rehabilitation ward (2 years) Support worker mental health ward (3 years) Support worker stroke ward (1 year) Support worker in an EMI care home (2 years)	**E Band 3 Rehabilitation Support Worker** 3 x physiotherapy inpatients practice placements of 5 weeks each as a physiotherapy student.
C Dietetic Support Worker Band 3 HCA District nursing (5 years) Social Therapist - Mental health (8 years) Bank HCA in hospitals (1 year) Nursing home assistant (2 years) Home care assistant (2 years)	**F Band 3 Ultrasound Helper** Ultrasound department (6 years) A&E department (6 years) Colorectal ward (4 years) Agency and bank (4years)

Table 6 Examples of profiles of AHSWs' previous healthcare work experience

61 % of 135 survey respondents reported that they are satisfied and 24% that they are very satisfied with their current job (figure 10). This fact is borne out in the response to their plans to stay in their post as illustrated in figure 11. Out of the 124 who completed this question 40 plan to stay until they retire

or for the foreseeable future and 36 are unsure or have no plans to leave their current employment. Only 26 stated they plan to leave within 12 months and one respondent was concerned that they may lose their job as it was subject to a change proposal.

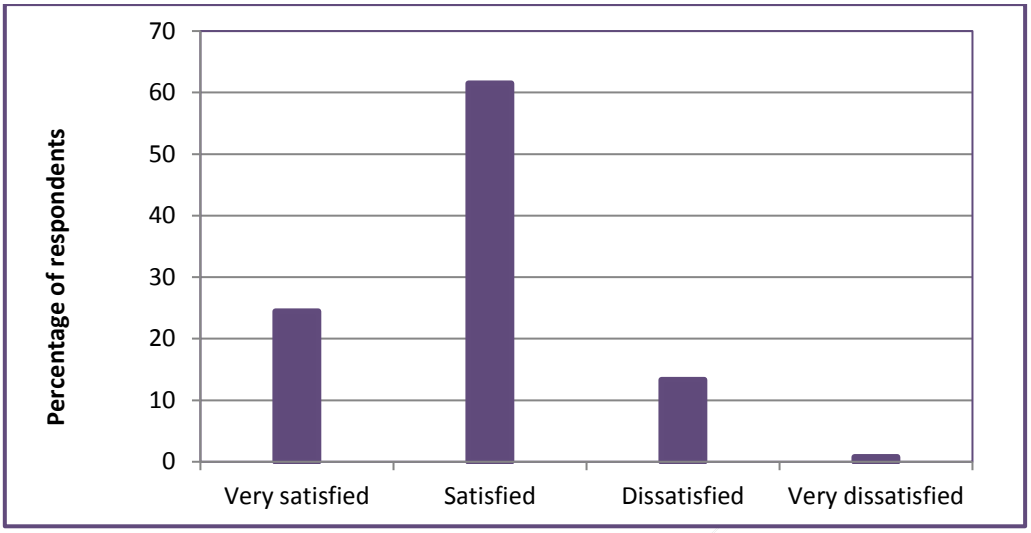


Figure 10 Reported job satisfaction levels

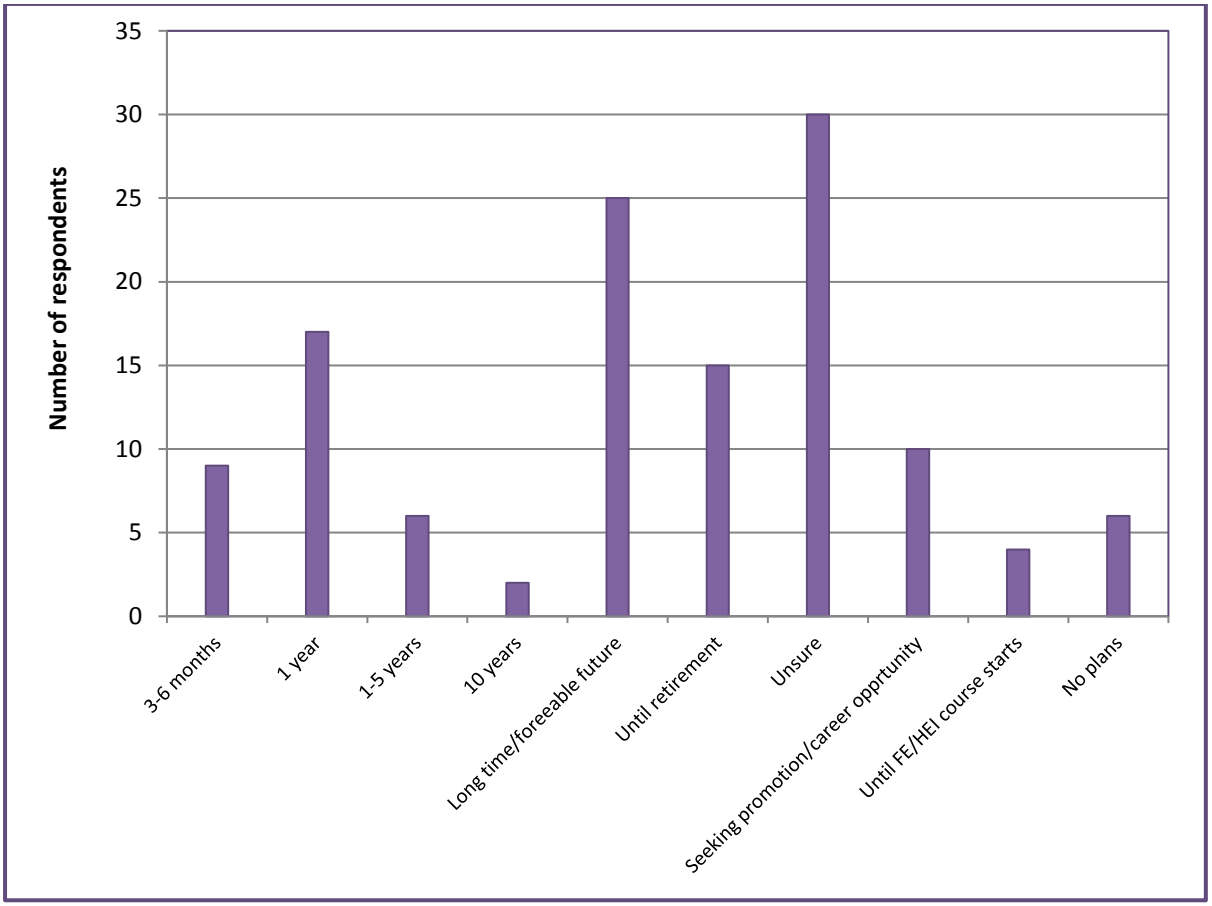


Figure11 Support workers plans to stay in the job

Anecdotally it is suggested that many of the AHSWs aspire to become an allied health professional. This assertion was tested as part of SWAP. The survey respondents were invited to comment on their aspirations to qualify as an AHP and if so in which profession. Their aspirations are evenly split with 46% (n=61) advising that they do wish to become an AHP. Of those who stated they wish to become an AHP 34% (n=21), want to become a physiotherapist, 28% (n=17) an occupational therapist and 16% (n=10) a radiographer (figure 12). These preferred professional careers are unsurprising as these are the service areas in which many of the respondents already work.

Some of those who stated they did not wish to become an AHP advised about an alternative career plan such as a move into healthcare management or return to nursing *'as there are so many more career opportunities in nursing'* than in allied health services.

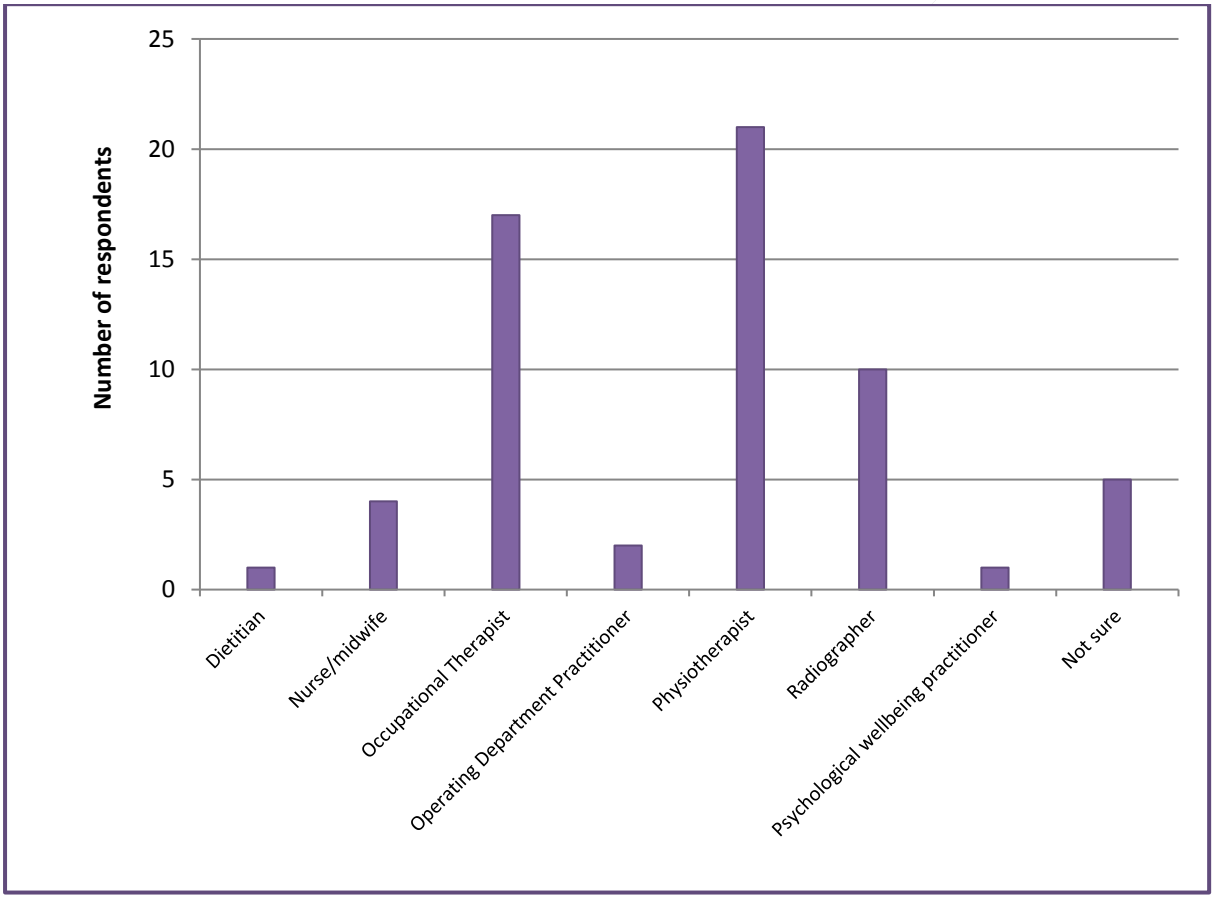


Figure 12 Professional career aspirations

4.9 Challenges associated with supporting this workforce

The AHPs who attended the workshops reported three challenges associated with supporting the AHSWs:

1. Allied health support worker team leadership
2. Career progression
3. Role boundaries

Allied health support worker team leadership

It is recognised that this workforce is not well represented, although the AHPs maintained that they are part of the team. There was differing views as to whether departments should consider appointing an AHSW team leader at Band 5 from amongst the support workers. Those opposed to this approach strongly argued that it would be unfair on the qualified Band 5s who had trained for a number of years to get to that position. However, those in favour of this approach argued that many of the support workers have a significant amount of experience and already perform above and beyond a Band 4. They also pointed out that as qualified clinicians they have many career opportunities available to them which are not available to the support worker.

Career progression

AHPs are very aware that there is normally a career progression ceiling for the support workers at Band 4. Most departments operate a very flat AHSW structure with the majority of this workforce employed at Band 3. At department level this results in either a very static workforce or a high turnover of staff. Both these scenarios were reported at the workshops. Some of the participants noted that although they train the support workers quite well there is no progression for them to go forward. This situation results in the more ambitious support workers seeking ways to train as a professional as there are currently very few supported routes to a registered qualification. Others seek work at another trust to gain different clinical experience.

Uniquely in an allied health service the LAS has very clear guidelines about progression from an EAC to a paramedic. Every year 54 EACs, in London, are given the opportunity to enter a two-year competitive entry, work-based programme that leads to HCPC registration as a paramedic.

Role boundaries

The third challenge that the AHPs raised is the sensitive issue about respecting role boundaries. The AHPs reported that some of the support workers, particularly those with long established experience don't fully understand their scope of practice and the legal boundaries within which they work. They suggested that the task a registered professional performs may appear to be very straight forward, however, the clinical reasoning behind the approach is what differentiates the professional from the support worker. A senior physiotherapist suggested that *'what it means to be a support worker should be debated'*.

4.10 Other topics discussed

Many different issues were raised by the AHSWs who attended the focus groups. This section documents the five issues that the study team thought were important to record.

1. Membership of professional bodies

Very few participants were aware that they could become members of a professional body and those who were commented that the cost of the membership was prohibitive on their salary and they were not sure what value it was to them.

2. Identity

Other than the very controversial topic about what they are called the issue about uniform was raised. Some departments have a uniform for their support workers but others give them whatever is available. This is an issue in departments where they still employ many locums.

3. Appraisals

The support workers commented on the fact that they have to have appraisals but they do not mean anything, because the evidence to date is that they will be doing exactly the same thing next year.

4. No previous experience in healthcare

Most trusts state that they require the support workers to have previous care experience. However, this requirement is not always followed through and some of the participants who had no previous care experience reported that they found being on an acute ward for the first time very daunting and quite scary particularly when they are expected to *'reassure the patient'.*

5. Cost of working in the community service

An unexpected finding from SWAP is that some of the therapy support workers employed in the community are financially disadvantaged because they are required to use their car. For example:

- difficulty in claiming back the cost of the mileage,
- the increase in the cost of hospital parking applies to them even though they may be part-time and seldom use the facilities,
- some trusts limit the annual mileage that will be refunded and if they have to exceed this then they have to pay the extra mileage themselves,
- support workers have to pay for the petrol and parking in advance. There used to be an advanced payment to help towards this expense but this has been stopped.

5.0 END OF STUDY WORKSHOP

The 40 workshop participants were invited to take part in a shift and share session and were asked to debate the following three topics:

1. If we were to standardise the job title of the allied health support workers what would we use?
2. What would a North Central and East London network for allied health support workers look like?
3. If trusts implemented an AHP support worker lead role what responsibilities would that post holder have?

Individuals were invited to comment; their thoughts were shared and the six table leads was asked to draw together the discussions and reach a table consensus (table 7) for each of the three topics.

Topic	Group consensus by table
Job title	1. Associate Practitioner, may add specific discipline + 'senior' 2. Support Worker/Assistant - profession specific e.g. Physiotherapy Support worker, Oncology Assistant 3. Allied Health Assistant with area specific term 4. Allied Health Support Worker or Assistant/Associate Practitioner 5. Allied Health Assistant 6. Allied Health Assistant
North Central East London AHSW network	1. Lead on education, hold a meeting during the year 2. On line and face-to-face training and education Peer support and network Feedback to trusts 3. Regional hub and spokes: advocacy for professional groups 4. Small network first before anything bigger, hub and spoke model 5. Hub and spoke 6. Networks modelled around stroke networks or CEPNs
AHSW lead role responsibilities	1. Training and CPD, promoting AHSWs 2. Training, competency, advocacy, improving inclusivity, raising profile of AHSWs 3. Representing and influencing, leadership 4. Link into apprenticeship route to release money. Trust wide voice. Representative, influencing, leadership 5. Link into apprenticeship route to release money Representative, influencing and leadership 6. Support worker to take a lead on competencies, training and career progression

Table 7 Outcomes of the group discussions

The animated discussions around the tables highlighted a willingness to engage in a debate about a more standardised title for this workforce, the perceived value of setting up a network of AHSWs and the importance of establishing a lead AHSW role in a service provider organisation.

As shown in the table the preferred title for this workforce is Allied Health Assistant, although there was extensive discussion about how this would be interpreted by those who use the service. It was proposed that an explanatory phrase/word could be added e.g. Allied Health Assistant (Therapy) or Allied Health Assistant (Imaging). It was agreed that more work needs to be done on naming the support worker.

There was a unanimous decision that a North Central and East London AHSW network should be established. The hub and spoke model was the favoured model. It was proposed that this network could take a lead on supporting the education and development for AHSWs.

The idea of having an AHSW lead in a trust was initially quite an obscure concept for many of the workshop attendees. However, once the discussions got underway they agreed that this would be an important development. It was proposed that this AHSW lead would be an experienced AHSW and would report to the senior AHP. They would be the champion for this group and lobby for education and training opportunities.

6.0 GENERAL DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

This study set out to

A. Raise the awareness of the local Allied Health Professionals (AHPs) with regards to current support worker policy landscape.
B. Map the current support worker roles in services delivered by AHPs.
C. Identify potential new roles for support workers and apprenticeships in these services.
D. Collate information about the current education, training and development opportunities for the allied health support workforce.

Before considering the findings of the study, it is important to consider the key limitations of the study itself that are relevant to the conclusions that are drawn, any key messages for stakeholders and the recommendations that are made.

There are three specific points to take into consideration. Firstly the study was limited to three Community Education Provider Network (CEPN) footprints: 1) Barking and Dagenham, Havering and Redbridge, 2) Barnet and 3) Tower Hamlets. However, two of these areas are relatively large and the third has a high population density so the findings can confidently be translated to other areas. Secondly the majority of participants are employed in the acute sector, although not exclusively, and work primarily in therapy or diagnostic imaging services. The total sample sizes of the workshops and focus groups were good at 66 and 99 respectively and there was a 57.5% response rate to the survey. On this basis, the study team are confident that the findings are reliable.

One of the strengths of the study was that the findings from the workshops and focus groups triangulated well with the data from the survey. A further strength of the study was that it became a vehicle to inform AHPs about the changing policy landscape of the support workforce.

When reading this chapter, it is important to take into account new policy developments in respect of support staff that have been introduced since this study started. The most significant are the formal launch of the Shape of Caring and the bedding down of the apprenticeship levy, both will have an impact on this workforce.

In this section, we discuss the findings from the study, identify the conclusions and set out the key recommendations. These recommendations relate solely to the SWAP study and the sequence of the recommendations does not indicate any relative importance of any particular recommendation.

There is no doubt that the contribution the AHSWs make to the service is significant and worthy of this greater understanding. HEE NCEL is to be commended for having the foresight to commission this study.

For each of the six recommendations there is a short narrative relating to the evidence gathered from SWAP that led to the recommendation; the specific recommendation, and how implementing this recommendation should lead to an improvement in the service.

6.1 Standardisation of Education and Training of the AHSWs

Evidence for standardisation of AHSW's education and training

Beyond the statutory and local mandatory training there is very little standardised education and training for the Band 3 and Band 4 AHSWs. Where it exists, it is normally delivered through an in-service model often designed for newly qualified staff. SWAP did not find any evidence of common standards of education and training for AHSWs. However, the study did uncover some excellent practice such as competency manuals for Band 3 AHSWs and the nationally approved programme that is followed by all Band 4 Emergency Ambulance Crew.

Currently this workforce is not required to demonstrate their knowledge and skills, although their level of clinical responsibility is increasing, as the demands on the service continue to rise. Furthermore, the contribution that the allied health workforce can make to achieve the Five Year Forward View and the Sustainability and Transformation Plans is increasingly being recognised.

39% of the respondents to the survey stated there wasn't any education and training available for them, they suggested the following courses would really help them to do their job:

1. Basic medical terminology
2. Basic anatomy
3. Basic leadership
4. English language sessions
5. Specific clinical skills to help then in their day to day work.

Recommendation 1

Trust education and training departments should work closely with HEE to standardise an approach to developing this workforce.

The benefit of a standardised approach to education and training of the AHSWs

A standardised approach to educating and training this workforce will safeguard against inappropriate assumptions about the knowledge and skills of this workforce. It will improve the baseline level of care provided to patients and guarantee that this workforce receives the development it is entitled to. It would also enable networking opportunities across this workforce in NCEL.

6.2 A bespoke Care Certificate for the allied health support worker

Evidence for designing an AHSW bespoke Care Certificate

The Allied Health Professionals who attended the workshops were pleased to learn about the Shape of Caring in particular the education route from the Care Certificate to a professional qualification. This study has highlighted how few AHSWs knew about the Care Certificate or have been enabled to study for this nationally approved award. However, those who have been given this opportunity recommended including AHSW specific standards as part of an AHSW Care Certificate. The AHPs and AHSWs considered that the current Care Certificate is nursing focused and primarily designed for Band 2 Health Care Support workers, and that it could be further developed to meet the general clinical needs of the AHSWs, in particular the therapy support workers.

Recommendation 2

Trust education and training departments should ensure all their allied health support workers have the opportunity to study the Care Certificate and that the learning outcomes are of direct clinical benefit to this workforce and the service they provide.

The benefit of designing an AHSW bespoke Care Certificate

A modified Care Certificate programme would enable the service provider organisations to not only deliver a key development programme for the AHSWs but to also ensure a baseline standard that the AHP community would recognise.

6.3 Review of the approach to employing and deploying the AHSWs

Evidence for reviewing the approach to employing and deploying the AHSWs

There are local variations as to how AHSWs are deployed. However, there are clear patterns of deployment within a particular type of service. For example, for support workers employed in the community, they reported undertaking a greater range of activities, than those working in the acute sector, and also that they may move from site to site during a working week. Whereas, those employed in the acute sector will be either static in one department (imaging), or work between a few specific wards (rehabilitation). Nonetheless, SWAP found some quite concerning evidence of scenarios where the skills of the experienced AHSWs are in such demand that they are *'running from ward to ward or site to site'*.

SWAP found considerable dissonance in the sector about what it means to be a Band 5 and that the top of the career ladder for an AHSW is firmly fixed at Band 4. Some of the newly qualified staff asserted that it would not be fair if the AHSWs were promoted to Band 5 as they had studied for a number of

years to reach this level. However, others asserted that they thought it was totally acceptable for some AHSWs to be employed at Band 5 and that they learnt a lot from some of the AHSWs.

This study highlighted the fact that what is so often forgotten is that 25-30 percent of this workforce already possesses a first degree and that this group could potentially make an even greater contribution to the service if they were supported to do so.

Recommendation 3

Human resources and organisational development departments of service provider organisations should review their approach to employing and deploying the allied health support workers and aim for parity of activity.

The benefit of having a more strategic approach to employing and deploying the AHSWs

A more strategic approach to employing and deploying the AHSWs across a service provider organisation would reduce the current inequity of employment practice that exists amongst this workforce. It would also enable the AHPs they work with to have a greater understanding of the AHSWs scope of practice and whether it is appropriate to impose an artificial ceiling at Band 5. Where AHSWs are underutilised in a service, this would be highlighted, and similarly where they are at risk of AHSWs practising outside of their scope, this would also be underlined, and any risks to quality of care minimised. This would also help inform the education and training requirements of AHSWs in service provider organisations.

6.4 Review of the environment in which AHSWs work

Evidence for reviewing the environment in which the AHSWs work

Throughout this study the AHSWs reported feeling quite isolated. The SWAP focus groups and the end of study workshop provided an opportunity for them to meet each other and to network. One of the three topics for discussion at the end of study workshop was what a local AHSW network would look like and it was suggested that a hub and spoke model could be used for establishing a NCEL AHSW network. There was enthusiasm and agreement for the development of a NCEL AHSW network and the benefits a network would bring.

It is unclear from this study as to how the AHSW voice is heard within an organisation or indeed within a department. Some departments have appointed a newly qualified AHP to assist and represent the AHSWs. Others have appointed a more senior AHP. However, one department has developed a senior AHSW role, which is well regarded by the AHSWs and the registered workforce, and is in line with international developments.

One of the topics for discussion at the end of study workshop was the concept of developing an AHSW lead in an organisation. The attendees were very supportive of this proposed initiative and suggested that this role would include the responsibility for raising the profile of this workforce in the organisation; having an overview of their education and training needs, and championing the service they provide.

An unexpected strand of evidence that emerged from this work is the extent to which AHSWs are valued by the AHPs, how undervalued the AHSWs themselves feel and what would help them to feel more valued. Many AHPs and AHSWs advised that this workforce is undervalued and their true contribution to the service is not always fully appreciated. The perception by some of the support workers, that they will be given the tasks and duties that other members of staff do not want to do, suggests to them that they are not truly valued. Nevertheless, not one of the AHPs suggested that the support workers are surplus to the team or the service. In fact, the majority value the contribution they make and trust them to do their work. Many suggested that the service would be more efficient if there were more of them.

Recommendation 4

Organisations and departments review the environment in which the allied health support workers are employed. With the aim of:

a. enabling them to network together both within and outside of the organisation;
b. enabling their profile to be raised;
c. ensuring the contribution, they make to patient care, is evidenced.

Benefit of reviewing the environment in which the AHSWs work

Strengthening the representation of the AHSWs within an organisation would enable the service provider to have even greater engagement with this workforce and to quantify the contribution they make to patient care.

Increasingly the healthcare sector is promoting networks of practice as a forum for sharing information, ideas and expertise with the aim of improving patient care. This proposed network would benefit the members, enhance their profile and promote the value of this significant workforce.

6.5 Consistent approach to naming the AHSWs

Evidence for developing a more consistent approach to naming the AHSWs

There was extensive debate, throughout the whole of the study, about the naming of the AHSWs. This is a highly sensitive issue but one that must be addressed for the benefit of the patients. What this workforce is called is often left to the local teams and even the AHSWs themselves. Within the scope of SWAP, it is suggested that it should be a priority for organisations. For example, between the 99 AHSWs who attended the focus groups they used a total of 25 different titles.

Recommendation 5

Organisations should adopt a more consistent approach to naming the allied health support workforce.

The benefit of adopting a more consistent approach to naming the AHSW

The benefits of a more consistent approach to naming this workforce are threefold: firstly, the patients would be less confused as to who the member of staff is, secondly other staff in the organisation would more readily recognise this workforce and thirdly the organisation would have a clearer record of the numbers of AHSWs employed in the service and which department they are employed in.

6.6 Increasing professional body support

Evidence for increasing professional body support for AHSWs

Very few of the AHSWs, who contributed to SWAP, reported belonging to any professional body. This was a disappointing finding and one that should be further understood. Those AHSWs who commented on the professional bodies suggested that the fees were prohibitive and the information not very accessible. They were not clear what level of support is available and if any education framework exists. Even those professional bodies which have robust structures in place to provide advice and help to the AHSWs were not commented on by the workforce who engaged in SWAP.

Recommendation 6

All Allied Health Professional Bodies should consider reviewing their approach to supporting the allied health support workers.

The benefit of increasing professional body support for AHSWs

Both the AHSWs and the professional bodies would benefit from a refreshed approach to engaging with this workforce. The professional bodies would raise the profile of their work and potentially increase their membership and the AHSWs would have a body to liaise with, for professional guidance and support, which according to contributors to SWAP would be a welcome development.

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8.0 Appendix

8.1 This section provides details of the number, band and deployment of allied health support workers in the three North Central and East London CEPNs collated from the returned proforma.

CEPN	Service	Band	Number
Barking and Dagenham, Havering and Redbridge	Diagnostic Imaging	4	6
		3	37
	Dietetics	3	2
	Foot care	3	3
	Radiotherapy	3	2
	Therapy/ Rehabilitation	4	12
		3	45
		2	4
Barnet	Diagnostic Imaging	4	2
		3	2
	Dietetics	3	2
	Therapy/ Rehabilitation	6	0.5
		5	1
		4	17
		3	39
		2	1
Tower Hamlets	Diagnostic Imaging	4	3
		3	15
	Dietetics	4	1
		3	6
	Therapy/ Rehabilitation	4	10
		3	22
	Stroke Care	3	16

8.2 Online survey for AHSWs

The survey was completed by 143 Allied Health Support Workers. The breakdown of responses by department is as follows:

Department	Number	Percentage
Accelerated Discharge	3	2.1
Community Respiratory Service	2	1.4
Diagnostic Imaging	29	20.3
Dietetics	5	3.5
Integrated care	1	0.7
Occupational Therapy	10	7.0
Physiotherapy	6	4.2
Podiatry	3	2.1
Radiotherapy	2	1.4
Rehabilitation	45	31.5
Speech and Language Therapy	3	2.1
Therapy	32	22.4
Others	2	1.4

Survey questions

1. Which organisation do you work for?

2. Which department do you work in?

3. What is your job title?

4. Please tick below which Band you are employed on.

- Band 2
- Band 3
- Band 4
- Band 5

5. Do you work full-time or part-time?

6. How many hours per week do you work and what are your daily hours?

7. How long have you been in this post?

8.Please state the clinical professional (or professionals) that you report to and also give their Band of employment.

9. For each of the members of staff listed in Q8 state the amount of time you work with them.

10. If the person who supervises you on a day to day basis is not identified in Q8 above please give their details.

11. How much time do you spend with the supervisor identified in Q10?

12. Do you have a rotational job or are you static? Please tick the most appropriate boxes

- I do not rotate, I work in a static post
- I work in a rotational post
- I rotate every 4 months
- I rotate every 6 months
- I rotate every 8 months

13. If you do not rotate would you like to?

14. Please list the key tasks that you undertake in this job.

15. Have you worked in a healthcare setting before?

16. Please list the healthcare jobs that you have had and the length of time you were in that post.

17. Which of the following qualifications do you hold?

- 1 - 4 O levels / CSEs / GCSEs (any grades), Entry Level Foundation Diploma, NVQ Level 1, Foundation GNVQ, Basic Skills
- 5+ O levels (passes) / CSEs (grade 1) / GCSEs (grades A*- C), School Certificate, 1 A level / 2 - 3 AS levels / VCEs, Higher Diploma
- NVQ Level 2, Intermediate GNVQ, City and Guilds Craft, BTEC First / General Diploma, RSA Diploma
- Apprenticeship
- 2+ A levels / VCEs, 4+ AS levels, Higher School Certificate, Progression / Advanced Diploma
- No school qualifications

18. Which of the following qualifications do you hold?

- NVQ Level 3, Advanced GNVQ, City and Guilds Advanced Craft, ONC, OND, BTEC National, RSA Advanced Diploma
- Degree (for example BA, BSc), Higher degree (for example MA, PhD, PGCE)
- NVQ Level 4 - 5, HNC, HND, RSA Higher Diploma, BTEC Higher Level
- Professional qualifications (for example teaching, nursing, accountancy)
- No vocational / higher qualifications

19. If you hold a degree please give the title of the degree.

20. If you hold a health professional qualification please state the qualification and the country where it was obtained.

21. Do you hold any of the following?

- A foundation degree specifically for healthcare support workers
- NVQ in health (any level)
- An Apprenticeship in health
- A Higher Apprenticeship in Health
- The Care Certificate

23. Other than the statutory training that healthcare providers are required to deliver, what staff development and training opportunities have you had since you started this post?

24. What education and training opportunities do you currently have?

25. What education and training would help you do your job even more effectively?

26. How satisfied are you with your job? Please tick one of the following.

- Very satisfied
- Satisfied
- Dissatisfied
- Very dissatisfied

27. How long do you plan to stay in this job?

28. Do you aspire to becoming an Allied Health Professional in the future?

29. If yes what Allied Health Professional do you aspire to become?

30. If you have an alternative healthcare career plan please provide an outline.

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